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The Impact of Psychosocial Support Activities on the Resilience of Conflict-Affected Adolescents in Iraq: A Sample of Nineveh Governorate

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Abstract
UNHCR has reported that the number of displaced people around the world reached 65 million by the end of 2015, while IOM has reported that the number of displaced individuals in Iraq between 2014 and 2016 reached 3.4 million. Among those individuals affected by conflict and/or crisis, resilience has been proven essential to their survival and well-being. One mode of strengthening this resilience is psychosocial support activities, which provide them with numerous chances to recover, feel better, and thrive. This study examines the resilience of adolescents affected by ongoing crises in Iraq as well the effect of psychosocial support activities on their resilience levels. Employing a quantitative model, this study was conducted by measuring the resilience of participants on two different occasions, before and after their participation in psychosocial support sessions in schools and centers both in camp and non-camp settings. The results indicate that the participants possessed medium levels of resilience and that the psychosocial support activities had positively affected their resilience levels. Moreover, female participants exhibited higher levels of resilience than did males.
Keywords: Iraq crises, Resilience; Psychosocial support

1. Introduction

Each day, global conflicts and crises increase the amount of suffering and affected individuals around the world. Accordingly, conflict- and crisis-affected individuals experience numerous physical, psychological, social, and economic impairments. Conflicts and armed clashes in some countries such as Iraq, Syria, Mali, Congo, Sudan, and Yemen have either killed, injured, or displaced millions of displaced people (CARE, 2017). The United Nations High Commissioner for Refugees (UNHCR) has stated than over the past few years, global crises have yielded displacement among 65 million individuals (2016). Moreover, the span of global conflict and crisis is expected to increase over the next few years. The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) (2018) has estimated that, "in 2018, conflict will remain the main driver of humanitarian needs, while natural disasters will also cause many people to need emergency aid. Overall, more than 136 million people in 25 countries will need humanitarian assistance and protection" (p.4).

In order to address the various detrimental effects of ongoing conflicts and crises, multiple types of services should be provided to affected individuals both during and after the crises to aid them in recovering, returning to normalcy, and becoming successful individuals. These services should include programs that promote and strengthen their psychosocial well-being and overall resilience. The Inter-Agency Standing Committee (IASC) (2006) has reported the following:

> "Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risk of diverse problems and tend to amplify pre-existing problems of social injustice and inequality". (p.2)

Regarding children in particular, the Committee on Pediatric Emergency Medicine (COPEM) (2015) has suggested that children are especially vulnerable to the impacts of disasters and painful events due to their lack of skills, experience, and ability to develop their social emotional, mental, and behavioral health needs independently. Similarly, Lavik, Hauff, Skrondal, and Solberg (1996) have stated that traumatic experiences such as crisis place individuals—especially children—at a high risk of developing psychological and emotional problems. Another study concluded that losing homes, parents, siblings, friends, schools, lifestyles, habits, and expected futures may cause many types of problems, namely, aggressiveness, sadness, nightmares, sleeping difficulties, anxiety, depression, low self-esteem, guilty feeling (Ajdukovic,1998).

In most crisis-affected countries, humanitarian entities provide programs that aim to provide psychosocial support (PSS) to the above individuals. The International Organization for Migration (IOM) (2018) has highlighted the following:

> "During a crisis response, psychosocial (PSS) assistance aims to promote, protect and support the well-being of crisis-affected populations, with activities aimed at reducing psychosocial vulnerabilities, promoting community resilience and ownership, and supporting aid that takes into account psychosocial and cultural diversity issues". (p.1)

As Iraq has been facing a number of humanitarian crises over the few decades, many organizations have continued to coordinate psychosocial support and resilience-building initiatives. Therefore, it is important to

assess the effectiveness of these programs.

