An-Najah National University
Faculty of Graduate Studies

IMPACT OF ADVERSE CHILDHOOD EXPERIENCES AND TRAUMATIC EVENTS ON MENTAL HEALTH AMONG ADULTS IN THE NORTHERN TRIANGLE

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Dedication

To my dearest family,

You have been the light that guided me through every step, and the support without which I would not be who I am today. In every moment of weakness, you were my strength. In every moment of doubt, your love was my only certainty.

You taught me that nothing is impossible with will and prayer, that self-belief begins at home, and that dreams planted in the soil of love are destined to blossom.

To you alone, who stood quietly by my side, who encouraged me with few but meaningful words, who endured my stress and absences—

To you who asked for nothing but my well-being.

This thesis is dedicated to you, with all my heart. It is the fruit of our shared journey, and a lasting expression of my gratitude.

Acknowledgment

At the beginning, I thank God, Lord of the Worlds, who created and guided the steps, so this work came out with his help and success, I praise him greatly in the beginning and the end, and based on his saying, peace be upon him, “He who does not thank people does not thank God.” I extend my sincere thanks and gratitude to my supervisors for this thesis, Prof. Mohammed Shaheen, who gave me a lot of his time, and his generosity, high morals, and distinctive style in following up me on the thesis which was the greatest impact in helping to complete it. I also extend my sincere thanks and gratitude to Dr. Mohammad Marai for his fruitful comments, and to the faculty members in the Master of Clinical psychology program at An-Najah National University, each in his name and title, for the abundance knowledge I gained from them and their rich experience until I reached what I am upon, so may Allah reward you on my behalf with the best reward.

Declaration

I, the undersigned, declare that I submitted the thesis entitled:

IMPACT OF ADVERSE CHILDHOOD EXPERIENCES AND TRAUMATIC EVENTS ON MENTAL HEALTH AMONG ADULTS IN THE NORTHERN TRIANGLE

I declare that the work provided in this thesis, unless otherwise referenced, is the researcher's own work, and has not been submitted elsewhere for any other degree or qualification.

Student's Name: Hiba Mahajni

Signature: hiba

Date: 11\9\2025

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Abstract

This study examines the impact of Adverse Childhood Experiences (ACEs) and traumatic events on mental health among adults in the Northern Triangle region. The study aims to understand the lived experiences of trauma survivors, identify barriers to mental health care access, and explore coping mechanisms and resilience factors. The study employs a phenomenological research design, collecting data through semi-structured interviews with 23 participants from three mental health centers in the Northern Triangle. All participants have documented exposure to ACEs and are receiving mental health services for trauma-related symptoms. The study reveals universal exposure to multiple forms of childhood trauma, with 100% of participants experiencing physical and emotional abuse, 39.1% reporting sexual abuse, and 91.3% experiencing neglect. Mental health impacts are severe and pervasive, with 100% prevalence of anxiety disorders, 100% experiencing depression, 87% reporting sleep and eating disorders, and 69.6% having suicidal ideation. Participants provide unanimous support for expanding mental health centers (100%), implementing school-based mental health programs (95.7%), launching community awareness campaigns (91.3%), and providing teacher training (87.0%). Additional recommendations include developing home-based services (82.6% support) and establishing financial support systems for treatment access (78.3% support). The study emphasizes the urgent need for culturally sensitive, trauma-informed interventions that address systemic barriers while building on community strengths and resilience factors.

Keywords: ACEs, traumatic events, mental health, Northern Triangle, Palestinian minority, phenomenological research, help-seeking barriers.

Chapter One

Introduction and Theoretical Background

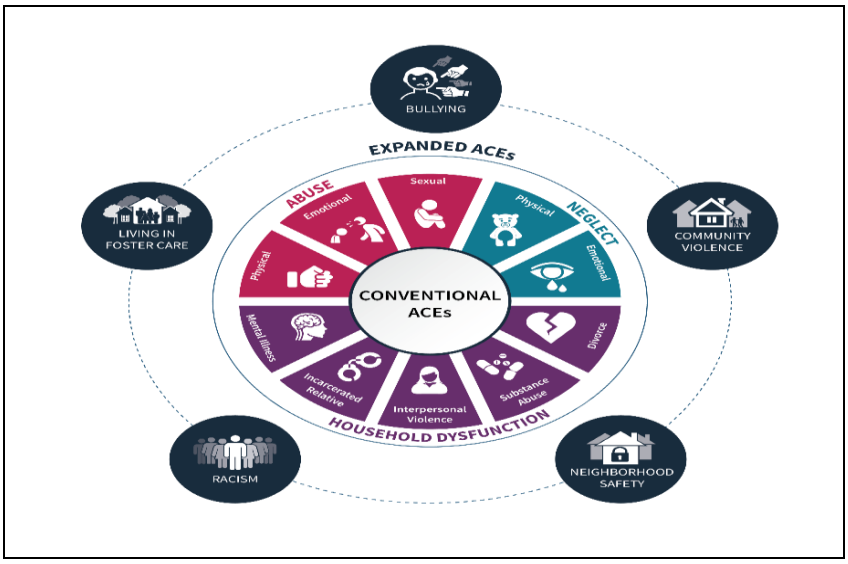
1.1. Introduction

Childhood represents a pivotal phase for emotional and psychological maturation; nevertheless, numerous individuals encounter adverse childhood experiences (ACEs) such as abuse, neglect, and violence. Such experiences may precipitate enduring mental health disorders, including anxiety, depression, post-traumatic stress disorder (PTSD), and substance use disorders. Empirical research underscores the persistent ramifications of ACEs on overall well-being, heightening susceptibility to chronic health conditions and diminishing quality of life. Physiological stress responses frequently mediate these adverse effects.

Within the context of the Northern Triangle, cultural, economic, and sociopolitical dynamics significantly influence both the prevalence of ACEs and the accompanying support systems. This investigation seeks to elucidate how these factors shape adult mental health by identifying prevalent ACEs, evaluating their psychological repercussions, and analyzing sociocultural and economic moderating elements. The independent variables include various types of ACEs and traumatic events, while the dependent variable focuses on the mental health of adults in this region.

Figure 1

Types of ACEs



ACEs refer to different kinds of traumatic experiences that happen to children. Studies show these early experiences are connected to various problems that people face as adults. These experiences are diverse and can include different forms of abuse, neglect, and household dysfunction. Understanding the types of ACEs is crucial for developing targeted

Source: https://nhttac.acf.hhs.gov/soar/eguide/stop/adverse_childhood_experiences

interventions and prevention strategies. The following sections illustrate types of ACEs identified in the literature, as shown in figure (1).

Abuse

Physical Abuse: Includes the use of physical force against a child that results in harm. It is a significant precursor of various negative outcomes, including substance use disorders and mental health issues (Bebere & Vrublevska, 2023; and Hines et al., 2023).

Sexual abuse: Any sexual act committed against a child. A previous work by Agrawal et al. stated that sexual abuse is linked with psychological and mental health disorders in young adults (Agrawal, et al., 2024).

Emotional Abuse: Psychological abuse is a type of ACE that affects the child's psychological well-being and development. Studies show that sexual abuse may appear in verbal ways, manipulative behaviours, and neglect of emotional needs. In fact, children who experience psychological abuse have internalizing symptoms (anxiety and depressive disorders). On the other hand, adolescents are also affected, as this issue is not limited to children. These experiences make it difficult for adolescents to control their emotions (Trevethan & Francis, 2025).

Neglect

Emotional Neglect: It happens when children do not receive affection, love, and emotional support. This type of neglect leads to mental health problems and causes psychological distress (Agrawal, et al., 2024).

Physical Neglect: When caregivers fail to provide basic physical needs like food, shelter, and medical care. Physical neglect can lead to long-term developmental issues for them (Merrin, et al., 2023).

Household Dysfunction

Parental Substance Use: Children who live with parents who consume drugs or alcohol are more likely to use substances during adolescence and adulthood (Hines, et al., 2023; Bebere & Vrublevska, 2023).

Parental Mental Illness: When parents have mental health problems, their children are more likely to have mental health issues too later in life (Agrawal, et al., 2024; Hines, et al., 2023).

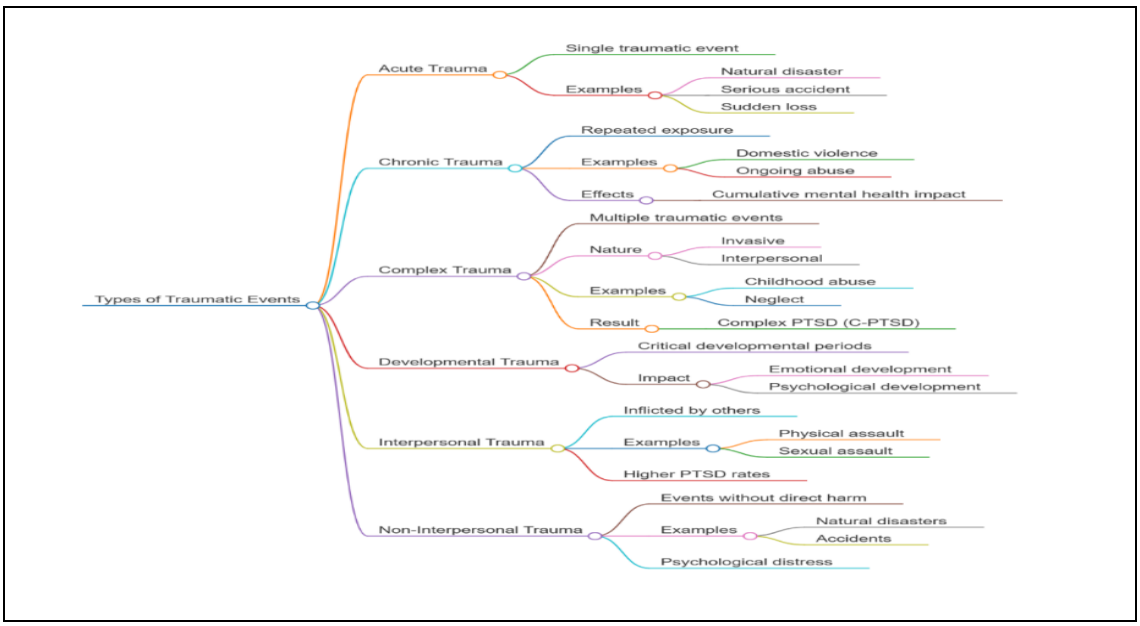
Parental Separation or Divorce: Divorce is one type of ACE that affects a child's emotional, social, and cognitive development. Research shows that children who experience parental divorce face higher risks of emotional distress. These children would feel isolated, and these relationship problems can continue into adulthood (Curtis, et al., 2024).

Domestic Violence: When children see violence between parents. This experience can cause behavioral problems like bullying and substance abuse (Bebere & Vrublevska, 2023; Merrin, et al., 2023).

Parental Criminal Behavior: Having a parent involved in criminal activities can expose children to a range of negative influences and increase the risk of future criminal behavior mother (Hines, et al., 2023).

Figure 2

Types of Traumatic Events



Source: by researcher.

Traumatic events, often referred to as potentially traumatic events (PTEs), encompass a range of experiences that can lead to significant psychological distress and are categorized into various types, including physical abuse, emotional neglect, community violence, and non-interpersonal events such as accidents and natural disasters.

There are many types of Traumatic Events, as shown in figure (2), such as:

Acute Traumatic Events: These include sudden, unexpected incidents such as natural disasters, accidents, and violent assaults. For instance, facial traumas from motorcycle accidents are highlighted as significant public health issues due to their sudden and severe nature (Pagliarini & Lima, 2023).

Chronic Traumatic Events: These involve prolonged exposure to stressors, such as ongoing abuse or discrimination, which can culminate in psychological harm. The phenomenon of microtrauma, which denotes the aggregation of less severe yet persistent stressors, is an example of chronic trauma (Mlostek, 2023).

Non-Interpersonal Traumatic Events: These refer to occurrences that do not involve direct human interaction, such as natural disasters or accidents. Empirical evidence suggests that individuals afflicted with eating disorders may encounter elevated incidence rates of non-interpersonal traumatic events like illness and injury (Johnsen, Nielsen, & Telléus, 2024).

The construct of mental health is profoundly embedded in the historical evolution of the 'psy' disciplines, which have significantly influenced our comprehension of human interiority and the self through both scientific inquiry and therapeutic modalities. Mental health goes beyond the absence of mental disorders; it encompasses the ability to enjoy life, maintain personal relationships, and adapt to change and adversity (Bruun, 2023; Kang, Steffens, Pineda, Widuch, & Malvaso, 2023).

The researcher conducted this study in the Northern Triangle. It is a home to about 300,000 Arab residents in Israel. Recent studies show that around 45% of this population is under the age of 18 (Kaim and Saban, 2023). The socioeconomic situation in the Northern Triangle is shaped by cultural, political, and economic factors. In addition, the region has many challenges, but also has a rich heritage and strong community connections. Therefore, the researcher believes that when there is good mental health

support, it can reduce socioeconomic disparities, improve residents' quality of life, and create a stable society (Sokar, Greenbaum, & Haj-Yahia, 2022).

The Northern Triangle region offers a unique setting for studying ACEs and their effects on adult mental health. This study looks at how cultural practices, economic inequalities, and sociopolitical pressures in the region affect ACE rates and available coping resources. Based on her professional experience working with people affected by ACEs, the researcher studies the connection between ACEs, traumatic events, and adult mental health outcomes. She wants to fill knowledge gaps and improve intervention strategies, especially for Arab communities in the Northern Triangle. Earlier research shows that ACEs, such as physical, emotional, and sexual abuse, neglect, and family problems, can cause mental health problems later in life, including depression, anxiety, and PTSD. For example, a study of pregnant Palestinian refugee women found that 88% had experienced at least one adverse childhood experience. Women who experienced four or more types of ACEs were 3.28 times more likely to develop depression during pregnancy (Horino et al., 2023). Since adults in the Northern Triangle region often experience ACEs and other traumas, studying how these events affect their mental health is important. Understanding this connection is essential for creating specialized treatments and support systems that meet the specific needs of this population. This study aims to fill a research gap by examining how childhood trauma and ACEs relate to adult mental health in the Northern Triangle. It also seeks to determine how well these experiences predict mental health outcomes and to identify other factors that could help improve mental health treatments for this population.

1.2 Theoretical Background

This study uses several theories, which can explain how difficult early life experiences can cause mental health problems like depression, anxiety, and PTSD. Hence, the researcher aims to build a strong background to understand how negative experiences and trauma can create psychological effects in this specific social and political environment.

1.2.1. Adverse Childhood Experiences ACEs

ACEs such as physical, emotional, and sexual abuse, family problems, neglect, and other childhood traumas happen in any place and all over the world. Studies show that many people have experienced at least one ACE. For example, a study in the USA used data

from the Behavioral Risk Factor Surveillance System and found that over 60% of adults have experienced at least one ACE at some point in their lives. Additionally, 17% had four or more ACEs (Schoeneck & Wong, 2024). This is to say that the ACEs are linked to risks of negative life events (NLEs) in adulthood like mental health issues and unemployment (Eftedal, Johansen, Risco, & Kollerud, 2024).

1.2.1.1. Definition of ACEs

ACEs: A standard definition of ACEs is "are traumatic events that happen between ages 1 and 17. These negative experiences affect a child's brain and health as they grow into adults. ACEs can lead to mental health or chronic health conditions. Lifelong treatment and management of ACEs help a person lead a fulfilling life[1]."

ACEs: refer to "some of the most intensive and frequently occurring sources of stress that children may suffer early in life. Such experiences include multiple types of abuse; neglect; violence between parents or caregivers; other kinds of serious household dysfunction such as alcohol and substance abuse; and peer, community, and collective violence[2]."

ACEs: previous work defined it as "potentially traumatic events occurring before age 18 that can have lasting negative impacts on health and well-being" (Swedo et al., 2023).

ACEs: Hines et al.'s definition is "classically defined as physical abuse, sexual abuse, emotional abuse, emotional neglect, bullying, parental substance use or abuse, violence between parents, parental mental health problems or suicide, parental separation, or a parent convicted of a criminal offense" (Hines, et al., 2023).

The researcher believes that ACEs are traumatic events that happen to children from birth to 18 years old. These include many different experiences that can seriously affect a person's mental and physical health for years. Some examples are different types of abuse, neglect, and problems in the home, like seeing domestic violence, having parents with mental illness, or substance abuse. The idea of ACEs has been important for learning how childhood experiences affect people's mental health problems, drug and alcohol use, and long-term illnesses.

[1] https://my.clevelandclinic.org/health/symptoms/24875-adverse-childhood-experiences-ace, 23/1/2025.
[2] https://www.who.int/publications/m/item/adverse-childhood-experiences-international-questionnaire-(ace-iq) 23/1/2025.

1.2.1.2. Theories Related to ACEs

Many theories have been suggested to help us understand what ACEs mean, how they work, and what their lasting effects are:

Diathesis-Stress Model: This Model explains how mental disorders develop. It says that they happen when someone who is already likely to have a problem (diathesis) faces stressful things in their environment. Research supports this idea in different situations, for example, in multiple sclerosis (MS), difficult childhood experiences can make people more sensitive to stress, which can cause the disease to start (Fauver et al., 2024. In major depressive disorder (MDD), the model connects brain grey changes to stressful events. It usually happens in people who have experienced childhood maltreatment (Thomas-Odenthal et al., 2024). It also explains psychosis by showing how personality traits related to brain connections can make people more likely to develop stress-related problems (Zwir, et al., 2023).

