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UNDERSTANDING POLITICAL TRAUMA AND GENDER-BASED VIOLENCE PERPETRATION: THE PSYCHOLOGICAL IMPACTS, RISKS AND PROTECTIVE FACTORS AMONG FEMALES IN PALESTINE

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By

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ABSTRACT

This dissertation aimed to investigate and understand the potential role of political trauma on gender-based violence (GBV) from the perspectives and perceptions of females, males, and mental health care providers in the Palestinian context, by applying an exploratory mixed method approach; it also sought to identify factors that could help in developing conceptual models to enhance mental health status of Palestinian females who have suffered from political trauma and gender based violence in upcoming research. Within the mainstream literature, it was found that exposure to political violence often increases the risk of GBV by intensifying social tensions and weakening protective societal frameworks (Manjoo & McRaith, 2011; Sigsworth, 2008). The increase in GBV is strongly connected to the harmful impact of political violence on mental health, highlighting the importance of examining these dynamics within the wider context of conflict and its consequences (Cougle, Resnick, & Kilpatrick, 2009; Iverson et al., 2011; Krause et al., 2006). With the present work, I tried to fill the gap in literature, as despite previous research suggesting that suffering from political trauma increases the risk of experiencing violence among females (Heath et al., 2013; Cougle et al., 2009), there is still a notable gap in research attempting to understand the relationship between political trauma and GBV in the Palestinian context, both quantitatively and qualitatively. Most reviewed articles have focused on examining the association between political violence and GBV, primarily from

the perspective of females (Coker et al., 2002; Giacaman, 2010; Manjoo & McRaith, 2011; Sousa, 2013).

An exploratory mixed-method design was adopted to investigate the relationship between political violence, political trauma, and GBV among Palestinian adults. The qualitative phase, guided by grounded theory, aimed to explore the types of political violence experienced by Palestinians and its impact on mental health, as well as the relationship between this impact and GBV victimization and perpetration. Semi-structured interviews were conducted with 27 adult Palestinians (14 females and 13 males) and 11 mental health care providers, leading to the identification of key variables that were tested on 1,038 Palestinian adults (371 males and 667 females) in the subsequent quantitative phase using self-reported questionnaires.

Two conceptual models were developed. The first model examined the associations between exposure to political violence, political traumatic symptoms, GBV victimization , and mental health outcomes and distress among Palestinian females. It also explored the mediating role of self-concept and coping strategies. The second model focused on political trauma, political violence, and aggression among Palestinian males, investigating the association between aggression, mental health outcomes and distress, as well as the mediating role of self-concept and coping strategies.

The research findings highlighted the significant impact of political trauma on GBV victimization and perpetration among Palestinians. Five key themes and several subthemes related to GBV were detected from the perspectives of females, males, and mental health care providers. The quantitative analysis supported the two models; the first identified GBV as a predictor, with self-concept and coping strategies as mediators, and mental health distress and outcomes as an outcomes. The second model identified aggressiveness as a predictor, with self-

concept and coping strategies as mediators, and mental health distress and outcomes as an outcomes.

Political trauma was strongly associated with both GBV victimization and perpetration, with self-concept and coping strategies playing crucial mediating roles between GBV and mental health distress and outcomes. Addressing these factors could help mitigate the negative mental health effects and reduce GBV among populations in areas affected by war. This research provided a comprehensive understanding of how political trauma influenced both GBV victimization and perpetration, while also highlighted the associated risk and protective factors in the Palestinian context.

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INTRODUCTION

Political violence, particularly in the Global South, is linked to significant psychosocial and mental health challenges. The shift in warfare since the late 20th century from inter-state conflicts to intra-state violence in civilian areas has intensified the vulnerability of civilian populations to severe human rights abuses, such as disappearances, torture, and sexual violence (Tol et al., 2010).

The impact of modern conflicts extends beyond the immediate loss of life and destruction of infrastructure, deeply affecting the collective health and well-being of affected populations, whether they remain at home or are displaced. Contemporary wars threaten to erode the social and cultural fabric, including people's histories, identities, and value systems—elements crucial for their survival. The pervasive fear, social division, and enforced militarization of daily life (Martin-Baró, 1989) lead to profound changes in civilian lifestyles, such as increased powerlessness and the erosion of social capital. These changes are challenging to quantify in terms of life expectancy or health burden. However, the collective responses to extreme violence and loss play a vital role in survival and recovery and should be recognized as critical mechanisms for resilience.

Despite the growing number of armed conflicts and wars throughout the world, not enough attention has been paid to the local patterns of distress being experienced and the long-term health impact and psychosocial consequences of the various forms of political violence against individuals, communities, or specific ethnic groups. The mental health effects of a changing social and economic context (i.e., globalization) and the impact of political violence and wars have not been sufficiently documented (Pedersen, 2002).

One significant psychosocial impact of political violence is gender-based violence (GBV), which can occur both as victimization and perpetration. Exposure to political violence often exacerbates the risk of GBV by amplifying social tensions and undermining protective social structures (Manjoo & McRaith, 2011; Sigsworth, 2008). This increase in GBV is closely linked to the negative effects of political violence on mental health, underscoring the need to address and understand these dynamics within the broader context of conflict and its repercussions (Cougle, Resnick, & Kilpatrick, 2009; Iverson et al., 2011; Krause et al., 2006).

Gender-based violence (GBV) refers to physical, psychological, or sexual violence carried out against an individual or a collective based on their gender or adherence to gender norms (Cooper, et al., 2013). GBV, predominantly directed at women, is an extensive, worldwide problem that affects both Global North and Global South (Purohit et al., 2015). Worldwide, approximately 30% (1 in 3) of women have experienced either physical or sexual intimate partner violence in their lifetime, with the majority of these incidents occurring among women aged 15–49 years (Akudolu et al., 2023). The report further indicates that the prevalence of lifetime partner violence varies, ranging from 20% in the Western Pacific, 22% in high-income countries, to 25% in the WHO regions of the Americas, and up to 33% in the WHO African region, 31% in the WHO Eastern Mediterranean region, and 33% in the WHO South-East Asia region. Additionally, globally, 27% of women and girls aged 15–49 have reported experiencing some form of physical and/or sexual violence by their intimate partners.

GBV originates from inequalities in gender, primarily impacting women. It constitutes a significant public health and human rights issue, encompassing emotional, physical, social, psychological, sexual, economic, and domestic dimensions (Rikhotso et al., 2023). GBV is notably prevalent in regions afflicted by conflict (Shalak et al., 2024). Women in humanitarian

crises report higher rates of GBV exposure, with 70% experiencing it compared to 35% globally (OCHA, 2021). Moreover, in conflict zones, women and children are found to be marginalized groups, with approximately 20% of displaced women in these areas subjected to sexual violence (Shalak et al., 2024).

In the Palestinian context, various factors, including poverty, political conflict, traditional patriarchal norms, and deteriorating living conditions, contribute to the complexity of GBV (UNFPA, n.d.a). Statistics reveal that on average, 37% of women in Palestine experience GBV, with this figure soaring to 51% in the Gaza Strip (UNFPA, n.d.b). Palestinian women endure multiple forms of violence and discrimination, with 57% reporting psychological violence, 19% physical violence, 9% sexual violence, and 10% cyber violence (UNFPA, n.d.a). However, the same report indicated that the utilization of GBV services remains notably low, with less than 2% of survivors seeking healthcare, legal, or protection services due to inadequate protection systems and national referral.

Additionally, approximately 10% of households in Palestine report that women and girls avoid certain areas due to feelings of insecurity related to the Israeli occupation and conflict-related violence (OCHA, 2022). Concerns regarding the safety and security of girls are mentioned by 31% of households in the West Bank and 19% in Gaza, while worries about the safety and security of women are expressed by 24% and 17% of households in the respective regions (OCHA, 2022).

GBV targeting women has significant effects on their physical, mental, and psychological well-being. Increasingly acknowledged is the understanding that such acts of violence are not isolated occurrences but rather constitute a recurring pattern of behavior that encroaches upon women's rights, constrains their societal involvement, and undermines their

health and overall well-being (Banat, 2015). Moreover, despite some advancements in women's rights, they continue to be disproportionately impacted by various forms of violence and discrimination across all facets of life (Bond, 2003).

GBV with its adverse effects on both individuals and communities, has garnered considerable attention from sociologists, psychologists, social workers, and local and international organizations alike. In the Palestinian context, numerous studies have explored the mental health repercussions experienced by Palestinian women due to exposure to violence (Alhajjar, 2013; Canetti et al., 2010; Haj-Yahia, 2000; Kira et al., 2015; Sousa et al., 2014; Sousa et al., 2018; Veronese et al., 2023). However, literature revealed that exhibiting trauma-related symptoms increased the risk of experiencing violence among females (Heath et al., 2013; Cougle et al., 2009). The majority of previous literature have investigated the correlation between political violence and GBV, predominantly from the viewpoint of females (Coker et al., 2002; Giacaman, 2010; Manjoo & McRaith, 2011; Sousa, 2013). Furthermore, the bulk of studies on this topic in the Palestinian context adopt quantitative approaches (Haj-Yahia, 2000; Sousa et al., 2018; Thabet et al., 2015; Veronese et al., 2023; Zedan & Haj-Yahia, 2023), with even qualitative inquiries primarily focusing on intimate partner violence (IPV) (Sousa et al., 2018; Zedan & Haj-Yahia, 2023), thus neglecting a significant demographic; unmarried females.

Therefore, to fill the above mentioned gaps, this dissertation addresses the followed aims: (1) To investigate and understand the potential role of political trauma on GBV from the perspectives and perceptions of females, males, and mental health care providers in the Palestinian context, by applying an exploratory mixed method approach; (2) and to understand factors that can help in developing conceptual model to enhance mental health status of

Palestinian females who have suffered from political trauma and gender based violence in upcoming research. More specifically, this study seeks to understand the victimization of GBV and the potential contributions of political trauma and political violence to it. Additionally, it aims to explore how both political trauma and political violence may contribute to the perpetration of GBV by men. Moreover, this research endeavors to comprehend GBV within the Palestinian context, characterized by prolonged occupation, from the perspectives of females, males, and mental healthcare providers. It also aims to investigate the potential risk and protective factors associated with GBV victimization among women and GBV perpetration by men.

To address the gaps in the existing literature and fulfill the aims of the study, we opted to employ an exploratory mixed-method design, utilizing multiple samples. In this approach, the qualitative assessment conducted in the initial phase provided deeper insights into the types of political violence that Palestinians are experiencing and its negative impact on mental health, and the influence of this impact on GBV victimization and perpetration. Moreover, several protective and risk factors were identified to mitigate the negative impact of exposure to GBV among Palestinian females and to decrease the probability of GBV victimization and perpetration within the Palestinian context, and aided in the identification of specific variables to which were examined in the subsequent quantitative phase. The methodology of the qualitative study was guided by the grounded theory approach, given the limited understanding of the phenomenon in the Palestinian context and the absence of explanatory models. Moreover, grounded theory offers the opportunity to explore the phenomenon from various perspectives, that is by not referring to a specific theoretical perspective and not being limited while doing the analysis.

The first step of the current mixed method study was to better understand GBV victimization/perpetration among Palestinian adults in the context of political violence and trauma and to explore the risk and protective factors associated with GBV victimization/perpetration. Semi-structured interviews were adopted for data collection. After analyzing the qualitative data, we identified key variables that we subsequently examined in the quantitative phase of our study.. The quantitative data were collected using self-reported questionnaires. We then identified and tested two conceptual models.

The first model examined the relationships between exposure to political traumatic events, PTSD symptoms, and GBV among adult Palestinian females. It explored how GBV victimization is associated with mental health outcomes such as depression, anxiety, and feelings of hopelessness, and the mediating role of self-concept and coping strategies (both healthy and unhealthy) in these relationships.

The second model focused on the relationships between political trauma, political violence, and aggression among adult Palestinian males. It investigated how aggression relates to mental health outcomes and distress, including depression, anxiety, and risky behaviors, as well as the mediating effects of self-concept and different coping strategies in these associations.

Throughout this dissertation, we conducted a comprehensive exploration of how females and males perceive GBV and its association to political violence and political trauma. We also examined how experiencing GBV affects their mental health and delve into both the risk and protective factors associated with GBV.

Conversely, we investigated the types of violence males perpetrate from their perspective and explored how political violence, political trauma, and other psychosocial

factors contributed to aggressive behavior towards females. Additionally, we gained deeper understanding into the risk and protective factors of aggression in men.

To enhance our understanding of this phenomenon, we interviewed mental health care providers, including psychologists and sociologists, within the Palestinian context. They provided insights into how political violence and trauma contribute to GBV victimization and perpetration in Palestine, as well as other psychosocial factors influencing GBV. Additionally, we inquired about the impact of experiencing GBV on women's mental health and identified the risk and protective factors associated with GBV victimization and perpetration. The work is divided into 5 chapters, outlined as follows:

Chapter 1 offers a comprehensive overview of political violence, political trauma, and GBV, focusing on their intersections and mental health outcomes, particularly among females in areas affected by war. It begins with an examination of trauma among adults and theoretical perspectives on political trauma, followed by a discussion of GBV in politically violent contexts and relevant theories. A scoping review is conducted to address three key questions: (1) the correlation between political violence, political trauma, and GBV among females in the Global South, (2) the correlation between political violence, trauma, and GBV perpetration among males, and (3) the psychological consequences of GBV associated with political violence. The chapter concludes with a separate analysis of risk and protective factors for GBV.

Chapter 2 provides a contextual and methodological framework for the research, focusing on the occupied Palestinian territories and the specific experiences of Palestinian women. It begins with a brief historical and political overview of the region, highlighting the wars on Gaza and the situation in the West Bank and Jerusalem. The chapter explores what it means to be a woman in Palestine, emphasizing GBV, its psychological effects, and protective factors. It then

outlines the research project, discussing the theoretical framework of the qualitative study—grounded theory—along with its aims, objectives, and research questions for the qualitative part, and hypotheses for the quantitative part. The chosen methodology, a mixed-method approach with a sequential exploratory design, is introduced, encompassing both a qualitative study exploring the impact of political trauma on GBV, and a quantitative study testing the developed conceptual models. The chapter concludes with a discussion of ethical considerations and reflections on the fieldwork conducted in Palestine.

Chapter 3 presents a qualitative inquiry into GBV victimization and perpetration within the Palestinian context, focusing on political violence, political trauma, and GBV. Using a grounded theory approach, the study aimed to understand the types of political violence Palestinians experienced and its effects on mental health, particularly how political trauma influenced GBV among females and aggressiveness among males. Interviews were conducted with Palestinian females, males, and mental health care providers to explore these themes, along with the psychological consequences of GBV and the associated risk and protective factors. The chapter outlines the research context, participants, ethical considerations, and methods used, including semi-structured interviews. The data analysis revealed insights from the perspectives of the three groups interviewed, leading to the development of two conceptual models that were tested in the subsequent quantitative phase of the research.

Chapter 4 presents the quantitative assessment, which aimed to evaluate the relationships between political traumatic events, political trauma symptoms, and GBV, as well as its impact on mental health outcomes and distress among Palestinian females. Additionally, it explored the role of self-concept and coping strategies in mediating the relationship between GBV, mental health outcomes, and distress. For Palestinian males, the study examined the relationship

between political trauma, aggressiveness, and mental health, investigating whether self-concept and coping strategies mediated these relationships. The chapter outlines the participants, procedures, and research instruments used, which were translated, validated, and pilot-tested for accuracy. Structural equation modeling (SEM) was employed to test two conceptual models: one for GBV among females and one for aggressiveness among males. The results are presented for females, males, and combined data, followed by a preliminary discussion of the findings.

Chapter 5 offers an integrated discussion of the study's findings from both the qualitative and quantitative inquiries. It synthesizes the results to provide a comprehensive understanding of the relationships between political trauma, GBV, and mental health outcomes among Palestinians. The chapter explores the theoretical, practical, and policy implications of the findings, highlighting how they contribute to existing knowledge and inform future interventions. It also addresses the limitations of both studies, acknowledging any constraints and areas for improvement. The chapter concludes with a summary of the key insights gained and their significance for addressing GBV and mental health in areas affected by war.

CHAPTER ONE
Literature Review

1.1 Political violence, and political trauma: A brief overview

Many countries experience widespread conflict, exposing millions of people to political violence and increasing their risk of suffering from its aftereffects (Pat-Horenczyk & Schiff, 2019). Globally, more than 150 countries have documented human rights breaches, and the proportion of civilian casualties from wartime relative to military personnel is increasing (Johnson & Thompson, 2008).

During wartime, individuals are at risk of experiencing a range of traumatic events, from those involving imminent danger to those causing significant moral distress (Stein et al., 2012). Examples of such traumatic experiences include bombings, shootings, home demolitions, and loss of family members, as well as moral injuries like mass detention and exile (Jabr & Berger, 2017; Jong et al., 2000).

War has far-reaching and adverse consequences for individuals, communities, and societies, leading to fatalities, disabilities, and the destruction of families, communities, and cultures (Sidel & Levy, 2008). In addition, it generates significant psychosocial issues and threatens long-term stability (Jong et al., 2000). Paradoxically, war trauma can sometimes increase victims' acceptance of breaches of humanitarian standards (Elcheroth, 2006), and it affects marital harmony, community resilience, and overall life satisfaction (Shamai et al., 2007).

Contemporary warfare is linked to reduced direct deaths, but is accompanied by increasing and enduring mental health outcomes (Rozanov et al., 2018). The impact of warfare on mental well-being is considerable, resulting in elevated rates of mental disorders within the

general populace, particularly among vulnerable groups such as women, children, the elderly, and individuals with disabilities (Murthy & Lakshminarayana, 2006). The repercussions of war trauma can persist over time, adversely affecting individual mental health and heightening the likelihood of experiencing depression (Bratti, 2016).

In addition, ongoing war found to result in high levels of cumulative trauma among adults, with significant negative impact on psychological well-being, as Ogle et al. (2014) found that greater PTSD severity was predicted by exposure to cumulative trauma among adults. As well as, individuals exposed to multiple traumatic events are prone to experiencing more intense symptoms of PTSD and depression compared to those who encounter a singular event (Suliman et al., 2009).

1.1.1 Importance of studying trauma among adults

Scholars' attention to the study of trauma has notably increased since the 1990s, coinciding with the emergence of trauma studies as a pivotal academic trend (Andermahr & Pellicer-Ortín, 2013). This scholarly interest has expanded across diverse disciplines, including biblical studies (Garber, 2015) and literary criticism (Balaev, 2014). Historians have also begun exploring the concept of trauma, particularly concerning the persistent challenge of comprehending and coping with catastrophic events (Di-Capua, 2015).

The study of trauma among adults in post-conflict regions is essential for comprehending the enduring effects of warfare on mental health and overall well-being and for exploring the prevalence and trajectory of trauma (Cook & Simiola, 2017). Summerfield (1999) questions the medicalization of trauma, stressing the significance of cultural context and local knowledge in addressing the suffering endured by survivors of war. Ehntholt & Yule (2006) emphasizes the

necessity of evidence-based interventions for young refugees, who frequently grapple with mental health challenges like PTSD, depression, and anxiety. Jensen & Shaw (1993) and Schwarz & Perry (1994) draw attention to the intricate interplay of developmental, familial, and communal factors in the aftermath of war-related trauma, underscoring the imperative for further investigation in this domain.

Furthermore, scholars have shown interest in examining trauma among adults in post-war regions in order to understand the factors contributing to resilience in individuals affected by war, as it is vital for enhancing their overall health and societal integration (Alamdari et al., 2022).

1.2 What is political trauma?

War trauma is traditionally associated with PTSD and the direct consequences of armed conflict, leading to fatalities, disabilities, and societal destruction (Sidel & Levy, 2008; Jong et al., 2000). It often results in significant psychosocial issues and affects community resilience and life satisfaction (Shamai et al., 2007).

In contrast, political trauma refers to the psychological and social impacts of state violence, political repression, or systematic human rights abuses, which may occur in the absence of active armed conflict (Elcheroth, 2006). This form of trauma can also lead to significant psychological and social consequences, but it is distinct from the direct impacts of war.

The term trauma is historically rooted in medical terminology and symptomatology. It refers to massive injury incurred as a result of a severe and sudden blow, but which may not manifest itself fully directly following the occurrence of the event. Although Freud (1920) laid the groundwork for formulation of the psychological counterpart of medical trauma, it was the

work of his daughter Anna and her colleagues during World War II that provided the scientific community with the first studies on the effects of war on individuals (Baker, 1999).

Trauma is considered as a complex concept with different definitions and interpretations, which can understood as a response to an incident perceived as physically or emotionally harmful, resulting in a negative effects on individuals' well-being (Leahy & Iglesias Lino, 2022).This response can overwhelm an individual's coping mechanisms, leading to disruptions in self-regulation and other enduring consequences (Leahy & Iglesias Lino, 2022). Trauma can metaphorically be viewed as an injury, penetrating the psyche and interrupting the symbolic processing (Garland, 2018; Strozier & Flynn, 1996).It extends beyond life-threatening situations, encompassing events that challenge one's fundamental beliefs (Leahy & Iglesias Lino, 2022). The impact of trauma varies greatly among individuals, with different events having diverse effects on different people (Wade & Schenck, 2012).

Trauma extends beyond mere physical experience; it refers to an underlying distressing event (Humphrey, 2010). In clinical psychology, trauma is conceptualized as a manifestation of a traumatic experience that has not been fully processed psychologically; a memory that remains unassimilated and disrupts the natural flow of time by collapsing the past into the present (Humphrey, 2010). This psychological phenomenon became recognized as PTSD (post-traumatic stress disorder) and was initially perceived as a sign of physical frailty (Humphrey, 2010).

Also, trauma is defined by Muldoon (2024) as a process involving multiple elements, including both the traumatic experience itself and the responses that follow. These elements are interconnected through an individual's capacity to adapt, the availability of support, and their ability to respond and act in ways that they find helpful. Traumatic responses encompass the

health and social outcomes that emerge from the traumatic experience, as well as the individual's ability to negotiate and adjust to these events. These responses are influenced by a person's social, psychological, and material resources and play a crucial role in how they manage the transition and change associated with trauma.

On the other hand, political traumas refer to intensely distressing incidents triggered by politically driven behaviors and endured by groups of people (Vertzberger, 1997). The repercussions of political trauma transcend geographical and temporal confines, exerting adverse impacts on individuals who align with the political affiliations of the victims. These effects persist in the collective historical recollections of the affected group for an extended period (Montiel, 2000).

Furthermore, this trauma can persist and be strengthened through the memorialization of violent occurrences like wars, genocides, and terrorist attacks, by establishing locations and rituals aimed at managing and taking ownership of traumatic experiences (Farrar, 2004).

According to Koopman (1997), trauma as a response of being exposed to a political traumatic event characterized by the symptoms of post-traumatic stress disorder and acute stress disorder. In which traumatic events identified as any experiences, whether within or beyond the scope of typical experiences, that most individuals would anticipate to be exceedingly distressing for those subjected to its aftermath (Koopman, 1997).

In a study conducted by Sioh (2018), political trauma is defined as a type of trauma experienced by individuals or groups that arises from systemic, ongoing social, economic, or political conditions, often inflicted upon people due to their identity or status within a socio-political context. It is characterized by a profound sense of disempowerment and helplessness, where victims feel unable to resist or change the forces impacting their lives. This sense of

helplessness is often exacerbated by the perception that those responsible for the trauma have "gotten away" with their actions, reinforcing feelings of humiliation, anger, and resentment. Unlike trauma from a single, isolated event, political trauma often involves repeated or continuous harm—whether psychological, economic, social, or legal—creating a form of coercive control that remains largely invisible yet pervasive. Symptoms include chronic anxiety and a diffuse, ongoing fear stemming from gradual, incremental changes, such as those brought about by globalization or socio-economic restructuring. This anxiety, combined with a strong emotional response of anger directed at perceived perpetrators, contributes to a desire to find scapegoats and attribute blame, deepening the psychological distress and perpetuating a sense of injustice among the affected individuals or groups. Overall, political trauma reflects a complex interplay of ongoing oppression, emotional distress, and a pervasive feeling of powerlessness within a broader socio-political context.

While according to Donoso (2018), political trauma can be defined as as the psychosocial destruction that affects both individuals and the broader social and political structures of a society. It has a dual impact, harming the psychological well-being of individuals and disrupting the fabric of entire communities. Political trauma undermines social relationships, not only between individuals but also between individuals and their society, creating a destructive cycle of psychological distress and social fragmentation. This type of trauma is specifically a result of gross human rights violations and state violence against individuals or groups, reflecting a continuous, interactive process where individual psychological states and social environments influence and exacerbate each other.

In addition, political trauma is identified by the fears, anxieties, and sadness experienced by students, as observed in how teachers navigated the days following the 2016 U.S. presidential

election. This form of trauma reflects the emotional and psychological impact that significant political events can have on individuals, particularly when these events create feelings of threat, uncertainty, or disempowerment (Sondel et al., 2018). The definition of political trauma in this study aligns with the definitions introduced by (Donoso, 2018; Sioh, 2018; Sondel et al., 2018), with a focus on psychological outcomes, primarily characterized by PTSD symptoms, as these are recognized as the most common psychological response following exposure to a traumatic event (Muldoon, 2024).