1.1. The Crises in Iraq

Over the past three decades, Iraq has suffered three destructive wars that have negatively impacted all domains in the country. Moreover, since 2004, various kinds of conflicts and crises—from Zakho in the north to Basra in the south—have been burdening Iraqis. However, 2014 marked the worst year of crisis in Iraq, when the so-called State of Iraq and the Levant (ISIL) attacked and controlled cities north of Baghdad, Iraq's capital. The violent attack caused great chaos among people in many cities, with individuals experiencing and/or witnessing death, abduction, displacement, and other forms of violence. When ISIL attacked and controlled these cities, individuals were forced either to flee to other cities in Iraq, usually seeking refuge in camps with poor living conditions, or to remain under ISIL authority. In both situations, individuals continued to be exposed to violence and a lack of basic human resources such as water, food, education, and health services. The IOM (2017) has reported that 3.4 million individuals were displaced between 2014 and 2016, while the Iraq Body Count (IBC) (2017) has recorded more than 50,000 civilian deaths from the violence between 2014 and 2017. As for children in Iraq, reports have indicated that the crisis heavily affected their routine activities and qualities of life. According to the United Nations International Children's Fund (UNICEF), as of 2016, "Iraq [was] one of the most dangerous places in the world for children [and that] four decades of conflict, sanctions, violence, insecurity and economic stagnation [had] brought development in the country to its knees" (p.5). In addition, this report stated that assistance was required for almost 4.7 million children across Iraq, more than 3 million of whom were prone to death, injuries, recruitment into armed groups, sexual violence, and other types of risks. The report cited hundreds of verified cases of child death, injuries, recruitment, and separation as well as thousands of cases of sexual violence among females from minority religious communities. Last but not least, the report cited large numbers of disease and out-of-school cases among children in different Iraqi cities (2016).

Recently, the Iraqi government has regained control of the above-mentioned cities after heavy combat with ISIL in which thousands of houses, schools, hospitals, and public service facilities have been destroyed. Subsequently, thousands of families still live as displaced people in camps or in non-camps shelters while government entities, UN agencies, and non-governmental organizations (NGOs) have begun rehabilitating public service facilities such as schools, hospitals, and bridges. These entities have also begun providing individuals there with food, education, and health services. In addition, some humanitarian entities have begun facilitating trainings, awareness-raising campaigns, and psychosocial support sessions to aid in individuals' recovery.

Despite the above-mentioned humanitarian efforts in Iraq, there still remains an aid deficit in terms of the number of individuals requiring assistance. Recently, UNOCHA (2018) has reported the following:

> "Humanitarian partners estimate that 8.7 million people across Iraq will require some form of humanitarian assistance. This number represents the aggregate, rather than absolute number of people who will need some form of assistance. Hundreds of thousands of people who have been brutalized by violence, including women and children, require specialized support and services, many of which are only partially available". (p.8)

The above-cited report also details the humanitarian *status quo* in Iraq and presents a service plan in terms of protection, health, water, sanitation, hygiene, food, security, shelter, education, and cash assistance. The plan includes programs that provide PSS and resilience-building activities for individuals more generally as well activities that build essential life-skills for adults and children. It also includes programs targeting conflict-affected students and teachers. These generally include PSS and resilience-building activities while aiming to enhance teachers' awareness of how conflict may have affected the learning processes of their students.

1.2. Hypotheses

In this study, the following is hypothesized:

1. Iraqi adolescents have low resilience levels.
2. Structured PSS activities enhance the resilience of conflict-affected adolescents in Iraq.
3. Iraqi male adolescents are more resilient than Iraqi female adolescents.

2. Literature review

2.1. Psychosocial support (PSS)

According to the International Federation of the Red Cross (IFRC) (2014), the term "psychosocial" refers to the following:

> "[It is] the dynamic relationship between the psychological and social dimension of a person, where the one influences the other. The psychological dimension includes internal, emotional and thought processes, feelings and reactions. The social dimension includes relationships, family and community networks, social values and cultural practices". (p.11)

Similarly, the IASC (2006) has explained the term in the following manner:

> "[It is] the inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other. The term psychosocial emphasizes the close connection between psychological aspects of our subjective experiences (involving personal thoughts, emotions and behaviour) and broader intersubjective social experiences (involving relationships, tradition and culture)" (p.1)

The importance of PSS has been emphasized by numerous researchers, especially in terms of crisis-affected individuals. For instance, the IFRC (2014) explains the following

> "Psychosocial support helps people recover after a crisis has disrupted their lives. It aims at enhancing the ability of people to bounce back and restore normality after adverse events, and refers to the actions that address both the social and psychological needs of individuals, families and communities" (p.11).