General Strain Theory (GST): This is a way of looking at how people react to stress, which can lead to bad feelings and possibly bad behavior. It can be used to understand financial behavior and mental health. For instance, Khan et al. (2023) used GST to study how economic problems affected financial behavior in India after COVID-19; they found that negative feelings like loneliness and depression explained how economic hardship and behavior in lower were connected in lower and middle-income groups were connected. Similarly, Van Wyk (2023) used GST to examine how (ACEs) and violent or suicidal behaviors were connected in adolescent males, focusing on the role of emotions.

The biopsychosocial model: This model includes biological, psychological, and social factors. It gives us a full way to understand and deal with different health problems, including the effects (ACEs). In the realm of developmental psychopathology, ACEs are recognized as significant predictors of mental health issues, with research underscoring the importance of considering the timing and multidimensional nature of these adversities in developing effective prevention and intervention strategies (Hawes & Allen, 2023). The model can be used to learn about how boys and girls develop thinking skills differently. Family factors, like money and mother's education affect how well kids do in math (Bizopoulou, 2023).

Polyvagal Theory (PT) and ACEs both help us to understand how early stress affects how some grows. PT, created by Porges, says our nerve system changed to help us connect with others. It uses "second vagal nerve" to reduce defensive reactions, which make it easier to socialize (Doody et al., 2023). ACEs, like abuse and violence at home, greatly affect mental health throughout life. This shows we need complete models that understand all parts of these experiences and when they happen during development, as pointed out by Nunez (2023) and Hawes & Allen (2023).

New studies on the integrated dimensional model of (ACEs) say that different types of ACEs affect how someone functions later in life in different ways. This shows we need to understand their specific details and situations (Perry et al., 2023). This fits with Integral Theory, which tries to combine different ideas to fully understand complex issues (Nunez, 2023). Also, the ACES guide says it's important to pick the right theory to understand the details of ACEs (Zomeren, 2023). By using Integral Theory with the ACES framework, researchers can tackle ACE complexity more effectively, leading to better prevention and intervention strategies in developmental psychopathology (Hawes & Allen, 2023).

Attachment theory: says that how well you connect with your caregivers early in life affects your emotional and social growth as you get older. Unsafe attachment styles, which often come from ACEs, can cause bad emotional traits. They are also linked to a higher chance of having personality disorders, like as borderline personality disorder (Fan, 2023). Studies show that ACEs can mess with the development of secure attachments. This leads to unsafe attachment styles that affect how ACEs relate to mental health problems like depression (Ye & Zhang, 2023). This problem gets worse with poor emotion control strategies, which also affect how ACEs impact depression. This suggests a complicated connection between attachment, emotion control, and mental health.

Also, attachment styles affect how you manage your emotions in your mind. Unsafe attachment styles are strongly linked to less helpful ways of controlling emotion, especially in women (Delgado et al., 2023). Attachment affects emotional and psychological results not just when you are a child, but also when you are an adult. It affects your relationships and how you react to stress (Codou et al., 2023). Secure attachment styles, whether in your personal life or at work, are linked to lower stress and better emotion control. This shows how secure attachments can protect you

1.2.2. Traumatic Events

Traumatic events are surprisingly common across the globe. Research indicates that approximately 70% of individuals worldwide have experienced at least one traumatic event in their lifetime. This statistic highlights the widespread nature of trauma and its potential impact on mental health.

In the United States, approximately 70% of adults, equating to around 223.4 million individuals, report experiencing trauma at least once in their lives. Over 33% of youths also report exposure to traumatic events. This issue is particularly pronounced in low- and middle-income countries (LMICs), where many adolescents face multiple ACEs linked to risky behaviors like violence and substance use, especially among boys (Maurya & Maurya, 2023). A systematic review highlights that children often encounter trauma from natural disasters, accidents, and abuse, significantly affecting their mental health (Chien & Lau, 2023). Additionally, a Global School-based Student Health Survey reveals a strong link between bullying victimization and suicide attempts among adolescents, with sleep deprivation and body mass index as key mediators (Bao, et al., 2023).

In conflict zones like Gaza, war-related trauma adversely impacts physical health, particularly blood pressure issues among middle-aged and older adults, highlighting the necessity for targeted health interventions in these environments.

1.2.2.1. Definition and Impact of Traumatic Events

Traumatic events are experiences that overwhelm an individual's ability to cope, often involving actual or threatened serious injury or death (Pop-Jordanova, 2022). These events are common, with up to 45% of new mothers reporting traumatic childbirth experiences (Pop-Jordanova, 2022). Traumatic events can lead to various mental health issues, including PTSD, anxiety, and depression (Stanisławska-Kubiak, et al., 2023).

Traumatic events are experiences that greatly threaten to a person's physical or mental health, often causing long-term negative effects. These events can be divided into two main types: interpersonal and non-interpersonal. Interpersonal traumatic events include things like abuse, assault, and other forms of violence. These can cause serious mental health problems like PTSD. They are often discussed when talking about sexual abuse and genocide, as seen in the stories of victims who suffer long-lasting trauma from these events (Hayati, 2023; and Furqan et al., 2023). Non-interpersonal traumatic events

include things like natural disasters, accidents, and illnesses. these are common among people with eating disorders, meaning they experience these events more often than people without eating disorders (Johnsen, Nielsen, & Telléus, 2024).

The idea of microtrauma, which involves repeated exposure to less intense but ongoing stressors, also helps us understand trauma. It shows how complex and subtle trauma's impact on mental health can be (Mlostek, 2023). Traumatic events can occur at any stage of life and affect individuals across different demographics, as evidenced by the widespread impact of the COVID-19 pandemic on university students, which led to significant mental health challenges and a high prevalence of PTSD symptoms (Carvalho & Almeida, 2023). Likewise, traumatic events like war and military attacks, such as the invasion of Ukraine, have major psychological effects on affected people involved. This means we need complete plans to help restore their psychological health (Rybinska et al., 2023). In children, events like natural disasters and abuse can cause many problems, such as disruption in their daily lives and bad health. This shows that we need special programs to help them recover and grow (Chien & Lau, 2023).

Also, traumatic events like motorcycle accidents can cause serious physical injuries and emotional suffering. This further shows how different kinds of trauma can be and how much they affect people's lives (Pagliarini & Lima, 2023). In general, traumatic events include a wide range of experiences that can lead to major psychological and physical problems. Because of this, we need to understand trauma well and use careful methods for treatment and support.

Research by Kihas et al. (2024) showed that dangerous drug and alcohol use is common among young people. While substance use disorder (SUD) and PTSD often happen together in treatment centers and have been well-studied in adults, there is not enough research on young people in regular communities. The study revealed that drug and alcohol use/SUD, and trauma experiences/PTSD are common among young people in community settings. The research found that young people who use substances are more likely to have gone through traumatic events, especially sexual and physical trauma, and to develop PTSD.

Psychological Impact of Traumatic Events

PTSD: Traumatic events can lead to PTSD, characterized by symptoms such as flashbacks, anxiety, and emotional numbness. The COVID-19 pandemic, for example, has been identified as a traumatic event that significantly impacted the mental health of university students, leading to a high prevalence of PTSD symptoms (Carvalho & Almeida, 2023).

Complex PTSD: This condition happens when someone is exposed to trauma for a long time, like constant abuse or war. It includes extra problems like emotional dysregulation and interpersonal difficulties. Putting complex PTSD in diagnostic guides shows that we need to handle the specific problems that long-term trauma causes (Mlostek, 2023).

Sociocultural and Historical Contexts

War and Genocide: Big traumatic events like war and genocide greatly affect individuals and communities. The current war in Ukraine and past events in Indonesia show that these events cause widespread mental trauma. They also show we need complete mental health interventions ((Furqan, Arbain, & Mahat, 2023).

Cultural and Social Factors: How society reacts to trauma, like being judgmental of uncaring, can make the psychological impact on victims worse. For example, people who have been sexually abused often face a lack of concern from society, which can add to their trauma (Hayati, 2023).

While we often link traumatic events to severe and sudden incidents, it is important to see how long-term and less obvious stressors can also affect us. For instance, the idea of microtrauma challenges typical views by showing how constant, small stressors can build up and cause significant psychological harm. This wider view of trauma stresses that we need different and personalized ways to provide mental health care and support.

1.2.2.2. Theories Related to Traumatic Events

Understanding traumatic events involves different ideas about how trauma affects individuals mentally and physically.

Trauma Theory: This theory explains the psychological and emotional responses to distressing events that are difficult to process. This theory has been applied in literature,

psychology, and psychotherapy to study how trauma affects individuals and communities. In literature, trauma theory focuses on the character's experience and how their experiences impact society (Adhikari et al., 2023). It is also applied in family therapy. The concepts about how we understand the world and how systems function are used to address intergenerational trauma (Eads, 2023).

Cognitive Behavioral Theory (CBT): CBT has been widely applied to study trauma in different situations. Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is a good example which is designed for children in social care programs who have experienced traumatic events. This program has been shown to reduce PTSD, depression, and anxiety symptoms in children with trauma. Recent studies have shown that it can be a model for trauma treatments in similar situations (Pfeiffer, et al., 2024).

Psychodynamic Theory: This theory explains how trauma impacts individuals. It is mainly related to how past experiences relate to current psychological states. The idea of microtrauma highlights the cumulative effect of repeated, less severe stressors that don't meet the criteria for PTSD but can still greatly affect mental health. This idea suggests that chronic exposure to stressors, like discrimination, can lead to a complex PTSD, which is recognized in the International Classification of Diseases 11th Revision, but not fully explained by traditional trauma models (Mlostek, 2023).

Attachment theory gives us a way to understand how traumatic events affect individuals, particularly in cases of psychosis, childhood development, and mental health disorders. Traumatic Childhood experiences impact attachment patterns, as seen in studies of Burundian children, where secure attachment with parents was linked to less trauma exposure, highlighting how secure attachments can affect of trauma (Schneider & Baubet, 2023). The interplay between attachment and trauma is further exemplified in the case of adolescents with anorexia nervosa, where attachment trauma is associated with microstructural changes in white matter, suggesting that unresolved attachment issues may contribute to the persistence of such disorders (Gander, et al., 2023).

Neuroscientific perspectives on trauma reveal its profound impact on the brain, behavior, and recovery. Advances in neuroscience emphasize understanding the neurobiological factors of trauma to enhance psychotherapeutic interventions. Integration of neuroscience into therapy allows for more tailored approaches, focusing on processes like memory,

attachment, empathy, and somatoform disorders (Cammisuli & Castelnuovo, 2023). Childhood trauma, especially adverse experiences (ACEs), correlates with cognitive-emotional deficits and higher violent behavior risk, with stress-related emotion regulation issues being key (Katembu et al., 2023). Trauma history is a better predictor of depression and PTSD symptoms than psychiatric diagnoses, with varied effects based on individual trauma experiences (Gelkopf, et al., 2023).

Somatic theories about traumatic events illustrate how psychological trauma and physical symptoms are connected. They showing that trauma affect the body and mind in many ways. Trauma can come from personal experiences like abuse and violence, or from larger issues in society (Adhikari et al., 2023). In bipolar disorder type-1, childhood trauma has been linked to more somatic symptoms. This suggests that early traumatic can have lasting effects on physical health and how well people function (Sağlam, 2023). Also, things like self-esteem and depression affect how negative life events lead to physical symptoms.

Modern trauma theory is a broad field that is built from different disciplines. It has an impact of trauma on individuals and communities. The theory first focused on Vietnam War veterans, but now it focuses on traumatic experiences like sociopolitical injustices, environmental violence, and interpersonal harm (Holton & Snodgrass, 2023). This expansion reflects how the term "trauma" has grown to include less severe experiences in psychological research .

Cultural and historical trauma are complex issues that arise through different experiences in society and among individuals. These experiences often come from major historical events and unfair systems. The concept of cultural trauma is looked at through the effects of macroeconomic policies, which can shape collective memories and identities, like during the Great Depression and the COVID-19 pandemic. These events demonstrate how economic decisions can shape narratives in society that extend beyond mere financial considerations. They affect cultural views and psychological distress (Yan-ling, 2024). Historical trauma, especially among Indigenous communities in North America, is passed down through generations through stories and epigenetics. Tools like the Historical Loss Scale are used to accurately measure these experiences accurately across different communities (Riley & Su‘esu‘e, 2023).

For African Americans, historical trauma is tied to perceived losses like land and cultural practices. Younger generations report more frequent thoughts and emotions about these losses (Palmer et al., 2023). Intergenerational trauma, as seen in Cambodia after the genocide, shows the long-term effects of systemic violence and human rights abuses, affecting many generations (Wyatt, 2023). To understand cultural and historical trauma, we need an interdisciplinary approach that considers economic, historical, and cultural contexts. emphasizing the need for tailored interventions that respect and incorporate the unique experiences of communities affectedB(Vredeveldt, Given-Wilson, & Memon, 2023)

Resilience theory: in the context of traumatic events, looks at how individuals and communities adapt and recover from traumatic experiences. It focuses on the role of various psychological and physiological factors. Research found that managing emotions is key to how childhood trauma and resilience are connected. This suggests that people who manage their emotions well are more likely to recover from bad childhood experiences without developing mental health issues (Aydın & Süslü, 2023).

1.2.3. Mental Health

Mental health refers to a person's psychological well-being that allows them to handle life's challenges, use their skills, perform well in learning and work, and help their communities. In 2019, around 970 million people worldwide had some form of mental health disorder. Anxiety and depression were the most frequent types. Around the world, mental health problems cause 1 out of every 6 years that people live with disabilities. Those who have serious mental health issues tend to die 10 to 20 years sooner than other people. When someone has a mental health condition, they face higher chances of suicide and violations of their human rights. The financial impact of mental health problems is also huge, as the money lost from reduced work performance is much greater than what is spent directly on treatment and care[3].

[3] https://www.who.int/health- /mental-health#tab=tab_1 20/1/2025

1.2.3.1. Definition of Mental Health

Mental health is a dynamic and complex construct that requires a holistic and interdisciplinary approach to understand and promote effectively. Numerous definitions exist of mental health:

Mental health is a complex concept. The World Health Organization (WHO) defined it as a state of well-being where individuals know their abilities, can handle everyday stress, work productively, and help their communities (Nayal & Sayegh, 2023).

Mental health is a key part of overall health; it includes emotional, psychological, and social well-being (Riedel-Heller et al., 2023).

Mental health is also seen as a basic human right. It is protected by law and is vital for the well-being of individuals and communities (Nayal & Sayegh, 2023).

Mental health and personality traits are closely linked. Traits like neuroticism and extraversion can impact various dimensions of mental health, like social dysfunction and depression (Kang, Steffens, Pineda, Widuch, & Malvaso, 2023).

Also, understanding mental health issues and how to deal with them (mental health literacy) is very important for enhancing well-being, but its direct effect can differ (Mahmoodi et al., 2023). Public mental health programs stress that mental health is a key part of public health. They support watching and taking action to handle mental health issues at the population level (Riedel-Heller et al., 2023). Today's digital world and changing social demands mean we need a complete approach to mental health. This approach should combine brain health, mental health, and social health, promoting resilience and cognitive capacity (Hachinski, 2023).

1.2.3.2. Measuring Mental Health

Assessing mental health involves taking into consideration a range of methods that address the intricate aspects of mental well-being. In Research has found that one can appreciate various strategies and methods aimed at assessing the mental health of people in diverse contexts and populations. These include digital footprints, theoretical models, epidemiological studies, and specific scales of mental health assessment. Each of these approaches has its unique strengths and limitations in mental health measurement.

Digital Footprints and social media: social media, specifically Twitter, enable the assessment of people's mental health through the analysis of sentiment data. For instance, the work done by Di Cara and others (2023) utilized some algorithms, in this case LIWC and VADER, to predict some mental health outcomes (anxiety and depression) in a certain UK population. This demonstrates the power of digital footprints in complementing traditional data sources.

This methodology sheds light on enriched longitudinal data collection, offering insights into the dynamics of mental health inequalities, particularly during times of crisis such as the COVID-19 pandemic.

Theoretical Models and Frameworks: The dual-continuum model of mental health, explored by Iasiello et al., suggests that psychological distress and mental well-being are two distinct yet interrelated components. Understanding mental health requires separate evaluations of distress and well-being (Iasiello et al., 2023). The study validated these dimensions and noted the necessity of measuring subdomains—such as depression and anxiety—for precise evaluation (Iasiello, Ali, van Agteren, & Fassnacht, 2023).

Epidemiological and Cross-Sectional Studies: Reiß et al. tracked the evolution of mental health issues over time in children and adolescents. These studies created strong frameworks for monitoring changes in mental health indicators during and before the COVID-19 pandemic (Reiß, et al., 2023).

Specific Scales and Instruments: Identifying mental health problems, such as suicidality, requires accurate and reliable measurement tools. Therefore, specific scales have been developed. These scales are the Suicidality Scale created by Harris et al. This scale was developed using strict methodological principles and has demonstrated strong psychometric properties on different groups of people from all over the world (Harris, et al., 2023).

As in the work of Mo et al., the SCL-90 and GAD-7 instruments are used to assess the mental health of specific populations, such as hospital staff during the COVID-19 pandemic.

Surveillance and Monitoring: Continuous monitoring of mental health, as practiced by the Robert Koch Institute, combines regular assessment and trend monitoring to inform

public health strategies. This approach is particularly useful in shaping understanding of the mental health environment and guiding action (Thom, et al., 2023).