PTSD encompasses a variety of symptoms typically grouped into five main clusters: (1) Exposure to actual or threatened death, serious injury, or sexual violence , (2) Intrusion , (3) Avoidance of stimuli associated with the traumatic event(s), (4) Negative alterations in cognitions and mood associated with the traumatic event(s), and (5) Marked alterations in arousal and reactivity associated with the traumatic event(s) (Pacella et al., 2013).

1.2.1 Political trauma: Theoretical perspectives

Political psychology examines how psychological processes influence and are influenced by political behaviors, attitudes, and systems. It explores the impact of unconscious intra- and interpersonal psychological dynamics on political attitudes, decisions, and phenomena. This field integrates insights from both psychology and political science to understand how mental processes shape and are shaped by political environments and events (Huppertz, 2018).

Utilizing political psychology perspectives enhances the understanding of traumatic political events and its consequences, as this understanding can help in preventing or mitigating of the occurrence of the traumatic event or the post psycho-social consequences of it (Koopman, 1997). Furthermore, the increasing frequency and the escalating of such traumatic events, underlines the importance of understanding trauma from a politico-psychological perspective, in

order to avoid the expected catastrophic consequences on the quality of individuals' life (Koopman, 1997).

Psychological studies on political trauma identify politico-military events as significant sources of trauma, highlighting that their effects are often widespread and collective. These studies demonstrate that such trauma impacts large groups of people rather than just isolated individuals, revealing the extensive and shared nature of its consequences within affected communities (Montiel, 2000).

As mentioned in Kalmanowitz & Lloyd (2004) "The personal consequences of violence are interwoven with the political and can include human rights violations, repression, abductions, rape, unjustified imprisonment, intimidation, … and these can impact the civilians of a country leading to a sense of vulnerability and helplessness and a feeling of un-safety and insecurity" (p. 58).

While from a psychoanalytical perspective, traumatic events are seen as threats to the ego, leading individuals to employ repression as a defense mechanism (Cash, 2006). When traumatic stressors intersect with daily stressors, the ego can become overwhelmed, resulting in PTSD symptoms (Cash, 2006). In political psychology, this understanding is crucial as it helps explain how political trauma, which often involves intense and persistent stressors, can lead to similar psychological responses. By examining how political events impact the ego and contribute to PTSD, political psychology can offer insights into the mechanisms behind the psychological effects of political trauma and inform strategies to address and mitigate these effects.

In political psychology, the social approach to PTSD highlights how environmental stressors, such as oppressive political conditions or systemic violence, contribute to the

development of trauma. This perspective emphasizes the role of broader socio-political contexts in shaping individuals' psychological experiences, illustrating how persistent and widespread stressors within political environments can lead to PTSD.

Conversely, the person-centered approach focuses on the impact of interpersonal negative emotions, such as shame and guilt, and avoidance behaviors directed towards the traumatized individual (Maercker & Hecker, 2016). In the context of political psychology, this approach examines how individuals may experience personal shame and guilt related to their involvement in or exposure to political violence. Additionally, it considers how political environments can foster stigma and avoidance, further isolating individuals and complicating their recovery. By integrating both approaches, political psychology can offer a comprehensive understanding of how political contexts influence PTSD, addressing both the environmental stressors and the personal, interpersonal dynamics that shape individuals' psychological responses to political trauma.

The intersection of attachment theory and political psychology provides a framework for understanding how political violence and instability lead to psychological trauma, particularly PTSD. According to attachment theory, disruptions in close relationships, such as the loss of loved ones, forced displacement, or separation, undermine attachment security, increasing vulnerability to PTSD (O'Connor & Elklit, 2008). In contexts of political violence, these disruptions are exacerbated by ongoing threats, fear, and instability, weakening individuals' emotional resilience. Political oppression and state violence create collective trauma, where communities face systemic insecurity, leading to the intergenerational transmission of unresolved trauma. This dynamic, where political events disrupt emotional bonds and attachment

security, intensifies the long-term mental health impact on civilian populations, particularly in war-torn regions (O'Connor & Elklit, 2008).

While by linking emotional theories of PTSD to political psychology, scholars highlight how individuals' emotional and cognitive responses to political violence can shape their trauma outcomes. Emotional theories suggest that PTSD arises when individuals cannot effectively cope with or adapt to traumatic events (Suveg & Zeman, 2004), which is highly relevant in politically unstable environments where exposure to violence is chronic. In such contexts, those with rigid pre-trauma beliefs, whether overly positive or negative are particularly vulnerable. For example, rigid positive beliefs about the safety of the world may be shattered by political violence, while rigid negative beliefs about the self or others may be confirmed, reinforcing PTSD symptoms (Park et al., 2014).

1.2.2 Political violence and political trauma: Literature review

War and conflict are recognized worldwide as stress-inducing events that heighten the risk of psychological trauma (Raza et al., 2023). While PTSD rates tend to be highest in post-conflict settings, Palestine presents a distinct case of continuous trauma due to ongoing political violence and instability. The psychological effects in such environments may not align with typical PTSD classifications, as the trauma is not confined to a singular event but is a persistent part of daily life.

Previous literature has documented the prevalence of PTSD in war-affected areas. A meta-analysis that explored the aggregate prevalence of PTSD in conflict zones from 1945 to 2022 found an overall prevalence of 23.5%, with no significant difference between civilians and military groups (Lim et al., 2022). Another meta-analysis of 20,138 participants, of whom 3,403

met the diagnostic criteria for PTSD, revealed higher rates of trauma among refugees (Oakley et al., 2021). Additionally, a systematic review and meta-analysis that investigated PTSD and major depression (MD) in war-affected countries between 1989–2019 reported that 26.51% of participants had PTSD, and 23.31% experienced MD. These findings suggest that in 2019, approximately 316 million adults worldwide were living with PTSD or MD as a result of war (Hoppen et al., 2021). Another systematic review found a PTSD prevalence rate of 26% among adults in war-affected areas (Morina et al., 2018), while a study focused on the Iranian population reported a prevalence of 47% for PTSD related to war exposure (Sepahvand et al., 2019).

Notably, PTSD rates are higher in low- to middle-income countries compared to high-income nations (Atwoli et al., 2015; Hoppen et al., 2021), with female gender and unemployment serving as key predictors of higher trauma rates (Morina et al., 2018; Tahan et al., 2021). In Palestine, as an example of ongoing political trauma, the experience differs from post-conflict zones where trauma is associated with past events. Continuous exposure to political violence, including daily threats and human rights violations, leads to persistent psychological distress. A review by Johnson & Thompson (2008) found that exposure to political violence increased the likelihood of developing trauma-related symptoms, particularly in women and older individuals. This is supported by a study in Palestine, where exposure to political violence was found to significantly increase the risk of trauma (Hall et al., 2015). Exposure to torture and other political violence also correlatesd with higher trauma rates (Steel et al., 2009). Among female civilians, exposure to war-related trauma remains a key predictor of psychological distress (Stevanović et al., 2016), as observed in studies on Syrian Kurdish refugees, where trauma exposure and torture were associated with trauma symptoms (Ibrahim & Hassan, 2017).

The severity and duration of symptoms associated with continuous trauma in such regions can vary, impacting individuals over extended periods (Hunt, 2010). For refugees, displacement exacerbates existing trauma as the psychosocial challenges of adjusting to a new environment often compound the effects of the trauma endured in their homeland. Indeed, the reception in a host country may present greater challenges than the original traumatic events (Hunt & Gakenyi, 2005), further contributing to ongoing psychological distress.

1.2.3 Political trauma and other psychological disorders: Literature review

The co-occurrence of mental disorders associated with PTSD and traumatic experiences is observed. However, it's uncertain whether the link with other mental disorders is primarily due to the traumatic event itself or the symptoms of PTSD (Sareen, 2014).

Experiencing collective trauma from events like earthquakes and war can evoke shared emotions among communities, fostering pro-social behaviors that mitigate the negative impacts of such events on individuals (Wang et al., 2023). Conversely, interpersonal trauma, such as abuse, neglect, or sexual violence, often leads to adverse consequences that individuals internalize, persisting chronically and evolving into what Piaget termed “trauma mode” (Wang et al., 2023). This state is characterized by enduring feelings of depression, negative cognition, negative self-concept, and behaviors such as self-harm or suicidal tendencies (Wang et al., 2023).

Political trauma or war-related PTSD found to be associated with numerous psychiatric conditions including chronic somatic problems, depression, generalized anxiety disorder, suicidal ideations, panic disorder with agoraphobia, and alcohol abuse among a sample of a PTSD-diagnosed war veterans (Klaric et al., 2017). As well as, major depressive disorder, substance use

disorders, and personality disorders were more prevalent among Israeli men exhibiting symptoms of PTSD compared to those who had experienced combat but did not report such symptoms (Skodol et al., 1996). While, Farhood et al. (2006) explored the relationship between PTSD and nonspecific general psychiatric morbidity in a civilian population residing in Southern Lebanon after the exposure to war- related traumatic events, and the results revealed a strong relationship between PTSD and psychological impairments characterized by (somatic, anxiety, depression symptoms, and social dysfunction).

PTSD severity can result in an impairments in psycho-social areas such as work, leisure activities, and home management, as this was supported in a study conducted on a Congolese refugees in Uganda, in which PTSD severity found to be highly associated with psycho-social dysfunctioning (Ainamani et al., 2017). As well as, in a review, PTSD symptoms, specifically numbing/ arousal symptoms found to be associated with family distress among veteran's families (Galovski & Lyons, 2004). Furthermore, PTSD mediated the association between war- traumatic events and post-war antisocial behavior following military service among Vietnamese veterans (Fontana & Rosenheck, 2005).

PTSD is considered as a risk factor for violent behaviors after being exposed to a traumatic event (Gillikin et al., 2016). This is further supported by the findings of a study explored the association between PTSD and aggressive behavior among combat veterans, as the findings found that combat veterans with PTSD showed more aggressive behaviors than veterans without PTSD. The same study found that verbal aggression was mostly directed against known individuals, while impulsive reactions were more directed against unknown individuals (Begić & Begić, 2001).

Exposure to political traumatic events particularly in war-affected regions, has been associated with several psychological disorders, including PTSD, which can exacerbate issues such GBV and IPV (Bell & Orcutt, 2009; Gilbar et al., 2021). In regions affected by political violence, PTSD often emerges as a response to traumatic events and can lead to heightened aggression and interpersonal conflict. A meta-analysis, largely based on samples from the United States, Spain, Canada, South Africa, and the United Kingdom, found a strong correlation between PTSD and IPV, with PTSD being more strongly associated with IPV perpetration than victimization (Spencer et al., 2022). These findings were consistent with earlier research by Spencer et al. (2019), which also highlighted the link between PTSD and violence within intimate relationships. Additionally, PTSD has been shown to partially mediate the relationship between GBV and alcohol misuse, further complicating the psychological impact of trauma in politically volatile environments (Nguyen et al., 2023).

1.3 GBV: What is it?

GBVis likely the most widespread but under acknowledged infringement of human rights in contemporary society (Djamba & Kimuna, 2015). While both men and women frequently fall victim to such violence, it disproportionately affects women and girls (Mittal &Singh, 2020). Osotimehin, the Executive Director of UNFPA, emphasized in his November 25, 2014 appeal to end violence and discrimination against women, "today there is no country, not one, where women and girls live free from violence" (UNFPA, 2014).

The global health and development concern of GBV against women has been acknowledged by the United Nations. Consequently, various policies and public education

programs have been implemented worldwide with the objective of mitigating this form of violence (Russo & Pirlott, 2006).

GBV refers to violence directed at individuals or groups due to their gender identity or expression (Fu, 2015). GBV is primarily perceived as violence against women (Aghtaie & Gangoli, 2014). In 1993, the United Nations' Office of the High Commissioner for Human Rights' Committee on the Elimination of Discrimination against Women defined violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (United Nations, 1993, p.2).

GBV against women extends beyond physical harm inflicted directly on the victim (Izumi, 2007). It encompasses psychological harm and the fear of recurring violence, which undermines a woman's self-esteem and hampers her capacity to resist or confront her abuser. Furthermore, it constitutes a breach of her fundamental human rights (Izumi, 2007).

The significance of the UN definition of violence against women lies in its acknowledgment of the state's obligation to safeguard the human rights of women (Baldasare, 2012). It underscores that violence against women is rooted in gender and transcends the private struggles of individual victims (Baldasare, 2012).

GBV stems from imbalanced power dynamics between men and women and is perpetuated by deeply ingrained patriarchal beliefs that subordinate women to men (Sanjel, 2013). These beliefs persist due to factors such as illiteracy, poverty, and the low social status of

women within society (Sanjel, 2013). Which means that this violence is firmly entrenched within structural, social, and political dimensions (Jaramillo-Bolívar & Canaval-Erazo, 2020).

GBV has different forms such as domestic violence, intimate partner violence, rape, sexual assault, and stalking are considered as a forms of GBV (Jakobsen, 2014; Rees et al., 2011).

1.3.1 Gender-based violence among female in contexts with political violence

GBV is considered as a significant public health issue (Beyene et al., 2019). It is predicted that approximately one out of three women will encounter violence during their lifetime, with intimate partner violence being prevalent (Omoni, 2010).

War found to be a risk factor for increasing the prevalence of GBV, in which domestic violence appeared to be the most post-war prevalent form of violence (Manjoo & McRaith, 2011). In general war increases violence specifically domestic and sexual violence, with gender inequality as the main cause for violence against women (Sigsworth, 2008).

In a systematic review and meta-analysis explored the risk factors associated with violence against women (VAW) in nations exhibiting the highest 12-month prevalence rates of intimate partner violence (IPV), armed conflict, witnessing parental violence, and child abuse were considered as factors affecting the prevalence of VAW (Mannell et al., 2022).

During the exposure to political traumatic events in areaes affected by war, it was found that there are several demographic and psychological factors that are considered as a risk factor for perpetrating violence against women. For example, being younger, single and internally displaced found to be risk factors for experiencing sexual violence among Ukrainian female during the conflict in eastern Ukraine (Capasso et al., 2021). While The findings of a study

conducted among urban women in Somalia, who were impacted by war and either belonged to a minority clan or had no clan affiliation, revealed that previous encounters with physical or sexual violence during childhood were linked to heightened occurrences of adult physical or sexual non-partner violence. Additionally, those who faced financial constraints, lacking sufficient funds to cover basic needs for a significant portion of the month, and whose current or previous partners used khat, were also more prone to report a history of intimate partner violence (IPV) (Wirtz et al., 2018).

In a longitudinal study conducted in conflict-affected areas and refugee-hosting communities in northern Ecuador, household-level factors including socioeconomic status, food security, and male or female participation in labor, alongside perceived discrimination and exposure to psychosocial stressors such as instances of robbery, death of household members, physical attacks, natural disasters, and other adverse events, were identified as risk factors for both emotional and physical or sexual intimate partner violence (Treves-Kagan et al., 2022). Furthermore, separate studies in South Africa and among immigrants in Boston that was examined the association between exposure to political violence among South Africans and exposure to premigration political violence among a sample from Boston revealed that men who had experienced political violence were over twice as likely (and in one study, up to six times as likely) to perpetrate intimate partner violence compared to those who had not been exposed to political violence (Gupta et al., 2009; Gupta et al., 2012). Additionally, various forms of prior victimization such as childhood abuse, exposure to traumatic events during war, and abduction, were positively correlated with experiencing partner violence in the present (Widom et al., 2008).

Furthermore, amidst political violence, research has shown that women displaying significant symptoms of PTSD due to exposure to war traumatic events face an elevated risk of experiencing further interpersonal violence and victimization. Moreover, it has been observed that more severe symptoms of PTSD predispose women to a heightened risk of subsequent interpersonal violence (Cougle, Resnick, & Kilpatrick, 2009; Iverson et al., 2011; Krause et al., 2006). Another study, focusing on the prevalence and predictors of partner violence among couples residing in rural areas of Uganda post-war, revealed that higher levels of partner violence against women were associated with re-experiencing trauma symptoms among females (Saile et al., 2013). Additionally, Iverson et al. (2013) investigated the impact of distinct PTSD symptom clusters (re-experiencing, avoidance, numbing, and hyper-arousal), dissociation, and coping strategies (engagement and disengagement coping) on IPV re-victimization among recently abused veterans women. Their findings indicated that PTSD hyper-arousal symptoms, dissociation, engagement coping, and disengagement coping each significantly predicted physical IPV re-victimization

1.3.2 Gender-based violence from theoretical perspectives

GBV against women is considered a complex phenomenon, for which there is no specific theory that fully accounts for all types of violence against women, due to the different and several factors associated with it (Renzetti et al., 2011).

According to the psychiatric approach, characterized by a medical orientation and a focus on individual dysfunction. In relation to domestic violence, scholars have endeavored to construct a psychological profile of the perpetrator, which encompasses traits such as low self-esteem, high sensitivity to frustration, inability to be self-examining, resistance to criticism, irresponsible for his behaviors, impulsive decision-making, with a history of substance abuse,

and a pattern of resorting to violent behavior as a means of conflict resolution (Bell & Chance-Hill, 1991).

While according to the social- psychological theory, violence against women can be understood by understanding and analyzing the external environmental factors affecting the family (Gelles, 1980). Moreover, this perspective takes into consideration the daily familial dynamics that precede instances of violence. Theoretical frameworks that explore stress, the intergenerational transmission of violence, and patterns of family interaction align with the social psychological model (Gelles, 1980).

Furthermore, according to the Social exchange theory, violence is inherited in the family, in which it suggests that violent behaviors are the result of rewarding the violent behaviors. It means that if the violent behavior was rewarded then it will be generalized as a technique to solve problems, while if it was punished then won't be generalized to be used to solve problems (Gelles, 1983).

From the perspective of resource theory, individuals with greater access to resources such as money and social support show less tendency to resort to violence as a means of achieving their objectives. However, for some individuals, violence becomes a resource they turn to when other resources are unavailable or consumed (Allen & Straus, 1979).

Based on Seligman (1975) findings related to the theoretical concept "learned helplessness", the co-occurrence of violence and the inability to escape a violent relationship, can be understood as while women fail to exert any control over the violence they face, this can eventually lead to a state of learned helplessness and depression (Walker, 1992). This is because

the repetitive nature of the abuse, gradually reduces the woman's motivation to react (Walker, 1992).

According to the feminist-political theory, violence against women can be seen as a way to control women, which means that men tend to beat women in order to control them from the believe rooted in the patriarchal cultures that they are dominant and privileged to have power (Walker, 1986).

In addition, according to the gender role conflict approach, men became aggressive toward women when they find themselves unable to do their roles that were defined by the patriarchal culture in the society, whether because of the negative psychological effect or the negative social outcomes after the exposure to a traumatic event (Gilbar et al., 2021). Gender Role Conflict, refers to a psychological condition wherein conventional gender expectations lead to harmful outcomes for individuals or those around them. It manifests when inflexible, prejudiced, or limiting gender norms lead to constraints, devaluation, or infringement upon oneself or others (O'Neil, 2008).

1.3.3 A brief understanding of political trauma and GBV

GBV perpetration/ victimization found to be correlated positively to PTSD symptoms in areas affected by war (Spencer et al., 2022). According to the psychological theoretical model of PTSD and aggression that was proposed by Chemtob et al (1997), the relationship between PTSD and male-perpetrated IPV, as men with increased PTSD symptoms might be more prone to being overly alert and more sensitive to unclear social and environmental signals, increasing the likelihood of misinterpreting their partners' actions as threatening, especially during relationship conflicts. This misinterpretation could trigger anger, increased arousal, biased hostile attributions, reduced capacity for rational decision-making to find non-aggressive

solutions, and intensified urges to respond aggressively to the perceived threat (Bell & Orcutt, 2009).

Furthermore, symptoms of trauma, can heighten the risk of IPV by compromising women's ability to detect threats and employ safety behaviors (Machisa & Shamu, 2022). These mental health symptoms might impede women's capacity to recognize potential dangers or risks of violence in their relationships due to the emotional numbing (Iverson et al., 2022; Machisa & Shamu, 2022). Moreover, they could hinder their effectiveness in responding to warning signals from their partners, as well as complicate their decision-making processes and actions needed to exit abusive relationships (Iverson et al., 2022). Specifically, trauma-related symptoms may obstruct help-seeking behaviors and the efficient utilization of available resources essential for preventing future instances of relationship violence (Smith et al., 2020).

1.3.4 Political violence, political trauma, GBV and mental health outcomes among females in the Global South: A scoping review

1.3.4.1 Aims and objectives

Many scholars and researchers in the field of psychology and sociology have been interested in studying violence against women in areas affected by war (Manjoo & McRaith, 2011; Spencer et al., 2022), and for the sake of this study and to better understand GBV and the gaps in the literature regarding the relationship between political trauma and GBV among adult females, and political trauma and aggressive behavior among adult males in the Global South. More specifically, a broad review questions was deliberately formulated to encompass various sources: (1) What evidence currently exists regarding the correlation between political violence, political trauma and GBV among females in the Global South experiencing war?; (2) What evidence currently exists regarding the correlation between political violence, political trauma

and GBV perpetration among males in the Global South regions experiencing war?; (3) What are the psychological consequences following exposure to GBV associated with political violence or political trauma?

1.3.4.2 The search strategy

This scoping review adhered to the PRISMA standards for systematic reviews (Moher et al., 2009), which are evidence-based guidelines for reporting in systematic reviews and meta-analyses. The review was conducted in February 2024, utilizing PubMed, Web of Science, Scopus, PsycArticles, and EBSCO databases to collect all peer-reviewed publications from 2014 to February 2024 relevant to the topics of political violence, political trauma and gender-based violence (GBV) among females in the Global South regions affected by war, and the psychological impact of being exposed to GBV related to political violence or political trauma, as well as political violence, political trauma and aggression among males in similar contexts. The time frame of 2014 to 2024 was chosen to incorporate the most recent literature on the subject. Searches were restricted to publications containing keywords within a defined matrix of relevant terminology present in the study title or abstract. The search utilized a combination of keywords and subject headings including: (1) political violence, conflict, war, military violence, colonial violence; (2) political trauma, PTSD, trauma, psychological trauma; (3) GBV victims, females, girls, women; (4) mental health; (5) GBV, GBV perpetration, domestic violence, intimate partner violence, violence against women, aggression, aggressive behavior; and (6) men and males. Studies were selected based on the criteria outlined below.

1.3.4.3 Eligibility criteria

As previously mentioned, only articles published from 2014 to the present were considered to thoroughly assess the latest developments in literature concerning political

violence, political trauma, and GBV among females in areas within the Global South affected by war, as well as the psychological effects of exposure to GBV associated with political violence or political trauma, and political violence, political trauma, and aggression among males in similar contexts. Qualitative, quantitative, and mixed-method studies were included, while case studies, case reports, and narrative or systematic reviews were excluded. Furthermore, articles subject to full review met the following criteria: (1) addressing political violence and GBV against females; (2) addressing political trauma and GBV against females; (3) addressing political violence and GBV perpetration; (4) addressing the psychological impact of exposure to GBV related to political violence or political trauma; (5) addressing political trauma or political violence and aggression among males; (6) focusing on adult females or males (aged 18–65 years); (7) focusing on civilian populations residing within the Global South of political violence and armed conflicts; and (8) being available in English, peer-reviewed, and published (unpublished or non-peer-reviewed materials were excluded). Articles were also excluded if they originated from book chapters, dissertations, conference proceedings, conference abstracts, workshops, or brief reports, if they did not meet the age criteria, or if they were not available in English.

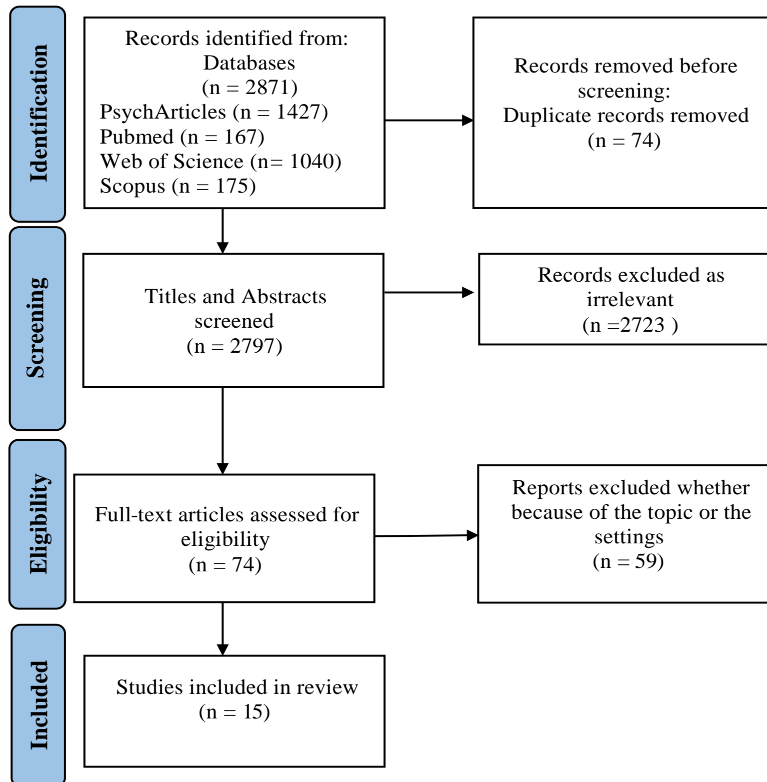
1.3.4.4 Results

Database queries yielded 2,871 distinct studies, each of which had its abstract evaluated for relevance. Those that did not meet the inclusion criteria were excluded. Articles encompassing both adults and individuals under 19 were excluded. Search result references were cross-referenced to eliminate duplicates. Materials such as opinion pieces, editorials, reviews, and special issues were disregarded. Subsequently, 74 full-text articles underwent further evaluation for eligibility. Among these, 58 were excluded for not meeting the study criteria (see

Figure 1). Following the final screening, 15 studies fulfilled the inclusion criteria and are summarized in (Table 1).