Regarding children in particular, one study has highlighted the importance of the PSS that teachers can provide for children who have lost their parents, study states, and daily routines (Smart, 2003). Similarly, Jacobs (2011) has confirmed that an important aspect of psychosocial well-being involves the ability of children to practice their life skills they have acquired in school. In light of this necessity, Richter, Manegold and Pather (2004) have observed that "programs could work with schools to make curricula more directly relevant to children's lives by including life skills, household management training and care for children and ill adults (p.31). They further explained that teachers need to be trained to address the psychosocial problems of children which lead to poor performance and drop-out. Batra (2013) has emphasized that that peers, schools, teachers, and books all are important factors affecting children's emotional development but that these factors are often under-appreciated and unrecognized. Moreover, UNICEF (2009) has reported that three important psychosocial domains affect children's lives: knowledge and skills such as life skills; emotional well-being such as self-worth; trust in others and feeling safe; and, finally, social well-being such as a sense of belonging, relationships with others, and social roles (p.10).

2.1.1. PSS Activities

It is important to differentiate between the psychosocial support provided by specialists such as psychologists, psychiatrists, psychiatric nurses, doctors, and counsellors on the one hand and that supplied by communities, family, parents, governments, and NGOs on the other. The figure below (PSS Pyramid) simplifies the role of each category of individuals:

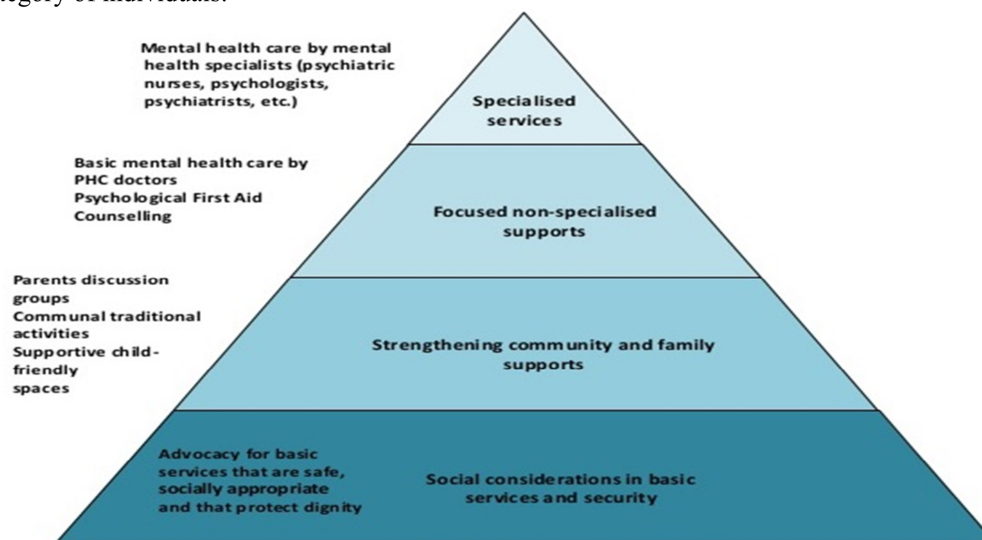

Figure 1 depicts the PSS Pyramid, which differentiates between the types of psychosocial support.

Regarding the types of psychosocial support, the IFRC (2014) reported the following:

> "When people hear the term 'psychosocial,' they often link it to clinical psychological treatment. Community-based psychosocial support activities are very different to this, and vary greatly depending on the needs of the affected populations". (p. 12)

As described above, community-based psychosocial support considers how a crisis has affected a community of individuals and determines appropriate activities for meeting their needs. This consideration also includes the availability of local resources as well as the culture, customs, attitudes, and beliefs of the target population. It differs from clinical psychological treatment in that such as medication, therapies, or consultancy. While the PSS could be activities as teaching life skills, difficulties handling, overcoming challenges skills, etc. these activities could be provided by the parents, community members, schools, or centers with some trainings

and simple available resources.

Similarly, UNICEF (2005) has stated the following regarding psychosocial support among children:

> "PSS activities should aim directly or indirectly to reconnect the children with their communities, foster social connections and interactions, including in situations where children are separated from their family or community of origin, normalize daily life, promote a sense of competence and restoration of control over one's life, build on and encourage children's and community's innate resilience to crisis, and respect the dignity of children, their caregivers and communities". (p.1)

With this intention, PSS activities do not provide children with clinical medication or treatment. In reality, PSS activities help children after any crisis to return to a sense of normalcy, promote their psychological and psychosocial well-being, strengthen their social connections, and improve their traits and behaviors.