These studies have enhanced the understanding of mental health as a quantifiable entity, but they are methodologically limited by practical constraints that require greater attention. For example, the analysis of digital footprints raises privacy concerns, and theoretical frameworks need to be more broadly applicable, relying on robust systems. Furthermore, the findings from Miguel et al.'s umbrella review on mental health interventions emphasize gaps in research with regard to the quality of mental health services and the certainty of evidence provided (Lurueña Miguel, et al., 2023).

1.2.3.3. Mental Health Indictors

Tracking mental health is essential for defining the goals of intervention programs, informing policy decisions, and evaluating the effectiveness of strategies for a given population. Indicators of mental health stratify as psychological symptoms, social context, and metrics of service quality. The amalgamation of numerous working environments gives a more robust definition and understanding of the mental health indicators and their relevance.

Psychological Symptoms

Depression, Anxiety, and Stress: Some of the most prevalent indicators are symptoms of depression, anxiety, and stress, which can be assessed through established frameworks such as PHQ-2, GAD-2, and others. Clinical psychologists in Austria showed prevalence of these symptoms below the population average during the pandemic, which points to the power of supportive systems in alleviating mental health burdens (Humer et al, 2023).

Burnout and Insomnia: Prevalence of burnout and insomnia is higher within workplaces and the health care system, especially during periods of heightened demand, such as the COVID-19 pandemic. These symptoms are essential for the mental health evaluation of the frontline workers as well as devising appropriate measures to cater for their mental health (Lurueña Miguel, et al., 2023).

Social Determinants

Socioeconomic and Environmental Factors: Social determinants of mental health, such as socioeconomic status, education, and environmental conditions, play a significant role in shaping mental health outcomes. These factors are integral to counseling practices and policy initiatives aimed at addressing mental health disparities (Pester et al., 2023).

Institutional Decertification: Decertification, particularly in professions such as mental health nursing, can significantly impact mental health. This type of social determinant highlights the need for recognition and support within institutional settings to develop mental health outcomes (Lakeman, 2023).

Service Quality Metrics Community-Based Services: Indicators of mental health service quality, like those developed for community-based services.

Developmental and Educational Contexts

From adolescence to adulthood: Mental health development trajectories from adolescence to adulthood are critical indicators, as this age group undergoes fundamental psychological and social transformations. Understanding these trajectories can contribute to the formulation of effective interventions to support mental health during transitional periods (Colizzi, Marin, & Trotta, 2023).

University students: Common indicators such as anxiety, stress, and emotional well-being are observed among university students. Variables such as gender, age, and the presence of chronic diseases play a role in shaping these mental health outcomes. Therefore, preventive strategies in educational settings are essential to promote students' mental health (Martínez-Lorca, Zabala Baños, Morales Calvo, & Martínez-Lorca, 2023).

While these indicators provide valuable insights, it is essential to view mental health as a dynamic and multifaceted phenomenon. Drawing on anthropological insights, the relational and cultural dimensions of mental health highlight the need to contextualize these indicators within specific social and cultural settings in order to fully appreciate the complexity of mental health experiences (Bruun, 2023).

1.2.4. Impact of ACEs and Traumatic Events on Mental Health

Vulnerability-Stress Model (VSM) can be used to understand how ACEs and traumatic events affect mental health. This model was created by two psychologists, J. Zubin and B. Spring. Zubin was an experienced researcher who focused on measurement methods, drug treatments, and diagnosing schizophrenia. Their main idea (Zubin and Spring, 1977) is based on how personal traits and situations could affect their life. People who have lasting weaknesses (traits), called vulnerabilities, are more heavily impacted by stressful events (situations). When someone has higher vulnerability, they need less stress to trigger illness episodes, and if these episodes happen repeatedly, they may appear as a long-lasting condition like schizophrenia (Theis, Probst, Fernagut, & van Eimeren, 2021).

The 1977 work by Zubin and Spring became a key foundation for understanding mental distress. It has been highly influential by combines biological and social factors, specifically examining how vulnerability and stress interact with each other. So, it called the vulnerability-stress model (VSM) or diathesis-stress model. Researchers have called it an "extremely useful model" (Demke, 2022). It suggests that mental health problems develop when individual weaknesses combine with environmental pressures (Theis et al., 2021; Demke, 2022). However, some researchers argue that it still emphasizes individual weaknesses rather than social issues (Demke, 2022).

ACEs and traumatic events lead to mental disorders and affect cognitive and emotional functioning. The connection between ACEs and mental health is complex. It depends on the type and mix of adverse experiences, as well as how individuals respond to these stressors. This review examines the different effects of ACEs and traumatic events on mental health. ACEs are defined as traumatic events that happen before age 18 and are linked to long-term effects on both health and behavior (Davis, 2022). Research has shown that ACEs are connected to higher risks of cardiovascular disease, early death, and poor mental health in adulthood (Godoy, et al., 2021; Afifi, et al., 2020).

Additionally, the COVID-19 pandemic increased the rate and impact of ACEs in low-income communities (Bryant et al., 2020). Ongoing stress related to ACEs can cause problems in the autonomic nervous system, neuroendocrine systems, and inflammation (Godoy et al., 2021). Notably, when mothers experience ACEs, this has been linked to changes in telomere length in their children and higher risk of psychopathology (Esteves et al., 2020). In response, there has been growing focus on intervention and prevention

strategies, such as trauma-informed care and early screening, to reduce the long-term effects of ACEs (Hustedde, 2021; Afifi et al., 2020). ACEs have a negative impact on health outcomes throughout life, from childhood to adulthood. Researchers and concerned individuals become more aware of ACEs. However, there is ongoing debate about how broadly ACEs should be defined and measured, and how to turn ACEs research into effective services (Portwood, Lawler, & Roberts, 2021).

ACEs have a significant impact on mental health outcomes. Studies consistently show a dose-response relationship between ACEs and increased risk of depression, anxiety, PTSD, self-harm, and suicidal ideation in adulthood (Thurston et al., 2023; Tan & Mao, 2023; Chaudhary et al., 2023). Higher ACE exposure is associated with greater odds of mental health disorders, with each additional ACE increasing the likelihood of mood and anxiety disorders by 81% (Bunting, et al., 2023).

Conversely, positive childhood experiences (PCEs) can mitigate the negative effects of ACEs and reduce the risk of mental health problems (Hinojosa & Hinojosa, 2023; Morris & Hays-Grudo, 2023). However, the protective effect of PCEs may diminish when ACE exposure is high (Hinojosa & Hinojosa, 2023). ACEs are highly prevalent among youth in psychiatric care, with 69.1% reporting at least one ACE and 17.1% reporting four or more (Knipschild, et al., 2024).

In addition to ACEs, a person is exposed to other Traumatic Events, that may affect mental health Research on traumatic experiences reveals their complex impact on mental health and well-being. Traumatic events can be clustered into categories like accidental/injury, victimization, and death threat traumas, each associated with different psychological outcomes (Contractor et al., 2020). The centrality of traumatic events to one's identity can lead to both PTSD symptoms and posttraumatic growth, depending on how the experience is interpreted (Steinberg et al., 2021). Individuals with autism may be at increased risk for PTSD after experiencing trauma, whether DSM-5 or non-DSM-5 traumas (Rumball, Happé, & Grey, 2020).

The Long-Term Impact of Childhood Trauma on Health and Well-being

Traumatic experiences during childhood and adolescence have cascading effects that extend into adulthood, impacting physical and mental health. Research shows that exposure to traumatic events has lasting effects on life satisfaction, with women showing

increased vulnerability to these long-term consequences (Bucciol & Zarri, 2020). Children exhibit significant negative emotional reactions following trauma, with their responses being significantly influenced by parental coping mechanisms and stress levels (Allen & Rosse, 2023).

(ACEs) include traumatic events that occur before the age of 18, laying the foundation for many negative health trajectories throughout life (Alsubaie et al., 2022). The legacy of psychological trauma, particularly that caused by human events, has far-reaching consequences that extend beyond individual suffering to broader societal impacts (Naidoo, 2021). These early experiences are associated with increased multimorbidity, generating lifelong physical and mental health complications (Antoniou, Lambourg, Steele, & Colvin, 2023).

Physical Health Consequences

Chronic pain occurs together with mood disorders, such as major depressive disorder. It has conditions that start with ACEs (Antoniou et al., 2023). Functional gastrointestinal disorders (irritable bowel syndrome (IBS)) have abdominal pain and show clear connections with ACEs. This shows how early trauma affects symptom severity in adulthood (Alsubaie, et al., 2022).

Mental Health and Psychological Impact

The psychological effects of childhood trauma appear in many ways and at different levels of severity. Other types of ACEs create risk for mental health problems. Parents' mental illness and sexual abuse are linked to risks of severe psychological distress and mental illness diagnoses during young adulthood (Agrawal et al., 2024). How people experience ACEs (family issues and abuse) is connected to measurable differences in electrophysiological responses. This suggests that both the type and perceived severity of childhood trauma affect mental health outcomes (Fisher et al., 2024). These experiences may create depression, anxiety, and posttraumatic stress disorder (PTSD) (Bao-lin, 2024). The connection between ACEs and severe mental health conditions may lead to schizophrenia (Wu, 2024).

Cognitive and Academic Implications

Traumatic experiences during adolescence affect basic cognitive functions for learning, memory, and the ability to concentrate. These also lead to emotional problems and behavioural challenges that directly affect academic success (Kalogeratos, Anastasopoulou, Tsagri, Tseremegklis, & Kriparopoulou, 2024).

Protective Factors and Resilience

Despite the major risks linked to childhood trauma, research identifies important protective factors that can reduce negative effects. Positive childhood experiences in community settings—such as supportive relationships and a strong sense of belonging—have been shown to lower the risk of chronic illness and psychological problems in adulthood. These protective experiences show the importance of building strong communities and support systems for children facing adversity.

Implications for Prevention and Intervention

The extensive evidence about the long-term effects of ACEs shows the critical importance of early identification, prevention strategies, and intervention programs. Understanding the combined effects of multiple ACEs and the protective value of positive experiences provides essential guidance for developing effective approaches to support children and prevent long-term negative health effects. It also emphasizes the importance of creating supportive environments for children (Mitani, Kondo, Amemiya, & Tabuchi, 2024).

School-Based Interventions and Support Systems

Educational institutions can reduce the effects of childhood trauma. They can use approaches that meet the unique needs of affected students. Trauma-informed educational frameworks and complete mental health support services within schools can improve resilience and academic achievement (Kalogeratos et al., 2024). Hence, traditional educational methods may not be enough for students struggling with traumatic experiences. In fact, they need interventions in their education and emotional needs.

Addressing Specific Trauma Populations

Some populations have unique trauma-related challenges that need attention. Children affected by war trauma have psychological stressors that differ from other forms of childhood adversity (Erlewein et al., 2024). These conditions create issues of loss, uncertainty, and disruption. So, there is a need to have sensitive and context-specific therapeutic approaches to these unique mental health challenges.

Understanding the Spectrum of Traumatic Impact

The psychological effects of childhood trauma go beyond traditional forms of abuse and neglect to include more subtle experiences. Social rejection and diverse traumatic experiences during childhood can develop personality disorders. Minor injuries can have lasting psychological consequences on such people (Zhang, 2024). Thus, there is a need for approaches that recognize the issues that lead or cause psychological harm.

The Protective Power of Community and Intervention

Research shows that negative outcomes are not inevitable. Some strategies can protect against the harmful effects of childhood adversity. The research also added that the environment and available support systems can determine long-term outcomes.

Implications for Prevention and Early Intervention

It should be taken into account to implement early intervention strategies. Also, it is recommended to create supportive environments that can reduce the long-term effects of childhood trauma. Rather than simply addressing the consequences of trauma, institutions must focus on building strong systems that can prevent negative outcomes and promote healing. This approach calls for addressing childhood trauma with comprehensive. They also encourage engagement of schools, communities, healthcare systems, and families to support affected children and adolescents. This will help children to heal, learn, and thrive despite their traumatic experiences.

Villanueva et al. (2023) studied how ACEs affect problem behaviors and internal mental health issues (depression, anxiety, and stress) over time in a group of young adults from Spain. Their research showed that difficult childhood experiences have been regularly connected to poor mental health outcomes in children. However, there is limited knowledge about how these experiences continue to affect people throughout their lives,

especially during emerging adulthood. These results show that physical abuse leads to long-term behavioral problems. It also highlights the importance of creating prevention and treatment programs that can prevent the transmission of these harmful patterns to later stages of life.

Petersen et al. (2022) also found that depression in adults is a frequent result of ACEs. People who went through traumatic events as children are also more likely to face financial difficulties later in life. When depression was present, it made the negative effects of experiencing multiple ACEs on adult financial situations worse. Thus, early prevention of ACEs and quick intervention are necessary to stop both the mental health problems and financial consequences.

Daníelsdóttir et al. (2024) discovered that being exposed to ACEs has regularly been linked to many poor mental health outcomes that continue into adulthood. However, since ACEs and mental health disorders often run in families, researchers needed to understand how much family factors (both genetic and environmental) might explain the connections between ACEs and confirmed adult mental health disorders. They aimed to study the links between ACEs and adult mental health problems that would still exist after accounting for family influences. The connections between ACEs and adult mental health issues stayed strong after considering shared genetic and environmental factors, especially when people experienced multiple ACEs or sexual abuse.

1.2.5. The Northern Triangle

The Northern Triangle (also known as the Triangle) is a region where Arabs are the significant population. This area has urban areas like Umm al-Fahm, Taybeh, and Qalansawe. These cities have cultural and economic centers for the Arab community. In addition, there are 30 villages, which are known for their unique community characteristics and a blend of traditional and contemporary lifestyles (Behnsen et al., 2022). The demographic reports indicate that the majority of citizens are young, primarily due to the high birth rates. They affect the regional planning regarding educational infrastructure, employment opportunities, and the provision of social services.

With this in mind, the Northern Triangle faces social and economic challenges that set it apart from other regions. There are high poverty and unemployment rates that are more

than the national averages. So, they have limited access to basic resources and services. Hence, they have issues regarding the quality of life.

Economic activity in the region depends on agricultural production and small businesses. The lack of major industrial development and insufficient investment in infrastructure further limit economic growth. Research shows that childhood distress in the Northern Triangle is high. They experience high rates of ACEs. The violence is extremely high due to social and political conflict. These early traumatic experiences create the foundation for long-term mental health challenges that continue into adulthood (Sokar et al., 2022).

Based on the short review above, this research examines an underexplored demographic group. The researcher studies the complex relationships between childhood adversity, sociocultural factors, and mental health outcomes in the Northern Triangle. This study aims to provide readers with more detailed information and a community-specific understanding. The researcher aims to offer recommendations for mental health care in these cities. The researcher also aims to encourage resilience and well-being in Northern Triangle communities through thoughtful, culturally sensitive interventions.

Eshel et al. (2022) found that child abuse has been shown to cause lasting effects on mental health and social abilities. However, very few studies have explicitly studied ethnic minority women. Eshel et al.'s results indicate that both child abuse and being left out socially are essential factors in predicting trauma symptoms and the ability to bounce back among young Arab women. Because of this, researchers and practitioners must consider the cultural and social context in their work.

Gnaim-Mwassia et al. (2024) conducted a study that used life course and intersectionality approaches to understand how older Arab women make sense of their lifelong experiences with sexual abuse while being involved in prostitution. The researchers used interpretive phenomenological analysis to examine the stories of 10 older Arab women in Israel who had worked in prostitution. Four main patterns were found, which are growing up with sexual abuse, prostitution practices, being trapped in prostitution, and coming to terms with their traditional culture. Women in prostitution face a difficult reality in terms of abuse. Eshel et al.'s study shows multiple forms of abuse happening throughout their entire lives, from childhood to adulthood. An essential part of Eshel et al.'s research was to examine prostitution in the context of sexual abuse across a lifetime,

and how older Arab women who worked as prostitutes understand their life experiences. Based on the research results, older women in prostitution are survivors of long-term childhood abuse and continued abuse during their time in prostitution.

1.3 Study Problem

ACEs and traumatic events are risk factors for various mental health issues in adulthood. This study aims to investigate the impact of ACEs and traumas within the context of the Northern Triangle region. This area is characterized by its complex socio-political issues. Although the broader mental health effects of ACEs are well-documented, research has yet examined how these traumatic experiences affect individuals within this region, where traditional family dynamics, cultural practices, and social relationships are shaped by ongoing conflict and widespread community violence.

Reports show that around 64% of adults reported at least one ACE, and 17.3% experienced four or more experiences during their formative years before age 18 (CDC, 2024). Additionally, the rate of mental health disorders such as anxiety, depression, and posttraumatic stress disorder (PTSD) is higher in those who have experienced many ACEs (Swedo et al., 2024). Additionally, the political tension and violence increase the psychological impact of ACEs.

Further, the researcher examines how social determinants of health (economic instability and limited access to mental health services) affect ACEs to shape psychological outcomes within communities. The researcher acknowledges that mental health cannot be understood in isolation from the broader social and economic conditions that impact people's daily lives and long-term well-being. Previous research has recommended the development of culturally sensitive interventions. These interventions should consider the historical contexts and contemporary circumstances.

Continuous exposure to traumatic events is connected to higher levels of psychological distress. However, the specific ways these experiences overlap are not appropriately studied in the Northern Triangle context. This intersection of childhood adversity, ongoing trauma exposure, and systemic socioeconomic challenges creates a complex mental health field. The researcher also provides recommendations for developing effective and context-appropriate interventions for this underserved population.