Figure 1.

Flow of Information Through the Different Phases of the Review



We examined the outcomes of 16 pertinent studies concerning different facets of GBV in the Global South. These findings are outlined in the narrative synthesis provided in the subsequent sections, which delve into investigating the correlation between GBV and mental health outcomes among females; psychological distress characterized by PTSD, PTSS, and maladaptive behaviors such as aggression; political violence and trauma characterized by PTSD and PTSS; and political violence and GBV perpetration. For more information (see Table 2),

where the findings were grouped and summarized. Eight studies investigated the mental health outcomes of GBV exposure among females, conducted across various countries including Bangladesh, Rwanda, The Democratic Republic of Congo, Afghanistan, South Africa, and three in Palestine. Additionally, eight studies explored the correlation between mental distress (symptoms of political trauma) and GBV in conflict-affected regions; two in South Africa, three in Israel, two in Afghanistan, and one in Zimbabwe. Furthermore, eight studies examined the link between political violence and GBV, with two conducted in South Africa, three in Israel, and one each in Afghanistan, Palestine, and Bougainville province of Papua New Guinea. Also, six studies assessed the relationship between political violence and political trauma, in which they conducted in South Africa, Israel, Afghanistan, and Bougainville province of Papua New Guinea. For further information regarding the sample size and methods of the studies (see Table 1). Ultimately, the discussion section outlines the policy implications, identifies gaps in the literature, and offers recommendations to guide future research and interventions. These points are summarized and detailed in (Table 3).

Table 1.

List of the Studies Investigated

Author (s), Year	*Study location*	*Sample and method*	*Instruments*	*Aim*
Akter, F., & Deeba, F. (2022)	Bangladesh	Quantitative study: Adult women (n= 600)	Questionnaires	Studied the relationship between specific types of GBV and mental health outcomes
Bahati, C., Rukundo, G.,	Rwanda	Quantitative cross- sectional	Questionnaires	Compared the prevalence of mental

Nyirahabimana, N., Izabayo, J., Niyonsenga, J., & Sezibera, V. *(2022)*		study: 20,381 participants; 8199 males and 12,182 females Age range (14-65)	Single binary question	disorders among IPV exposed and non-exposed individuals in Rwanda
Dossa, N. I., Zunzunegui, M. V., Hatem, M., & Fraser, W. D. *(2015)*	The Democratic Republic of Congo	Quantitative cross- sectional study: 320 women aged (15- 45)	Questionnaires	Assessed the effects of sexual violence (SV) in armed conflicts on women's mental health
Gibbs, A., Abdelatif, N., Said, N., & Jewkes, R. (2021)	Occupied Palestinian Territories	Quantitative cross- sectional study: Adult women (n= 534)	Questionnaires Checklist	Summarized the occurrences of occupation-related events among women aged 18 and above residing in the oPT. Evaluated the factors linked to these occurrences and their descriptive attributes. Investigated the health consequences of these events, particularly in terms of intimate partner violence (IPV) and mental well-being. Lastly, analysed the pathways between occupation-related events and experiences of IPV

Gibbs, A., Corboz, J., & Jewkes, R. (2018)	Afghanistan	Quantitative cross- sectional study: 935 Adult women aged (18-49)	Questionnaires Binary questions	Explored the factors correlated with intimate partner violence (IPV) within the last 12 months among married women in Afghanistan, concentrating on the factors commonly presumed to influence IPV; and elucidated whether IPV exhibits an independent association with various health outcomes
Gilbar, O., Dekel, R., Spector-Mersel, G., & Levi, O. (2019)	Israel	Qualitative phenomenological study: 14 former combat soldiers	Comprehensive interviews	Examined how Israeli veterans with PTSS perceived their masculinity as a result of the traumatic combat event
Gilbar, O., Wester, S. R., & Ben-Porat, A. (2021)	Israel	Quantitative study: Adult men (n= 234)	Questionnaires	Studied the possible indirect effect of PTSD and gender role conflict- restricted emotionally in the relationship of traumatic event exposure and IPV severity committed by men
Jewkes, R., Corboz, J., & Gibbs, A.	Afghanistan.	Quantitative study: 1,463 Adult	Questionnaires Binary	Examined the hypothesis that (mostly war related) trauma is a key driver

(2018)		women aged (18-48)	questions	of partner violence
Jewkes, R., Jama-Shai, N., & Sikweyiya, Y. (2017)	Bougainville province of Papua New Guinea	Quantitative study: Adult men(n = 864) and women (n = 879)	Questionnaires Interviews	Explored the impact of witnessing a decade long civil war, and how it relates to mental illness and violence against women
Machisa, M. T., Chirwa, E. D., Mahlangu, P., Sikweyiya, Y., Nunze, N., Dartnall, E., ... & Jewkes, R. (2021)	South Africa	Quantitative study: 1293 female students (18- 30) years	Questionnaires	Described the factors and inter-relationships associated with female students' increased vulnerability to past year experience of partner sexual violence and non-partner rape in South African higher education settings
Machisa, M. T., Christofides, N., & Jewkes, R. (2017)	South Africa	Quantitative study: Adult women (n= 511)	Questionnaires	Examined the correlations between child abuse, mental health issues, and intimate partner violence (IPV), and elucidated the underlying pathways linking these variables
Machisa, M., & Shamu, S. (2018)	Zimbabwe	Quantitative study: Adult men (n= 2838)	Questionnaires	Investigated the prevalence and factors associated with IPV perpetration by men in heterosexual

				relationships
Sousa, C. A., Yacoubian, K., Flaherty Fischette, P., & Haj-Yahia, M. M. *(2018)*	Palestine	Adult women (n= 122)	Questionnaires	Explored the relationships between IPV and political violence (both lifetime and past-month exposure) and tested their independent relationships to PTSD and depressive symptomology
Veronese, G., Mahmid, F. A., & Bdier, D. *(2023)*	Palestine	Adult women (n= 332)	Questionnaires	Investigated the relationship between gender-based violence (GBV), subjective quality of life, and mental distress manifested by anxiety, depression, and stress among Palestinian women exposed to political and military violence
Zedan, H. F., & Haj-Yahia, M. M. *(2023)*	Israel	Quantitative study: 770 Palestinian adults (64.9% were women and 35.1% were men aged 21–66	Questionnaires	Examined the relationship between exposure to socio-political stressors and psychological and physical IPV perpetration among Palestinians in Israel

1.3.4.5 Discussion

Overall, the studies selected offer varied insights into understanding gender-based violence (GBV) in war-affected regions, illuminating the associations between political violence, political trauma, and GBV. They also delve into the mental health outcomes of women exposed to violence, providing perspectives from both females and males. Across different countries in the Global south, researchers identified multiple risk factors contributing to GBV perpetration or victimization in war-affected regions. Recognizing the importance of comprehending GBV within war-affected areas and acknowledging the intertwined nature of individual psyche and social context as emphasized by (Gadd & Jefferson, 2007), the subsequent discussion of findings is framed through a psycho-social lens. This lens considers personal, political, individual, and social dimensions in understanding social phenomena (Woodward, 2015). The discussion will pinpoint social and psychological factors contributing to GBV perpetration or victimization with the focus on exposure to political traumatic events and showing symptoms of political trauma as main drivers of GBV, as well as mental health outcomes for women experiencing GBV. Finally, implications for research, practices, and interventions gleaned from the reviewed studies will be addressed.

Table 2.

Critical Findings

Social factors contributing to GBV victimization / perpetration

- Exposure to political traumatic events
- Socio- political stress

Psychological factors contributing to GBV victimization/ perpetration

- Mental ill-health (PTSD & depression) in both women and men.

Mental health outcomes of females' exposure to GBV

- Post-traumatic stress disorder
- Depression
- Major depression
- Anxiety
- Panic disorder
- Suicide attempts
- Delusion symptoms
- Substance Use and alcohol use
- Social anxiety disorders

Social factors contributing to GBV victimization/ Perpetration

According to the review political violence exposure found to be correlated significantly and positively correlated with GBV, as the exposure to traumatic events results in several social, emotional, and physical problems that increase the likelihood of perpetrating GBV (Jewkes et al., 2017).

Exposure to political traumatic events. Based on the studies examined, exposure to political traumatic events found to increase the risk of gender based violence, and it would be more elevated if the woman exposed to the traumatic event directly. It was discussed that the exposure of both women and their spouses and families to events associated with political violence influences their family dynamics within the household, presumably affecting the mental well-being and self-esteem of both women and men, exacerbating poverty, and causing emotional stress due to the separation of support structures (Gibbs et al., 2021).

Violent political practices sought to affect the educational attainment, indicating that exposure to traumatic events serves as an indicator of the broader exclusion of women and girls from education (Jewkes et al., 2018). This exclusion may result from the destruction of schools or the practice of keeping girls confined at home to protect them from conflict. Moreover, exposure to trauma influenced women's perceptions of gender attitudes within the community. Women who experienced trauma perceived their communities as more patriarchal (Jewkes et al., 2018).

Moreover, War practices result in food insecurity and poverty, which negatively impact mental health and make women more vulnerable to experiencing violence. This is particularly true for women living in contexts of inequitable relationships and/or economic dependency (Machisa et al., 2021).

Socio- political stress. Socio-political stress was assessed as a risk factor for GBV in the reviewed studies. Socio-political stress can be considered as a factor that contributes to GBV against women. Direct exposure to sociopolitical stressors affects the interactions between men and women, both directly and indirectly, likely through psychological distress and cognitive appraisals (Zedan & Haj-Yahia, 2023). The way how individuals start to perceive the socio-political stressors, put them under a huge psychological stress which increases the likelihood of GBV. Furthermore, war has been found to elevate rates of interpersonal violence and crime in societal contexts, thereby affecting domestic violence, including violence against women (Machisa et al., 2017).

Psychological factors contributing to GBV victimization/ perpetration

The results suggested that mental-illness, such as depression or PTSD, increase the likelihood of women experiencing GBV. Among these conditions, depression emerges as a more potent predictor of GBV victimization in women compared to PTSD. Conversely, PTSD is identified as a stronger predictor of GBV perpetration in men than depression.

Symptoms related to PTSD, such as irritability and anger, might increase the probability of perpetrating GBV by undermining emotional intimacy, adopting maladaptive dependency patterns, or encouraging aggressive behaviors (Gibbs et al., 2018). On the other hand, PTSD symptoms such as poor of concentration may render women more prone to experience GBV (Jewkes et al., 2018). In addition, PTSD and depression can distort women's perceptions of assault risk, leading them to be less inclined to take actions to protect themselves. Furthermore, these conditions can heighten women's vulnerability, making them more prone to violence by being a potential targets for perpetrators (Machisa et al., 2021).

While in studying aggressive behavior among veterans, experiencing post-traumatic stress symptoms (PTSS) undergoes a reevaluation of their masculinity influenced by their interpretation of the ideal warrior figure (Gilbar et al., 2019). This process gives rise to a distinct type of gender role stress known as a narcissistic masculine wound (Gilbar et al., 2019). This psychological state may prompt men to use violence and hyper-sexuality as means to regain a sense of their masculinity (Gilbar et al., 2021).

Another explanation on how PTSD and depression symptoms in men can be related to GBV perpetration, is that they alter perceptions of cues and reduce inhibitions, resulting in increased aggression (Machisa & Shamu,2018).

Mental health outcomes of females' exposure to GBV

According to the reviewed studies, mental health illness and issues found to be a risk factor for GBV victimization and an outcome for being exposed to violence among women. The documented mental health issues are: Post-traumatic stress disorder, depression, major depression, anxiety, panic disorder, suicide attempts, delusion symptoms, substance use and alcohol use, and social anxiety disorders.

The current review, the literature presents studies investigating the mental health consequences following exposure to political violence among women in diverse contexts, including the Democratic Republic of Congo (Dossa et al., 2015), Palestine (Gibbs et al., 2021; Sousa et al., 2018), and South Africa (Machisa et al., 2021). Additionally, other research has examined the correlation between IPV, GBV, and mental illness and exposure to political violence in conflict-affected regions across various countries, such as Rwanda (Bahati et al., 2022), Afghanistan (Gibbs et al., 2018), South Africa (Machisa et al., 2017), Palestine (Sousa et al., 2018; Veronese et al., 2023), and Bangladesh (Akter & Deeba, 2022).

Certain types of gender-based violence were found to be reliable indicators of psychiatric symptoms, while others were not (Akter & Deeba, 2022). Specifically, psychological, sexual, and economic violence were correlated with psychiatric symptoms, whereas physical and emotional violence showed no such correlation (Akter & Deeba, 2022; Gibbs et al., 2018). This discrepancy can be attributed to the fact that women often view physical and emotional violence as common occurrences in life and therefore do not perceive them as life-threatening, enabling them to endure such violence (Akter & Deeba, 2022). However, sexual, psychological, and economic violence are seen as genuine threats to women's lives, leading to feelings of fear and

concern about their future (Akter & Deeba, 2022). Consequently, these forms of violence were more strongly associated with the mental health of women (Akter & Deeba, 2022).

Furthermore, the psychological distress linked to psychological intimate partner violence (IPV) can be elucidated by its detrimental impact on self-esteem, potentially leading the victim to perceive herself as inadequate, unlovable, deficient, and worthless (Sousa et al., 2018). This perception may be exacerbated if the victim believes that her partner's psychologically abusive conduct is justified, ultimately leading to mental health issues (Sousa et al., 2018).

In conflict zones, women exhibit heightened vulnerability to developing mental health disorders following exposure to GBV (Bahati et al., 2022; Gibbs et al., 2021). The enduring effects of violence, loss, and historical trauma stemming from colonization are believed to significantly contribute to the elevated rates of mental health disorders among affected women (Bahati et al., 2022). Moreover, the disruption of social structures post-colonization, compounded by post-colonial violence, may serve as a risk factor for the increased prevalence of both GBV and mental health disorders (Bahati et al., 2022). Furthermore, being caught amidst widespread limitations on freedom imposed by colonization and cultural boundaries that limit opportunities for self-determination and fulfillment, along with a lack of social support, leads to increased risks of depressive withdrawal, stress, and anxiety among victims of GBV (Veronese et al., 2023). Additionally, the victims may perceive their quality of life as inadequate and experience diminished subjective well-being as a result (Veronese et al., 2023).

Table 3.

Implications for Practices, Policy, and Research

When devising and implementing interventions aimed at addressing GBV, it's crucial to consider the following points:

- Focus preventive efforts on fostering positive child-rearing approaches that empower girls to cultivate strong self-esteem, enabling them to assert their rights and prevent abuse rather than merely building resilience to it.
- Acknowledge the common co-occurrence of GBV and mental health disorders, emphasizing the need to address both issues simultaneously.
- Tackle GBV by addressing both the aftermath of political traumas and transforming gender norms, especially in conflict-affected regions.
- Recognize that solely providing economic support to women may not effectively prevent IPV and could potentially exacerbate it. Economic interventions should involve husbands, families, and community-level efforts to shift gender norms.
- Implement comprehensive interventions addressing various interconnected risk factors to effectively reduce women's vulnerability to violence.
- Engage men in interventions aimed at combating gender inequality and mental health issues to reduce violence against women.
- Consider political violence and violence against women when designing interventions and conducting research.
- Incorporate individuals' narratives and anticipated protective factors into intervention development.
- Exercise caution in clinical work by empowering women's social networks and personal skills to actively engage in their recovery from GBV.
- Promote new conceptions of masculinity to encourage less harmful behaviors among men, thus enhancing their psychological well-being.

At an institutional level:

- Ensure access to mental health services across different levels of the healthcare system.
- Provide adequate healthcare services to survivors of violence.

At the national and international levels:

- Take all necessary measures to eliminate the abhorrent destruction of ethnic groups.
- Establish global initiatives to prevent both political violence and violence against women, with a specific focus on addressing violence against women in contexts of mass conflict and disasters.

At the community level:

- Implement community-wide interventions to prevent the victimization of women.

In addition, researchers studying GBV and VAW in conflict-affected areas should:

- Include diverse samples of violence victims in future research.
- Investigate motivational factors and gender differences related to the social and environmental drivers of the association between mental health problems and GBV perpetration.
- Prioritize research in higher education to develop, test, and scale effective GBV interventions.
- Consider the political context when studying GBV in conflict zones.

In screening individuals with mental illness or GBV experiences, mental health workers should:

- Consider the impact of economic violence when assessing the mental health of GBV victims.
- Address other psychosocial factors contributing to GBV during the screening process for VAW.
- Screen individuals seeking mental health care for GBV and offer appropriate interventions

The authors underlined an urgent need to study GBV against women in war affected areas taking into confederation predicted contributing factors whether political, social, and psychological in order to develop effective interventions to prevent GBV and mitigating the effects of the exposure to GBV. Accordingly, the association between, political violence, political trauma, and GBV victimization/ perpetration needed to be explored and understood within a psycho-social framework (Gadd & Jefferson, 2007; Woodward, 2015). Furthermore, researchers are increasingly highlighting the significance of political violence in exacerbating mental health issues and increasing women's susceptibility to Gender-Based Violence (GBV), as well as the likelihood of men displaying greater aggression towards women and engaging in GBV perpetration (Bahati et al., 2022; Breet et al., 2019; Gibbs et al., 2021; Sousa et al., 2018; Zedan & Haj-Yahia, 2023). Another notable aspect discussed is the importance of investigating additional factors that could contribute to the victimization of GBV, such as unequal gender

norms and interpretations of masculinity (Gilbar et al., 2019; Machisa et al., 2021; Veronese et al., 2023).

Additionally, interventions aimed at reducing GBV must recognize the frequent coexistence of GBV and mental health disorders, emphasizing the need for simultaneous addressing of both issues (Breet et al., 2019). Furthermore, the impact of political traumas and the transformation of gender norms in conflict-affected areas must be taken into consideration (Gibbs et al., 2021; Gibbs et al., 2018; Jewkes et al., 2018; Machisa et al., 2017; Machisa & Shamu, 2018). Moreover, economic support initiatives should involve not only women but also their husbands and families. A comprehensive, multi-dimensional approach is recommended for targeting GBV interventions effectively (Gibbs et al., 2018). Researchers also emphasized the importance of including men in GBV interventions, whether through financial empowerment or engagement in efforts to combat gender inequality and enhance their mental health and overall well-being (Gibbs et al., 2018; Machisa & Shamu, 2018). Additionally, researchers stated that it is essential when designing interventions, to consider the narratives of individuals regarding their experiences and the anticipated protective factors (Sousa et al., 2018).

On the other hand, it was documented that it is crucial to take into account the ramifications of economic violence, to tackle additional psychosocial factors that contribute to GBV when screening the mental well-being of GBV survivors, and to screen individuals seeking mental health support for GBV and provide suitable interventions (Akter & Deeba, 2022).

Researchers emphasized the importance of prioritizing preventive measures alongside therapeutic interventions, such as implementing positive child-rearing approaches that foster high self-esteem among women (Akter & Deeba, 2022). Besides, researchers highlighted the

crucial role of communities, national governments, and the international community in addressing GBV by preventing ethnic cleansing, stopping political violence, and promoting gender norms that are equitable (Dossa et al., 2015; Sousa et al., 2018).

Lastly, researchers underscored the significance of considering the following aspects when studying GBV in war-torn regions: Incorporating varied samples of violence victims (Akter & Deeba, 2022); examining motivational factors and gender disparities linked to the social and environmental influences on the relationship between mental health issues and GBV perpetration(Breet et al., 2019); giving priority to research in higher education aimed at developing, testing, and implementing effective GBV interventions; and acknowledging the political backdrop (Machisa et al., 2021).

1.3.4.6 Limitations of the study

The limitations of this review are notable and include several key factors. The variability in study design and methodology across the reviewed research introduces inconsistencies and challenges in comparing results directly. Additionally, the geographic and cultural diversity of the studies may affect the generalizability of findings due to differing socio-political contexts. Many studies are cross-sectional, limiting insights into the long-term effects of political trauma on GBV and mental health. Underreporting and stigma related GBV and mental health issues further complicate the accuracy of prevalence estimates. Variations in GBV definitions and focus on specific demographics may also skew findings, while potential selection bias and insufficient attention to intersectional factors can impact the representativeness of the data. Furthermore, variability in reporting standards and resource limitations in conflict settings can affect data quality and research comprehensiveness. Addressing these limitations in future research is

crucial for developing a more nuanced understanding of the complex relationships between political trauma, GBV, and mental health outcomes in war-affected areas.

1.3.4.7 Conclusion

The purpose of this scoping review was to synthesize the body of existing knowledge on the association between political violence, political trauma, and GBV victimization. As well as, the association between exposure to GBV and mental distress amongst women in war affected areas, while specifically summarizing information that could be useful in developing direct interventions aimed at preventing GBV exposure, or mitigating its adverse effects. Armed conflict and political violence have been found to negatively impact mental health of both women and men(Dossa et al., 2015; Gibbs et al., 2021; Machisa et al., 2021; Sousa et al., 2018), which in turn increasing the probability of GBV victimization/ perpetration (Breet et al., 2019; Gibbs et al., 2018; Gilbar et al., 2019; Gilbar et al., 2021; Jewkes et al., 2018; Machisa et al., 2021; Machisa & Shamu, 2018).

These findings underscore the significance of both exposure to political traumatic events and mental distress in increasing the occurrence of GBV victimization or perpetration. Additionally, they demonstrate the impact of GBV exposure on women's mental well-being. This review unequivocally confirms the psychosocial nature of GBV in conflict-affected regions. Furthermore, these cross-country studies strongly advocate for the implementation of community-based interventions aimed at promoting equitable gender norms. In addition to community-based interventions, scholars stress the importance of stopping political violence and ethnic cleansing. The majority of recommendations in the reviewed studies emphasize the necessity of considering the political context when examining GBV in conflict zones. Moreover, they highlight the need for a multidimensional approach to addressing GBV. In conclusion,

scholars emphasize the interrelation between GBV and mental health distress, considering them as indicators of each other.

1.3.5 Risk and protective factors of GBV among females: An overview

Regarding this study, risk factors are defined as those characteristics, variables, or hazards that, if present for a given female, make her more vulnerable to experience (GBV) than other females. While protective factors are defined as a characteristic at the biological, psychological, family, or community level that is associated with lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes (Institute of Medicine (US), 2009).

Previous literature have documented several risk and protective factors of GBV among females in war affected by war. In a systematic review that reviewed 77 studies exploring the risk and protective factors associated with violence against women and girls (VAWG) in contexts of conflict and natural disasters, findings revealed several key risk factors contributing to male perpetration or female victimization of violence (Murphy et al., 2023). These included factors such as poverty and economic strain, substance abuse among men, exposure to violence, shifting gender dynamics within environments characterized by unequal gender norms, and a lack of social support (Murphy et al., 2023). Additionally, circumstances specific to conflict or natural disaster settings, such as displacement, insecurity or overcrowding in displacement camps, societal militarization, loss of family members, and property destruction, were found to correlate with a heightened prevalence of VAWG in these contexts (Murphy et al., 2023).

While according to a systematic review investigated the risk and protective factors for IPV among Chinese women, the risk and protective factors identified encompass various levels of influence (Cao et al., 2023). At the individual level, these factors include demographic

characteristics such as younger age, unplanned pregnancy, abortion, parenthood, and migration status (Cao et al., 2023). Socioeconomic status, indicated by income levels and partners' educational attainment, also plays a significant role. Attitudinal factors, such as beliefs that justify IPV and adherence to traditional gender roles, contribute to risk. Behavioral factors such as alcohol consumption by women and their partners, as well as frequent gambling by partners, are also implicated (Cao et al., 2023). Adverse childhood experiences, like witnessing violence during childhood, further elevate risk, as do personal characteristics such as chronic illness and overall health status. Furthermore, factors at the relationship level found to encompass conflicts within intimate partnerships, power dynamics within these relationships, and social capital (Cao et al., 2023). Social capital is reflected in aspects such as the size of social networks, women's and their partners' participation in these networks, and the presence of social control mechanisms (Cao et al., 2023).

In addition, Mojahed et al. (2022) conducted a systematic review In an aim to study the risk factors from an integrative ecological theoretical framework of IPV among women in the Arab countries. Results of the individual level revealed that early marriage, lower levels of education among women, and unemployment among women or their partners are factors that heighten the likelihood of experiencing IPV (Mojahed et al., 2022). Conversely, it was discovered that women with higher education levels or employment status were also at increased risk of IPV (Mojahed et al., 2022). Furthermore, the study revealed that both women's exposure to violence and their partners' exposure to violence, as well as witnessing marital violence during childhood, were correlated with IPV experiences in adulthood (Mojahed et al., 2022). Additionally, political violence exposure experienced by both women and men emerged as a risk

factor associated with male-to-female IPV (Mojahed et al., 2022). Lastly, there was a positive association between alcoholism and perpetrating IPV against women (Mojahed et al., 2022).