2.2. Resilience

Resilience is essential to helping people lead normal lives, especially in abnormal situations and environments. According to the Oxford English Dictionary (2013), "Resilience is the ability of a substance or object to spring back into shape; elasticity or the capacity to recover quickly from difficulties; and toughness." The term is derived from the Latin word "resilio" which means "jump back" or "bounce back". However, researchers have attributed various dimensions to the term, defining it as "the ability to successfully adapt to stressors, maintaining psychological well-being in the face of adversity" as well as "a dynamic process encompassing positive adaptation within the context of significant adversity or trauma" (Luthar and Cicchetti, 2000, p.543). Moreover, Masten (2001) has defined resilience as "good outcomes in spite of serious threats to adaptation or development" (p.228). In terms of resilience studies, Boss, Bryant, and Mancini (2016) have asserted the following:

> "Resilience researchers explore the coping and adapting process under stress conditions as chronic illness, death of a loved one, abuse, neglect, disasters, and stressful life events. Essentially, many resilience researches shed the light on the individuals of a given community who face difficulties or problems in their lives". (p.124)

Similarly, Tusaie and Dyer (2004) have pointed out that early studies were conducted in relation to stressful transition times, while Spiegel and Grinker (1945) examined the individual's capacity to recover and move on with life. Others such as Friborg (2006), Bonanno (2004), and Carver, Pozo, Harris, Noriega, Scheier, Robinson, and Clark (1993) have explored resilience in relation to experiences of loss, trauma, and illness, while still more research has considered resilience as it relates to individuals experiencing poverty, community violence, and other negative social conditions (Garmezy, 1991). Targeting children, Werner and Smith (2001) observed a group of 700 children over a long period of time and exposed them to various internal as well as external protective factors. A small number of these children who had been classified as exhibiting resilience at the age of 18 nevertheless displayed many problems at the age of 30. These results demonstrate that resilience is changeable and can be developed at any phase of life.

2.3. PSS and Resilience in Iraq

Prior to 2014, the term "psychosocial support" was new or unknown to most of the Iraqi population. However, after the ISIL crisis, humanitarian partners began implementing widespread programs to promote PSS among the Iraqi population, especially among those who had been displaced or affected by the conflict. NGOs such as Save the Children, Mission East, Voice of Older People (VOP), Sonahi Organization for Social Development (SOSD), Hope,, Al-Rajaa, and UPP (Un Ponte Per) have engaged differently aged individuals in structured PSS activities. Their curricula have consisted of various activities promoting education, health, tolerance, cohesion, integration, gender equality, protection, awareness, and others. These values have been implemented via different activities such as playing, drawing, singing, and lessons.

Regarding the psychosocial studies in Iraq, Bolton, Michalopoulos, Ahmed, Murray, & Bass (2013) have investigated the mental health and psychosocial problems experienced by survivors of torture and genocide in Kurdistan, Northern Iraq. In the same manner, Al-Obaidi, Corcoran, Hussein, & Ghazi (2013) have examined psychosocial trainings in Iraq and asserted that there is a lack of psychosocial support studies in Iraq. On the other hand, some psychosocial support studies have been concerned with Iraqi refugees abroad. For example, Al-Obaidi and Atallah, (2009) investigated the psychosocial health of Iraqi refugees in Egypt and concluded that "more research should be planned to assess mental and psychosocial problems of Iraqis living in the Middle East, particularly among the most vulnerable groups (women and children)" (p.149)

Regarding the term "resilience" in Iraq, the situation is the same as with "psychosocial support." Resilience is a new and often unfamiliar term among the Iraqi population. Again, it is clear that familiarity with the term has gradually increased alongside the ongoing efforts of humanitarian entities in the region. Entities such as the Regional Refugee & Resilience Plan (3RP) as well as the Iraq Crisis Response and Resilience Program (ICRRP)

have been providing many resilience programs to individuals affected by the conflict. (UNHCR, 2016). At the beginning of the crisis, humanitarian agencies began training humanitarian aid workers regarding the concept of resilience and its promotion. In turn, these workers began implementing programs and activities aimed toward enhancing resilience. Thus, day-by-day, Iraqis have begun developing an understanding of resilience.