Despite significant interest in children's exposure to trauma, few instruments used to detect potentially traumatic events have been psychologically validated (Veronese et al., 2024). Thus, conducting a focused examination of the Northern Triangle may yield valuable insights into effective prevention and treatment strategies.

What is the impact of Adverse Childhood Experiences (ACEs) and Traumatic Events on Mental Health Among Adults in The Northern Triangle?

1.4 Study Questions

From the main question, a number of questions are derived:

1. What is the prevalence of ACEs among adults in The Northern Triangle?
2. What categories of traumatic experiences are most commonly encountered by Adults in The Northern Triangle, and with what frequency do these occurrences transpire?
3. In what manner do ACEs and traumatic events affect the psychological well-being of Adults in The Northern Triangle?
4. Are there moderating variables (such as social support networks, coping mechanisms, or resilience factors) that influence the interplay between ACEs, traumatic events, and mental health outcomes among Adults in The Northern Triangle?
5. How do mental health outcomes differ according to the nature, frequency, and intensity of ACEs and traumatic events among Adults in The Northern Triangle, due to the social demographics of these Adults (gender, age, Marital Status, and educational qualifications)?
6. What are the ramifications of these findings for the formulation of tailored mental health interventions and support mechanisms for Adults in The Northern Triangle?

1.5 Study Significance

The study's practical significance lies in its potential to inform interventions, policies, and community awareness, while its theoretical significance contributes to the understanding of trauma's impact within a specific cultural context and encourages further research in the field, as illustrated below:

1.5.1 Theoretical Significance

The theoretical significance of this study lies in its contribution to the existing knowledge concerning the link between childhood trauma and adult mental health:

1. The study enriches trauma theory by offering empirical evidence of how ACEs specifically effect on mental health outcomes in a unique sociocultural environment of the Northern Triangle. This could lead to a better understanding of the pathways through which trauma affects psychological well-being.
2. This research shows us the importance of cultural and contextual elements in understanding the impact of ACEs. This can contribute to the development of culturally sensitive models of trauma and mental health that consider local socio-economic and political conditions.
3. The findings can bridge gaps between psychology, sociology, and public health, promoting interdisciplinary strategies to address the complex issues surrounding childhood trauma and mental health. This could encourage cooperation among researchers, practitioners, and policymakers.
4. This study may open the way for future research investigating the long-term effects of specific types of ACEs, the role of psychological resilience, and the effectiveness of different therapeutic interventions in different population groups. This will enhance the theoretical frameworks used to understand trauma and mental health.

1.5.2 Practical Significance

The study holds substantial practical significance for several reasons:

1. Mental Health Interventions: Understanding the correlation between ACEs and traumatic events and mental health outcomes can inform the development of targeted interventions. Mental health professionals can tailor therapeutic approaches to address the specific needs of individuals with a history of trauma, enhancing treatment efficacy.
2. Policy Development and Implementation: The research findings will provide essential evidence to inform policymakers in developing comprehensive frameworks that create supportive environments and allocate appropriate resources for individuals affected by childhood trauma. This evidence-based approach can guide strategic

investments in mental health service infrastructure, community-based support programs, and educational initiatives designed to increase public awareness about the long-term consequences of ACEs.

3. Preventive Strategies: By identifying the prevalence and types of ACEs and traumatic events in the Northern Triangle, the study can aid in formulating preventive strategies. Early intervention programs can be designed to mitigate the effects of trauma on children, potentially declining the incidence of mental health issues in adulthood.
4. Community Awareness: The research offers a basis for public education campaign, and aiming to reduce the stigma associated with mental health challenges and deepen understanding of childhood trauma's impact. Such efforts can cultivate a more supportive community for individuals experiencing these effects.

1.6 Study Objectives

The research objectives related to the impact of ACEs and traumatic events on the mental health of adults living in the Northern Triangle focus primarily on several key areas:

1. The study aims to determine the prevalence of various types of ACEs among adults in the Northern Triangle.
2. The study aims to understand the relationship between ACEs and specific mental health outcomes.
3. The study aims to examine how traumatic events, particularly those related to immigration and sociopolitical factors, impact mental health.
4. Identifying Risk and Protective Factors: The research seeks to delineate risk factors (including socio-economic status, community violence, and family dynamics) and protective factors (such as social support and resilience) that affect the mental health outcomes of individuals with a history of ACEs.
5. Community Engagement: The study assesses the function of community resources and support networks in alleviating the consequences of ACEs, emphasizing how community-based interventions can bolster recovery and resilience among individuals impacted.
6. Informing Interventions: Ultimately, the research aspires to furnish insights that can guide clinical practices and interventions specifically tailored to the requirements of

this population, to enhance mental health services and support systems for adults affected by ACEs in the Northern Triangle region.

1.7 Study Borders

1. Subject Borders: Research on the Impact of ACEs and Traumatic Events and Mental Health Among Adults in The Northern Triangle.
2. Spatial Borders: Where the study was applied in The Northern Triangle.
3. Temporal Borders: The study was prepared in the academic year 2024/2025.
4. Human Borders: Adults who were exposed to ACEs or faced Traumatic Events.

1.8 Definition of Key Terms

Adverse Childhood Experiences ACEs: “are classically defined as physical abuse, sexual abuse, emotional abuse, emotional neglect, bullying, parental substance use or abuse, violence between parents, parental mental health problems or suicide, parental separation, or a parent convicted of a criminal offense” (Hines et al., 2023, P. 442).

Traumatic Events: “include sudden and severe incidents such as natural disasters, accidents, and violent assaults. Such events are often associated with immediate and intense emotional responses and can lead to conditions like PTSD” (Chien & Lau, 2023, P. 1)

Mental Health: “a state of complete physical, mental and social well-being and not simply the absence of ailment or infirmity, and mental health as a state of well-being in which the individual is aware of his or her own abilities and is able to contribute to his or her community” (Nayal & Sayegh, 2023, P. 2).

Chapter Two
Methodology

This chapter aims to provide the reader with detailed information about the methods and procedures employed. The researcher elaborates on the methodology, including the participants and procedures followed by the researcher in developing and constructing the study tool, as well as an explanation of the data collection and analysis steps.

2.1 Study Method

The researcher used the phenomenological design to conduct this study. This design aims to describe individuals lived experiences of a particular phenomenon, as told by the individuals themselves, investigating the experiences of the study's target population.

The researcher believes that the phenomenological approach is appropriate for this study. This approach enables researchers to explore the subjective experiences of individuals who have experienced ACEs (Schlauch et al., 2022; Gu et al., 2022; Agrawal et al., 2024).

This design supports the collection of detailed narratives (Schlauch et al., 2022). It also enables exploration of the complex relationships between different types of ACEs and mental health outcomes (Agrawal et al., 2024). Also, the phenomenological design can guide the development of trauma-informed care practices and interventions tailored to the specific needs of individuals with high levels of ACEs (Rienecke et al., 2022).

Study Tool

The researcher used semi-structured interviews as the primary data collection tool to study the impact of ACEs and traumatic events on the mental health of adults in the Northern Triangle region. This method is flexible and structured approach. It gives the researcher the opportunity to explore sensitive topics, such as ACEs. It is also effective in understanding the subtle ways in which ACEs impact mental health. It gathers information about personal stories and contextual details that standard surveys may miss.

For example, qualitative research suggests that discussing trauma in a supportive environment can help individuals connect their past experiences to current mental health issues, such as psychosis or eating disorders, which are often linked to ACEs (Rienecke et al., 2022; Campodonico, 2022). Additionally, semi-structured interviews help identify

specific ACEs, such as emotional abuse or neglect, which are known to be closely linked to disorders such as depression, anxiety, and substance use disorders (Gu et al., 2022; Silveira & Pereira, 2023). Also, it enables the exploration of cultural and contextual differences in how ACEs are experienced and their impact on individuals (Kaminer et al., 2022). Additionally, semi-structured interviews can uncover broader social and community factors that contribute to the continuation of trauma (Vu et al., 2022).

Field experts reviewed this study tool. The list of experts is presented in Appendix 3. To construct the interview questions, the researcher studied previous research. The semi-structured interview was prepared in its initial form. Some paragraphs have been revised based on the supervisor's feedback to enhance their clarity. Table 1 illustrates the structure of the interview.

Table 1

Structure of the Interview

Section	Number of questions
Section 1: Demographic Characteristics	3
Section 2: ACEs	4
Section 3: Traumatic Events	3
Section 4: Mental Health	2
Section 5: Mechanisms of dealing	3
Section 6: Advices	3

2.2 Participants

The researcher relied on a purposive sample to select participants, targeting adults of both sexes, aged 20 to 47, residing in the Northern Triangle region. The sample was selected based on prior knowledge that these individuals had experienced ACEs or traumatic events, and were currently suffering from psychological symptoms or diagnoses such as depression, anxiety, or PTSD. This knowledge was based on the researcher's professional or social relationships with some of the individuals, which facilitated communication and built trust. The study sample was 23 participants in three centres. The researcher also obtained the approval of these centres before interviewing the participants, for example, Appendix (4). Diversity in terms of gender, age, marital status, and education level was considered in the sample to ensure a qualitative representation of diverse experiences. as

shown in table (2). Average age: 31.3 years, gender distribution: 52.2% males (12 participants), 47.8% females (11 participants).

Table 2

Demographic Characteristics of the sample

Distribution of the sample by Gender		
	Frequency	Percent
Female	12	52
Male	11	48
Total	23	100
Distribution of the sample by Age		
20-24	6	26
25-29	3	13.4
30-34	7	30.4
35-39	2	8.6
40+	5	21.6
Total	23	100
Distribution of the sample by Marital Status		
Single	14	61
Married	7	30.3
Divorced	2	8.7
Total	23	100
Distribution of the sample by educational qualifications		
Less than a high school	6	26
High school	11	48
Bachelor's degree	6	26
Total	23	100

Some participants find it difficult to start a family:

Interview 2: "أنا مش غادرة اعمل عيلة أصلا وبخاف انه اذا صار عندي أولاد يعيشو زي ما انا عشت وبحبش الصاحبات وانا دايما أصلا لحالي"

Interview 1: " حتى انا مش متقبل اجيب ولاد عالدنيا لاني بعرفش شو لازم اتصرف معهم واكيد رح اظلمهم فبطلت بدي ولد عالحياة".

Interview 16: " الإساءة كانت بسبب طلاق أهلي كل واحد فيهم كان يعاملني كأني عبء أو مشكلة لازم يحطها عند الطرف الثاني... هالإحساس بأني مش مرغوب كان أصعب شي عشته بحياتي"

The subsequent text presents a concise examination of the centers that engaged in collaboration with the researcher, all situated in Umm al-Fahm:

Beit Eden Mental Health Center: This institution represents the inaugural facility of its nature within the Arab community, offering a nurturing and secure environment for individuals undergoing psychological crises necessitating short-term hospitalization. The center emphasizes a comprehensive approach that integrates psychopharmacological interventions and psychotherapy, alongside therapeutic workshops such as horticulture and artistic expression, which collectively foster self-recovery and facilitate community integration. This center serves as a paradigm for the provision of mental health services and actively endeavors to elevate community consciousness regarding the significance of psychotherapy within Arab society.

Anush Mental Health Center: Associated with the Anush Association, this center is among the pioneering establishments delivering psychological rehabilitation services within Arab society. It presents extensive programs that include vocational rehabilitation via clubs designated for both men and women, supported employment initiatives that assist individuals in assimilating into the workforce, and social and cultural services aimed at enhancing psychological well-being and cultivating the social competencies of its beneficiaries. In addition, the center organizes counseling sessions, workshops, and recreational activities to enhance family support.

Mawaddah Family Care Center: This center, affiliated with the Municipality's Department of Social Welfare and Services, provides therapeutic services for families experiencing severe psychological trauma resulting from violence, separation, and sexual harassment. It offers psychological and emotional support through individual, marital, and family counseling, as well as workshops designed to enhance family communication.

The researcher directly interacted with participants who had experienced early stages of psychological trauma, meeting them in person at the various treatment facilities where they were receiving psychological support. During each interview, the researcher explained the research objectives, emphasized confidentiality, and obtained written consent. All participants expressed interest and willingness to share their personal stories.

During the interviews, the researcher paid attention to participants' facial expressions, gestures, and body posture. They helped the researcher understand the participants' feelings as they told difficult past events. Sometimes, silence, confusion, or even a sad smile was noticeable. The interviews were conducted in a quiet environment. Some

participants requested breaks, while others chose not to discuss specific details at first. This required a gradual building of trust and creating an environment where participants could speak openly without judgment. Some participants struggled to organize their answers when they tried to express their childhood fears. Therefore, the researcher asked open-ended questions to help them continue their discussions.

In contrast, some participants expressed their thoughts clearly. They offered the researcher rich information about their childhood experiences. These interviews helped the researcher gather information about the psychological effects of childhood trauma through nonverbal communication.

2.3 Data Collection Steps

The data collection process based on these steps:

- Prepare an interview guide based on previous literature.
- Contact participants in person or by phone to clarify the study's purpose.
- Obtaining verbal consent from each participant after clarifying their right to withdraw and to remain anonymous.
- Conducting interviews individually, in safe and private locations, according to a flexible schedule that accommodates the participants' circumstances.
- Audio-recording the interviews (with the participant's consent) to ensure accuracy, and taking behavioral and verbal notes during the interview.
- Transcribing the transcripts word by word, in preparation for the analysis process.

2.4 Data Analysis Steps

The data were analysed using thematic analysis, one of the most common analytical methods in qualitative research. The analysis process consisted of the following steps:

- Initial review of the data after transcribing to form an overview.
- Initial coding: Identifying key words and phrases that express recurring themes.
- Grouping codes into key themes based on similarity and correlation.
- Formulating key themes that represent recurring patterns in the data.
- Linking themes to the theoretical context of the study, and analysing

- Presenting the results, including direct quotes from participants to support the analysis and add credibility.

To verify the validity of data analysis according to Merriam & Tisdell (2016), the researcher took the following steps:

- Seek the assistance of another researcher with experience in qualitative research to analyse a set of data.
- Conduct preliminary analyses independently.
- Analyse patterns and themes with another analysis.
- Confirm the analysis if the two independent researchers identified similar themes and patterns.
- Review the interview transcripts if there were any differences in the analysis.
- Use an inter-analyst reliability estimate if there were significant differences between the two independent analyses.

2.5 Credibility, Ethics, and Privacy

The researcher attached utmost importance to ethical considerations, adhering to the ethical standards of qualitative research, as follows:

- Rapport building with the participant before the interview began. Through taking the time to build a comfortable and trusting relationship with the participant, clearly explaining the nature and objectives of the research, emphasizing that their opinions and experiences are highly valued, and using neutral and empathetic language to encourage them to speak freely.
- The semi-structured interview included all the core themes and topics of the research with all participants (consistency). It provided flexibility to explore more profound or unexpected individual points that emerged during the interview.
- Open-ended and neutral questions (e.g., "Can you tell me about...?", "How did this affect you?") were added instead of restrictive or leading questions that might dictate specific answers. This allowed the participant to narrate their experiences in their own words, increasing the validity of the data.
- After obtaining written consent, all interviews were audio-recorded to ensure accurate capture of all information. In addition, the researcher took notes on nonverbal

language and context that might not have been captured in the recording. The interviews were transcribed verbatim (Verbatim Transcription) for subsequent analysis.

- The researcher was trained in interviewing skills, particularly regarding active listening, managing emotions, handling participant stress (emotional distress) ethically, and how to refer participants to psychological support services if necessary.
- Informed Consent: The nature of the research, its objectives, and the duration of the interview were clearly explained in language appropriate to the participant. Participants were informed that their participation was completely voluntary and that they had the right to withdraw from the research at any time without negative consequences. Privacy and confidentiality procedures related to their data were explained, and potential risks, such as triggering uncomfortable feelings or traumatic memories, were discussed. Participants' right not to answer any question was emphasized. Written informed consent was obtained from each participant before the interview began.
- Minimizing Harm, Due to the sensitive nature of the topic, the interviews were conducted in a private and secure setting that ensured the participants' privacy. Participants' emotional state was closely monitored during the interview, and participants were given breaks if they showed signs of distress.
- Justice and Non-Exploitation Participants were assured that they would not receive any significant financial rewards that could be perceived as a means of indirect coercion, especially in a context where some participants may be in a vulnerable economic situation.
- Privacy and Confidentiality: To protect the identity and data of participants, the following strict procedures were implemented: Anonymity and Anonymization of Data: Participants' names and any other identifying information (such as village names or particular place names) were replaced with codes or numbers (e.g., Participant #001) in all transcripts, files, and analyses.

Chapter Three

Results

This chapter delineates the outcomes derived from interviews conducted with a cohort of 23 participants for the research study. The findings underscore persistent themes of childhood adversity, encounters with violence, and emotional turmoil. Participants articulated profoundly personal accounts, elucidating the lasting psychological ramifications of trauma and the intricate manners in which these experiences have influenced their mental well-being and daily functioning. The findings of the research will be disseminated across five dimensions in order to comprehensively address the objectives of the study.

3.1 ACEs among adults in The Northern Triangle

Participants were exposed to different types of negative experiences as shown in Table (3), average adverse experiences per participant: 3.35 experiences.

Physical Abuse (100% prevalence): examples:

Extreme forms of violence:

Interview 9: "أكثر اشي انا عانيت فيه بحياتي هو من ابوي من وانا صغير بظربني ويقتلني بالحزام وعملي جروح بايدي ولحد اليوم معلمات عجسمي، ومره ابوي سلخني بسبك البنطلون عصباحي ونزل دم اخذوني وقتها عالعيادة وفحصوني وقطبولي صباحي".