Furthermore, Ghoshal et al. (2023) systematically reviewed 32 studies in order to examine the risk and protective factors of IPV in low-and-middle-income countries. The review findings indicated several factors associated with increased risk of experiencing IPV, including women under the age of 45, male partners' substance dependence, prior history of abuse by either partner, and acceptance of wife-beating by either partner. Additionally, both employment and unemployment among women were found to elevate the risk (Ghoshal et al., 2023). Conversely, factors such as men attaining secondary or higher education levels, engaging in more gender-equitable relationships, women without children, residing in smaller families, and living in rural areas were identified as protective factors against IPV (Ghoshal et al., 2023).

CHAPTER TWO

Mapping the Landscape: Context and Research Framework

Over the past quarter-century, there has been a notable surge in studies examining the mental health impacts of political violence (Miller et al., 2006). This increased focus began in the 1980s, when research emerged exploring the prevalence of psychiatric disorders and the negative consequences of warfare and other organized forms of violence (Miller et al., 2006). These conflicts encompassed various events such as dirty wars that refers to a conflict characterized by the use of covert, unlawful, and often brutal tactics by political actors, typically governments but sometimes non-state actors, to suppress perceived threats to their authority. These threats, often labeled as "terrorist" in nature, may be domestic or international. In a dirty war, the targeted victims are usually specific segments of the civilian population rather than organized groups, and the political actor involved disregards or suspends legal protections and human rights. The methods employed can include torture, extrajudicial killings, and other forms of violence that violate established legal and ethical standards, making the conflict distinct from conventional warfare or legitimate state actions (Smith & Roberts, 2008); civil conflicts; ethnic cleansing; and colonial occupation (Miller et al., 2006). Based on this, it becomes evident that the dominant worldwide discourse on mental health has primarily leaned towards a biomedical perspective. In this view, mental health is often likened to physical illness conceptually, with cultural and socio-economic factors considered as secondary rather than fundamental influences in understanding how 'mental health or ill-health' manifests and is perceived within a specific society or context (Giacaman et al., 2011).

This approach came under criticism for limiting our comprehension of mental health across diverse contexts and failing to provide a realistic explanation of mental health-related

issues in such contexts (Giacaman et al., 2011). Therefore, to gain a deeper insight into gender-based violence against women in the Palestinian context, which has endured over 75 years of ongoing prolonged occupation, it is crucial to consider political violence and political trauma as main factors in understanding GBV in the Palestinian context, along with other contributing factors that may exacerbate the prevalence of GBV.

In this chapter, we aim to introduce the research project, including its objectives, hypotheses, theoretical and methodological background, and the particular areas of inquiry. We will begin with a concise overview of the historical and political background, as well as a description of the Palestinian context where the research was conducted. This will include essential points concerning the protracted and chronic conflict between Israel and Palestine. Such contextualization is fundamental to our study and analyses, preventing both the reader and the researcher from overlooking the broader context of the investigation. Following this historical overview, we will underscore the significance of this study. Subsequently, we will outline the objectives and hypotheses that guided our research project, along with the theoretical framework and methodological approaches employed to address them. Additionally, we will give specific details about the locations where the fieldwork was conducted.

2.1 The occupied Palestinian territories

Despite its small area and population, Palestine holds immense significance within the Middle East and Arab regions, deeply interwoven into their history, culture, politics, and religion For centuries, Palestine and its people have served as a crucial link between the Mashreq (Eastern Arab world) and Egypt and the Maghreb (Western Arab world or North Africa). Palestinians share familial, economic, religious, and political connections with Lebanon and

Syria to the north, Jordan and Iraq to the east, Saudi Arabia to the southeast, and Egypt to the southwest (Farsoun, 2006).

Approximately 14.3 million Palestinians reside in both Historical Palestine and the global diaspora. Diaspora, or al-ghurba, began in 1948 with the displacement of approximately 750,000 Palestinians due to conflict and expulsion, resulting in their refuge in neighboring Arab countries and elsewhere. This forced migration created a fragmented existence, where Palestinians faced not only physical separation but also the denial of their right to return to their homeland, as outlined in United Nations General Assembly Resolution 194. The diaspora thus represents both the physical displacement and the ongoing struggle for the right of return and recognition (Peteet, 2007).

According to population assessments conducted by Palestinian Central Bureau of Statistics (PCBS, 2022), around 5.35 million Palestinians are situated in the State of Palestine (Gaza Strip and the West Bank), comprising 2.72 million males and 2.63 million females. The estimated population of the West Bank stands at 3.19 million individuals, with 1.62 million males and 1.57 million females. Similarly, the estimated population of the Gaza Strip in the same period amounts to 2.17 million, consisting of 1.10 million males and 1.07 million females (Palestinian Central Bureau of Statistics, 2022).

2.1.1 A brief historical and political overview

Commencing over six decades ago, the Israeli-Palestinian conflict has frequently been characterized as one of the lengthiest, most contentious, and acrimonious disputes globally. Its roots extend to the early 1900s when, in reaction to anti-Semitic policies in Europe, the British government (during the British mandate) issued the Balfour Declaration, aiming at endorsing the European Zionist colonial project in the Middle East.

After a short period following the Israeli declaration of independence, the initial inter-communal conflict, triggered by the recommendations of the United Nations Special Committee on Palestine (UNSCOP), escalated into a full-scale war between a coalition of Arab States and the newly established State of Israel. Despite being outnumbered twice over, the Israeli military emerged victorious after months of intense combat. As a consequence of the 1948 Arab-Israeli conflict (referred to as the War of Independence by Israelis or The Nakba/The Catastrophe by Palestinians), Israel seized control of 77% of the historical Palestine, including areas designated for Palestine in the UN backed Partition Plan. Since then, the official policy of the Israeli government has been not only to maintain control over the annexed land but also to reject any peace settlement mandating withdrawal from the territories annexed during the war (Adem, 2019).

According to the United Nations Conciliation Commission for Palestine (UNCCP), 750,000 individuals from the Arab population either "fled" or were "expelled" from areas under Israeli control during the Arab-Israeli War (Adem, 2019). As well as, ten significant Palestinian towns or mixed townships fell down, along with the loss of all their resources, the occupation, and complete devastation of 416 Palestinian villages, accompanied by the confiscation of all their lands (Khalidi, 1991).

The Nakba, the "Catastrophe" among Arabs, reverberated throughout the region, escalating the Arab-Israeli interstate conflict from a local dispute. This was further complicated by the Cold War dynamics when radicalized Arab nations sought support from Moscow to counterbalance Western backing of Israel (Khalidi, 1991).

Following a twenty-year period after the initial phase of Zionist colonization, the June 1967 war marked a significant turning point. However, during this interval, little progress was

made in addressing Palestinian grievances and suffering due to global indifference, Arab disunity, Cold War tensions, Israel's refusal to acknowledge responsibility for Palestinian welfare, and Arab states' inability to adapt to new realities (Khalidi, 1991).

In the June war, Israel not only seized Sinai and the Golan Heights, escalating interstate tensions with Arab nations but also captured the remaining Palestinian territories not annexed in 1948: East Jerusalem, the West Bank, and the Gaza Strip, effectively asserting control over the entirety of historical Palestine (Khalidi, 1991).

The ongoing conflicts after 1967 in the region subsequently led to the emergence of resistance factions in Palestine (Hayruni, 2014). These clashes reached their peak in 1987 with the outbreak of the First Intifada, also known as the 'war of the stone,' on December 9th, 1987 (Hayruni, 2014). It began in the refugee camp inof Jabalya in Gaza and spread to other areas including the West Bank and Jerusalem (Hayruni, 2014). The frustration of Palestinians, along with the infringement of their fundamental rights, including home demolitions, arbitrary imprisonments, prisoner torture, mass detentions, and deportations, were key factors leading to the outbreak of the First Intifada (Hayruni, 2014). However, the triggering event that ignited the uprising was a fatal car accident, in which an Israeli truck collided with a Palestinian car carrying workers back home, resulting in the death of four Palestinians (Neff, 1997). The First Intifada led to a significant number of deaths, with 1,362 casualties on the Palestinian side and 231 on the Israeli side (Awad et al., 2007). Then in the year of 1993, the First Intifada was ended by the assignments of Oslo agreement when both of the Palestinian and Israeli parties accepted to recognize each other (Baylouny, 2010).

Under the Oslo agreement, Israel persisted in expanding settlements, exerting control over Palestinian lives and borders (Pressman, 2003). Additionally, as more Israelis relocated to

Jerusalem, the West Bank, and Gaza, Israel implemented a policy targeting Palestinians who couldn't prove Jerusalem as their primary residence, resulting in the removal of over 1,600 Palestinians and their families between 1996 and 1998 (Pressman, 2003). Israeli practices of land expropriation and house demolitions, hallmarks of the occupation since 1967, continued unabated (Pressman, 2003). From September 1993 to June 1998, around 670 Palestinian homes were demolished in the West Bank, including Jerusalem, while Israel confiscated 41,000 acres of West Bank land in the first two years after the signing of the Declaration of Principles. Another 10,000 acres were seized in 1999. These actions fractured the continuity of Palestinian towns and villages, disrupted natural growth patterns, and hampered agricultural efforts in affected areas (Pressman, 2003).

In addition to the factors outlined above, including the collapse of discussions at Camp David between Palestinians and Israelis, the Second Intifada erupted in late September 2000, sparked by the Israelis storm of Al-Aqsa Mosque led by the Israel Prime Minister, Ariel Sharon(Baroud, 2015; Uddin, 2022). Accompanied by 1,000 soldiers, he proceeded to enter the Al-Aqsa Mosque in Jerusalem, triggering a clash between Palestinian defenders of their holiest place and the security forces protecting Sharon (Baroud, 2015; Uddin, 2022). The second intifada or as it is also called al-Aqsa Intifada, it resulted in a significant loss of life, with over 4,412 Palestinians killed, including more than 100 children (Asalya, 2019). Notable among the casualties were Mohammed Al-Durra, a young girl named Sarah, and four-month-old baby Iman Hijo.The impact of Zionist attacks on Palestinian society was profound, leading to a large number of fatalities and over 15,000 injuries). Conversely, approximately 1,000 Israelis lost their lives and 6,700 were wounded during the Second Intifada (Asalya, 2019).

Two months after the uprising of the Second Intifada, the project to build the separation wall was authorized by Ehud Barak's tenure in November 2000 (Esposito, 2005). Land seizures and the subsequent building of a segment of the separation wall commenced around June 2002, specifically in the Jenin area (Mall Dibiasi, 2015). This structure serves to isolate Palestinian communities, severing villagers from their lands, and potentially impacting Palestinian access to water resources in the long run (Mall Dibiasi, 2015). Upon completion, the Wall encompassed 9.5% of West Bank territory, deviating sporadically from the Green Line, which traces back to the 1949 Armistice agreements between Israel and its Arab neighbors (Mall Dibiasi, 2015). Its composition varies, with most sections consisting of an electronic fence flanked by trenches and pathways, while in populous areas like Jerusalem, Bethlehem, or Qalqilia, it takes the form of a six to eight meter high concrete barrier (Mall Dibiasi, 2015).

Since the Second Intifada, the concept of intifada has evolved into a continuous battle against oppression, where even mundane activities like car trip become acts of defiance (Junka-Aikio, 2015). These small individual acts collectively contribute to a larger resistance movement. Moreover, following the Second Intifada, there has been little change from the Israeli perspective, except for a worsening situation. For instance, in the West Bank, the construction of the 'separation fence' (referred to as the 'apartheid wall' by Palestinians) since 2002 has intensified feelings of confinement, isolation, territorial division, and economic hardship that characterize life in the Occupied Palestinian Territories (OPT) (Junka-Aikio, 2015). Meanwhile, the Gaza Strip has faced nearly complete closure of its border crossings, particularly since Hamas won the Palestinian parliamentary elections in January 2006, followed by its political and military control of the Gaza Strip a year later (Junka-Aikio, 2015).

Furthermore, the internal closures implemented two months into the Second Intifada, which restricted movement between different areas of the West Bank and between the northern and southern regions of Gaza, as well as the prohibition on entry into Jerusalem and Israel proper, have remained in place until the present time (Johnson & Kuttab, 2001).

After that, the Abraham Accords, signed in 2020 between Israel and several Arab states, including the UAE, Bahrain, Sudan, and Morocco, were intended to normalize relations and foster economic and diplomatic cooperation. However, they have had negative implications for Palestine. The Accords are widely seen as undermining the Palestinian cause, as they prioritize the economic and political interests of the signatory states over the long-standing Arab solidarity with Palestine. This shift weakens Palestinian leverage in negotiations and diminishes the influence of the Arab Peace Initiative, which had called for full Israeli withdrawal from occupied territories in exchange for normalization (Baqai & Mehreen, 2021). While the UAE initially claimed the Accords halted Israel's annexation of parts of the West Bank, this has not led to any significant de-escalation of Israeli aggression in Gaza and the West Bank, where violence against Palestinians has persisted. Additionally, the Accords have failed to influence Israeli policies toward Palestine and have, in fact, empowered extremist Palestinian factions like Hamas, which reject normalization with Israel. As a result, Palestinian politics have become further polarized, and leaders like President Abbas have adopted harsher rhetoric to maintain their legitimacy. Despite fostering economic ties, the Abraham Accords have ultimately weakened Palestinian standing, reduced regional support for their cause, and failed to curtail Israeli actions against them (Abbas, 2024).

2.1.2 Wars on Gaza

After the Second Intifada, a series of five wars ensued, commencing with the conflict spanning two years from 2008 to 2009 (Bayeh, 2014). During this war, Israel's actions resulted in the deaths of hundreds of Palestinians in Gaza, predominantly civilians, including a significant number of children (Bayeh, 2014). Residential homes and civilian properties were destroyed due to Israel's indiscriminate attacks on Gaza (Bayeh, 2014). Adding to the complexity, humanitarian issues were exacerbated as Israel targeted infrastructure, resulting in widespread destruction (Bayeh, 2014). Israel employed disproportionately and indiscriminately destructive tactics against civilians, constituting acts that could be deemed as war crimes (Bayeh, 2014).

Then in November 2012, the Israeli Defense Forces initiated Operation Pillar of Cloud, an eight-day campaign in the Hamas-governed Gaza Strip, following Hamas' rocket attacks on IDF positions. These attacks were in response to the killing of Ahmad al-Jabari, the commander of Hamas' Gaza military wing, in an Israeli airstrike. The Israeli government stated that the operation was launched due to the Palestinian firing of over 100 rockets at Israel within a 24-hour period, as well as an attack by Gaza militants on an Israeli military patrol jeep along the Israeli border (B'Tselem, 2013). Palestinians, however, blamed the Israeli government for escalating violence, citing their attack on Gaza civilians days before the operation. They pointed to the blockade of the Gaza Strip and the occupation of the West Bank, including East Jerusalem, as reasons for the rocket attacks. During the operation, Israel targeted 1,500 sites in the Gaza Strip, while in a concurrent operation called Hijarat Sijil, the al-Qassam Brigades, Hamas, and Islamic Jihad launched 1,465 rocket attacks on Israel. After a day of negotiations between Egypt and the US, a ceasefire was announced on November 21 (Fanack, 2013).

The 2014 summer war in Gaza, known as Operation Protective Edge, marked the third such war in the preceding six years and was particularly significant in several aspects (Shehadeh, 2015). 2,205 Palestinians lost their lives, with at least 1,483 of them identified as civilians, including a significant number of women and children (Bouris, 2015). This means that over 67 percent of the total casualties were civilians (Bouris, 2015). On the Israeli side, 71 individuals were killed, comprising 66 soldiers, one security coordinator, and four civilians (Bouris, 2015). The conflict also resulted in the displacement of 500,000 Palestinians, equivalent to one-third of Gaza Strip's total population, with approximately 18,000 housing units destroyed (Shehadeh, 2015).

After that the eruption of violence in the ongoing Palestinian-Israeli conflict on May 10, 2021 was the start of another war on Gaza, and persisted until a ceasefire was implemented on May 21 (Manaz, 2021). The outbreak coincided with al-Qadr night, observed by Muslims, and was characterized by protests, rioting, police intervention, rocket attacks on Israel by Hamas and Islamic Jihad, and Israeli airstrikes targeting the Gaza Strip (Manaz, 2021). The violence led to the deaths of 256 Palestinians, including 66 children, and 13 Israelis. The Gaza Ministry of Health reported over 1,900 Palestinians and around 200 Israelis injured (Kingsley & Kershner, 2021). Hamas initially proposed a ceasefire on May 13, which was rejected by the opposing side. On May 18, France, along with Egypt and Jordan, announced plans to submit a UN Security Council resolution for a ceasefire. Finally, on May 21, a ceasefire was agreed upon by both parties, ending the conflict (Kingsley & Kershner, 2021)

On October 7, 2023, one of the most devastating, horrible, and catastrophic wars in Gaza's history began. By the 27 of December 2023; the 82nd day of the genocide on Gaza, as reported by the Euro-Med Human Rights Monitor (2023), a staggering toll had been exacted:

29,124 Palestinians had lost their lives, with 26,706 identified as civilians, among them 11,422 children and 5,822 women. Additionally, the number of injured Palestinians had reached 56,122. Tragically, 101 Palestinian journalists had been killed, and 165 media offices had been entirely demolished. Furthermore, 481 Palestinian healthcare workers had been targeted, resulting in 266 fatalities and 255 injuries. A total of 135 Palestinian medical facilities had been attacked, including 23 hospitals, 56 clinics, and 55 ambulances. The onslaught had also left 183 mosques and 3 churches damaged. Moreover, approximately 2,000,000 individuals had been displaced, enduring precarious conditions without secure shelter. The relentless Israeli assaults had led to the complete destruction of 65,600 homes and partial damage to 177,200 others.

As a reaction to the Israeli genocide in Gaza, South Africa filed a case against Israel at the International Court of Justice (ICJ) in January 2024, accusing Israel of committing acts of genocide against Palestinians under the 1948 Genocide Convention. accusing Israel of committing acts of genocide against Palestinians in Gaza under the 1948 Genocide Convention. On January 26, 2024, the ICJ ruled that South Africa had presented a plausible case, ordering provisional measures for Israel to prevent further acts of genocide, protect civilians, and allow humanitarian aid into Gaza. Though the ruling did not directly halt Israeli military operations, it implied that a de facto ceasefire would be necessary to comply with these orders. Israel was required to report back to the ICJ on its actions, but continued violence and obstruction of aid raised concerns about compliance. The ruling was met with mixed reactions; while human rights organizations supported the decision, challenges in enforcing the ICJ's directives persist due to complex geopolitical factors (Welch, 2024).

In response to the ICJ's ruling, South Africa has continued to advocate strongly for international intervention and relief efforts, emphasizing the urgency of addressing the dire humanitarian

situation in Gaza. South African officials and diplomats have urged for increased global pressure on Israel to adhere to the ICJ’s provisional measures, seeking to mobilize international support for humanitarian aid and protection of civilians. Despite these efforts, the ongoing conflict has presented significant obstacles to effective implementation of the court's decision, highlighting the need for sustained and coordinated international action. The ICJ’s decision underscores the severe humanitarian crisis in Gaza and sets the stage for a prolonged legal and diplomatic process, with both the court and South Africa calling for urgent measures to alleviate the suffering of Gaza’s population (Welch, 2024).

Furthermore, the October 7th war on Gaza also has significant environmental ramifications. It not only resulted in environmental pollution due to the detonation of 25,000 tons of explosives but also highlighted the distressing trend of conducting warfare in densely populated urban areas. This pattern has had devastating and enduring effects on local communities (Buheji & Al-Muhannadi, 2023).

Israeli actions have plunged Palestinians in Gaza into conditions resembling a famine, as the Israeli Forces (IDF) have instigated incidents that severely disrupted the food supply chain in the region. These incidents have included the bombardment or destruction of food stores, convoys, and other crucial civilian food infrastructure. Commercial shops and warehouses storing food and essential goods have also been targeted, often as part of broader military operations or specific strikes (Buheji & Hasan, 2024). Additionally, deliberate actions by the IDF have obstructed the distribution of food, water, and other vital commodities to the 2.2 million residents of Gaza. By impeding the distribution of essential goods, Israel is effectively leaving Gaza's citizens without sustenance, leading to the threat of starvation (Faris et al., 2024). These

actions hinder humanitarian aid efforts, effectively preventing citizens from receiving necessary assistance, potentially resulting in loss of life.

2.1.3 The case of the West Bank and Jerusalem

Under the guise of the Oslo Accords, Israel has established a stringent apartheid regime in the West Bank, East Jerusalem, and Gaza characterized by the systematic oppression of Palestinians, the negation of their communal rights, their degradation, and the impoverishment of a growing population (Hilal, 2014). The methods employed to sustain this collective oppression are widely recognized: the domination and settlement of land and vital resources (see Figure 3); regulation of borders, international commerce, and the provision of essential utilities like water and electricity; frequent acts of violence by Israeli settlers targeting Palestinian civilians and their assets; and a lack of respect for the sacredness of Muslim and Christian religious sites, among other tactics in the West Bank and East Jerusalem (Hilal, 2014).

Sociopolitical and Economic Structures and Processes in International Relations illustrates the complex reality of the Oslo Accords, which, while intended to grant Palestinians partial control over the West Bank, instead led to increased fragmentation. Despite these intentions, the West Bank was divided into three distinct areas: Area A, which includes the main urban centers and covers about 18% of the land, is home to 55% of the Palestinian population and is fully controlled by the Palestinian Authority (PA) for security, civil, and administrative matters. Area B, encompassing approximately 21% of the land and 41% of the population, features a shared control where the PA manages civil affairs while Israeli military forces oversee security. Area C, which comprises 60% of the land but only 4% of the population, remains entirely under Israeli control, including law enforcement, urban planning, and construction(Kersel, 2015). Although the Oslo Accords were meant to lead to a gradual transfer

of authority to the PA, Israel has maintained full control over Area C, perpetuating a fragmented and non-contiguous West Bank (Rabaia et al., 2014). This division has complicated Palestinian governance and led to restrictions on movement, trade, and access to essential services (Akesson, 2014). The ongoing expropriations, home demolitions, and border closures further exacerbated tensions, ultimately contributing to the eruption of the Second Intifada in 2000.

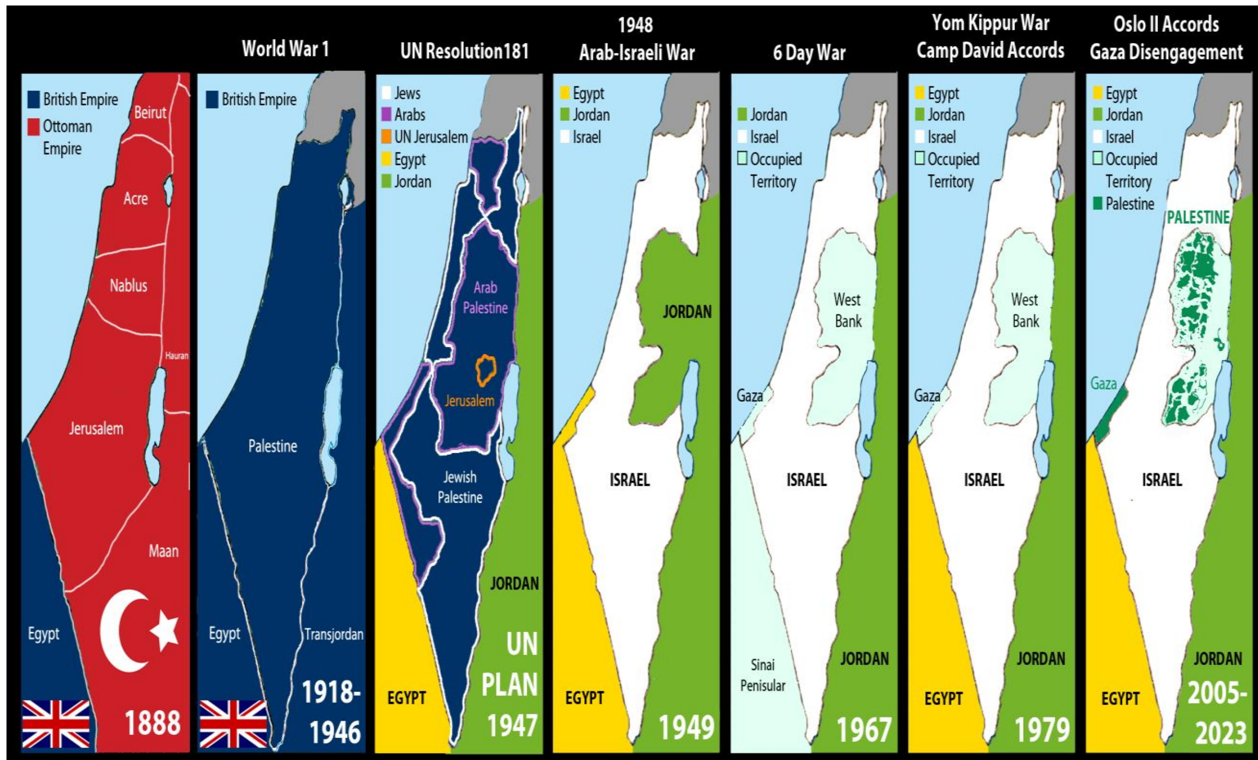
Moreover, as a settler colonial regime, Israel has seized control of Jerusalem and its surroundings, actively displacing indigenous Palestinians from both Jerusalem and Area C established by the Oslo Accords, while replacing them with Israeli Jewish settlers. Two decades post-Oslo, one out of every four individuals in the West Bank is now a settler (Hilal, 2014). Since Israel imposed a blockade on Gaza in 2007, a severe humanitarian crisis has unfolded in the region. Gaza, home to 1.8 million people, has effectively become a vast "Human Cage" on the eastern Mediterranean, with its residents trapped in dire conditions from which they seemingly have no escape. The Israeli occupation, coupled with the ongoing and comprehensive blockade, has resulted in numerous violations of International Humanitarian Law. By restricting trade and the movement of people, the blockade has severely undermined civilians' basic rights and obstructed critical rehabilitation efforts. This prolonged blockade has caused the erosion of livelihoods, the destruction of infrastructure, and the collapse of essential social services (Butt & Butt, 2016). Additionally, Israel's intentional strategy includes fragmenting the West Bank and Gaza into segregated enclaves akin to "Bantustans," achieved through the construction of Israeli-exclusive bypass roads linking settlements directly to cities and towns within Israel proper, the erection of the separation wall, the proliferation of checkpoints and roadblocks, and the relentless blockade of Gaza (Hilal, 2014).