Concerning resilience studies, to the best of the researcher's knowledge, few have been conducted in Iraq. One of these was conducted by the British Council and dealt with displaced individuals and refugees in Iraq, Lebanon, Turkey, and Syria. The study argued that learning languages is one of many ways to enhance resilience among displaced individuals in these countries (British Council, 2015).

3. Methodology

The current study employed a quantitative research method. The Connor and Davidson CD-RISC-25 Scale was used to measure the resilience of conflict-affected adolescents in Iraq. The scale was utilized on two separate occasions, both prior to and following the facilitation of structured PSS activities among participants, in order to assess their resilience levels and as well as to evaluate the effectiveness of the PSS activities in increasing resilience levels.

3.1. Data Collection Tools

One data collection tool was employed, namely the Connor and Davidson CD-RISC-25 Scale, as detailed below.
3.1.1.The Connor and Davidson Scale (CD-RISC)
The Connor and Davidson CD-RISC-25 Scale was utilized to measure the resilience of Iraqi adolescents who were affected by conflict in Iraq. This scale consists of twenty-five items concerning resilience. Connor and Davidson (2015) reported that this quantitative scale extensively has been used to measure resilience, and more than 400 resilience studies have utilized the scale. It has been translated into many languages; thus, the present study adopted the formal Arabic version to assess 143 subjects. The participants were asked to rate statements according to the extent to which they agreed by using the following scale: "Not true at all = 0," "rarely true" = 1, "sometimes true" = 2, "often true" = 3, and "true nearly all the time" = 4. The sum of all items was utilized to determine the resilience score. Therefore, the full range of the scale was from 0 to 100. The scores between 0-49 were considered as representing low resilience levels, 50-79 as medium levels, and 80-100 as high resilience levels.

In addition to the above, Connor & Davidson (2015) have stated that the CD-RISC-25 Scale represents five main factors: the notion of personal competence, high standards, and tenacity; trust in one's intuition, tolerance of negative affect, and the strengthening effects of stress; positive acceptance of change and secure relationships; control; and spiritual influence.

3.2. Participants

This study was conducted in Nineveh Governorate, were people have been affected differently by ongoing conflict. Some still live as displaced individuals in camps north and south of the city, and some have lost their family members, friends, properties, jobs, and schools. Others have witnessed deaths, injuries, armed conflict, and air strikes. Many NGOs have been providing these individuals with PSS activities. In this study, (143) subjects (33 females and 110 males aged between 12-17 years and from 12 groups) completed the CD-RSIC-25 both prior to and following structured PSS activities designed by Mission East and Save the children NGOs, and administered by four different NGOs (see Table 1).

Table1. Participants Summary

N. male	N. female	Number of the groups	place	Setting	NGO
	20	2	Telkeef female school	Non- camp	Al-Gaad
10		1	Telkeef male school	Non- camp	Hope
5		1	Al-Nethal school	Non- camp	Al-Gaad
10		1	Al-Amal school	Non- camp	Hope
14	6	2	Essyan center	Essyan camp	VOP
21	7	2	Mam Rashan center	Mam rashan camp	VOP
50		3	Al-Rasheed school	Non- camp	UPP
110	**33**	**12**			

Table 1 indicates that participants were distributed among different schools and centers in different locations. 33 female and 110 male participants came from five schools in non-camp settings and from two childcare centers in two different camps.

3.3. Procedure
Various types of crises and conflicts have taken place in Iraq since 2014. Thus, people have been affected differently, even within in the same cities. As a result, the situation now is also different from one place to another. In Nineveh Governorate, some individuals still live in camps while others reside in rented shelters and dilapidated buildings. Accordingly, these individuals exhibited different emotional, psychological, and psychosocial outcomes according to their losses and experiences.

However, many humanitarian entities have been providing PSS activities for these individuals in different locations such as schools, centers, and governmental buildings. In the current study, (5) schools and (2) child centers were randomly selected for participation. The schools were dispersed throughout the city, while the centers were in (2) large camps for displaced individuals located to the north of Nineveh.