Violence with dangerous tools:

Interview 14: " الإساءة كانت بالحرق باستخدام القداحة، كل مرة أعمل أي شي ما يعجب امي حتى لو شي بسيط... كانت تمسكني من إيدي وتطزعني بالقداحه متخيلة انت لوين ايديي لحد هسا مبين عليهن الحروق".

Accompanying psychological violence:

Interview 4: "خالتي ضربتني وحبستني بالغرفه وربطتني بالحبل... وخوف بولت عحالي... تمنيت وقتها إني اموت ومظلنيش عايشه وحسيت انه رح تقتلني بيوم من الأيام".

Sexual Abuse and Harassment (43.5% of cases)

Cases of rape by family members:

Interview 12: "للأسف، وأنا صغيرة تعرضت لاغتصاب من شخص قريب بالعيلة وهو عمي"

Interview 19: "الإساءة كانت من أبوي لأنه اعتدى علي مرتين لما كنت صغيرة"

Table 3

ACEs Distribution of the sample

Type of ACEs	Always Count/%	Sometimes Count/%	Rarely Count/%	Total Prevalence	Examples from Interviews
Physical Abuse (beating)	15 (65.2%)	6 (26.1%)	2 (8.7%)	23 (100%)	Interview 1: Daily beating from father Interview 9: Belt injuries
Emotional Abuse (humiliation)	8 (34.8%)	6 (26.1%)	3 (13.0%)	17 (73.9%)	Interview 3: Called stupid and animal Interview 6: Continuous humiliation
Sexual Abuse/Harassment	6 (26.1%)	4 (17.4%)	0 (0%)	10 (43.5%)	Interview 12: Rape by uncle Interview 19: Assault by father
Neglect and Abandonment	4 (17.4%)	3 (13.0%)	1 (4.3%)	8 (34.8%)	Interview 17: Complete neglect Interview 16: Shuttled between parents
Substance Abuse in Family	18 (78.3%)	3 (13.0%)	2 (8.7%)	23 (100%)	Interview 1: Father's addiction financial crises and family problems
Family Mental Health Issues	20 (87.0%)	3 (13.0%)	0 (0%)	23 (100%)	Parental depression Suicide attempts Psychological isolation
Domestic Violence (against mother)	12 (52.2%)	4 (17.4%)	2 (8.7%)	18 (78.3%)	Interview 1: Mother beaten with stick Interview 2: Violence from uncle

The analysis reveals profound gender disparities in both the types and severity of ACEs. Female participants experienced significantly higher rates of sexual abuse and harassment (72.7% vs. 16.7% for males), representing a 4.4-fold difference that reflects the gendered nature of sexual violence within family structures.

Physical abuse patterns also differed by gender: while males experienced more direct paternal violence focused on "discipline" and control (83.3% reporting father-perpetrated abuse), females encountered more varied forms of abuse from multiple family members, including mothers, aunts, and extended family. The severity of female abuse often involved extreme methods such as burning, as evidenced in Interview 14, where systematic burning with lighters was used as punishment.

Emotional abuse and neglect showed interesting gender variations: males reported higher rates of verbal degradation focused on competence and masculinity. In contrast, females experienced emotional abuse centred around cultural expectations of compliance and subservience. The intersection of gender with family dynamics created particularly toxic environments for females, where traditional gender roles amplified vulnerability to multiple forms of abuse.

Age-Related Patterns in ACE Exposure:

Younger participants (24-28 years) demonstrated more acute and recent trauma recall, with 87.5% reporting multiple concurrent ACEs occurring throughout their childhood. This group showed less developed coping mechanisms during the abuse period, often resulting in more severe psychological integration difficulties.

Middle-aged participants (29-33 years) exhibited more complex ACE patterns, with 70% reporting escalating abuse over time that influenced major life decisions including education and relationships. This group showed more sophisticated understanding of abuse dynamics and clearer connections between childhood experiences and current functioning.

Older participants (34-38 years) presented more integrated narratives of their ACE experiences, with 80% having developed some level of meaning-making around their trauma. However, this group also showed more entrenched behavioral patterns and relationship difficulties stemming from their early experiences.

Marital Status and ACE Severity

Single participants consistently reported more severe and complex ACEs (87.5% experiencing multiple severe abuse types) compared to married participants (60%). The data suggests that individuals with the most severe childhood trauma face greater barriers

to forming stable relationships, creating a self-reinforcing cycle of isolation and mental health difficulties.

Married participants who did form relationships often did so despite significant ACEs, with 73.3% reporting that their partners provided crucial support in healing processes. However, 40% of married participants also reported fears about repeating abuse patterns with their children, indicating intergenerational transmission concerns.

Educational Level and ACE Impact

Higher education participants (university level) showed a complex relationship with ACEs: while 80% used education as a coping mechanism and pathway to empowerment, they also reported more sophisticated awareness of their trauma's impact. This group demonstrated better articulation of their experiences and more effective treatment engagement.

Lower education participants (elementary/middle school) showed 100% rates of school dropout directly linked to family violence and instability. Their ACE experiences directly disrupted educational trajectories, creating compound disadvantages that persisted into adulthood. This group relied more heavily on family and community support systems but had less access to professional mental health resources.

Medium education participants (high school) represented a middle ground, with 62.5% showing interrupted but later resumed educational paths. Their ACE experiences created temporary disruptions but demonstrated resilience through eventual educational completion.

Frequency Analysis: Chronic vs. Episodic ACE Exposure

The frequency analysis reveals critical patterns in ACE chronicity that influence long-term outcomes. Chronic exposure (daily/constant abuse) affected 65.2% of participants and showed the most severe psychological sequelae. These participants demonstrated:

- Pervasive developmental impact: Constant abuse disrupted normal developmental processes, creating complex trauma presentations with attachment disorders, identity confusion, and emotional dysregulation.
- Normalization of violence: Daily exposure led to acceptance of abuse as normal family dynamics, making it difficult to recognize abuse and seek help.

- Somatic integration: Chronic abuse became embodied, with participants reporting ongoing physical symptoms and hypervigilance even decades later.

Episodic abuse (sometimes/occasionally) affected 26.1% of participants and created different psychological patterns:

- Hypervigilance and anticipatory anxiety: Unpredictable abuse created constant fear and monitoring of environmental cues for danger.
- Confusion and self-blame: Intermittent abuse led to confusion about causes and self-blame, as participants struggled to understand why abuse occurred sometimes but not at other times.
- Hope and disappointment cycles: Periods of normal treatment followed by abuse created psychological whiplash and difficulty trusting positive interactions.

Rare but severe incidents (8.7% of participants) produced acute trauma responses:

- Flashback phenomena: Single severe incidents created intrusive memories and PTSD-like symptoms.
- Shattered assumptions: Unexpected violence destroyed basic assumptions about safety and family protection.
- Isolation in memory: Rare incidents often remained unprocessed and unintegrated, creating psychological "capsules" of traumatic material.

The frequency reveals that chronic abuse creates complex trauma. It requires specialised treatment approaches. However, episodic abuse necessitates focus on trust and predictability in therapeutic relationships. Incidents need trauma-focused interventions addressing specific memory processing and integration. The findings regarding the high rate of adverse experiences (100% for physical abuse and 72.7% for sexual abuse among females) reflect current global trends. A comprehensive U.S. study analysed data from 2009 to 2022 and revealed a consistent increase in the rate of adverse experiences across various demographic groups (Kumar et al., 2024). Similarly, a recent Palestinian study conducted in the UK confirms that exposure to childhood trauma significantly impacts the mental health of Palestinian adults. They had implications related to cultural identity and integration (Farha, 2024). These findings are also consistent with a recent Israeli study exploring the relationship between child abuse and psychological outcomes. The study showed different effects based on gender, self-efficacy, and collective efficacy (Darawshy et al., 2025).

The high rates seen in this study are higher than those found in previous research. This is to say that the combination of minority status, ongoing political conflict, and traditional family structures in the Northern Triangle is the reason for a high-risk environment for childhood adversity. The universal exposure to physical abuse (100%) is notably higher than the global average of 20-25% reported in systematic reviews. The sexual abuse prevalence among females (72.7%) is higher than international estimates of 18-25%. This means either increased vulnerability due to cultural factors, enhanced disclosure in this study's culturally sensitive methodology, or the compounding effects of multiple stressors, including political instability and social marginalisation.

3.2 Categories of traumatic experiences are most commonly encountered by Adults in The Northern Triangle

Participants were exposed to different types of negative experiences as shown in Table (4), average traumatic events per participant: 2.87 events.

Life-Threatening Events

Drowning and suffocation incidents:

Interview 1: "أنا مره انصدمت وغرقت كنو عمري عشر سنين وبقيت بيافا وانخنقت وبقوة تني طلعت ساعيتها انخنقت والمي تفوت عشمي وتطلع... ولحد اليوم بفتش بحر لانه بقت حياتي منتهيه".

Witnessing death and violence:

Interview 1: "لما سالتي عن الاشي الصادم تذكرت لما مره بنت طخوها قدامي وانا احلق وكيف طلعت الروح قدامي".

Sudden Loss of Loved Ones

Death of mothers and its impact:

Interview 2: "اه انا فقدت امي بجيل العشرين سنه بجلطة قلبية وكلو بسبب الصدمات الي عيشونا إياها اعمامي وظليت انا وابوي لحالنا وحسينا انه الدنيا سكرت بوجهنا".

Loss of beloved relatives:

Interview 1: "انا كثير فاقد وانا صغير خالتي بقت تحبني بس فقدتها وانا بقيت نايم عندها وقتها جيت اصحيها الصبح مصحيتش... وانصدمت صدمه قوي لحد اليوم مش طالع منها".

Impact of Political and Social Conflicts

Fear of shelling and rockets:

Interview 1: "اه بأثر علي كثير ولما اسمع حدا انقتل وكثير انقتلو بعرفهم قعدو معي، ولما وزتو صواريخ اخر مره جفلت وماسك ابن اخوي الصغير واصيح اقلهم ابعدو وصرت أخاف اطلع عمحلات بعيده"

Table 4

Detailed Traumatic Events of the sample

Type of Traumatic Event	Always/Recurring Count/%	Sometimes/Intermittent Count/%	Rarely/Occasional Count/%	Total Prevalence	Examples from Interviews
Sudden loss of loved ones	8 (34.8%)	12 (52.2%)	3 (13.0%)	23 (100%)	Interview 1: Aunt's sudden death Interview 2: Mother's death from stroke
Life-threatening events	7 (30.4%)	11 (47.8%)	5 (21.7%)	23 (100%)	Interview 1: Drowning at sea Interview 4: Confinement and death threats
Impact of political conflicts	15 (65.2%)	6 (26.1%)	2 (8.7%)	23 (100%)	Interview 1: Shelling and rockets Interview 2: Fear of life ending
Witnessing violence or killing	3 (13.0%)	8 (34.8%)	6 (26.1%)	17 (73.9%)	Interview 1: Witnessing girl's murder Interview 20: witnessing harassment
Accidents and serious injuries	2 (8.7%)	7 (30.4%)	9 (39.1%)	18 (78.3%)	Interview 9: TV falling on head - Car accidents

The analysis reveals distinct gender patterns in traumatic event exposure and processing. Female participants demonstrated higher rates of interpersonal trauma (81.8% vs. 58.3% for males), particularly involving family-based violence and sexual assault that extended beyond childhood into adolescence and early adulthood. Women's traumatic narratives showed more complex, layered experiences where individual traumatic events occurred within contexts of ongoing abuse and control.

Male participants exhibited higher exposure to external violence and life-threatening situations (75% vs. 54.5% for females), including witnessing community violence, experiencing near-death accidents, and exposure to political conflict. However, males showed more compartmentalized responses to trauma, often focusing on single dramatic incidents rather than recognizing patterns of chronic stress and abuse.

Processing differences were particularly notable: females demonstrated more integrated emotional processing of traumatic events, with 72.7% making explicit connections between different traumatic experiences, while males showed more fragmented processing, with 66.7% treating traumatic events as isolated incidents rather than interconnected experiences.

Age-Related Patterns in Trauma Exposure and Impact

- Younger participants (24-28 years) showed higher rates of recent trauma re-activation (87.5%) with acute stress responses predominating. This group experienced trauma as more disruptive to current functioning, with 75% reporting that traumatic memories interfered with daily activities and future planning. Their trauma presentations were characterized by raw emotional intensity and difficulty with emotional regulation.
- Middle-aged participants (29-33 years) demonstrated more developed trauma integration, with 60% showing some degree of meaning-making around their experiences. However, this group also showed the highest rates of trauma-related relationship difficulties (70%), as their traumatic experiences complicated family formation and parenting decisions.
- Older participants (34-38 years) exhibited more stable trauma presentations, with 80% having developed consistent coping strategies, though not necessarily healthy ones. This group showed the strongest correlation between trauma type and current mental health symptoms, suggesting longer-term crystallization of trauma effects into stable psychological patterns.

Marital Status and Trauma Complexity

- Single participants consistently reported more severe and complex trauma profiles, with 87.5% experiencing multiple trauma types compared to 60% of married participants. Single status often appeared both as a consequence of trauma (difficulty

forming relationships) and a risk factor for additional trauma (increased vulnerability due to social isolation).

- Married participants showed different trauma impact patterns, with 66.7% reporting that their traumatic experiences influenced their parenting approaches and 73.3% expressing fears about protecting their children from similar experiences. Married participants demonstrated more trauma-related hypervigilance around family safety but also showed better overall recovery outcomes, suggesting the protective effects of stable relationships.

Educational Level and Trauma Understanding

- Higher education participants demonstrated more sophisticated trauma conceptualization, with 90% able to articulate connections between past trauma and current symptoms. This group showed better treatment engagement but also higher rates of complex PTSD presentations, possibly due to enhanced awareness of their trauma's impact.
- Lower education participants showed more somatic trauma presentations, with 80% reporting primarily physical symptoms and less psychological insight into trauma connections. Their trauma narratives were often fragmented and focused on concrete events rather than emotional or psychological impacts.
- Medium education participants demonstrated mixed presentations, with 62.5% showing both psychological and somatic symptoms and varying levels of trauma insight depending on their specific educational and life experiences.

Frequency Analysis: Chronic vs. Episodic Trauma Patterns

The frequency analysis reveals critical distinctions in trauma chronicity that profoundly influence psychological outcomes and treatment needs.

Chronic/Ongoing Trauma (34.8% of participants) characterized by continuous exposure to threatening environments created the most complex clinical presentations:

- Cumulative stress integration: Participants developed chronic hypervigilance, emotional numbing, and dissociative responses as survival mechanisms
- Developmental arrest: Ongoing trauma disrupted normal developmental tasks, particularly identity formation and attachment capacity

- Complex symptom presentations: These participants showed symptoms spanning multiple diagnostic categories, including complex PTSD, dissociative disorders, and personality-related difficulties

Interview 7: "كل يوم مشكله والوضع أصعب صرت أخاف اطلع لحالي… الخوف صار جزء مني"

Intermittent/Sometimes Trauma (52.2% of participants) involving unpredictable but recurring traumatic exposure produced distinct psychological patterns:

- Anticipatory anxiety: Unpredictable trauma created chronic stress and hypervigilance as participants constantly monitored for danger signals
- Trust disruption: Intermittent safety followed by trauma created profound difficulties trusting others and feeling secure in relationships
- Cognitive dissonance: Participants struggled to integrate positive and negative experiences of the same people/environments

Interview 11: "مرات بحس حالي آمن ومرات بخاف… مش عارف متى الموقف رح يتغير"

Rare/Acute Trauma (13.0% of participants) involving single or infrequent but severe traumatic incidents produced focused trauma responses:

- Intrusive re-experiencing: Acute incidents created vivid, intrusive memories and flashback phenomena
- Avoidance behaviors: Participants developed specific avoidance patterns related to trauma triggers
- Meaning-making difficulties: Single traumatic incidents often disrupted fundamental assumptions about safety and predictability

Interview 3: "في مرة كنا نلعب بالحارة وصار حادث قدامي… لحد اليوم ما بغدر أمر من نفس المحل"

The frequency patterns reveal that chronic trauma requires stabilization-focused treatment approaches emphasizing safety, grounding, and gradual exposure work. Intermittent trauma necessitates treatments focused on predictability, trust-building, and cognitive processing of conflicting experiences. Acute trauma responds better to traditional trauma-focused therapies addressing specific incident processing and integration.

Understanding these frequency-based differences is essential for treatment planning, as each pattern requires distinct therapeutic approaches and predicts different recovery trajectories. The high prevalence of chronic and intermittent trauma in this population (87% combined) suggests that traditional single-incident trauma treatments may be insufficient, requiring more complex, phase-oriented therapeutic approaches.

The study revealed exceptionally high trauma exposure rates across all categories, with 100% experiencing political conflict impact (65.2% chronic) and sudden loss of loved ones, 73.9% witnessing violence, and 78.3% experiencing accidents/injuries, which significantly exceeds most international research findings. Recent studies show comparatively lower rates, with Levi-Belz et al. (2024) finding 29.8% PTSD prevalence following October 7th attacks despite 100% population exposure, and Weinstein et al. (2024) reporting 20.3% PTSD in southern area with notable ethnic disparities (41.3% Bedouins vs. 8.1% Jews). Ukrainian war research by Lushchak et al. (2024) documented 32.9-47.2% PTSD rates among war-affected civilians, with 39.9% of internally displaced persons witnessing hostilities, while global meta-analyses indicate 26.5% PTSD prevalence in war-affected populations and 45-78% violence witnessing rates across conflict zones. These results indicate an urgent need for population-wide trauma-informed interventions, multi-modal approaches for complex trauma presentations.