Furthermore, Israel possesses nearly unrestricted authority in the territories, enabling it to penetrate regions designated under agreements as Area A to detain Palestinians, enforce closures or curfews, and conduct military actions resulting in significant casualties on the Palestinian side (Cohen, 2013).

Between 2008 and 2024, Palestinian casualties in the West Bank due to Israeli attacks totaled 1,492, with over 73% being men, more than 23% children, and around 3.3% women (OCHA, 2024). Additionally, there were 95,329 injuries, predominantly affecting men and children, with approximately 2% being women (OCHA, 2024). On the other hand, by 2022 the policy of home demolition, left 74 families in East Jerusalem without homes (OCHA, 2022). As well as, In 2023, there was a rise in demolitions in the West Bank, resulting in the destruction of 1,171 dwellings. Of these, 457 were homes, leading to the displacement of 2,261 people, including 1,044 children (DCIP, 2024).

Figure 2.

Various Maps Depicting the Gradual Shrinking of Palestinian Territory



Note: retrieved online from https://www.reddit.com/r/MapPorn/comments/1780rb7/

2.2 What does it mean to be a woman in Palestine?

Palestinian women confront both violence and humiliation from the Israeli occupation, along with violence and prejudice within their own community (Rought-Brooks et al., 2010). Both male perpetrators of violence and sexual misconduct against women in Palestinian society, as well as Israeli perpetrators of violence and human rights violations, are able to act without fear of consequences, evading investigation and punishment (Rought-Brooks et al., 2010).

During times of colonial- political violence, women often encounter two distinct forms of violence: firstly, they may endure violence similar to that experienced by men, which is typically

acknowledged as a violation of human rights and condemned universally; secondly, they may face violence solely because of their gender, which often goes unrecognized as a violation of human rights because it is perceived as related to gender roles (Holt, 2003). In the Palestinian territories under occupation, numerous reports indicate that Palestinian women and girls have alleged that Israeli interrogators have used threats of rape and subjected them to sexually degrading tactics during questioning (Holt, 2003).

Palestinian women face various forms of marginalization and oppression. Approximately 76 percent of adult Palestinians and 83.4 percent of Palestinian children residing in East Jerusalem live below the poverty line, in contrast to average poverty rates of 21.7 percent and 30 percent respectively among these demographics in Israel. Furthermore, certain groups of women, such as elderly women, those with disabilities, or female-headed households, found to experience even greater levels of marginalization compared to other women in Palestine (Khodary et al., 2020).

In addition, Palestinian women whose husbands have been detained by Israelis are compelled to assume dual roles, bearing the full responsibility of managing households and raising children, while also maintaining the societal expectation of fulfilling the role of the supportive wife to a hero. These additional burdens place significant pressure and stress on women in these circumstances (Segal, 2015).

Moreover, colonial policies and the practice of demolishing homes have made numerous Palestinian girls and women homeless, transforming them into internally displaced individuals. This situation has caused them to lose their feelings of safety, security, and belonging due to the continuous political conflict between Israelis and Palestinians. Additionally, their suffering is often denied, and their voices are silenced (Shalhoub-Kevorkian, 2010).

Lastly, Palestinian women living under occupation suffer a multitude of human rights violations, such as being arrested at streets, at checkpoints, and during aggressive nighttime raids on their homes, resulting in significant physical and psychological problems. Additionally, they experience the loss of land, homes, property, and means of livelihood, as well as injuries, fatalities, and harassment at checkpoints. Their freedom of movement is restricted, and their family connections are severed due to physical barriers imposed by geographical constraints (Aghabekian, 2017).

2.2.1 Gender-based violence among Palestinian females

Exposure to political violence has been linked to an increased risk of perpetrating gender-based violence. Additionally, exposure to political violence has been found to have adverse effects on the mental health of women, leading to symptoms such as PTSD, trauma re-experiencing, hyper-arousal, dissociation, engagement coping, and disengagement coping, all of which have been identified as predictors of physical intimate partner violence (IPV) re-victimization and domestic violence (Cougle et al., 2009; Heath, Hall etal., 2013; Krause etal., 2006). Moreover, the occurrence of GBV is likely to be exacerbated in contexts where a culture of violence and discrimination against women and girls existed before the onset of conflict (Manjoo & McRaith, 2011).

In a preliminary investigation targeting Palestinian women in the West Bank and Gaza Strip, 33% reported no history of encountering any form of violence. Of the 4,372 surveyed women, 34.8% experienced psychological violence, 17.6% endured physical violence, and 14.6% were subjected to sexual violence (Okasha & Abu-Saada, 2014). Furthermore, data from the Palestinian Central Bureau of Statistics (PCBS) revealed that 27% of currently or previously married Palestinian women had encountered some form of violence (PCBS, 2019)

2.2.2 Psychological effects of political violence and GBV among Palestinian females

GBV has been linked to various psychological issues among Palestinian females. For instance, research by Haj-Yahia (2000) demonstrated that women who were battered and abused in the West Bank exhibited elevated levels of anxiety, depression, and reduced self-esteem. Similarly, Veronese et al. (2023) discovered that gender-based violence was associated with stress, anxiety, and depression among Palestinian women in the West Bank. Additionally, Thabet et al. (2015) found that anxiety, depression, and post-traumatic stress disorder (PTSD) were positively correlated with domestic violence among women in the Gaza Strip. Moreover, gender discrimination was identified as a predictor of increased PTSD, cumulative trauma disorders, general anxiety, annihilation anxiety, and decreased self-esteem (Kira et al., 2015). Furthermore, Sousa et al. (2018) noted a negative association between IPVand depressive symptoms, as well as between political violence and PTSD among Palestinian women.

Additionally, the ongoing political violence in Palestine leads to the depletion of both interpersonal and intrapersonal resources among Palestinian women, which has been associated with post-traumatic stress disorder (PTSD) and major depression (Canetti et al., 2010). Moreover, activities such as surveillance, home invasions, and the actual or threatened destruction of women's homes induce feelings of fear, anxiety, grief, humiliation, and helplessness among Palestinian women (Sousa et al., 2014). Furthermore, nurses working in Gaza hospitals experience severe post-traumatic symptoms following prolonged exposure to the stress of war during Israeli military operations in Gaza (Alhajjar, 2013).

2.2.3 Protective factors against political violence and GBV among Palestinian females

Although existing literature indicates that exposure to political violence and gender-based violence (GBV) has detrimental effects on mental health, Palestinian women have shown

resilience in coping with these stressors. Various sources of agency and empowerment have been identified as protective factors for Palestinian women during times of stress, aimed at helping them realize their abilities and make strategic decisions to enhance their quality of life (Kamal, 2011). Problem-solving skills, support from family and religious communities, and political or civic engagement have been observed to aid women in the West Bank in coping with political violence, highlighting their resilience (Sousa, 2013). Additionally, life events calendars demonstrate Palestinian women's ongoing efforts to balance traumatic events with sources of well-being, particularly social support and family ties, in the Gaza Strip (Veronese et al., 2020).

Factors such as human security, strong family bonds, psychosocial resources (e.g., friendship and support from others), individual strengths (e.g., spirituality, activism, education, work, play, and humor), and motherhood have been identified as key contributors to maintaining positive psychological functioning and adapting to traumatic war events among Palestinian women following acute armed conflict (Veronese et al., 2019). Social support has been found to be a protective factor against depression, anxiety, PTSD symptoms, and suicide attempts among women who have experienced IPV (Coker et al., 2002). Additionally, education and economic independence are considered important protective factors against IPV among Palestinian women (Baloushah et al., 2019; Haj-Yahia & Clark, 2013).

Furthermore, Abu-Lughod (2010) investigated coping mechanisms and strategies of adaptation among women who experienced GBV in a Palestinian refugee camp in Jordan. The study revealed that hope and religious resources were commonly utilized coping mechanisms to deal with stressors among the participants.

2.3 The research project

2.3.1 The theoretical framework of the qualitative study: Grounded theory

The qualitative study of the project is adopting grounded theory as a research technique, and since grounded theory based on generating new model from data, and not to test the data based on existing theory, and so it involves the construction of hypotheses and models through the collecting and analysis of data using an inductive, bottom-up, data driven approach (Birks & Mills, 2015). Grounded theory is recognized as a powerful technique for studying social structures and processes within their specific contexts (Razaghi et al., 2022). In addition, Hammersley (2002) intriguingly characterizes the results and significance of such deeply context-specific research as offering "moderate enlightenment. Policymakers and practitioners, by definition, lack comprehensive understanding, and research serves the purpose of illuminating the actuality of their actions and guiding their future approaches (Hammersley, 2002). Moderate enlightenment diverges from the strong generalizations often asserted in natural sciences approaches and their staunch embrace of positivist perspectives (Hammersley, 2002).

By adopting grounded theory, we emphasize the significant role of psychosocial factors in violence against women. Notably, most studies in the Palestinian context have been quantitative (Haj-Yahia, 2000; Sousa et al., 2018; Thabet et al., 2015; Veronese et al., 2023; Zedan & Haj-Yahia, 2023), while qualitative research has predominantly focused on intimate partner violence (IPV) (Sousa et al., 2018; Zedan & Haj-Yahia, 2023), often overlooking unmarried women. Grounded theory allows us to explore and understand gender-based violence (GBV) against women from diverse perspectives, including those of females, males, and mental health care providers.

2.3.2 Aims and objectives

In the Palestinian society, which grapples with the challenges of living under occupation, individuals face heightened levels of environmental stressors and ongoing trauma, such as militarization, poverty, limited employment opportunities, and cultural pressures (Mahamid & Bdier, 2021). Additionally, restrictions on movement between communities, a lack of recreational facilities, and cultural norms emphasizing gender segregation further limit positive social outlets (Mahamid & Bdier, 2021). These conditions may contribute to GBV, as evidenced by previous studies underscoring the high levels of violence experienced by Palestinian women and the absence of human security (Tamimi, 2017). Furthermore, with men being deported, imprisoned, or killed, Palestinian women often assume multiple roles, including the responsibility of raising children and providing for the family economically (Khamis, 1998). These factors are recognized as risk factors for perpetrating violence against women (Gupta et al., 2009; Gupta et al., 2012; Haj-Yahia, 2000; Treves-Kagan et al., 2021; Wirtz et al., 2018). Moreover, the patriarchal system prevalent in Palestinian society has been shown to increase the vulnerability of women to violence, particularly in regions experiencing political conflicts (Manjoo & McRaith, 2011; Rubenberg, 2001).

Previous literature suggested that exposure to political trauma increases the risk of experiencing violence among females (Heath et al., 2013; Cougle et al., 2009). However, there is a notable gap in research attempting to understand the relationship between political trauma and GBV in the Palestinian context, both quantitatively and qualitatively. Most reviewed articles have focused on examining the association between political violence and GBV, primarily from the perspective of females (Coker et al., 2002; Giacaman, 2010; Manjoo & McRaith, 2011; Sousa, 2013). Therefore, the aims of this study are identified as:

1. To investigate and understand the potential role of political trauma on GBV from the perspectives and perceptions of females, males, and mental health care providers in the Palestinian context, by applying a mixed method approach;
2. To understand factors that can help in developing conceptual model to enhance mental health status of Palestinian females who have suffered from political trauma and gender based violence in upcoming research.

The qualitative part will answer the following questions:

1. What types of political violence do Palestinians experience?
2. How does political violence impact mental health of Palestinians?
3. How does political trauma impact GBV among Palestinian females residing in the West Bank and East Jerusalem?
4. How political trauma impact aggressiveness among Palestinian males?
5. How do Palestinian females narrate their experiences of GBV?
6. What is the impact of GBV on the mental health of Palestinian females?
7. What are the protective factors against GBV among Palestinian females?
8. What are the risk factors associated with GBV among Palestinian females?

The qualitative phase of the project aimed to explore several key questions that shaped the subsequent quantitative analysis. Understanding the types of political violence Palestinians experience helped to categorize and analyze specific forms of traumatic events in the quantitative phase. Exploring how political violence impacts mental health provides variables related to psychological outcomes that will be crucial for quantitative measurement. Investigating the impact of political trauma on GBV among Palestinian females in the West Bank and East Jerusalem will identify key variables linking political trauma to GBV, which can be tested

quantitatively. Examining how political trauma influences aggression among Palestinian males will generate variables related to aggression and its correlation with different mental health outcomes, useful for the quantitative model. Analyzing how Palestinian females narrate their experiences of GBV will reveal themes and variables that can be quantified in the next phase. Additionally, understanding the impact of GBV on the mental health of Palestinian females will provide data on mental health outcomes associated with GBV. Identifying protective factors against GBV will help in developing variables to test potential mitigating strategies, while examining risk factors associated with GBV will inform the identification of factors increasing the risk of GBV. Overall, the qualitative phase, guided by grounded theory, will uncover themes and relationships that inform the development of variables for the quantitative analysis, which will test and refine a theory on GBV in Palestine.

The qualitative phase of the project employed a data-driven, grounded theory approach to explore the impact of political trauma on GBVand mental health among Palestinians. This approach allowed for the emergence of relevant themes and variables directly from the data, without being constrained by pre-existing theories. Through detailed analysis of the qualitative data, several key variables and relationships were identified, such as the specific types of political violence experienced, the psychological impacts of this violence, and how political trauma influences GBV and aggression.

The grounded theory findings, combined with theoretical models developed through a top-down approach, informed the formulation of aims and hypotheses for the quantitative phase. The qualitative data revealed critical variables and relationships that were not fully captured by existing models, leading to the development of a refined conceptual model. This conceptual

theoretical framework incorporates both the emergent variables from the qualitative research and previous theories to test a comprehensive model of GBV in Palestine.

The hypotheses of the quantitative part are:

The hypotheses of the study and the conceptual models have been identified after analyzing the qualitative data. But generally, and based on the literature and scoping reviews of the study, the hypotheses would be:(1) political violence and Political trauma would be positively associated with GBV victimization among Palestinian females; (2) GBV would be positively associated with mental health outcomes among Palestinian females, (3) protective factors characterized by self-concept, healthy coping, and unhealthy coping would mediate the association between GBV and mental health outcomes among Palestinian females; (4) political violence and Political trauma would be positively associated with aggression among Palestinian males; (5) protective factors characterized by self-concept, healthy coping, and unhealthy coping would mediate the association between aggression and mental health outcomes and mental health distress among Palestinian males; (6) Socio-demographic factors characterized by residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members, would predict GBV victimization among Palestinian females; and (7) Socio-demographic factors characterized by residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members, would predict aggression in Palestinian males.

2.3.3 Chosen methodology

Determining the methodology to address the study questions and gain a better understanding of GBV and political trauma in the Palestinian context was easy. On one hand, the existing literature revealed an absence of mixed-method studies exploring this issue, particularly

a lack of qualitative inquiries. Consequently, there was an insufficient understanding of violence against women in the Palestinian context, primarily due to examinations predominantly from the female perspective. The lack of literature investigating GBV and political trauma, coupled with the prevalence of quantitative studies on GBV in the Palestinian context, prompted the adoption of an exploratory mixed-method design for this study.

Mixed-methods research emerged in the late 1970s as an approach that integrates both quantitative and qualitative data collection methods within a single study, facilitating an interactive dialogue between the two components (Lall, 2021). Exploratory sequential mixed methods, involves a systematic combination of qualitative and quantitative data collection and analysis across sequential phases (Mihas & Odum Institute, 2019). Initially, researchers gather and analyze qualitative data in the first phase, with the findings informing the subsequent quantitative phase, which may involve conducting surveys or employing other quantitative data collection methods (See Figure 3) (Mihas & Odum Institute, 2019) . Essentially, the qualitative analysis serves as essential groundwork for formulating specific research inquiries for the subsequent quantitative phase, which typically entails the administration of questionnaires, surveys, or other quantitative data collection instruments (Mihas & Odum Institute, 2019).

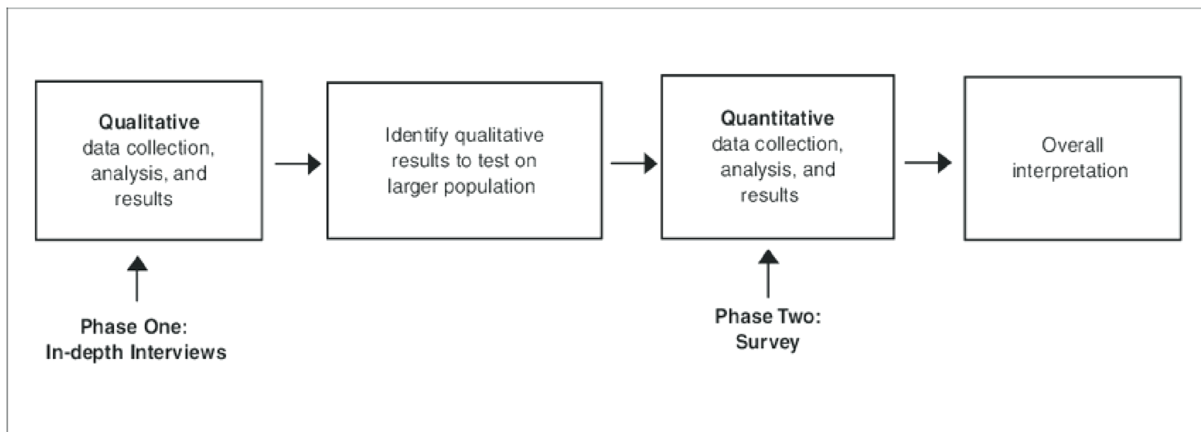
The rationale of this design is that qualitative assessment is employed to delve into the reasons or mechanisms behind a phenomenon, to construct a theory, or to delineate the nature of an individual's experience, whereas quantitative assessment addresses inquiries related to causality, generalizability, or the extent of impact (Berman, 2017).

Lastly, this study opted for an exploratory mixed-method design to enhance comprehension of GBV, political trauma, and political violence, as well as to investigate the

protective and risk factors associated with GBV. Another rationale for adopting this approach was to precisely define the variables to be examined in the quantitative assessment.

Figure 3.

Research Process: A Sequential Exploratory Design



Note: retrieved online from https://www.researchgate.net/figure/Fuentes-2008-sequential-exploratory-mixed-methods-design_fig2_249735787

2.3.4 Ethical guidelines and reflections

This research was carried out following APA ethical principles of psychologists and code of conduct (American Psychological Association, 2010). The study was approved by the Ethical Board of An-Najah National University, Nablus, Palestine (Ref:Med.Sep.2022/37).

In addition to the APA ethical principles, The World Health Organization (WHO) emphasizes several ethical considerations when investigating violence against women (Ellsberg et al., 2005). Foremost among these is the paramount importance of prioritizing the safety of both respondents and the research team, a principle that should guide all project decisions. Oral consent to take part in the study is deemed sufficient in case the participants did not agree to give a written consent, as it respects their safety and confidentiality while still ensuring informed participation.

Furthermore, prevalence studies must adhere to methodological rigor, drawing on existing research experience to mitigate the underreporting of abuse. Protecting confidentiality is crucial to safeguarding women's safety and ensuring the integrity of the collected data. It is imperative to meticulously select and adequately train all members of the research team, providing ongoing support throughout the study. Moreover, the study design should incorporate measures aimed at minimizing any potential distress experienced by participants. Fieldworkers should be trained to refer women seeking assistance to available support services, with provisions made for establishing temporary support mechanisms in resource-limited settings. Ethical responsibilities extend to researchers and donors, who must ensure that findings are accurately interpreted and utilized to inform policy and intervention development. Lastly, the inclusion of violence-related questions in surveys designed for other purposes should only occur when ethical and methodological standards can be rigorously met.

While when examining political violence, broader ethical considerations arise regarding potential harm to research subjects and other involved parties, including the researchers themselves (Mills et al., 2020). Harm to research subjects may stem not only from the research process but also, more significantly, from powerful actors—often parties engaged in the conflicts under investigation—seeking to access, utilize, or influence/manipulate research findings or their reception, understanding, and utilization (Mills et al., 2020). The former presents specific challenges regarding the confidentiality and security of data, while the latter necessitates careful consideration of the societal impact of the research. In both scenarios, an awareness of power dynamics, particularly the influence of the state, is essential (Mills et al., 2020).

Accordingly, all interviews and questionnaires were introduced in a non-threatening manner, ensuring a comfortable atmosphere for participants. Participants were informed that they

had the option to discontinue participation at any time if they felt distressed during the survey or interview. The investigator, a licensed mental health professional, received training in data collection and conducting semi-structured interviews and was available to address any immediate negative responses from participants. Additionally, all participants were provided with contact information for mental health services if symptoms were to appear following the interview. To maintain anonymity, all responses were kept confidential, eliminating the risk of identification.

Participants in the interviews were requested to provide written consent (See Appendix A) for participation although oral consent was accepted if some participants declined. The interview location was kept flexible to accommodate participants' preferences. They were given the option to choose a location of their preference if they declined the suggested one. Similarly, regarding the interview timing, the researcher offered multiple options, but if none suited the participant, the researcher remained open to suggestions for alternative times proposed by the participants.

Prior to obtaining consent, participants were informed about the study's objectives and the sensitive nature of the questions. They were assured that only researchers would have access to the data. In cases where participants refused to have their interviews recorded, they were asked if they would permit written documentation instead. Furthermore, The researchers who conducted the interviews are local researchers and they are native speakers of Arabic, which gave the participants a sense of trust, and they were not hesitant in expressing themselves.

2.3.5 The field work: where the research took place

The fieldwork for this research was conducted across various locations in the West Bank and East Jerusalem. The researcher being Palestinian herself offers the advantage of possessing

contextual knowledge and established connections. The primary rationale for addressing the study's issue across different contexts in Palestine is to ensure a more representative and comprehensive sample. Consequently, for quantitative data in particular, it was crucial to recruit participants residing in diverse areas within both the West Bank and East Jerusalem. Therefore, female and male participants in this study were drawn from urban, rural, and refugee communities in both regions.

The region situated west of the Jordan River, commonly known as the West Bank, encompasses about 21% of historic Palestine. Israel often refers to it as "Judea and Samaria," a term with political connotations aimed at asserting Israeli sovereignty over the area. Originally designated as part of the Arab State in the 1937 U.N. Partition Plan, it came under Jordanian control after the 1948 War. During the 1967 War, Israel seized control of the West Bank, including East Jerusalem, forming the majority of the newly Occupied Palestinian Territories alongside the Gaza Strip. The Oslo Accords of 1994 established the Palestinian Authority (PA) and delineated Areas A, B, and C.

Under the Oslo agreement, Area A in the West Bank falls under Palestinian administrative and police control, constituting 18% of the territory and hosting the highest population density among the designated areas. While Palestinians govern this region, significant land available for development lies along its borders with Area C. Area B, comprising about 22% of the West Bank, sees shared security control between Palestinian authorities and Israeli forces, with the Palestinian Authority overseeing administrative aspects such as education, economics, and healthcare. However, the division of areas A and B by Area C creates fragmentation, as Israel administers over 60% of the West Bank, encompassing numerous Palestinian and Israeli settlements. Within Area C, approximately 300,000 Palestinians reside

alongside 400,000 Israeli settlers, with a significant portion designated for military training, limiting Palestinian access to land for housing and agriculture. Many communities in Area C lack essential infrastructure, such as primary schools and water networks, forcing residents to endure long journeys for education and rely on costly, limited water supplies. Healthcare accessibility is also hindered by distance and checkpoint restrictions, underscoring the challenges faced by Palestinians in these areas.

In addition to the administrative divisions established by the Oslo Accords, the West Bank, with an area of 2,183 square miles (5,655 square kilometers), is further divided into 11 governorates: Bethlehem, Hebron, Jericho, Jenin, Jerusalem, Nablus, Qalqiliya, Ramallah, Salfit, Tubas, and Tulkarem. Its population, estimated at 4,137,000 as of 2024, contributes to the complex socio-political landscape of the region.