After conducting a pilot study involving (30) adolescents in one of the aforementioned schools and one of the centers and obtaining an (84) reliability score, (143) adolescents from 5 schools and 2 centers aged between 12 and 17 years were then invited to participate in this study (see Table 1). After obtaining their written consent, they were delivered an Arabic version of the CD-RISC-25 questionnaire. In all the schools and centers, the participants were asked to report their age and gender while receiving clarification about the purpose of this study and the questionnaire, all of which occurred in a calm and comfortable setting.

After analyzing the CD-RISC results via SPSS software and obtaining participants' resilience scores, the NGOs involved the participants in structured PSS activities which consisted of 20 sessions. Each session lasted for (15-40) minutes and included games, singing, drawing, stories, awareness, lessons, and sports. The activities were facilitated by Mission East, an NGO that promotes education, health, tolerance, cohesion, integration, gender equality, protection, and others. The 20-session course lasted for (4-8) weeks based on participants' availability and school times.

As soon as the participants had completed all 20 sessions, they were asked to complete the resilience CD-RISC-25 questionnaire again. As with the first time the questionnaire was administered, the participants were asked to report their consent, names, age, and gender after receiving clarification about the questionnaire and the purpose of their participation in this study. Again, they responded to the questionnaire items eagerly in a calm and comfortable setting. By analyzing the pre- and post-data obtained from the questionnaire and comparing these via SPSS software, the researcher obtained participants' resilience levels, assessed the impact of the PSS activities on their resilience levels, and observed resilience level differences based on gender.

3.4. Data analysis
In this study, the quantitative data (pre- and post-PSS activities) were collected via a CD-RISC-25 questionnaire and were analyzed using SPSS software, which quantitatively displayed participants' resilience levels. Also, SPSS was used to answer the three hypotheses of this study.

4. Findings
This study examined resilience among conflict- affected adolescents in Iraq who reside in camp and non-camp settings, assessing how PSS activities impacted their resilience levels. The findings of this study will be revealed according to each hypothesis separately.

4.1. Results of the First Hypothesis
The first hypothesis of this study was, "Iraqi adolescents have low resilience levels." According to the results obtained from the questionnaire before involving participants in PSS activities, Hypothesis 1 is rejected, as the results indicate that participants scored medium resilience levels (See Table 2).

Table 2. Participants' Resilience Description.

N	Minimum	Maximum	Mean	Std. Deviation
143	10.00	89.00	54.7483	17.11826

Table 2 displays descriptive data obtained from the CD-RISC-25 before involving the participants in PSS activities. The average CD-RISC mean score was 54.7483, which indicates a medium resilience level. The minimum score pre-PSS activities was 10.00, while the maximum score was 89.00. Moreover, the standard deviation was 17.11826.

4.2. Results of the Second Hypothesis
The second hypothesis of this study was, "Structured PSS activities enhance the resilience of conflict-affected adolescents in Iraq". The data collected via the CD-RISC questionnaire pre- and post-PSS activities indicate that Hypothesis 2 is verified (see Table 3

Table 3. Mean Differences pre- and post-PSS Activity Involvement.

Status	N	Minimum	Maximum	Mean	Std. Deviation
Pre-PSS activities	143	10.00	89.00	54.7483	17.11826
Post-PSS activities	143	45.00	96.00	70.2308	10.39413

Table 3 is a descriptive analysis indicated that the PSS activities had positively affected participants' resilience levels. The mean score before the PSS activities was 54.7483, and it increased to 70.2308 after these activities. The minimum score before the activities was 10.00, and it became 45.00 after the activities. The maximum score before the activities was 89.00, and it increased to 96.00 afterward. Finally, the standard deviation changed from 17.11826 to 10.39413.

4.3 Results of the Third Hypothesis

The third hypothesis of this study was, "Iraqi male adolescents are more resilient than Iraq female adolescents." The results obtained from the CD-RISC questionnaire pre- and post-PSS activities show that Hypothesis 3 is rejected (see table 4).

Table 4. Females Males' Mean Differences pre- and post-PSS activity Involvement

Female	Number	Mean score pre PSS activities	Mean score post PSS activities
Female	33	64.7576	73.9394
Male	110	51.7455	69.1182

Table 4 demonstrates that Iraqi female adolescents scored higher than male adolescents both pre- and post-PSS activities. Before the PSS activities, the female resilience score was 64.7576, while the male resilience score was 51.7455, which means the female adolescents were more resilient than the male adolescents. The table above also shows that the female adolescents exhibited higher resilience levels than did males following the 20 PSS sessions. The female adolescents' score increased to 73.9394, while the male adolescents' score increased to 69.1182, which means that females were more resilient than males even after the PSS activities.