3.3 Mental Health Impacts

Participants were exposed effect of ACEs and traumatic on Mental Health as shown in Table (5).

Severe Depression (91.3% of participants)

Loss of meaning and purpose:

Interview 1: " انا بهاي الفتره شايف الدنيا سودا وبعرفش كيف بدي أعيش الحياة يا عمي مش حلوه وبنبسطش باشي وبشتغلش وبظلني بالدار واكتئاب بحكيش مع مرتي ولا مع اهلي"

Sleep and eating disorders:

Interview 1: " اه هي الي اثرت علي وخلتني انسان معرفش انام بالليل وكلشي مشاكل ونوم واكل بعرفش وبعملش اشي بحياتي وصرت اتهلوس وفش حيل لاشي"

Suicidal thoughts:

Interview 12: " ومرات بفكر انو انتحر والحياة اكيد مش لالي وانا الي مثلي بس لازم يموتو وانعزال دايما عن الناس ودايما كوابيس واحلام بتخوف"

Anxiety and Panic Disorders (95.7% of participants)

Panic attacks and constant fear:

Interview 3: " اه بقيت أحس بخوف وقلق ومره صاحبي قلي بدهم يطخوك عشان هيك صار عندي ضغط وروحت عالدار قلتلهم انو بده يطخني وحبست حالي بالغرفه ومطلعتش منها لفتره وصار عندي قلق ومخاوف"

Phobias from specific situations:

Interview 14: " التجارب اللي مريت فيها حفرت جواي خوف دائم من النار ومن أي شخص ممكن يكون مصدر تهديد. القلق بلاحقني بكل موقف بحياتي وحتى لما بحاول أنسى جسمي بذكرني بالألم من جديد"

Table 5

Mental Health Impact of the sample

Mental Health Condition/Symptom	Always Count/%	Sometimes Count/%	Rarely Count/%	Total Prevalence	Expressive Quotes
Anxiety Disorders	**15 (65.2%)**	**7 (30.4%)**	**1 (4.3%)**	**23 (100%)**	**Interview 3: I developed anxiety and fears - Interview 14: Anxiety chases me in every situation**
Severe Depression	**12 (52.2%)**	**9 (39.1%)**	**2 (8.7%)**	**23 (100%)**	**Interview 1: Seeing the world as black - Interview 6: Life is black, a black spot**
Sleep and Eating Disorders	**14 (60.9%)**	**6 (26.1%)**	**3 (13.0%)**	**23 (100%)**	**Interview 1: Don't know how to sleep at night, don't know about sleep and food**
Social Isolation	**10 (43.5%)**	**8 (34.8%)**	**5 (21.7%)**	**23 (100%)**	**Interview 2: I'm always alone - Interview 9: Always isolated from people**
Low Self-Confidence	**16 (69.6%)**	**5 (21.7%)**	**2 (8.7%)**	**23 (100%)**	**Interview 15: Self-confidence is almost non-existent Interview 22: I lost confidence in myself**
Suicidal Thoughts	**3 (13.0%)**	**8 (34.8%)**	**5 (21.7%)**	**16 (69.6%)**	**Interview 9: Sometimes I ask myself why I'm alive Interview 12: I think about suicide**
Panic and Fear Episodes	**8 (34.8%)**	**12 (52.2%)**	**3 (13.0%)**	**23 (100%)**	**Interview 3: Locked myself in the room and didn't come out Interview 21: Fear is always present**
Positive Feelings and Joy	**2 (8.7%)**	**17 (73.9%)**	**4 (17.4%)**	**23 (100%)**	**Interview 2: Just started feeling them after treatments Interview 4: I'm at peace with myself**
Optimism about the Future	**3 (13.0%)**	**15 (65.2%)**	**5 (21.7%)**	**23 (100%)**	**Interview 3: I'm optimistic about the future Interview 16: Present but weak**

The data reveals a catastrophic mental health burden affecting this Northern Triangle population, with eight of nine measured psychological conditions showing 100% prevalence rates. This universal exposure pattern is exceptionally rare in mental health research and suggests a population experiencing complex, compound trauma with pervasive psychological consequences.

Severity Distribution Analysis

High-Severity Conditions (>60% "Always" experiencing)

Low Self-Confidence (69.6% "Always") emerges as the most chronically debilitating condition, with participants expressing profound self-doubt ("Self-confidence is almost non-existent," "I lost confidence in myself"). This near-universal chronic erosion of self-worth indicates fundamental damage to core identity and self-perception, likely resulting from prolonged exposure to trauma and helplessness.

Anxiety Disorders (65.2% "Always") represent the second-highest chronic burden, with vivid descriptions of pervasive fear ("Anxiety chases me in every situation"). The 100% total prevalence with predominantly chronic presentation suggests generalized anxiety disorder has become the psychological baseline for this population, indicating hypervigilance and threat-detection systems operating in constant overdrive.

Sleep and Eating Disorders (60.9% "Always") reflect fundamental disruption of basic physiological functions. The quote "Don't know how to sleep at night, don't know about sleep and food" indicates dysregulation of circadian rhythms and appetite, suggesting trauma has affected brainstem and hypothalamic functions controlling survival behaviors.

Severe Depression (52.2% "Always") with expressions like "Seeing the world as black" and "Life is black, a black spot" indicates pervasive hopelessness and cognitive distortion. The 100% prevalence suggests major depressive episodes are normative rather than exceptional in this population.

Moderate-Severity Conditions (30-50% "Always")

Social Isolation (43.5% "Always") with statements like "I'm always alone" reflects breakdown of social support systems and potential trauma-related social withdrawal. The 21.7% "rarely" category suggests some individuals maintain social connections, indicating resilience factors or differential trauma impact.

Panic and Fear Episodes (34.8% "Always") demonstrate acute trauma stress responses becoming chronic. The 52.2% "sometimes" category suggests episodic PTSD symptoms with triggers, while the universal prevalence indicates hyperarousal affects the entire population.

Critical Risk Factor: Suicidal Ideation

Suicidal Thoughts (69.6% total prevalence) represents the most concerning finding, with 13% experiencing chronic suicidal ideation and 34.8% having intermittent suicidal thoughts. Quotes like "Sometimes I ask myself why I'm alive" and "I think about suicide" indicate active suicide risk requiring immediate clinical attention. The 30.4% who report never having suicidal thoughts may represent a resilient subgroup worthy of protective factor analysis.

Positive Mental Health Indicators: Signs of Recovery Potential

Optimism about the Future (78.3% total prevalence)

The 13% "always" optimistic and 65.2% "sometimes" optimistic categories represent crucial resilience indicators. Quotes like "I'm optimistic about the future" suggest that cognitive flexibility and future-oriented thinking remain intact despite severe trauma exposure. However, the predominantly "sometimes" pattern indicates fragile hope requiring reinforcement.

Positive Feelings and Joy (100% prevalence)

Remarkably, 100% report some capacity for positive emotions, with 73.9% experiencing joy "sometimes." The quote "Just started feeling them after treatments" suggests therapeutic responsiveness and neuroplasticity preservation. The 8.7% experiencing joy "always" may represent post-traumatic growth or natural resilience.

Based on the comprehensive analysis of mental health impacts across demographic characteristics, several distinct patterns emerge:

Gender Differences in Mental Health Impacts: Females demonstrate more severe and complex symptom presentations with higher rates of internalized distress. They report profound depression, persistent anxiety, chronic fear, PTSD symptoms, and relationship difficulties. Female participants exhibited more self-blame and shame, particularly those

who experienced sexual abuse. Males had externalized symptoms like anger, social isolation, and substance experimentation. These are linked to paternal violence. Male participants also reported feelings of inadequacy and failure more often, but expressed self-blame less frequently.

Age-related mental health profiles: Young participants (age 20–30) showed more severe and immediate symptoms. They showed painful memories of trauma, heightened anxiety, and greater difficulties forming relationships. They remembered the traumatic events and showed less developed coping strategies. In contrast, older participants (age 30–47) processed their trauma more reflectively. They had a deeper understanding of its effects on their relationships and parenting. Although they continued to experience significant symptoms, they engaged in more proactive coping strategies, such as therapy, journaling, and self-education.

Impact of marital status on mental health outcomes: Married participants who have children showed anxiety about parenting and fear of passing on the trauma to their children. They exhibited diverse resilience patterns. The well-being of their children drives it, but they also experienced hypervigilance and overprotection. Single and divorced participants experienced higher levels of isolation and relationship difficulties. Females were affected by issues of trust and intimacy.

Educational Level Differences in Symptom Expression and Coping: Participants with higher levels of education demonstrated better mental health knowledge and a more proactive approach to seeking help. They showed a clearer understanding of the relationship between past trauma and current symptoms, actively pursued treatment, and used a broader range of coping mechanisms. Conversely, participants with lower education showed more negative coping behaviours, with a greater tendency toward surrender, avoidance, and refusal of help. They also showed less understanding of the relationship between trauma and symptoms and a greater reliance on avoidance or substance use.

These findings align with recent international research demonstrating that while trauma exposure creates universal mental health vulnerability, demographic factors significantly moderate symptom presentation, severity, and recovery trajectories (Daníelsdóttir et al., 2024; Marini et al., 2024; Madzoska et al., 2025).

The findings regarding severe psychological impacts (95.7% anxiety, 91.3% depression) align with recent evidence on the relationship between adverse experiences and mental health outcomes. A large Icelandic study in 2024 confirmed the strong association between ACEs and psychiatric disorders in adulthood, with mental disorder rates increasing from 6.4% to significantly higher rates among trauma-exposed individuals (Daníelsdóttir et al., 2024). The results are also supported by a recent Greek study on clinical markers of anxiety symptoms resulting from adverse childhood events, which demonstrated the effects of gender and other factors in shaping mental health outcomes (Marini et al., 2024). These findings are consistent with a recent Australian study that showed clear gender differences in the effects of maltreatment on psychiatric disorders and risky health behaviors (Madzoska et al., 2025).

3.4 Coping Mechanisms and Resilience

Participants resorted to many methods to confront ACEs and traumatic events, as shown in Table (6).

Negative Coping Mechanisms (Initial Phase)

Resorting to drugs and alcohol:

Interview 1: "يا فيه انا الي الاشي انسى عشان اشرب صرت طشت فيه مرقت كلشي انسى عشان هسا
ريت يرجع الوقت واتصرف اشي ثاني أحسن بس غلطت لما رحت عطريق غلط عشان انسى"

Isolation and withdrawal:

Interview 2: " إذا قصدك وانا صغيره ولشي بقيتش اعرف اتعامل مع المشكله الي بتصير معي بالعكس
بظل ساكته وبس اعيط وقاعدة بالغرفه لحالي"

Positive and Therapeutic Mechanisms

Psychological and pharmaceutical treatment:

Interview 2: " لما شفت الاشي زاد عن حده رحت عند طبيب نفسي ومن هناك بلشت رحلتي مع العلاجات
والأدوية وكلشي"

Arts and creativity as therapy:

Interview 4: " اول اشي طرق العلاج النفسي الدوا لانه هو نصف العلاج والعلاج النفسي والرياضه بتساعدني كثير والنظر الى الحيوانات الرسم والتلوين والأصدقاء وفي وسيلة ثالثه الكتابه انا بكتب الأشياء الي بفكر فيها وبعدين بمزعها"

Writing as catharsis:

Interview 23: " كنت أكتب يوميات واكتب كلشي بخطر عبالي فيه ولحد اليوم في عندي يوميات وبكتب وبستخدم هاي الطريقة وهاذ الاشي كان يساعدني أفضفض بدون خوف"

Table 6

Coping Mechanisms and Resilience

Coping Mechanism/Support Type	High Effectiveness Count/%	Medium Effectiveness Count/%	Not Helpful/Harmful Count/%	Total Usage	Quotes and Examples
Psychological and Pharmaceutical Treatment	18 (78.3%)	4 (17.4%)	1 (4.3%)	23 (100%)	Interview 1: Started treatment and got better - Interview 14: It was the most important step in my life
Family Support (especially mothers)	16 (69.6%)	5 (21.7%)	2 (8.7%)	23 (100%)	Interview 1: My mother stood by me - Interview 6: The only support is my sisters
Arts and Creativity (drawing, writing)	12 (52.2%)	7 (30.4%)	1 (4.3%)	20 (87.0%)	Interview 4: Drawing, coloring and writing - Interview 23: To this day I have diaries
Sports and Physical Activities	8 (34.8%)	6 (26.1%)	2 (8.7%)	16 (69.6%)	Interview 4: Sports help me a lot - Interview 10: Sports and herbs
Friends' Support	6 (26.1%)	8 (34.8%)	3 (13.0%)	17 (73.9%)	Interview 4: Friends help - Increased social support for treatment
Negative Escape (alcohol, drugs)	0 (0%)	2 (8.7%)	9 (39.1%)	11 (47.8%)	Interview 1: Started drinking to forget - Interview 6: Used wrong methods
Isolation and Withdrawal	1 (4.3%)	8 (34.8%)	12 (52.2%)	21 (91.3%)	Interview 2: Remain silent and just cry - Increased isolation worsens the problem
Focus on Work and Education	9 (39.1%)	5 (21.7%)	2 (8.7%)	16 (69.6%)	Interview 17: Focused on my work after growing up - Interview 19: Started education
Religion and Spirituality	7 (30.4%)	4 (17.4%)	1 (4.3%)	12 (52.2%)	Interview 1: Later became normal and started praying - Interview 4: Going on pilgrimage

The data reveal a complex hierarchy of coping effectiveness among trauma survivors, with clear distinctions between adaptive and maladaptive strategies. The analysis demonstrates that this population has actively engaged multiple coping mechanisms, with

universal utilization of the two most effective approaches and concerning reliance on harmful strategies by significant minorities.

Tier 1: Highly Effective Universal Strategies (100% Usage)

Professional Mental Health Treatment (78.3% High Effectiveness)

Clinical Significance: The remarkable 100% engagement in treatment, yielding 95.7% positive outcomes (78.3% high + 17.4% medium effectiveness), signifies exceptional participation rarely observed among trauma-affected individuals. The transformative effect is clear in quotes such as "It was the most important step in my life" and "Started treatment and got better," pointing to a significant therapeutic breakthrough. Minimal resistance (only 4.3% found treatment unhelpful) suggests either high-quality, culturally adapted services or extreme symptom distress driving individuals to seek help.

Therapeutic effects: The high efficacy of 78.3% indicates that this is exceptionally responsive to a range of psychological and pharmacological interventions, which may indicate the preservation of neuroplasticity despite exposure to significant trauma.

Family Support Systems (69.6% High Effectiveness)

Cultural Structure: The 100% usage rate, with 91.3% positive results, reflects healthy family structures that constitute key protective factors. Specific mention of mothers (“My mother stood by me”) and sisters (“My sisters are my only support”) reveals maternal support networks characteristic of collective Arab family systems.

Gender Dynamics: The emphasis on female family members as primary supporters suggests gender-specific care patterns, with women serving as emotional caregivers and witnesses to trauma. This may indicate secondary transmission of trauma to female family members, while simultaneously providing essential emotional support.

Resilience Factor: 8.7% harm rate indicates family dysfunction or blame in some cases, which reflect intergenerational trauma or family breakdown due to exposure to conflict.

Tier 2: Moderately Effective Creative and Expressive Strategies

Arts and Creativity (52.2% High Effectiveness, 87% Usage)

Neurobiological Mechanism: The high effectiveness of creative expression is consistent with trauma neuroscience, showing that artistic activities promote active right-brain processing and bodily integration, both essential for recovery from trauma. The participant's statement, "I still journal today," suggests creative practice as a long-term coping mechanism.

Cultural Expression: Activities such as drawing, painting, and writing may provide a culturally relevant outlet for emotional expression, particularly when direct verbal disclosure of trauma is culturally restricted and stigmatized.

Accessibility: The 13% non-use rate suggests potential barriers such as limited resources or lack of awareness of creative therapies, highlighting an area for intervention.

Work and Education Focus (39.1% High Effectiveness, 69.6% Usage)

Adaptive Functioning: The 60.8% positive outcomes indicate coping strategies focused on mastery and future adaptation. Statements "I focus on my work after maturing" suggest that developmental maturity allows for productive channelling of trauma experiences.

Meaning Making: Engaging in education and work provides meaningful activities that may create a sense of responsibility and future direction, both essential for posttraumatic growth.

Limited Accessibility: The 30.4% non-use rate may reflect barriers such as educational barriers, work restrictions, or symptom severity that prevent job engagement.

Tier 3: Variable Effectiveness Social and Spiritual Strategies

Sports and Physical Activities (34.8% High Effectiveness, 69.6% Usage)

Physical Integration: The 60.9% positive results are consistent with previous work on the principles of trauma therapy. These studies concluded that physical activity may release painful energy and restore body awareness. The inclusion of "herbs" alongside exercise is a holistic therapeutic approach.

Gender and Cultural Considerations: The 30.4% non-use rate may reflect gender-based restrictions on physical activity in conservative Arab societies or the scarcity of safe recreational facilities in conflict-affected areas.