Following the overview of the West Bank's administrative structure and population dynamics, it's crucial to delve into the specific challenges faced by Palestinians in East Jerusalem, which is integral to understanding the broader socio-political context of the region. currently, about 320,000 Palestinians call East Jerusalem home, alongside over 210,000 Israeli settlers residing in settlements established and expanded since 1967, despite international legal prohibitions (OCHA, 2018). However, approximately 4.5 million Palestinians from the rest of the occupied Palestinian territory are barred from living in East Jerusalem and can only enter the city with hard-to-obtain permits issued by Israeli authorities. Even with permits, access is limited to just three of the 13 checkpoints along the Barrier (OCHA, 2018). Due to constrained urban planning and the arduous process of obtaining building permits, residents of East Jerusalem face severe housing shortages, leading many to construct homes "illegally" and risk demolition (OCHA, 2018). Only 13%

of East Jerusalem is designated for Palestinian construction, much of which is already developed. Since 1967, over 14,600 Palestinians have lost their Jerusalem residency status, and more than 1,700 structures have been demolished since 2000, displacing or affecting nearly 7,000 people in the past decade alone. Alarmingly, at least 33% of Palestinian homes in East Jerusalem lack proper permits, putting over 100,000 residents at risk of displacement (OCHA, 2018).

CHAPTER THREE

Understanding GBV victimization/ perpetration in the Palestinian context: A qualitative inquiry

Based on insights gleaned from the prior chapter, it's evident that to enhance our comprehension of GBV within conflict-affected regions like Palestine, including the influence of political violence and political trauma on its escalation, particularly in relation to male aggression, and to examine the risk and protective factors from diverse perspectives, we recognize the necessity of employing a variety of tools and methodologies. The adoption of a mixed-method approach emerges as pivotal. The significance of embracing a mixed method approach lies in its ability to furnish a more comprehensive comprehension of the phenomenon compared to studies solely reliant on either quantitative or qualitative methodologies (McKim, 2017). This approach enriches the validity of findings by incorporating diverse data sources and perspectives, thus enhancing the depth and breadth of insights garnered (McKim, 2017). Additionally, the integration aspect of mixed methods instills greater confidence in the study outcomes and the derived conclusions among readers, as it allows for a more holistic synthesis of findings. Furthermore, mixed methods facilitate the generation of novel research ideas, serving as a catalyst for future inquiry and advancement in the field (McKim, 2017).

Considering the argument presented in this research and the literature examined, it became clear that relying solely on either quantitative or qualitative methods was insufficient for comprehensively exploring and grasping GBV victimization/perpetration in light of political trauma and political violence in Palestine. Nonetheless, both approaches play integral roles in advancing our understanding of the phenomena. Hence, this methodology was adopted to

achieve a more holistic, contextual, nuanced, and intricate understanding of the phenomena under investigation than could be attained through a singular methodological approach.

In this study, a specific theoretical framework is not employed, as the grounded theory method is adopted. This choice arises from a lack of existing knowledge about the study topic. Grounded theory is utilized to generate new theories directly from the data, rather than to validate existing theories based on the data.

Thus, the initial part of the study employed a qualitative approach to delve deeper into the understanding of GBV within the context of political violence and political trauma in Palestine. The objectives of this phase were to address the following inquiries: (1) What types of political violence do Palestinians experience? (2) How does political violence impact mental health of Palestinians? (3) How does political trauma impact GBV among Palestinian females residing in the West Bank and East Jerusalem? (4) How political trauma impact aggressiveness among Palestinian males? (5) How do Palestinian females narrate their experiences of GBV? (6) What is the impact of GBV on the mental health of Palestinian females? (7) What are the protective factors against GBV among Palestinian females? and (8) What are the risk factors associated with GBV among Palestinian females?

Conversely, the subsequent phase of the study, the quantitative assessment, aimed to validate the conceptual framework derived from the qualitative analysis and reinforce its findings. In-depth semi-structured interviews were chosen as the data collection method for the qualitative assessment, as confirmed by Charmaz (2006), who identifies qualitative interviewing as suitable for grounded theory. Interviewing is viewed as interactional due to the exchange and sharing of roles, feelings, beliefs, motives, and information (Gehrels, 2013), making it adaptable

to various respondent characteristics (Gehrels, 2013). Regarding the quantitative assessment, the questionnaire used would be determined specifically following the analysis of the initial phase.

Furthermore, literature suggests that to enhance understanding when studying phenomena in the Palestinian context, research should encompass diverse locations, including cities, villages, and camps (Akesson, 2012). This is because experiences of traumatic political events may differ across regions. For instance, Barber (1999) discovered that the experience of intifada was more prevalent in refugee camps compared to villages or cities.

3.1 The qualitative study: Why studying GBV in light of political trauma in the Palestinian context?

In Palestinian society, living under occupation imposes numerous challenges, leading to heightened environmental stressors and ongoing trauma such as militarization, poverty, and limited opportunities. Factors like restricted movement, lack of recreational facilities, and cultural norms contribute to limited positive social outlets, potentially exacerbating gender-based violence (Mahamid & Bdier, 2021). Palestinian women often assume multiple roles due to the absence of men, which can increase the risk of violence against them. The patriarchal system prevalent in Palestinian society further compounds this vulnerability, especially in conflict regions (Khamis, 1998).

While previous research (See chapter two) has shown a link between political trauma and violence against women, there's a notable gap in understanding this relationship quantitatively and qualitatively in the Palestinian context. Existing studies primarily focus on the association between political violence and GBV, often from the perspective of women, with a predominance of quantitative research. Additionally, qualitative studies tend to concentrate on intimate partner violence (IPV), neglecting unmarried females as an important category. Therefore, by adopting a

grounded theory method, this study endeavors to answer the following questions, from the perspectives of Palestinian females, males, and mental health care providers:

1. What types of political violence do Palestinians experience?
2. How does political violence impact mental health of Palestinians?
3. How does political trauma impact GBV among Palestinian females residing in the West Bank and East Jerusalem?
4. How political trauma impact aggressiveness among Palestinian males?
5. How do Palestinian females narrate their experiences of GBV?
6. What is the impact of GBV on the mental health of Palestinian females?
7. What are the protective factors against GBV among Palestinian females?
8. What are the risk factors associated with GBV among Palestinian females?

3.2. The research context

As mentioned before, literature suggests that to enhance understanding when studying phenomena in the Palestinian context, research should encompass diverse locations, including cities, villages, and camps (Akesson, 2012). This is because experiences of traumatic political events may differ across regions.

Therefore, this part of the research was carried out across nine distinct locations in the West Bank to investigate GBV in light of political violence and political trauma, and to explore the protective and risk factors of GBV. The following section provides detailed information about the participants and the sites.

3.3 The qualitative study

3.3.1 Participants

In this qualitative research, a total of 27 adult people and 11 mental health care providers participated. Among the adults, ages ranged from 22 to 65 years (M = 44.66; SD = 12.35), comprising 14 females (51.9%) and 13 males (48.1%). The distribution of participants in the study sample was as follows: 6 from East Jerusalem, 4 from Tulkarm, 4 from Balata camp, 3 from Nour-Shams camp, 3 from Jenin camp, 2 from Hebron, 2 from Illar village, 2 from Tulkarm camp, and 1 from Salfit. Marital status among participants was as follows: 4 were single (14.8%), 19 were married (70.4%), 2 were divorced (7.4%), and 2 were widowed (7.4%). Regarding the mental health care providers, there were 6 females and 5 males. Among them, 7 were psychologists (4 females and 3 males), 2 were mental health supervisors (both males), and 2 were social workers (both females), with years of experience ranging from 6 to 30 years.

The study's inclusion criteria required participants to meet the following: (1) be Palestinian adults (both females and males) aged 18 years or older; (2) possess proficiency in reading and speaking Arabic; and (3) have experienced at least one traumatic event, either directly or indirectly. While the eligibility criteria for mental health care providers are: (1) be Palestinian psychologists, social workers, or psycho-social supervisors ; (2) working in the field for more than one year; and (3) be eligible to read and speak in Arabic.

The sample was recruited using snowball sampling techniques, wherein initially, several females and males who had encountered political violence were identified. These individuals then referred others who shared similar experiences. Theoretical sampling was employed, with data saturation as the criterion, indicating the point where new data ceased to yield additional insights (Fusch & Ness, 2015). Eventually, theoretical saturation was achieved after interviewing

14 females and 13 males. All interviews took place between the end of September and November 2022. Similarly, mental health care providers were contacted through a psychologist who was nominated by the co-tutor. This psychologist facilitated connections with other mental health care providers. Theoretical saturation was reached after interviewing 11 mental health care providers.

3.3.2 Ethical considerations

All interviews were introduced in a non-threatening manner, ensuring a comfortable atmosphere for participants. Participants were informed that they had the option to discontinue participation at any time if they felt distressed during the interview. The investigators, licensed mental health professionals, received training in data collection and conducting semi-structured interviews and were available to address any immediate negative responses from participants. Additionally, all participants were provided with contact information for mental health services if symptoms were to appear following the interview. To maintain anonymity, all responses were kept confidential, eliminating the risk of identification.

Participants in the interviews were requested to provide written consent for participation, although oral consent was accepted if some participants declined. The interview location was kept flexible to accommodate participants' preferences. They were given the option to choose a location of their preference if they declined the suggested one. Similarly, regarding the interview timing, the researcher offered multiple options, but if none suited the participant, the researcher remained open to suggestions for alternative times proposed by the participants.

Prior to obtaining consent, participants were informed about the study's objectives and the sensitive nature of the questions. They were assured that only researchers would have access to the data. In cases where participants refused to have their interviews recorded, they were

asked if they would permit written documentation instead. Furthermore, The researchers who conducted the interviews are local researchers and they are native speakers of Arabic, which gave the participants a sense of trust, and they were not hesitant in expressing themselves.

The research was carried out following APA ethical principles of psychologists and code of conduct (American Psychological Association, 2010). The study was approved by the Ethical Board of An-Najah National University, Nablus, Palestine (Ref:Med.Sep.2022/37), on September 25th, 2022.

3.3.3 The study's methods

***Instrument*.** The research utilized the qualitative interview method using in depth semi-structured format for data collection. In-depth interviews (IDIs) are considered as highly effective instruments for delving into the depths of human understanding and exploring various social topics (Carter et al., 2014). Ranging from structured to unstructured interviews, these interviews have the capacity to extract comprehensive insights into personal experiences and viewpoints. The strength of IDIs lies in their ability to foster spontaneity, adaptability, and a keen responsiveness to the unique individuals being interviewed (Carter et al., 2014).

Semi-structured interviews, a form of qualitative research, involve gathering information through conversational exchanges, aiming to explore respondents' perspectives in relation to specific research objectives. These interviews facilitate direct interaction between the researcher and the participant, establishing a social relationship while studying the individual (Albaret & Deas, 2023). In the semi-structured interviews, the researcher employs a predefined set of questions but retains the flexibility to pose additional inquiries should new or intriguing topics arise during the interview (Mannan, 2020). This adaptability in questioning allows for thorough exploration of specific subjects.

An essential aspect of interview preparation involves developing an interview protocol- a document that guides the researcher through the interview process. Primarily, this protocol comprises a set of questions the researcher will pose to participants, alongside details about the project and the interview procedure provided to the participants (Karatsareas, 2022). Castillo-Montoya (2016) outlines a four-phase approach to developing an interview protocol aimed at ensuring researchers obtain comprehensive and robust interview data. The framework guides the process of developing the protocol, starting from aligning interview questions with the research project's objectives, to ensuring questions are clear and refined, and concluding with piloting the protocol with a small group of participants. Additionally, the protocol should incorporate strategies for redirecting interviewees back to the main topic if they veer off course during their responses. In such instances, researchers should respectfully allow interviewees to finish their thoughts and then gently guide them back on track, acknowledging their contribution and providing a brief explanation for the redirection, with time constraints serving as a plausible justification for intervention, if necessary.

Procedures. The researcher began developing the interview protocol by drafting preliminary interview questions while considering ethical considerations. She ensured that the questions were aligned with the study's objectives and were presented in a conversational manner. These steps resulted in a set of 13 questions for female interviews, 15 questions for male interviews, and 6 questions for interviews with mental health care providers. To pilot the protocol, the researcher employed three techniques. Firstly, internal testing involved reviewing the protocol with the tutor and co-tutor. Secondly, expert assessment was conducted by contacting three experts who agreed to review the protocol (See Appendix B, C & D). Lastly,

field-testing was carried out by testing the preliminary interview protocol with two potential study participants from each group.

The significance of this phase lies in its aim to validate the comprehensiveness and appropriateness of the content within the initial protocol, as well as to recognize any potential necessity for rephrasing questions and to evaluate its practical implementation (Kallio et al., 2016). Through the testing of the interview protocol, informed modifications and refinements to the interview questions were made, ultimately enhancing the quality of data collection. This process resulted in 5 questions for female interviews (See Appendix E), 6 questions for male interviews (See Appendix F), and 6 questions for mental health care provider interviews (See Appendix G).

The researcher initiated the data collection process by conducting interviews, with the duration of each interview ranging from 50 to 80 minutes, contingent upon factors such as the number of questions and the availability of participants to share their experiences. The interview procedure commenced with the identification of participants, followed by providing them with explanations regarding the research topic and objectives. Upon obtaining the participants' agreement, the interview time and location were arranged. At the outset of each interview, after securing participants' consent and ensuring confidentiality, recordings were made using a mobile phone. Demographic information was collected initially. It's worth noting that some interviews took place in participants' homes to ensure convenience and confidentiality, while others were conducted in locations suggested by the researcher and co-researchers. Consent for recording was obtained from participants at the beginning of each interview. Alternatively, if participants declined recording, their agreement for documenting the interview in written form was sought as an alternative.

Moreover, the data were collected from three distinct groups; women, men, and mental health care providers. This method, known as data triangulation, entails collecting data from various sources such as individuals, groups, families, and communities. Its purpose is to obtain diverse perspectives and validate the collected data (Carter et al., 2014).

3.3.4 The Data Analysis

All interviews were recorded audibly and then transcribed into Arabic by a native language researcher. The subsequent analysis of the 38 written interviews followed the thematic content analysis (TCA) methodology. TCA serves as a descriptive means of presenting qualitative data, showcasing the thematic content of interview transcripts by identifying recurring themes. It stands as a fundamental qualitative analytical approach, informing various qualitative methods. In TCA, researchers maintain an objective stance, grouping and distilling common themes from the texts to express the collective voices of participants (Anderson, 2007). Efforts are made to derive theme names directly from participants' words and to organize them in a manner that accurately reflects the entirety of the texts (Anderson, 2007).

Code typically refers to a concise word or phrase that symbolically encapsulates the essence, significance, or evocative nature of a segment of language-based or visual data. These codes serve as shorthand representations, capturing the essence of important categories yet to be fully explored within the data. Codifying involves systematically organizing elements, integrating them into a structured system or classification, and categorizing them accordingly (Jnanathapaswi, 2021).

In the current study, each interview was meticulously transcribed in Arabic a native language researcher. Thematic content analysis (TCA) was then applied to the transcripts to unveil the prominent themes emerging from the data. Using the MAXQDA 20 qualitative data

analysis software, the 38 interviews underwent coding. Additionally, an inductive, data-driven textual analysis approach was adopted to extract categories from the raw data (Parker, 2011; Strauss & Corbin, 1990). This involved closely examining each interview to identify underlying concepts rather than solely focusing on statements containing similar words. The analytical process proceeded in three main steps: first, researchers conducted an open-ended analysis of participants' narratives to identify major research themes; next, these themes were coded and organized into structured categories; finally, the categories were reviewed and confirmed by two judges (Riger & Sigurvinsdottir, 2016).

To elaborate, the data analysis initially transitioned from an inductive approach to a deductive one before returning to an inductive approach during the implementation of content thematic analysis. This can be understood as the study embracing the grounded theory method and theoretical sampling. Grounded theorists engage in concurrent data gathering and analysis throughout the entire research endeavor. As analysis progresses, codes and concepts emerge and evolve directly from the data, subsequently influencing the direction of further data collection (Thornberg et al., 2015).

3.3.5 Results

To better understand GBV victimization and perpetration in the Palestinian context, the study examined perspectives from females, males, and mental health care providers. Accordingly, the chosen methodological approach uncovered insights into how political violence, political trauma, and other risk factors contribute to GBV victimization and perpetration in the West Bank and East Jerusalem. Additionally, protective factors against GBV perpetration and victimization were identified. Furthermore, the results illuminated several

negative mental health outcomes associated with experiencing GBV, as reported by the participants.

TCA of the interviews revealed seven main themes and forty-two sub-themes from the females' perspective. Similarly, the analysis of males' interviews identified five key themes and twenty-nine sub-themes, while mental health care providers' interviews yielded five key themes and forty-six sub-themes. In the subsequent section, these main themes and subthemes are explored in depth to provide a comprehensive understanding of the investigated phenomena. As the researcher started presenting the findings from the analysis of the interviews with females.

3.3.5.1 Results from females' interviews

Theme 1- "Political violence"

Two subthemes emerged from the analysis (See figure 4). Participants mentioned being exposed to various types of potential politically traumatic events, which had a negative impact on their mental health and resulted in political trauma.

Here are more detailed description of the subthemes that emerged from the TCA of the female participants' narratives.

Direct exposure

Several participants among women reported that they and their families were directly exposed to political violence, which adversely affected their mental health and family dynamics. This exposure increased their vulnerability to experiencing gender-based violence due to its negative impact on mental health. T.A., a 43-year-old married woman from Jenin camp, said:

> I've been through several events, some before the moment of arrest and others at the moment of arrest. For example, the Israeli army had been chasing me more than once. Once, I had to jump from the second floor of a building to another building onto sand just

> to escape from them, even though I ended up fracturing three fingers. But the important thing is, thank God, I managed to escape from them.

While W.A., a 22-year-old single female from the city of Tulkarm, added:

> When the Israeli army invaded our house to arrest my brother, it was a strong shock. I still can't get it out of my mind. When they arrived, I confronted them, and they pointed their guns at me while I was still half asleep. As soon as I confronted them, they dragged us from the room and put us in the kitchen. It was extremely terrifying, to the point of being unnatural. They started shouting at us, threatening us while we were sitting. The Israeli soldier banged the table against the room's ceiling. At that moment, I was frozen, unable to move to the right or left. After the army invaded our house, we remained afraid. Whenever we left the house, my parents kept calling and asking us to come back quickly, and they started monitoring our comings and goings, warning us not to be late. Our family had never been like this before. We couldn't go out like we used to. The situation changed completely after the incident.

In the previous quotations, the participants described their experiences of being exposed to direct political violence. The first participant shared her experience of Israeli soldiers attempting to arrest her, while the second participant recounted her experience of political violence during the Israeli soldiers' invasion of their home to arrest her brother.

Indirect exposure

Some participants discussed being subjected to indirect political violence, emphasizing how this type of violence completely changed their lives and led to increased aggression from their husbands and family members. For instance, M.U., a 48-year-old married woman from Balata Camp, mentioned:

> Among the violence inflicted upon us by the occupation, there was an incident that occurred and changed the life of our entire family. My brother-in-law was 29 years old and was one of the young people who loved our country dearly. He was employed in a job that made him feel like he was contributing something meaningful to our nation. One day, some young men approached him and urged him to join the resistance. He was armed, but we were unaware of this. He then went to the area where the Israeli army had invaded in our city. He was hit by shrapnel from a tank bomb and suffered a severe head injury. He remained clinically dead for four days before he passed away.

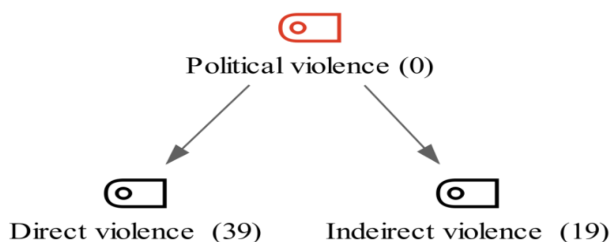
While S.A., a 28- year- old divorced woman from Tulkarm city reported:

> When my brother was released from the Israeli prison, he wanted to remain alone and avoid any disturbance, just as he was during his time in prison. He used to tell me to keep the noise down and not to let certain people come to us. He was keep saying I was living without noise, and I want to continue living like this without hearing any voice, but I it seems that I can't do this here. He is pressuring us with these things. The Israeli soldiers indeed had a significant impact on them, and it's difficult for them to adapt.

It's clear from the narratives of females how the indirect political violence affects all aspects of Palestinian life, including their mental health, and contributes to increased aggression in society.

Figure 4

Data-Driven Module for the First Theme



Note: The main theme is in red colour, the subthemes in black colour.

Thus, as illustrated in Figure 4, the first theme that emerged from the data of female participants was "political violence". This theme comprised two subthemes: direct violence and indirect violence. Content analysis revealed that direct violence was more frequently mentioned in the narratives of females compared to indirect violence.

Theme 2- "Political trauma and GBV"

Female participants documented several trauma symptoms in their narratives resulting from exposure to political violence. They emphasized that these effects were not limited to

themselves but also extended to their family members. Furthermore, they highlighted how these trauma symptoms contributed to their victimization by GBV. these symptoms were discussed in depth in the subsequent subthemes.

Re-experiencing. One participant reported re-experiencing part of the traumatic event through nightmares about the death of her son, as she kept remembering the moment and how her son was killed by Israelis. O.B., a 53-year-old married woman from Jenin camp, mentioned this:

> In my dreams, I often see him. I pray and say, 'Oh [1]Allah, I just want to dream of him, to hug him, and to see him in all of my dreams.' However, I cry a lot in my dreams, and my nerves and emotions are greatly affected because I often scream and cry when dreaming of him.

And H.A., a 54-year-old married woman from Tulkarm city, stated the following after the arrest of her son by the Israeli soldiers:

> I always feel suffocated, cry, and think about what happened. Everyone's spirits are low, and no one can bear the other. Anything bothers them and makes them angry. Even my daughters have become afraid of phone calls and don't say anything positive or negative over the phone. Especially my daughter in university tells us she doesn't belong with us and doesn't want to be close to us because she's so afraid. We tell her, "They took the boy, why are you afraid?" She has developed trauma because of something called occupation, and I am the same. For example, I'm terrified if I hear a loud noise or the sound of gunfire. And my husband has been very angry since our son was last arrested.

Avoidance. Participants talked about how they or their family members started to show avoidance behaviors after experiencing the traumatic event, and how this contributed to GBV victimization. As M.U., a 48- year- old married woman from Balata camp, mentioned: “After the Israeli army killed my brother-in-law, my husband and his brother, they stopped following the

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[1] Allah refers to God.

news. Even when Israelis were invading our camp, they stopped asking about what was happening. They became so careless".

I.M., a 59- year- old widow woman from Balata camp talked about the avoidance behavior that one of her family member started to show after the Israeli soldiers raided their house and she said:

> Even the adults, like my brother's wife, were psychologically affected. She couldn't sleep at home and always needs someone around her, and she started to leave her children behind and to go to her parents' house. The men started to be so angry at home because they couldn't control or manage anything regarding the invasions. Also, If his wife wasn't prepared or wasn't doing anything, he would get angry and bang on the door, for example, and shout. She wouldn't be doing anything because she's anxious and stressed.

Hyperarousal. The third subtheme that emerged from political trauma is hyperarousal, during which females or their family members began to exhibit symptoms of hyperarousal following exposure to political traumatic events. In the following section, we will explore how a sample of the study participants discussed this phenomenon and its relation to GBV.

In this regard, M.U., a 48- year- old married woman from Balata camp, mentioned:

> My husband started to do some things as if unconsciously. For example, if I made a cake or dessert, he would ask me what I had made. I used to say that I made it because the kids asked for it, but his response would be, 'Take this from my face.'

While, T.A., a 43- year- old married woman from Nour-Shams camp stated:

> Sometimes I get stressed when something happens, like when they arrest my brother or his sons, or when I hear news of someone's martyrdom. I get angry or upset, and my husband doesn't understand this. He starts yelling and getting angry, which creates distance between us, and I know that he has started to cheat on me.

Negative changes in emotions and feelings. After being exposed to political traumatic events, some of the participants and their family members began to feel sadness or numbness, and their feelings toward people changed. This sometimes led them to behave aggressively

towards others. Due to these changes in their feelings and behaviors, others couldn't understand them, making them vulnerable to psychological and emotional abuse.

H.A, a 54- year- old married woman from Tulkarm city, mentioned, “After the invasion by Israelis to our house, my husband became irritable. Anything would upset him, and he would shout and fight. I always feel suffocated and scream, and I think about what happened”.

And, S.H., a 22- year- old, single female from Tulkarm camp, mentioned:

> My father's hand became paralyzed due to torture, so when he comes out of the Israeli prison, he isolates himself. He spends periods without talking to anyone. Even now in the morning, he doesn't feel like talking to any of us. Even on regular days, he just goes to work and stays by himself. Although he tries to be with us, he has gotten used to solitude, and he remains sad even though my father is now 60 years old. It's been more than 30 years in this situation, and our entire situation is not normal.