4. Discussion and Conclusions

The current study investigated the resilience level of conflict-affected adolescents in Iraq. It also examined the impact of PSS activities on their resilience levels as well as differences in resilience level according to gender. Finally, it assessed the extent to which PSS activities had impacted participants' resilience levels.

This study reveals that the mean resilience score of participants before the facilitation of PSS activities was 54.7483. However, after they had participated in (20) PSS sessions, their mean score increased to 70.2308. The former score answers the first hypothesis in the current study, while the latter score answer the second hypothesis. However, both mean scores (pre- and post-PSS activities) indicate medium resilience levels, as they lie between 50-79. It is clear that the benefits of structured PSS activities extend to horizons other than resilience scores or recreational aims. That is to say, PSS helped to promote participants' notions of personal competence, tenacity, stress management, and adaptive ability. Thus, governments, NGOs, and schools should plan sufficient PSS activities that consider context-specific needs and are capable of reaching all of the children in crisis-affected cities.

It is also noteworthy to mention that the resulting scores of the first and second hypotheses are similar to the scores of many studies concerned with adolescents in other countries and utilizing CD-RISC-25. For instance, Jorgensen and Seedat (2008) investigated resilience among 701 South African adolescents and obtained a mean score of 56.3, while Fincham, Altes, Stein, & Seedat (2009) reported a mean score of 63.7 in a study concerned with posttraumatic stress disorder symptoms in adolescents. In a psychometric evaluation of the CD-RISC resilience scale among Iranian students, the mean score was 68.3 (Khoshouei, 2009). Finally, Vetter, Dulaev, Mueller, Henley, Gallo & Kanukova (2010), who studied the impact of resilience programs on adolescents surviving a terrorist attack, reported a mean score of 70.1.

The results of the third hypothesis in this research indicate that, despite the medium resilience levels exhibited by both (female and male) participants on two separate occasions, female participants were more resilient than males. The females' mean score was 64.7576 before the PSS activities, while the males scored only 51.7455. Again, after both groups had completed the 20 PSS sessions, the female mean score became 73.9394, while the mean score of the males increased to 69.1182. This incongruency may result from the fact that in Iraq, females spend more time at home with their families when compared to males. This may cause them to feel more safe, protected, and consequently more resilient. Similarly, Hartman, Turner, Daigle, Exum, & Cullen (2009) found that females scored higher than males when they conducted self-reports, and this could be another reason for the current study's gender resilience differences. On the other hand, Iraqi males in general spend more time than the females outside the home, which might indicate that they possess more experiences which may negatively impact their resilience levels. Moreover, reason could be interrelated with factors such as personal traits, gender, parents, school, culture, social coping strategies, and protection rules. Several other studies

employing the CD-RISC-25 observed similar gender differences, as well. For example, Ziaian, de Anstiss, Antoniou, Baghurst, & Sawyer (2012) examined resilience among adolescent refugees in Australia and noticed that the girls had scored higher than the boys. Also, Böell, Silva, & Hegadoren (2016) studied resilience among individuals affected by chronic diseases in Brazil, concluding that females were more resilient than the males. Bozikas, Parlapani, Holeva, Skemperi, Bargiota, Kirla, & Garyfallos (2016) in their study report similar results but among adults not children.

In combination with the above researches, the current study offers evidence of how PSS activities positively affect the resilience levels of crisis-affected adolescents in Iraq. The results encourage local governments, NGOs, and similar entities in Iraq to increase amount and extend the reach of such activities inside Iraq.

Despite the significant findings of this study, nevertheless it was limited to some degree. For example, the sample included only 5 schools and 2 child centers in Nineveh Governorate. By increasing the amount of samples and by including all the various PSS curriculums used by NGOs in crisis-affected areas, the results might become more precise. Moreover, the current study did not highlight resilience scores which decreased after the structured PSS activities. The conclusions were based solely on the mean scores that had positively increased as a result of the structured PSS activities. Thus, future studies might examine cases in which resilience scores decline or remain the same following the facilitation of PSS activities in order to determine the possible causes of this situation.

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