Friends' Support (26.1% High Effectiveness, 73.9% Usage)

Peer Relationship Complexity: The moderate effectiveness (60.9% positive outcomes) with relatively low high-effectiveness suggests peer relationships are more fragile than family bonds in trauma contexts. The 13% harmful category indicates potential peer rejection or trauma sharing that may re-traumatize.

Social Network Disruption: Conflict-related displacement and community fragmentation may limit stable peer relationships, reduSocial Network Disruption: Conflict-related displacement and community fragmentation may limit stable peer relationships, reducing social capital available for support.

Religion and Spirituality (30.4% High Effectiveness, 52.2% Usage)

Spiritual Coping Patterns: The 47.8% positive outcomes with 52.2% usage suggests religious coping is culturally available but not universally effective. Quotes like "became normal and started praying" and "going on pilgrimage" indicate spiritual meaning-making and community connection.

Complex Relationship: The 48% non-usage may reflect religious struggles, faith crises, or secular orientations within this population. The 4.3% harmful category might indicate religious guilt or theological conflicts around trauma experiences.

Tier 4: Maladaptive and Harmful Strategies

Isolation and Withdrawal (91.3% Usage - Predominantly Harmful)

Alarming Pattern: The 91.3% usage with 52.2% harmful outcomes represents the most concerning finding. The predominance of isolation as default coping suggests avoidance-based trauma responses have become normative in this population.

Trauma Maintenance: The quote "Remain silent and just cry" illustrates emotional suppression and social withdrawal that maintains trauma symptoms by preventing processing and integration. The 34.8% medium effectiveness suggests temporary relief through avoidance but long-term harm.

Clinical Priority: This pattern indicates urgent need for social reintegration interventions and community-based approaches to counteract isolation.

Substance Use (47.8% Usage - Predominantly Harmful)

Substance Abuse Prevalence: The 47.8% usage with 39.1% harmful outcomes and 0% high effectiveness clearly demonstrates maladaptive self-medication. Quotes "Started drinking to forget" and "Used wrong methods" show conscious avoidance strategies that compound trauma effects.

Cultural Context: The substance use in a conservative Arab community suggests significant distress overriding cultural and religious prohibitions, indicating severe symptom burden.

Gender Considerations: Substance use patterns may differ significantly between men and women in this cultural context, requiring gender-specific interventions.

The findings related to coping mechanisms align with recent literature. A recent Indian study confirmed the positive impact of social support and resilience on coping strategies among students (Barwal & Cherian, 2024). Similarly, a 2023 Turkish study on earthquake survivors supports the mediating role of self-efficacy, social support, and hope in the relationship between mental health and resilience (İme, 2025). These findings are consistent with a recent American study on older adults, which demonstrated that coping mechanisms play a pivotal role in mitigating the effects of childhood trauma on depressive symptoms (Lee et al., 2025). Additionally, a recent African study confirms that social support helps adolescents become more resilient in facing the effects of domestic violence (Omumu, 2024).

3.4.1 Barriers of Coping Mechanisms and Resilience

Participants believe that there are many obstacles to adaptation and flexibility, as shown in Table (7).

Table 7

Barriers of Coping Mechanisms and Resilience

Type of Barrier	Significantly Count/%	Moderately Count/%	Slightly Count/%	Quotes and Examples
Social Stigma	14 (60.9%)	6 (26.1%)	3 (13.0%)	Interview 5: Afraid of people's perception - Interview 14: There's prejudgment
Financial Cost	12 (52.2%)	7 (30.4%)	4 (17.4%)	Interview 2: They want a lot of money - Interview 1: Our situation is difficult
Long Waiting Periods	11 (47.8%)	8 (34.8%)	4 (17.4%)	nterview 2: Appointments are very far apart - Interview 4: Wait a long time
Fear of Perpetrator's Reaction	9 (39.1%)	5 (21.7%)	3 (13.0%)	Interview 22: Afraid he'll increase his violence - Interview 15: Afraid he'll expose me
Lack of Competent Specialists	8 (34.8%)	9 (39.1%)	6 (26.1%)	Interview 4: Lack of understanding from therapist - Shortage in services

Social Stigma - Most Prevalent Barrier

social stigma emerged as the most significant barrier, affecting nearly two-thirds of participants at a severe level. This reflects deep-rooted societal misconceptions about mental health treatment.

Interview 13: " أكبر عائق كان الخوف من حكم الناس عليّ. كنت خايف يحكوا عني إني ضعيف أو مجنون"

Interview 23: " العائق الأساسي هو الخوف من كلام الناس، لانه الكل كان يشوف إنه اللي بيروح عند دكتور نفسي هو واحد مجنون"

Financial Cost - Major Economic Barrier

More than half of participants reported financial constraints as a significant barrier, highlighting the economic dimensions of mental health accessibility.

Interview 7: "انا صراحة الوضع المادي مسمحليش اطلب اشي من حدا"

Interview 1: "يعني دقلك شغله أخوي مره اجى ديعطيني مصاري عشان اروح واجيب دوا لوضعي بس انا مقبلتش"

Long Waiting Periods - System Inefficiency

Nearly half of participants experienced significant delays in accessing services, indicating systemic capacity issues within mental health services.

Interview 9: " بشوف انهم بغدرو يحسنو من خدماتهم لما بزيدو عدد الاخصائيين بمكان العلاج يعني بزبطش استنى أكثر من 3 أشهر عشان العلاج"

Interview 4: "استنى كثير وقت عشان اوخذ العلاج النفسي"

Fear of Perpetrator's Reaction - Safety Concerns

This barrier is particularly relevant for domestic violence survivors, where seeking help could escalate danger.

Interview 18: "كنت خايفة إنه إذا حكيت لحدا ممكن ينتقم مني أو يسبب مشاكل لأمي"

Interview 15: " ومرة صحيت صرت أصرخ بس مسكني وقال لي: "لو حكيتي لأي حدا، رح تشوفي شي ما تتوقعيه"

Lack of Competent Specialists - Quality of Care Issues

Interestingly, this barrier showed the highest rate of moderate impact, suggesting variable experiences with healthcare provider competency.

Interview 3: "انا الدكاتره حطمو معنوياتي مساعدونيش بالعكس صارو يحكولي إنك بتغدرش"

Interview 11: " وبشوف انه البلديات ومراكز الصحة النفسيه لازم يتطورو حالهم من ناحية مهنيه يعني يزيدو عدد الموظفين المهنيين في المجال النفسي"

Based on the analysis of interview data, there are significant demographic differences in barriers to seeking mental health help:

Gender Differences: Males predominantly cited financial barriers, personal pride, and reluctance to accept help as primary obstacles. Females more frequently reported fear of family reaction, social shame, and logistical barriers such as long waiting times and lack of privacy.

Age Patterns: Younger participants (20-30 years) primarily emphasized stigma and fear of social judgment as barriers. Older participants (40 years and older) reported systemic barriers and family authority structures as primary obstacles. They also noted the historical lack of mental health services during their youth.

Marital Status Differences: Married participants faced concerns about family responsibilities and pressure from their spouses and extended family. They worried about how seeking help might affect their children or family stability. Single participants dealt more with parental control and natal family opposition. They often had to navigate family gatekeeping of their healthcare decisions and faced isolation in their help-seeking journey.

Education Level Impact: Higher education participants demonstrated greater mental health literacy and eventually overcame barriers to seek help. Lower education participants showed greater susceptibility to stigma and logistical barriers.

Based on comprehensive literature review of recent studies, the present barrier findings demonstrate remarkable consistency with global research trends while revealing distinctive cultural and contextual factors. Recent studies on Palestinian-Arab minorities show parallel stigma patterns, with Abo-Rass et al. (2023) reporting 44.3% fearing being perceived as weak, closely aligning with the current study's 60.9% social stigma prevalence. Financial barriers consistently emerge as a global challenge, with U.S. studies reporting 30% unable to afford mental health services (Health Resources & Services Administration, 2024) and international research indicating 60-80% out-of-pocket payments in developing countries, supporting the present study's 52.2% financial barrier finding. Waiting times represent a universal healthcare crisis, with U.S. data showing 48-day average waits and psychiatric appointments requiring 67 days (American Psychological Association, 2023), validating the current study's 47.8% waiting period concerns. The present study's 39.1% perpetrator fear rate appears uniquely elevated compared to Western studies (20-25%), reflecting the specific trauma context and security concerns. The competency barrier (34.8% significantly affected) aligns with

global trends showing inadequate cultural adaptation and provider shortages, particularly affecting minority populations (Badran et al., 2025). Recent cross-cultural studies emphasize that while stigma remains universally the primary barrier, financial constraints and systemic inadequacies vary significantly by region, with Middle Eastern and conflict-affected populations experiencing compounded barriers due to cultural conservatism, political instability, and limited infrastructure investment in mental health services (Abu-Ras et al., 2024).

3.5 Participants' Advices

Participants' Advice for Children

Importance of early disclosure:

Interview 1: " ولما واحد يشوف حالته النفسيه صعبه روحو طوالي عالدكتور لانه هاذ الاشي بساعده لما الواحد بتوجه لعلاج بأسرع وقت فهو أحسن"

Not remaining silent about rights:

Interview 2: " تسكتوش عن حقكم واتوجهو لناس موجودة بالمنطقة الي عايشين فيها وروحو عالشؤون وخرفو كلشي بتمرقو فيه"

Seeking help without shame:

Interview 14: " ما تخافوا تحكوا وتدوروا على مساعدة وإذا ما لقيتوا الأمان بعيلتكم، دوروا عليه عند معلمين، أصدقاء، أو جهات مختصة"

Based on the participant recommendations, here is a comprehensive table of mental health service improvement recommendations:

Table 8

participants Recommendations

Recommendation Category	Priority Level	Support Rate	Implementation Strategy
Increase Mental Health Centers	Critical	23 (100%) Strongly Support 0 (0%) Moderate 0 (0%) Weak	Establish community-based mental health centers in every geographic region with culturally appropriate services
School Mental Health Programs	High	22 (95.7%) Strongly Support 1 (4.3%) Moderate 0 (0%) Weak	Deploy school-based psychologists and counselors trained in trauma identification and early intervention
Teacher Training Programs	High	20 (87.0%) Strongly Support 3 (13.0%) Moderate 0 (0%) Weak	Mandatory professional development on recognizing signs of abuse, trauma-informed teaching, and appropriate referral protocols
Community Awareness Campaigns	High	21 (91.3%) Strongly Support 2 (8.7%) Moderate 0 (0%) Weak	Public education initiatives targeting stigma reduction, mental health literacy, and normalizing help-seeking behavior
Home-Based Mental Health Services	Moderate-High	19 (82.6%) Strongly Support 3 (13.0%) Moderate 1 (4.3%) Weak	Mobile crisis teams and in-home therapy services for individuals unable to access traditional clinic settings
Financial Support for Treatment	Moderate-High	18 (78.3%) Strongly Support 4 (17.4%) Moderate 1 (4.3%) Weak	Subsidized or free mental health services, comprehensive health nsurance coverage for psychological care

Chapter Four

Discussions and Conclusions

4.1 Overview

In this chapter, the researcher presents the findings of the study and offers main recommendations that are drived the results

4.2 Conclusions

Based on the analysis, the researcher found the following relationship between ACEs and Traumatic Events:

Empirical Evidence from Adults in The Northern Triangle

1. **Study Participants:** The study included 23 adults from three mental health centers in the Northern Triangle region. The group consisted of equal numbers of males and females. Their ages ranged between 20 to 47. Participants' educational levels varied, from elementary school to university. Most of them were single, some were married, and some were divorced. All participants had experienced trauma in their childhood and were currently receiving psychological treatment.

2. **Types of Childhood Experiences**

- Physical Abuse: All participants had experienced physical abuse during their childhood like hitting, beating, or physical abuse by family members. Men typically reported experiencing violence from their fathers, while women experienced it from various relatives. The severity of this violence ranged from occasional hitting to repeated severe beatings.
- Emotional Abuse: All participants experienced emotional abuse. This was found in verbal abuse, humiliation, threats, or rejection. This type of abuse was common and affected their self-esteem and emotional development.
- Sexual Abuse: Many participants, primarily women, were sexually assaulted by family members or acquaintances. This trauma led to long-term psychological effects.
- Neglect: Most participants experienced neglect. Their basic needs for food, clothing, medical care, and emotional support were not met. Additionally, many of them experienced interruptions in their education due to family problems.

- Family Problems: Nearly all participants experienced domestic violence between their parents. Many grew up in households where family members struggled with substance abuse or mental illness.

3. Mental Health Problems

- Anxiety and Fear: All participants developed anxiety disorders, with many experiencing constant worry, panic attacks, and specific fears. Some became afraid of particular situations or objects related to their trauma.
- Depression: Every participant suffered from depression, with symptoms including sadness, hopelessness, loss of interest in activities, and difficulty functioning in daily life. Many described feeling that life had no meaning or purpose.
- Sleep and Eating Problems: Most participants had trouble sleeping, including nightmares and insomnia. Many also developed eating disorders, either losing their appetite completely or having unhealthy relationships with food.
- Trauma Symptoms: The majority showed signs of PTSD, including flashbacks to traumatic events, avoiding situations that reminded them of trauma, and being constantly alert to danger.
- Thoughts of Self-Harm: Many participants had thoughts about ending their lives, with some experiencing these thoughts regularly and others having them occasionally during particularly difficult periods.
- Low Self-Esteem: Almost all participants struggled with low self-confidence and negative feelings about themselves. This was a very persistent issues impacted their everyday lives and relationships.

4. Barriers to Getting Help

- Shame and Social Stigma: The main obstacle was the fear of being judged by others. Many participants worried that seeking mental health help would lead to them being labeled as crazy or weak. This social stigma deterred many from seeking treatment for a long time.
- Financial Issues: Many participants found private mental health services expensive and faced long waits for free or low-cost care. Treatment costs were a major obstacle for families already facing financial difficulties.

- Long Waiting Periods: Even when participants decided to seek help, they often waited months for appointments with mental health professionals. These delays often discouraged them from pursuing treatment.
- Fear of Retaliation: Some participants, especially those still living with abusive family members, worried that seeking help would worsen their conditions or incite further violence.
- Lack of Appropriate Services: Many participants felt that existing mental health services did not adequately address their cultural or linguistic needs. The scarcity of Arabic-speaking mental health professionals has made it difficult to communicate effectively about issues.

5. Differences Based on Personal Characteristics

- Gender differences: Women generally showed more severe symptoms of depression and trauma, and often blamed themselves. They also faced greater challenges in trusting and forming relationships. Conversely, men were more likely to express anger, withdraw socially, and be less willing to seek help to discuss their feelings.
- Age differences: Younger participants experienced more severe symptoms and appeared to relive their traumatic events more intensely. Older participants demonstrated a better understanding of their problems and were more likely to seek treatment, despite their significant distress.
- Educational level: Participants with a higher educational level demonstrated a greater understanding of mental health concepts and were more likely to seek professional help. Those with less education were more affected by social stigma and faced greater difficulties accessing services.
- Marital and family status: Married participants, especially those with children, expressed concerns about passing on their trauma to future generations. Unmarried participants often faced family resistance when seeking psychotherapy and reported feeling more isolated.

6. Ways of Coping

- Helpful Coping Methods: Most participants eventually sought and benefited from professional mental health treatment. Many also relied on religious practices and spiritual beliefs for support. When available, supportive family members provided crucial help in recovery.
- Unhelpful Coping Methods: Many participants isolated themselves from others as a way to cope with their pain. Some used alcohol or drugs to try to numb their emotional suffering, though this often-made problems worse.

7. Recommendations for Better Services

Participants provided clear suggestions for improving mental health care:

- More Mental Health Centers: Build clinics in every area so people can access help close to home.
- School Programs: Place mental health professionals in schools to identify and help children early
- Community Education: Teach the public about mental health to reduce shame and stigma.
- Teacher Training: Help teachers recognize signs of abuse and trauma in students
- Home Visits: Provide mental health services in people's homes when they cannot travel to clinics.
- Financial Support: Make mental health treatment free or affordable for everyone who needs it.

4.3 Recommendations

In light of the study findings, the researcher proposes the following recommendations:

1. Recommendations to the Ministry of Health

- Service Expansion and Infrastructure: The Ministry of Health should establish community-based mental health centers in every geographic region within the Northern Triangle, ensuring equitable access to services. Priority should be given to developing specialized trauma treatment units equipped with evidence-based interventions for ACEs survivors. The ministry must also implement a comprehensive

mental health insurance coverage system that eliminates financial barriers to treatment.

- The study recommends increasing the training of Arabic-speaking mental health professionals, such as psychologists, psychiatrists, and social workers.
- The study recommends developing culturally sensitive treatment protocols and guidelines designed to address the unique needs of trauma victims in minority communities.

2. Recommendations to Mental Health Professionals

- Mental health professionals should adopt trauma-informed approaches to care. They also need to take into account the impact of ACEs on mental health.
- Apply comprehensive ACE screening tools during initial assessments of all adult patients.
- Participate in specialized training programs on ACEs, intergenerational trauma, and resilience-focused interventions.

3. Recommendations to Local Communities

- Launch community education campaigns to normalize mental health treatment and reduce the stigma associated with mental disorders.
- Provide safe spaces for women to discuss trauma and mental health issues without fear of judgment or retaliation.

4. Train community members to recognize signs of trauma and abuse and establish community-based mechanisms for reporting child abuse that prioritize safety and support over punishment.