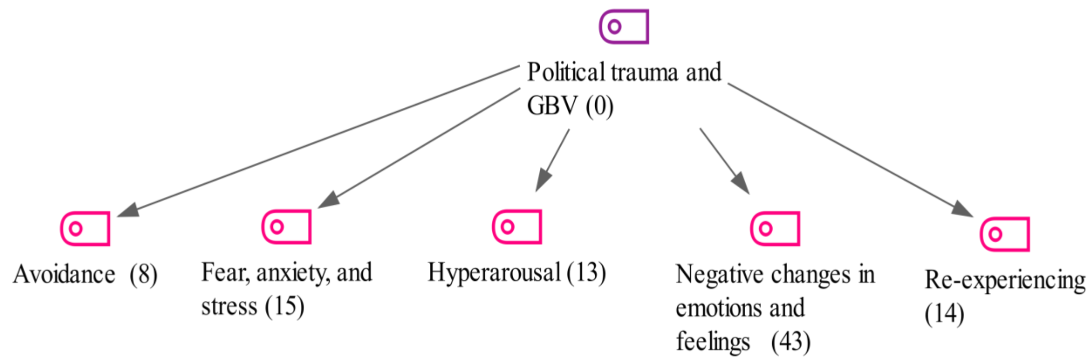
Fear, anxiety, and stress. It emerged as a subtheme of political trauma, in which some female participants reported suffering from fear, anxiety, and stress after the traumatic event. They are often anxious and stressed, constantly fearing that Israelis may invade their house or do something terrible to them or their family members at any time.

Regarding the current subthemes, O.M, a 45-year-old woman from Jenin camp, stated: “I always felt afraid and constantly wanted to ensure the safety of my sons.” She continued, “I would often tell my sons that I had a feeling something bad would happen to them.” Additionally, she expressed, “After they killed the journalist Shereen Abu-Aqleh, I am always terrified.” As well, I.M., a 59-year-old widowed woman from Balata camp, stated:

> I am always stressed, constantly fearing that the Israeli army may invade our camp or our house. I am mentally exhausted.” She continued, “I tremble whenever they invade the camp due to the sound of the bombs.” She added, “The fear has a huge impact on us”.

Figure 5

Data-Driven Module for the Second Theme



Note: The main theme is in purple colour, the subthemes in pink colour.

As shown in Figure 5, the second theme that emerged from the data of female participants was “political trauma and GBV”. This theme comprised five subthemes: avoidance, hyperarousal, negative changes in emotions and feelings, re-experiencing, and fear, anxiety and stress. Content analysis revealed that negative changes in emotions and feelings was more frequently mentioned in narratives of female participants compared to other subthemes.

Theme 3- “Types of GBV victimization”

In regard to exposure to political violence and political trauma, females reported experiencing various types of gender-based violence (GBV). They also emphasized that violence was not only directed towards them but also towards other family members. This will be explained in detail in the following subthemes.

Sexual violence. One participant reported that she was exposed to sexual violence by her husband, despite her mental state preventing her from being willing to engage in a sexual relationship. She was feeling sad as her son had been recently killed by Israeli soldiers, and she said:

> To be honest, me and my husband always quarrel, because he's always distressing me, and you know how is the relationship between the woman and her husband, and what can I say men are not the same as women, when they want '[2]that thing', they don't understand that the woman lost her son, and I am always quarrelling with him" (O.M., a 45- year- old married woman from Jenin camp).

As we can see from the above quotation, the woman's mental health has been affected as a result of her son's killing by Israeli soldiers. Consequently, she became unable to have a sexual relationship with her husband. However, she felt compelled to engage in sexual relations as he couldn't understand her sadness and its impact on her. This led to frequent quarrels between them.

Physical violence. Beyond instances of sexual violence, several participants recounted experiences of enduring physical violence directly linked to political upheaval or trauma. As O. J., a 60-year-old widowed woman from Illar village, said, after the Israeli soldiers killed her son: "My sister-in-law said, 'Your son was killed, and you are the reason for his death.' During his '[3]Azaa,' she attacked me in front of everyone and beat me up."

While H.A, a 54-year-old married woman from Tulkarm mentioned, that after her son was released from the Israeli prison, he became aggressive, and she mentioned:

> I started to ask his sisters to avoid him, because for example, once he had a fight with his sister and he attacked her and dragged her on the floor while pulling her hair, and she was about to abort because she was pregnant, and this was for no reason, she only said one word, and suddenly he was provoked because of it.

According to the above-mentioned quotation, females were found to experience physical violence as a result of exposure to political violence, such as the killing or arrest of their sons. Moreover, they experienced physical violence because those around them were mentally affected. In the first quotation, it appears that her sister-in-law was mentally affected by the loss

[2] That thing refers to having sexual relationship.
[3] Azaa refers to a funeral gathering, where people gather to support the family and relatives of the deceased.

of her nephew, while in the second quotation, it seems that her son, upon being arrested and imprisoned, experienced mental distress, becoming irritable and aggressive.

Psychological and emotional violence. Another type of GBV that emerged from the current theme is psychological and emotional violence, in which females were violated psychologically as a result of the political situation or the psychological effects it had on Palestinian individuals. The following quotations provide examples of this type of violence.

E.J.A., a 40- year- old single female from East Jerusalem mentioned:

> From one of the personal matters as a woman, I believe that my parents, due to what they hear about external problems, may not have confidence in me. They do not give me full opportunity or freedom, and I feel under psychological pressure.

According to what E.J.A. mentioned, as a result of the political situation in Jerusalem, her parents seem to have become anxious. They are not giving her the freedom to go wherever she wants. This might be because they are afraid that a political incident may occur while she's in that area, or because they fear that Israeli soldiers may abuse her.

While, S.H., a 22-year-old single female from Tulkarm camp, described a part of the psychological violence she is experiencing, stating:

> My brother was imprisoned for six years. His case is really different, he is mentally devastated. When he is in prison, he is usually '[4]the prince' there. So when he comes out, he wants to impose the same thing on us. So if he said about something no, then it means no.

This quotation illustrates how the participant is controlled by her brother, who expects her to comply with his commands without question. He became like this after he was imprisoned in Israeli prisons.

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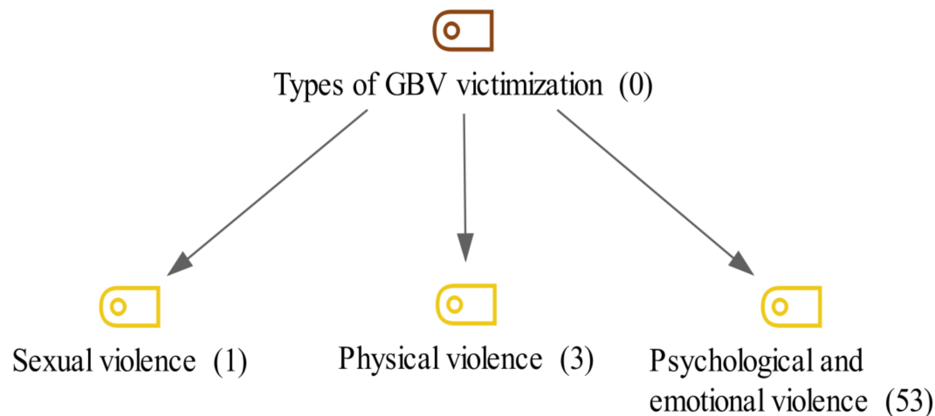
[4] The prince refers to the prisoned person chosen by his imprisoned individuals of his political group, who are in the same section, to be the responsible for managing their things, and representing them in the Israeli prisons.

Figure 6

Data-Driven Module for the Third Theme



Note: The main theme is in brown colour, the subthemes in yellow colour.

Figure 6 summarizes the third theme, 'Types of GBV victimization.' Females talked about the different types of GBV to which they were exposed. These types are related to political violence and political trauma. Furthermore, the content analysis showed that the subtheme "psychological and emotional violence" is more frequent than the other types of violence.

Theme 4- "Multidimensional GBV perpetration"

The fourth theme identified in the TCA is 'multidimensional GBV perpetration.' According to this theme, females reported experiencing violence from various groups. The following three subthemes will delve deeper into this topic. Political violence in the Palestinian context targets various groups, exposing them to its effects. As a result, females became at risk of experiencing violence from different groups.

The society. Females reported experiencing violence from both members of society and institutions, particularly after being exposed to political violence As T.A., a 43-year-old married woman from Nour- Shams camps said,

When I first came out of prison, I felt as if I had done something wrong or abnormal. At the moment of release, when people come to meet the female or male prisoner, I did not feel as much empathy as they were more interested in knowing if we had been subjected to sexual violence in prison. Despite many female prisoners talked about this topic.

In this quotation, the participant described how she was subjected to violence from society, as they showed concern primarily about whether she had experienced sexual violence in prison, rather than acknowledging her heroic role and sacrifice. Additionally, the quotation highlights society's tendency to forget that she is a victim, regardless of what they did to her in prison.

O. J., a 60-year-old widowed woman from Illar village added:

The violence increased from the people in my town as well. I bought a house on the street, and the first person who stood against me was the head of the municipality. He tried to stop the construction, and I fought with him. I told him, 'It's enough that I lost my sons.' He responded, 'Who asked your sons to go? Who asked them to become martyrs or prisoners?'

The participant's narrative sheds light on how she encountered violence from community members, notably from the head of the municipality in this excerpt. It exemplifies his effort to harm her by disregarding her identity as a woman and, more significantly, as the mother of a martyr and prisoners.

Violence committed by males. Another subtheme that emerged was “males”, as females reported experiencing violations from males after witnessing traumatic political violence. A.H., a 48-year-old married woman from Balata camp, described how the males in her family became aggressive after their house was invaded by the Israeli army. The invasion was horrifying; in addition to intruding, they shot her father-in-law in the leg. A.H., stated, “ after this, the males in the family started to be so irritated and nervous.” In addition, W.A., a 22-year-old single female from Tulkarm, said while describing how her brother was affected by the prison experience,

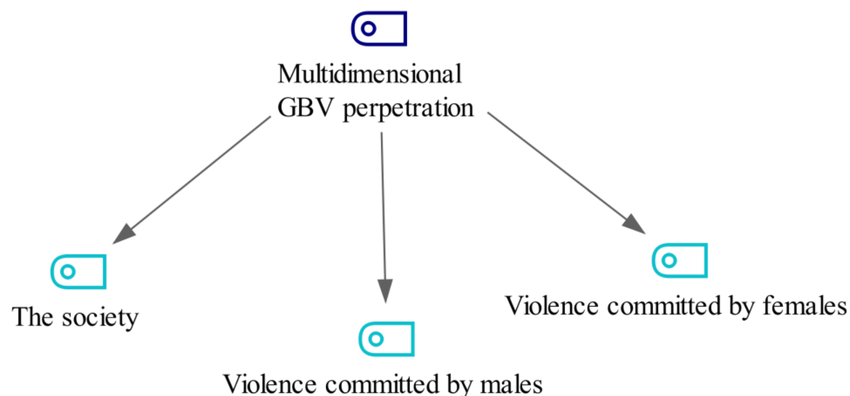
I was so close to him, but after he was imprisoned for the second time, we started to have fights, me and him. After being so close, we became like water and fire, and we started to quarrel over very silly things.

Violence committed by females. In the current study, some participants mentioned that females were also found to be violators of other females. According to the participants' narratives, this behavior may have started because they viewed the victims as vulnerable figures or because the violators themselves were affected by a traumatic political event.

After the death of her brother, as he was killed by Israeli army, D.I., a 57-year-old married woman from Balata camp stated, " my mother, she was closing the stove, and she was not allowing us to eat, and I was trying to eat without her knowing." And O. J., a 60-year-old widowed woman from Illar village, after her son was killed by Israelis, her sister-in-law started to blame her for his death. She described this by saying, "When she saw me crying, she asked me, 'Why do you cry? You are the reason he died.' Later, she attacked me and beat me up."

Figure 7

Data-Driven Module for the Fourth Theme



Note: The main theme is in dark blue colour, the subthemes in blue colour.

Figure 7 shows the fourth theme with its subthemes, "Multidimensional GBV perpetration". The subthemes are: "The society", "Violence committed by males", and "violence

committed by females". In which the content analysis revealed that the subtheme "Males" was the most frequent subtheme compared to other subthemes emerged from the fourth theme.

Theme 5- "Risk factors of GBV against females"

The fifth theme that emerged from the CTA is the risk factors of GBV against Palestinian females. In addition to political violence and political trauma, several socio-cultural factors were mentioned as risk factors in the females' narratives. The following subthemes discuss these factors in depth.

Cultural gender roles. This subtheme highlights that females are vulnerable to GBV when they are unable to perform their culturally assigned roles, and also when males are unable to fulfill their societal roles. I.M., a 59-year- old widowed woman from Balata camp, said while describing why her son became aggressive toward his wife: "If he found that his wife did not prepare anything and did not do anything, he would become nervous, scream, and slam the door." She added elsewhere, "When my son found himself unable to control anything regarding the invasions of the house by Israelis, he became nervous as a result of this."

In the mentioned quotations, the female was found to be at risk of experiencing violence from her husband because she was not able to do the home chores, a role identified for her by the culture of the society. On the other hand, as the male couldn't fulfill his role of protecting his family, he started to show aggressive behavior toward his wife.

Lack of knowledge about GBV & human rights. Lack of knowledge about GBV emerged as a subtheme in the current theme. When asked about their understanding of GBV, some participants defined it in terms of unrelated topics, such as the influence of others on someone. When referring to violence, they mostly discussed physical violence, indicating they did not recognize other forms of aggressive behavior as violence. Additionally, participants

mentioned that many females are unaware of their rights and unable to recognize specific behaviors as aggressive. Consequently, these women experience violence without acknowledging it as such, which prevents them from taking steps to stop it.

O.M., a 45-year-old married woman from Jenin camp, mentioned:

> GBV, we do not have any of this, I know that someone may '[5]Yetfashash' in someone else by beating him/her up, and we do not have this.

While, M.U., a 49-year-old married woman added:

> The only thing that a woman can do is only to cry, she does not have the right to complain. There is a lot of girls they do not realize that they have the right to report the abuse, and they do not understand that they are victims and that it is not their fault that they were abused. For example, they have to understand that when their husband scream in their faces, they have the right to ask them why they are doing this.

Lack of problem solving competences. The Current subtheme were mentioned by participants as one the risk factors related to GBV, one participant reported: "We are in a society that does not provide you with solutions, we only try to talk to the mother or to the sister, but we do not receive solutions from them."

The participant expressed that no one is providing her with a real solution for her problem with experiencing violence, and it is clear how she is relying on others to provide her a solution to stop the violence, forgetting that she may have her own resources to stop the violence.

Lack of social support. Females described that the lack of social support and not having someone to support them contributed to escalating their problem and preventing them from avoiding or stopping the violence against them.

M.U., a 48-year-old married woman from Balata camp, said: "I always say to myself that I did not have any choice, and no place to go to it. I did not have any idea about the institutions that provide services for victims of violence." Furthermore, S.A., a 28-year-old divorced woman

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[5] Yetfashash is a Palestinians used word which means that a person takes out their frustrations and negative emotions on others by displaying aggressive behavior towards them.

from Tulkarm, mentioned that no one or any institution tried to help them whether mentally or by providing them with any service, by saying: "No one provided us with any service or help."

Lack of assertive behavior in males. Males who do not show assertive behavior put their wives or other females in their families at risk of violence from others, such as members of the extended family, as they are unable to play any role in stopping the violence to which they are exposed.

O.J., a 60-year-old widowed woman from Illar village, said: "My husband had a weak personality, and he could not do anything for anyone." Moreover, O.M., a 45-year-old married woman from Jenin camp, added: "You can say that my husband have a weak personality, and he does not have any brothers."

Political groups. In Palestine, there are various political groups, with some being secular and others deeply religious. The religious factions sometimes misinterpret Islamic rules and principles, leading to the mistreatment of females.

This is stated by S.A., a 28-year-old divorced woman from Tulkarm, by saying:

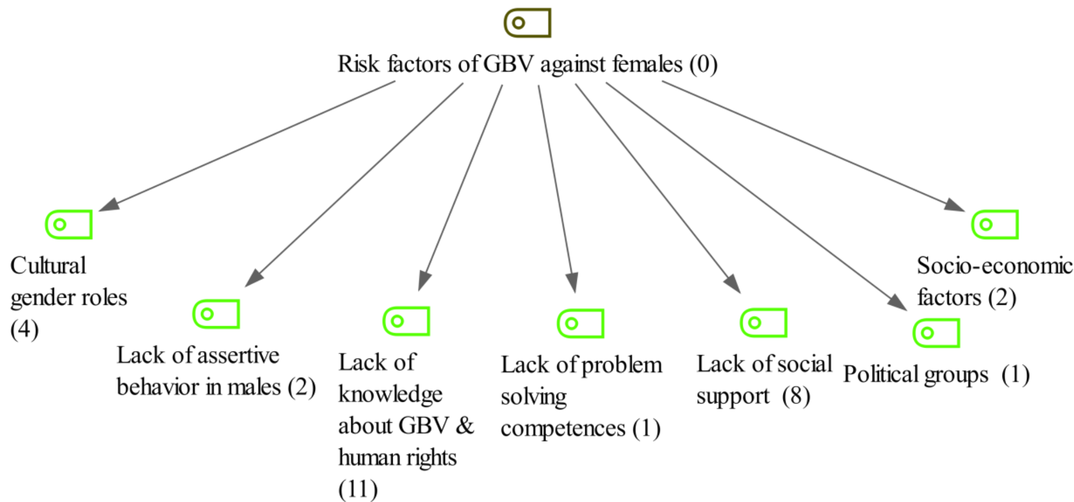
> We live in a country that include several factions, each faction has its own features, and depending on the faction, you can find people who are so religious, while others not. At first my brother was a member in one of the factions that is not sticking to religion, but then he changed and joined a faction that is so religious, which changed him, and started to try to control us.

Socio-economic factors. Poverty and lack of employment were found to be components of the theme socio-demographic factors contributing to violence against women. This can be explained by the cultural expectation in Palestine that men are responsible for satisfying the financial needs of the family. When men find themselves unable to fulfill this role, they may experience frustration and significant pressure, leading to aggressive behavior as a negative coping mechanism.

H.A., a 54-year-old married woman from Tulkarm, stated while she was mentioning the reasons that contributed in increasing his aggressive behavior, by saying, “The main reason is that he was prisoned, and the other reason is the lack of employment.” In addition, I.M., a 59-year-old widowed woman from Balata camp, added: “Poverty, numerous demands, lack of employment, and the news we see of martyrdom, arrests, killings, and beatings also it has an impact on us and increased violence.”

Figure 8

Data-Driven Module for the Fifth Theme



Note: The main theme is in dark green colour, the subthemes in light green colour.

Figure 8 summarizes the fifth theme and its associated subthemes. Apart from political violence and political trauma, additional factors were identified as risk factors for GBV against females. These include cultural gender roles, lack of knowledge about GBV & human rights, lack of problem solving competences, lack of social support, lack of assertive behavior in males, political groups, and socio-economic factors. The content analysis showed that the subtheme

“lack of knowledge about GBV & their rights” was the most frequent one compared to the other subthemes.

Theme 6- “Protective factors against GBV”

On the contrary of the risk factors of GBV, another theme has emerged from the analysis; “protective factors against GBV.” In which these factors according to the narratives of the participants found to help them in dealing with violence against them, or to mitigate its effect on them. The followed mentioned subthemes are discussing these factors in details.

Cognitive- behavioral coping. The current subtheme that emerged from the analysis of females’ narratives, highlighting behavioral activities that helped them cope with distress after experiencing violence. Conversely, cognitive restructuring in the perpetrators contributed to stopping the violence.

T.A., a 43-year-old married woman from Nour-Shams camp, described what she usually does when she feels under pressure after quarreling with her husband: “I really love walking. Whenever I feel stressed, I start walking long distances without feeling tired, and I ride horses whenever I feel stressed.” On the other hand, S.H., a 22-year-old single female from Tulkarm camp said:

> My brother, when he gets angry, has come to understand that he needs to be rational and support us. He has realized that we don't have to live through what he is experiencing, and that he is the one who chose this path for himself.

Moreover, the females mentioned various problem-solving techniques they adopted to avoid exposure to violence. These included avoiding the perpetrator, employing diplomatic strategies to understand his perspective, leaving the place where he stays, showing an assertive behavior and/or seeking intervention from a third party to stop the violence.

In this regard, S.A., a 28-year-old divorced woman from Tulkarm stated:

> By being diplomatic, you need to be diplomatic in your speech. You need to '[6]Tokhdeh ala qad aqluoh', so you can understand how he thinks and what's in his mind so you can understand how to deal with him. Otherwise, no.

In addition, M.U., a 48-year-old married woman from Balata camp, mentioned: "Because I started treating him the same way he treated me. When he stopped saying nice things to me, I stopped saying nice things to him. When he stopped caring, I stopped caring. This also had an impact." Furthermore, S.H., a 22-year-old single woman from Tulkarm, described her efforts to stop her brother's aggressive behavior towards them. She explained that her brother, who had been in prison, started to adopt an identification mechanism by trying to control them. She said, "The last time I told my brother that we are not in a prison, his response was to stay quiet because it is logical. We should not live this way; it does not work."

Feelings of empathy. Having feelings of empathy toward the perpetrator or the general family situation, and understanding what they went through due to experiencing political violence, played an important role in mitigating the psychological effects on the participants. When family members became aware of the impact of political violence on the perpetrator and what they had endured, they began to show empathy, realizing that the perpetrator needed help and that this behavior was not reflective of their true nature. Conversely, when the perpetrators began to notice how their family members or wives were affected by their behaviors, they started to feel sorry for them and began to change.

In this regard, M.U., a 48-year-old married woman from Balata camp, stated: "When my husband saw how I was affected, he wanted to help me. He started telling me to go join

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[6] Tokhdeh ala qad aqluoh means to try to understand him, and avoid engaging in any argument with him.

organizations, express my opinions, and that he wanted me to go back to how I used to be." While, S.A., a 28-year-old divorced woman from Tulkarm, mentioned:

> I started to see how everyone started to think, and how my sisters and brother started to turn against each other, so I was forced to overcome it because I couldn't stand to see my siblings against each other. I couldn't be weaker than them; I had to be stronger.

In the first quote, the participant's husband began to develop feelings of empathy toward her after noticing the effects of his abuse on her. She had previously been very active in society and involved in various community institutions. However, he became controlling and abusive towards her following the death of his brother, who was killed by Israelis. While, the second quote illustrates how the participant, despite experiencing violence from her brother, chose to understand him and not turn against him like her sisters did. She decided to bring them together and tried to understand him.

Mental health services. Females talked about the importance of receiving mental health services, and those who were already receiving mental health services stressed its role in improving their mental health status.

I.M., a 59-year-old widowed woman from Balata camp said:

> The mental health services, because I used to go for therapy and attending my sessions made me feel comfortable, because sometimes I did not like to talk to my children, friends, or family because I did not want anyone to bear my burden.

In addition, W.A., a 22-year-old single female from Tulkarm, stated:

> After what happened, If a doctor or a specialist came and sat with each one of us, talked to us, improved our mental state, and relieved the trauma we were experiencing, the situation could have been better, but no one cared.

Religiosity. Some of the participants tried to cope by practicing religious rituals such as praying, consoling themselves by reminding themselves of quotes from the Holy Quran that remind them of the rewards for patient people, and by their belief in God. This is expressed in the followed quotes.

I.M., a 59-year-old widowed woman from Balata camp, said: “With the help from Allah and our patience, we could overcome the difficulties.” Also, she added elsewhere, “I used to pray for Allah to be with us.”

Social support. Help from others, including family members, friends, and societal institutions, played a significant role in overcoming or stopping the violence toward them.

O.J., a 60-year-old widowed woman from Illar village said:

> One day, while my son was in prison, I got very tired and could not keep up with my work. My husband refused to take me to the hospital. That day, my son called me from prison and started asking me what I was doing. I began by telling him about what was happening with me. He said, 'Mom, what are you saying!' That day, he called his friend and asked him to take me to the doctor.

Financial and self-empowering. Some females after being exposed to violence and in order to stop it, they tried strengthening themselves by totally depending on themselves to find a way to stop it. Also, they narrated the important role of empowering women financially, so they can support themselves and to stop the violence or at least to be a coping strategy by spending time in work away from the perpetrator, and maybe if it was a group work targeting victims of violence, would be a good opportunity to express their feeling.

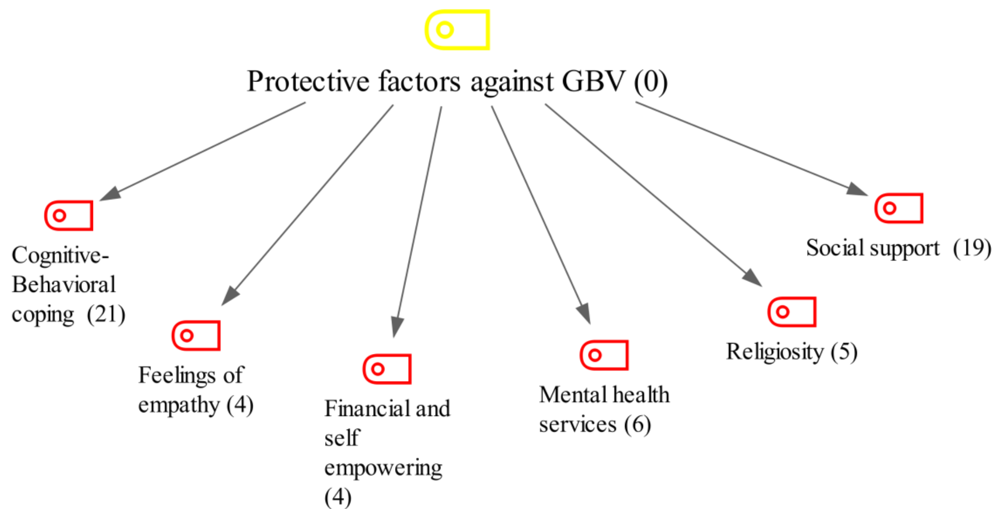
M.U., a 48-year-old married woman from Balata camp, mentioned:

> It is also very important that institutions provide financial support and that it be collective and through projects. This means not just giving money, but employing people in collective projects. It is important that these projects are collective, not individual, so that the sole aim isn't just making some money for oneself.