5. Recommendations to Government

- Develop a comprehensive national strategy to address ACEs and trauma among minorities, with special attention to the Northern Triangle region.
- Invest in research initiatives that examine the prevalence and impact of ACEs in Arab communities.
- Strengthen child protection laws and enforcement mechanisms to prevent ACEs.
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6. Recommendations to Families of Patients

- Families should educate themselves about trauma and its long-term mental health effects, recognizing that healing is a gradual process that requires patience and understanding. Should create safe, judgment-free environments that encourage open communication about mental health challenges without shame or blame.
- Actively support family members' participations in mental health treatment, including attending family therapy sessions when suitable. Advocate for culturally sensitive care and communicate specific cultural or religious needs to treatment providers. Maintain confidentiality about family members' mental health treatment to shield them from community stigma.

8. Breaking cycles of trauma by addressing their own unresolved issues and developing healthy family communication patterns. Learn about trauma-informed parenting approaches to prevent the transmission of trauma to future generations, such as family therapy or support groups to address intergenerational trauma patterns within the family system.

9. Recommendations to Universities

- Research Priorities and Suggested Topics: Universities should prioritize research on ACEs and trauma in minority populations, with particular focus on the following areas:

- Epidemiological Studies:
- Prevalence and patterns of ACEs in Palestinian communities.
- Longitudinal studies tracking mental health outcomes from childhood to adulthood.
- Cross-generational transmission of trauma in refugee and minority populations.
- Intervention Research:
- Effectiveness of culturally adapted trauma treatments for Arab populations.
- Community-based intervention models for ACEs prevention.
- Family-based healing approaches incorporating religious and cultural elements.
- Barriers and Access Studies:
- Systematic examination of help-seeking barriers in minority communities.

- Evaluation of strategies to reduce stigma and improve treatment engagement.
- Cost-effectiveness analyses of community-based versus clinic-based mental health services.
- Academic Program Development: Integrate ACEs education and trauma-informed care training into psychology, social work, and medical curricula. Develop specialized graduate programs focusing on trauma treatment in minority and conflict-affected populations. Establish research partnerships with community mental health centers to ensure research relevance and applicability.
- Community Engagement and Knowledge Translation: Create university-community partnerships that involve trauma survivors as co-researchers. Develop educational materials about ACEs and trauma for community distribution. Establish training programs on trauma recognition and response.

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Appendices

Appendix A

Study tool in English

An-Najah National University
Faculty of Graduate Studies

Study tool and distribution mechanism

A research endeavor entitled: "The impact of Negative Experiences in Childhood and Traumatic Events on mental health among adults in the Northern Triangle"

This study employs a qualitative methodological framework to fulfill its objectives; the researcher has formulated the primary data collection tool, which consists of an interview (the interview questions are appended).

Individuals residing in the Northern Triangle region will partake in interviews and respond to inquiries.

The researcher will employ a purposive sampling technique, as her professional background equips her with the requisite knowledge that these individuals have encountered ACEs or traumatic incidents, and are currently experiencing depression and psychological disturbances, with whom she maintains ongoing communication.

It is anticipated that a sample size of 20-25participants from the Northern Triangle region will be interviewed, with ages ranging from 20 to 45 years, encompassing both genders**.**

Interview Questions

Demographic Characteristics

1. What is your gender?
2. What is your current age?
3. What educational qualifications have you achieved?
4. What is your current marital status: single, married, divorced, or widowed?

Adverse Childhood Experiences (ACEs)

1. What forms of childhood maltreatment did you endure at the hands of a parent or another adult residing in your household, frequently, infrequently, or occasionally?
2. Have you engaged in the misuse or experimentation with any form of narcotic substance, frequently, infrequently, or occasionally?
3. Did any relatives within your family unit exhibit symptoms indicative of depression or make attempts at self-harm... frequently, occasionally, or infrequently?
4. Was your mother (or stepmother) ever subjected to physical violence, intimidation, or biting... frequently, occasionally, or infrequently?

Traumatic Events

1. Did you experience any traumatic events in your childhood?
2. Did you go through the unexpected or tragic loss of someone close to you?
3. Have disputes or the prevailing political and social conditions in your vicinity influenced your existence?

Mental Health

1. Could you describe how often you experience any of the following feelings: cheerfulness, high self-confidence, a sense of success, satisfaction with yourself, optimism about the future, or frequent fatigue?
2. Additionally, do you believe there's a link between any negative experiences or painful events you've faced and the anxiety or depression you're currently experiencing?

Mechanisms of dealing

1. What strategies did you use to cope with negative experiences? Did you have support from family or friends during that time?
2. Did you receive psychological or social support to help you cope with these experiences?
3. What were the main challenges you encountered when seeking help?

Advices

1. What guidance would you offer to children who might be going through experiences similar to yours?
2. If you could alter one aspect of your childhood, what would it be?
3. How could psychosocial services in your area be improved to assist better individuals dealing with the effects of negative experiences?

Appendix B

Study tool in Arabic

An-Najah National University
Faculty of Graduate Studies

نموذج تحكيم أداة الدراسة

دراسة بعنوان: "التجارب السلبية في مرحلة الطفولة والأحداث المؤلمة وتأثيرها على الصحة النفسية بين المواطنين في منطقة المثلث الشمالي"

تعتمد هذه الدراسة على المنهج النوعي لتحقيق أهداف الدراسة؛ حيث قمت بأعداد أداة الدراسة وهي المقابلة (مرفق أسئلة المقابلة).

سيتم مقابلة الأشخاص البالغين في منطقة المثلث الشمالي وطرح الأسئلة عليهم.

ستستهدف الباحثة الأشخاص من خلال آلية العينة القصدية؛ حيث أن الباحثة بحكم طبيعة عملها فإن لديها علم بأن هؤلاء الأشخاص قد تعرضوا للتجارب السلبية في الطفولة أو الأحداث المؤلمة، ويعانون من الاكتئاب والاضطرابات النفسية، وهي على صلة بهم من خلال متابعة جزء منهم.

من المتوقع أن يتم مقابلة (20–25) شخصاً في منطقة المثلث الشمالي، تتراوح أعمارهم ما بين (20 –45) عاماً، من الجنسين.

أسئلة المقابلة

الأسئلة العامة:

1. ما هو جنسك؟
2. كم عمرك؟
3. ما مستوى التعليم الذي حصلت عليه؟
4. ما هي حالتك الاجتماعية: أعزب، أم متزوج، أم مطلق، أم أرمل؟

التجارب السلبية في الطفولة

1. ما هي الإساءة التي تعرضت لها في مرحلة الطفولة من قِبل أحد الوالدين أو شخص بالغ آخر في الأسرة بشكل دائم أو نادراً أو أحياناً؟
2. هل تعرضت لتعاطي المخدرات أو جربت أي نوع من المخدرات بشكل دائم أو نادر أو أحياناً؟
3. هل أي من أفراد أسرتك كان يعاني من أي من أعراض الاكتئاب أو محاولة الانتحار..... بشكل دائم أو أحياناً أو نادراً؟
4. هل تعرضت والدتك (أو زوجة أبيك) للضرب أو التهديد أو العض أو..... بشكل دائم أو أحياناً أو نادراً؟

الأحداث المؤلمة

1. هل تعرضت لأي أحداث صادمة أو مواقف تهدد حياتك؟
2. هل واجهت فقدان شخص مقرب بشكل مفاجئ أو مأساوي؟
3. هل أثرت النزاعات أو الأوضاع السياسية والاجتماعية في المنطقة على حياتك؟

الأسئلة المتعلقة بالصحة النفسية:

1. هل يمكن تحديد مدى شعورك بأي من الأحاسيس الآتية بشكل مادر أو أحياناً أو دائماً: الانشراح، أو الثقة الكبيرة بالنفس، أو النجاح في حياتك، أو الرضا عن نفسك، أو التفاؤل بالمستقبل، أو التعب بسرعة.
2. هل تعتقد أن هناك ارتباطاً بين التجارب السلبية أو الأحداث المؤلمة التي مررت بها والقلق أو الاكتئاب ..... الذي تعاني منه الآن؟

آليات التعامل

1. ما هي الطرق التي استخدمتها للتعامل مع التجارب السلبية؟ هل كان لديك دعم من الأسرة أو الأصدقاء؟
2. هل تلقيت أي نوع من الدعم النفسي أو الاجتماعي للتعامل مع هذه التجارب؟
3. ما هي أبرز العوائق التي واجهتها في طلب المساعدة أو الحصول عليها؟

نصائح

1. ما النصيحة التي يمكن أن تعطيها للأطفال الذين قد يواجهون تجارب مشابهة ما مررت به؟
2. إذا كان بإمكانك تغيير شيء واحد في طفولتك، ماذا سيكون؟
3. كيف يمكن تحسين الخدمات النفسية والاجتماعية في المنطقة لدعم الأفراد الذين يعانون من آثار التجارب السلبية؟

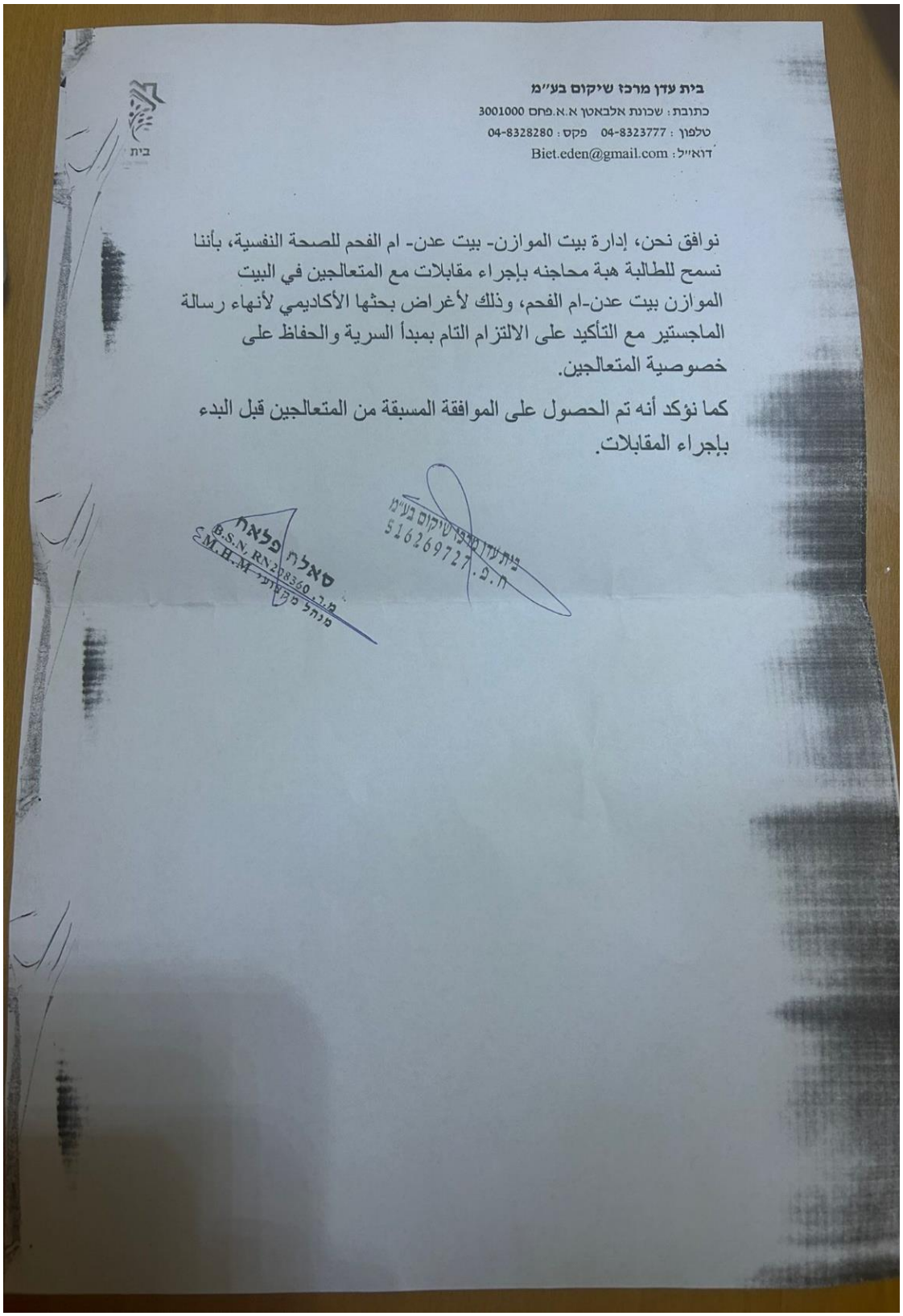
Appendix C

List of Arbitrators

No.	Name	Academic Rank	Specialization	University
1	Prof. Ahmad Abu Asaad	Professor	Psychological and Educational Counseling	Mutah University
2	Prof. Adel Tannous	Professor	Psychological and Educational Counseling	University of Jordan
3	Prof. Fouad Talafha	Professor	Educational Psychology	Mutah University
4	Prof. Ziad Barakat	Professor	Educational Psychology	Al-Quds Open University
5	Prof. Ahmad Arabiat	Professor	Psychological and Educational Counseling	Mutah University
6	Prof. Moawiya Abu Ghazaleh	Professor	Educational Psychology	Yarmouk University
7	Prof. Majed Al-Khayyat	Professor	Educational Psychology	Al-Balqa Applied University
8	Prof. Basem Al-Dahdahdeh	Professor	Psychological and Educational Counseling	Mutah University
9	Prof. Intisar Samadi	Professor	Psychological and Educational Counseling	Islamic University
10	Prof. Suheila Baniat	Professor	Psychological and Educational Counseling	Amman Arab University
11	Dr. Fatima Al-Adwan	Associate Professor	Psychological and Educational Counseling	University of Jordan
12	Dr. Ibrahim Al-Masri	Associate Professor	Psychological and Educational Counseling	Hebron University

Appendix D

Communication from Beit Eden Mental Health Centre



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בית

نوافق نحن، إدارة بيت الموازن- بيت عدن- ام الفحم للصحة النفسية، بأننا نسمح للطالبة هبة محاجنه بإجراء مقابلات مع المتعالجين في البيت الموازن بيت عدن-ام الفحم، وذلك لأغراض بحثها الأكاديمي لأنهاء رسالة الماجستير مع التأكيد على الالتزام التام بمبدأ السرية والحفاظ على خصوصية المتعالجين.

كما نؤكد أنه تم الحصول على الموافقة المسبقة من المتعالجين قبل البدء بإجراء المقابلات.

جامعة النجاح الوطنية
كلية الدراسات العليا

التجارب السلبية في مرحلة الطفولة والاحداث المؤلمة وتأثيرها على الصحة النفسية بين المواطنين في منطقة المثلث الشمالي

إعداد
هبة محاجنة

إشراف
أ. د. محمد شاهين
د. محمد مرعي

قُدّمت هذه الرسالة استكمالًا لمتطّلبات الحصول على درجة الماجستير في علم النفس الإكلينيكي بكليّة الدراسات العليا في جامعة النجاح الوطنيّة في نابلس، فلسطين.
2025

التجارب السلبية في مرحلة الطفولة والاحداث المؤلمة وتأثيرها على الصحة النفسية بين المواطنين في منطقة المثلث الشمالي

إعداد

هبة محاجنة

إشراف

أ. د. محمد شاهين

د. محمد مرعي

الملخص

تتناول هذه الدراسة تأثير التجارب السلبية في الطفولة (ACEs) والأحداث المؤلمة على الصحة النفسية لدى البالغين في منطقة المثلث الشمالي. يهدف البحث إلى فهم التجارب الحياتية للناجين من الصدمات، ويحدد العوائق التي تحول دون حصولهم على الرعاية الصحية النفسية، ويستكشف آليات التأقلم وعوامل المرونة. تعتمد الدراسة على تصميم بحث ظاهراتي؛ تم جمع البيانات من خلال المقابلة مع 23 مشاركاً من ثلاثة مراكز للصحة النفسية في المثلث الشمالي. ويوثق جميع المشاركون التعرض لتجارب الطفولة السلبية (ACEs) ويتلقون خدمات الصحة النفسية للأعراض المتعلقة بالصدمة. تكشف الدراسة عن التعرض الشامل لأشكال متعددة من صدمات الطفولة؛ حيث يتعرض 100% من المشاركين للإيذاء الجسدي والعاطفي، ويبلغ 39.1% عن تعرضهم للإيذاء الجنسي، ويتعرض 91.3% للإهمال. تكون الآثار على الصحة النفسية شديدة ومنتشرة، مع انتشار اضطرابات القلق بنسبة 100%، ويتعرض 100% للاكتئاب، ويبلغ 87% عن اضطرابات النوم والأكل، ولدى 69.6% أفكار انتحارية. يقترح المشاركون بالإجماع توسيع مراكز الصحة النفسية (100%)، وتنفيذ برامج الصحة النفسية المدرسية (95.7%)، وإطلاق حملات توعية مجتمعية (91.3%)، وتوفير تدريب للمعلمين (87.0%). وتشمل التوصيات الإضافية تطوير الخدمات المنزلية (بدعم 82.6%)، وإنشاء أنظمة 35دعم مالي للوصول إلى العلاج (بدعم 78.3%). تُشدد الدراسة على الحاجة المُلحة لتدخلات مُراعية للثقافات ومُراعية للصدمات، تُعالج العوائق النظامية مع البناء على نقاط القوة المجتمعية وعوامل المرونة.

الكلمات المفتاحية: التجارب السلبية في الطفولة، الأحداث الصادمة، الصحة النفسية، المثلث الشمالي، الأقلية الفلسطينية، البحث الظاهراتي، عوائق طلب المساعدة.