While, O.J., a 60-year-old widowed woman stated: “I strengthened myself on my own and did not rely on my husband.”

Figure 9

Data-Driven Module for the Sixth Theme



Note: The main theme is in yellow colour, the subthemes in red colour.

As illustrated in Figure 9, the sixth theme that emerged from the data of female participants was "protective factors against GBV". This theme comprised six subthemes: Cognitive-behavioral coping, feelings of empathy, financial and self-empowering, mental health services, religiosity, and social support. Content analysis revealed that cognitive-behavioral coping was more frequently mentioned in the narratives of females compared to the other subthemes.

Theme 7- "Psychological impact of GBV"

The seventh and final theme that emerged from the TCA of female interviews is the psychological impact of GBV, which highlights the effect on the mental health of participants who experienced GBV. Six subthemes emerged from this theme, discussing these mental health outcomes according to the participants' narratives.

Anxiety, depression, and traumatic symptoms. Some of the participants reported suffering from trauma symptoms as a result of experiencing GBV. As O.J. 60-year-old widowed woman from Illar village said: "I can never forget, I always remember what they did to me. '[7]Illa el-'asa ma bentasah'." According to this quote, it seems that O.J. is exhibiting symptoms of trauma, specifically intrusion and a persistent negative emotional state, after experiencing GBV from her husband, father, family-in-law, and the local society.

Furthermore, O.M., a 45-year-old married woman from Jenin camp, stated: "I cannot stand myself, and I prefer to stay alone. He keeps calling me, but I just cannot take it anymore." Referring to the words of O.M., it seems that she is exhibiting social withdrawal by saying 'I prefer to stay alone,' and avoidance by expressing her desire to stay alone, as sitting with her husband may remind her of his aggressive behavior towards her and provoke negative feelings. Moreover, she seems to show hyperarousal through the frustration expressed in 'I just cannot take it anymore,' which indicates irritability and sensitivity. These symptoms are often associated with hyperarousal.

While, One participant reported feeling anxious and stressed, as most of the time she was thinking of what might happen, and what her husband may do, as he is the one who used to abuse her. She stated: "When I wanted to sit by myself and drink coffee, for example, I could not do this anymore. I am always on edge and thinking about what may happen next."

Furthermore, Feeling sad, feeling guilty, feeling hopeless, and isolating themselves from others were among the symptoms that some participants began to show after being abused. They felt so sad that they would cry most of the time, and they felt guilty as they started to blame

[7] Illa el-'asa ma bentasah means that sorrow cannot be forgotten.

themselves for accepting such violence. Moreover, they began to prefer being alone and isolating themselves from others, as they could no longer enjoy social interactions.

In this regard, T.A., a 43-year-old married woman from Nour-Shams camp, said: “I feel myself helpless; not able to do anything.” She also added, “I cry a lot, and sometimes I faint from the stress. One time, I fainted and they took me to the hospital. The doctor told me these are symptoms of a stroke.”

Low self-perception. low self-esteem, low self-concept, and low self-confidence are found to be negative effects of experiencing GBV, as narrated by some of the participants. They became less confident about themselves and felt that their personality had changed to the extent that they started to see themselves as if they had become another person. The following quote exemplifies this subtheme:

> It is like my only role in life is as a wife and mother, under the control of others, ‘[8]Rouhi rouhi, taali taali.’ I am talking about myself, my personality has vanished, and at the age of 30, which is when a woman should feel her independence, identity, and personality, my personality has vanished. (M.U., a 48-year-old married woman from Balata camp).

After experiencing mainly psychological violence from her husband, this participant started to feel as if she were becoming someone else. She felt totally controlled, which was the complete opposite of what she used to be.

Feelings of humiliation. One participant reported that she started to feel humiliated as a result of psychological and emotional abuse from her husband. She studied art and used to draw and paint, but after the abuse, she couldn’t continue. She explained that drawing requires dignity, and after feeling humiliated, she felt she had lost that dignity. This is clarified in her statement:

> Drawing requires dignity, and I no longer feel that I have any dignity. My dignity does not mean that my husband lets me go wherever I want or not; my dignity is when I speak

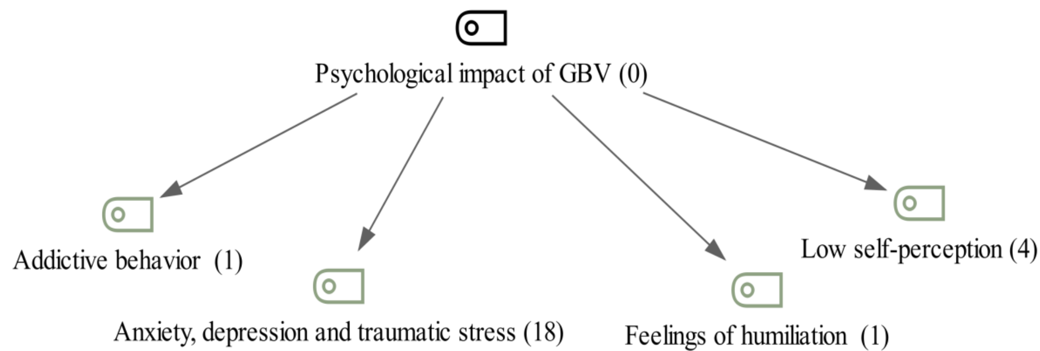
[8] Rouhi rouhi, taali taali, means that someone is completely following orders and is totally controlled.

and my husband listens to me and respects me. The respect was not there. (M.U., a 48-year-old married woman from Balata camp).

Addictive behavior. One of the participants reported that she started smoking after experiencing political violence and violence from her husband, as they were frequently quarrelling. Due to the persistent stress, she decided to start smoking. T.A., a 43-year-old married woman from Nour-Shams camp, said: "I smoke because of the stress, and I feel that smoking provides a lot of relief, not just a little; it brings comfort."

Figure 10

Data-Driven Module for the Seventh Theme



Note: The main theme is in black colour, the subthemes in gray colour.

Figure 10 summarizes the seventh theme and the subthemes that emerged. This theme comprised six subthemes: Addictive behavior, anxiety, depression, and traumatic stress, feelings of humiliation, and low self-perception. Content analysis revealed that anxiety, depression, and traumatic stress was the most frequent subtheme among all those that emerged within the current theme.

3.3.5.2 Results from males' interviews

Theme 1- "Political violence"

The first theme that emerged from the TCA of males' interviews is political violence. This theme comprises two subthemes: direct exposure and indirect exposure. Participants reported experiencing various political traumatic events, either directly or indirectly. These events included being injured, losing loved ones due to political violence, being arrested, threatened, tortured, losing land, being detained and deprived of food, having their homes invaded, being restricted from moving between cities at checkpoints, having family members injured, experiencing economic political violence, and enduring continued closures. The subthemes will discuss these incidents in depth through the provided quotes.

Direct exposure. The first subtheme that emerged from this theme is direct exposure. It describes the participants' direct exposure to political traumatic events, including being injured, tortured, arrested, detained, and deprived of food.

R.A., a 45-year-old married man from Hebron said:

> The last assault on me was a verbal and physical assault three years ago during their holidays and celebrations. They entered our old town and stayed for about six hours, and it could happen during this period as well. They placed the army at my shop's entrance, and the settlers passed by my shop's door. The settlers started insulting me and tampering with my merchandise. I told one of them not to touch the tray, but he started insulting me, using every kind of offensive language possible, and they pushed me back into the shop. About 5-10 minutes later, when the army heard the commotion at my shop's entrance, they intervened and pulled the settlers away. One of them threatened me, saying, 'You should be killed. These shops in the old town are all ours. People like you should noteven live here. You are here to be killed.' But I responded, 'When you know who you really are, then you can come and talk to me.'

In the previous quote, one of the participants described an assault by settlers in the old city of Hebron. They verbally assaulted him with offensive language, told him he did not deserve to live, and threatened to kill him. They also physically assaulted him by pushing him.

While, N.A., 47-year-old married man from Tulkarm camp, mentioned:

> They started throwing food to us over the fence while we were detained. They would throw it into the courtyard where we were being held, and I do not need to tell you that the food was just frozen sausages, not cooked, of course.

In the above quote, the participant described a traumatic event he experienced. He was detained with others in a schoolyard by the Israeli army during their invasion of Tulkarm camp, where he lives. After being deprived of food for 24 hours, they were offered only frozen, uncooked sausages.

Indirect exposure. Some participants talked about the indirect exposure to political violence by Israeli soldiers. In this regard, A.J., a 50-year-old married man from Nour-Shams camp stated:

> My brother was severely injured when they came to arrest him. The first time they came to the hospital, they wanted to arrest my brother. That day, they brought my father and mother in a jeep and started threatening my brother that if he did not turn himself in, they would kill them. Then, they arrested him at my sister's house and took him away without any clothes on.

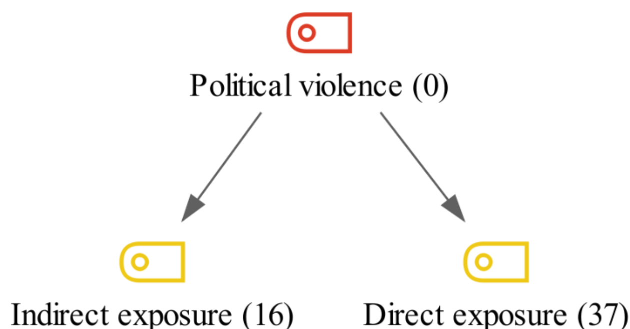
In this quote, the participant described a traumatic incident involving his brother, who was injured by Israeli soldiers and taken to the hospital for treatment. The soldiers tried to arrest him there, threatening to kill him if he did not turn himself in. The participant also recounted another incident when the Israeli army threatened to kill his parents if their son did not surrender. Additionally, they invaded his sister's house to arrest his brother, taking him away without any clothes on.

Moreover, B.H., a 40-year-old divorced man from Hebron, mentioned: “When you see children being arrested, when you see a soldier assaulting children, and when you see a soldier stopping about 30 students at a checkpoint, keeping the checkpoint closed for an hour or two while they remain standing.” In this quote the participant described an indirect exposure to

several political violent events, including seeing soldiers assaulting children, stopping students at the checkpoint and closing it for more than one hour, and arresting children.

Figure 11

Data-Driven Module for the First Theme



Note: The main theme is in red colour, the subthemes in yellow colour.

As illustrated in Figure 11, the first theme that emerged from the TCA of male interviews is political violence. This theme includes two subthemes: indirect and direct exposure to political violence. The content analysis showed that direct exposure was more frequent than indirect exposure.

Theme 2- "Political trauma and GBV perpetration"

Male participants described experiencing several trauma symptoms in their narratives due to exposure to political violence. They reported anxiety, stress, post-traumatic stress symptoms, and feelings of humiliation. Furthermore, they indicated how these trauma symptoms contributed to their perpetration of gender-based violence (GBV). The researcher explored these symptoms in detail in the subsequent subthemes.

Fear, anxiety, and traumatic stress. It emerged as a subtheme of political trauma, with some male participants reporting fear, anxiety, and stress following exposure to the traumatic event. They became afraid of what might happen to them and, specifically, to their family

members. Additionally, they reported being anxious and stressed due to restrictions on various aspects of life, such as work and movement. Furthermore, they mentioned that they think about the political situation most of the time.

M.E., a 40-year-old married man from East Jerusalem stated:

> Now life is difficult, and fear controls us, especially after the Sheikh Jarrah incidents. Why the weapons and violence? We have become afraid, and I am afraid to send my children to school. It is difficult to move around Jerusalem because I am Arab, and I am afraid to walk in the streets of Jerusalem in particular.

In the mentioned quote, a man from East Jerusalem expressed his deep concern about what might happen to them, particularly to his children, to the extent that he is afraid to send them to school because it is unsafe. He is also anxious and stressed about moving around Jerusalem, as he fears being attacked by settlers in the streets because he is Palestinian.

Furthermore, A.O., a 46-year-old married man from Salfit said: “You feel as if you are a burden to those around you because they become tied to you through a permit, travel, or even opening a bank account.” As a former inmate of Israeli prisons, this participant, like others in similar circumstances, experienced significant sanctions. These penalties also affected his family, limiting their travel outside of Palestine, including denying them access to Jerusalem, and preventing them from opening a bank account due to their connection with him. These sanctions left him feeling stressed and anxious, compounded by feelings of guilt for the difficulties his family endured as they are linked to him.

In addition, After exposure to political traumatic events, some participants began exhibiting symptoms of PTSD, including irritability, insomnia, avoidance, re-experiencing, negative emotions, emotional numbing, and feelings of guilt. These symptoms were found to increase the likelihood of males being aggressive towards their families, especially their wives. The following quote documents this in depth.

A.A., a 36-year-old married man from Tulkarm, stated:

> A while ago, I used to get excessively angry, and the main reason is not because I am naturally aggressive, but it was more like a ‘[9]Farfatet Rouh’. When I was coming back home and found myself unable to provide my family with the basic needs of life, sometimes my wife or child could not understand this. It is their right, for sure, that I provide them with everything. But due to the stress, I started to yell, my voice would rise, and sometimes I ended up hitting my wife. Most of the time, we were quarreling.

In the above mentioned quote, the participant expressed how his negative feelings and feeling suffocated, as a result of being exposed to economic political violence. The Israeli government imposing sanctions on the Palestinian authority resulted in this participant being unable to receive his salary and meet the needs of his family. This led him to feel suffocated, which caused him to become aggressive.

Furthermore, R.A., a 40-year-old married man from Nour-shams camp, said:

> I became angry in an abnormal way, to the point where my wife sometimes tells me I'm crazy. I usually shout and leave the house, but the important thing is that afterwards I come back, apologize, and admit my mistake. You know, there are things that really make me lose my temper. For example, I stopped following the news and unfollowed news pages on Facebook because they made me angry.

In the previous quotation, the participant recounted experiencing several trauma reactions, including hyperarousal, avoidance behavior, intrusive thoughts, and emotional dysregulation. Avoidance behavior is evident in his decision to stop following the news, while intrusive thoughts are illustrated when he discusses how certain news triggers him, possibly indicating intrusive memories related to his past experience as a prisoner under the Israelis. Emotional dysregulation is evident in his anger, which is connected to the hyperarousal symptom, as he describes shouting mainly at his wife, and feeling overwhelmed.

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[9] Farfatet Rouh means that someone feels overwhelmed and suffocated to the extent that he cannot tolerate anything.

Feelings of humiliation. Current subtheme describes the feelings of humiliation that they have after experiencing political violence whether it was a verbal or physical assault. It was described as follows.

R.A., a 45-year-old married man from Hebron, mentioned: "For me, this is something terrible. This feeling is to the extent that I say if he killed me it's easier than him humiliating me or assaulting me physically." In this quote, the participant conveyed his feelings of humiliation when he was physically attacked by a very young settler. He could not defend himself for fear of being arrested or shot.

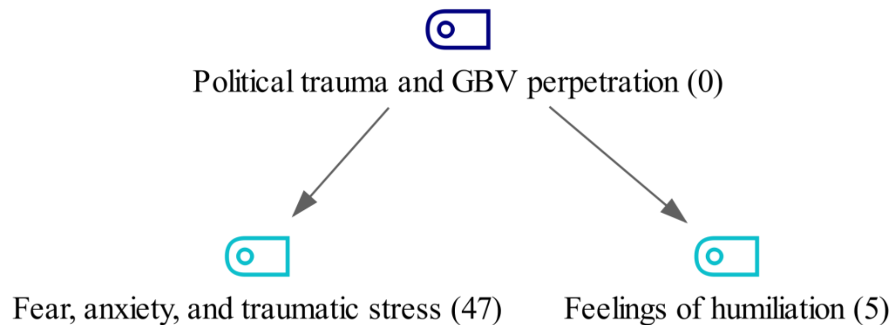
In addition, B.H., a 40-year-old divorced man from Hebron, stated: "You feel the humiliation, I feel myself worthless, I feel insulted, and having no value. You feel as if you are not a citizen, no one is there to protect you or even make you feel like a citizen." This quote conveys the feelings of humiliation and worthlessness that this participant is experiencing as a result of being exposed to several traumatic events. These include humiliating checks at checkpoints and being denied access to his house upon returning from work due to frequent area closures imposed. And he added:

> So, you feel anger and you want to live just like everyone else, meaning all the negative feelings are within you, and this anger could lead to violence. It means you might end up doing something and then stop it, meaning this violence could be directed towards someone weaker than you, possibly your family.

By elaborating, he discussed how feelings of humiliation induce aggressive behavior and anger in him.

Figure 12

Data-Driven Module for the Second Theme



Note: The main theme is in dark blue colour, the subthemes in light blue colour.

Figure 12 summarizes the second emerged theme, "political trauma and GBV perpetration", along with its subthemes characterized by feelings of humiliation, and fear, anxiety, and traumatic stress. Content analysis revealed that the subtheme "fear, anxiety, and traumatic stress" is the most frequent compared to the others.

Theme 3- "Types of GBV perpetration"

Regarding exposure to political violence and its psychological effects, males reported committing various forms of GBV. The violence was inflicted not only on their wives but also on other family members, colleagues, and friends. Further details will be elaborated in the subsequent subthemes.

Psychological violence. Some participants recounted that they became aggressive after experiencing political violence and its psychological impact. They noted that their aggression was directed at people in general, but predominantly at their wives, manifesting as verbal abuse and attempts to control them.

A.A., a 36-year-old married man from Tulkarm, said:

> When I got angry, my anger was directed at everyone, but it was most noticeable towards my family members who were at home and in front of me all the time. I could avoid other people, but I could not avoid my family. It is not that the woman is targeted, it is just that she is there and in front of me most of the time. I even remember that once I was about to hit my boss. I could not tolerate anything; there was nothing that could control me. I was just waiting to hear a word to use as an excuse to take my frustration out on someone.

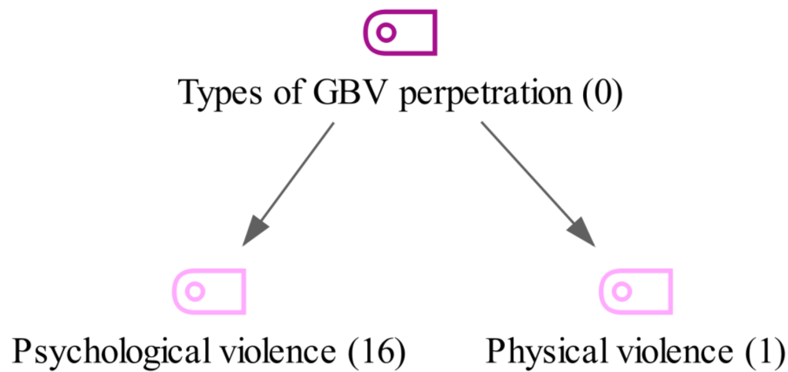
The participant reported that he became so angry that nothing could control him, leading to aggressive behavior towards everyone, including his wife and even his boss at work. He frequently yelled and quarreled with his wife. According to him, his aggressive behavior was primarily directed at his wife because she was always in front of him and he couldn't avoid her the same as other people, not because he intended to target her deliberately.

While, M.E., a 35-year-old married man from East Jerusalem, stated: "These circumstances we are living through have made me more harsh with my family, particularly when discussing matters that oppose my viewpoint." The participant expressed in this quote how the difficult living conditions under the Israeli occupation in East Jerusalem affected him, leading him to become aggressive and attempt to control his family members, especially when they contradicted his ideas.

Physical violence. The second subtheme that emerged from the current theme is physical violence. One participant reported that he began hitting his wife due to feelings of frustration stemming from experiencing political and economic violence. He mentioned: "I ended up hitting my wife, and most of the time we were arguing and quarrelling, which led to pushing or hitting her" (A.A., a 36-year-old married man from Tulkarm).

Figure 13

Data-Driven Module for the Third Theme



Note: The main theme is in purple colour, the subthemes in pink colour.

As shown in Figure 13, the third theme that emerged from the data of male participants was "types of GBV perpetration". This theme comprised two subthemes: psychological violence and physical violence. Content analysis revealed that psychological violence was more frequently mentioned in the narratives of males compared to the other subtheme.

Theme 4- "Risk factors for GBV perpetration"

The fourth theme that emerged from the CTA is the risk factors for GBV perpetration. In addition to political violence and its psychological impacts, several factors were identified as contributing to or increasing the likelihood of GBV perpetration in the Palestinian context from the perspective of males. The following subthemes discuss these factors in depth.

Prolonged proximity to the victim. This subtheme describes how being in the same place with the victim for extended periods may increase the likelihood of abuse. Even if the perpetrator does not initially consider her a target, frequent exposure reduces the chance to avoid her, especially if she is the wife, since they cannot stay outside the house all the time. This is shown in one of the participants' narratives.

A.A., a 36-year-old married man from Tulkarm, said: “The target here is not the woman; the target is everyone. Sometimes, since the woman or wife is the one confronting and arguing, out of anger, you might hit her. But for me, the violence was directed at everyone”. He also added, “I could avoid other people, but I could not avoid my family.”

Emotionally vulnerable. According to some participants, when men are fragile psychologically, they may tend to abuse women. They may do this because they feel weak and seek to project their vulnerability onto someone else.

J.A., a 37-year-old married man from Illar village, mentioned: “Because he is not a real man; if he were a real man, he would not take it out on a woman.” In this quote, the participant clarified his point of view, stating that if a man is strong in all aspects, he will not project his weaknesses onto women and will not abuse them.

Moreover, A.A., a 36-year-old married man from Tulkarm, added:

> Listen, I want to speak generally. If someone dominates over a woman and their goal is the woman, seeing her as weak and without support, and they exert control over her, then this is because they are weak in all aspects.

Lack of awareness about GBV. It emerged as a subtheme within the current theme. When asked about their knowledge of GBV, some participants replied that they did not understand what it meant, while others began by discussing reasons for GBV perpetration. Additionally, some defined it as the deprivation of women's rights. When males are unaware of the meaning of GBV and fail to recognize specific types of violence as aggressive behavior, they may continue to engage in it without acknowledging its aggressiveness.

In this regard, R.A., a 40-year-old married man from Nour-shams camp, responded when I asked him about GBV and violence against women, “I do not know anything about these concepts.” While, R.A., a 45-year-old married man from Hebron, expressed his views on GBV by saying:

> If the occupation pressures you through relatives and punishes you indirectly, for example, through economic means like imposing restrictions on the area or region where you live, this puts social pressure on you. It takes, for instance, detaining your father or uncle. So, what is the connection? It pressures you to comply with what they want through other people.

Lack of recreational facilities. One of the participants believed that the absence of recreational facilities and the family's poor financial status, which limits options for places to spend quality time together, adds pressure to families, often resulting in frequent quarrels. He said:

> The recreational aspect, for example, when your children do not have outings, this pressures the person and they feel bored, constrained, and continue to be suffocated from this life. This is due to family disputes within the household because everyone is under pressure, especially the children who don't understand this. (N.A., a 47-year-old married man from Tulkarm camp).

Vulnerable groups. According to participants' narratives, certain groups, particularly females, are viewed as more vulnerable, which some individuals perceive as a justification for abusing them. This belief stems from the notion that they are perceived as weak and unlikely to retaliate.

M.E., a 35-year-old married man from East Jerusalem, described the victim as someone who is weak and unable to fight back. He explained that this perception leads some individuals to abuse such groups of people, stating: "The victim is perceived as weak and unable to fight back." While, N.A., a 47-year-old married man from Tulkarm camp, mentioned: "From my perspective, a person's wife is the one who can bear and withstand the pressure they face, regardless of the cause of that pressure."

Socio-economic factors. Regarding this subtheme, some of the participants talked about some socio-economic factors that contributes to GBV perpetration. These factors included financial status, family size, and type of work. The larger the family size and the lower the financial status, the more pressure is placed on the family, often leading the man to become

aggressive towards the family. Additionally, the type of work was identified as a risk factor for GBV perpetration. For instance, some participants working in the medical field mentioned that working in a hospital adds stress, particularly due to the unstable political situation. The unpredictability of work-related situations contributes to their stress, which may lead to aggressive behavior.

A.A., a 36-year-old married man from Tulkarm, said:

> Since I work in the humanitarian field, it means I have to be present in any disaster or catastrophe. If there is a bombing by the occupation, I still have to go to work. Regardless of your circumstances, you have to go to work. When you work in the medical field, you cannot say no because these are humanitarian cases, with casualties and martyrs, and you have to be available at all times. You are not allowed to leave your city without notifying. All of this puts a lot of pressure on a person and can lead to violence.

In addition, N.A., a 47-year-old married man from Tulkarm camp, said:

> When the economy is in ruins and the government is unable to pay salaries, and my family consists of four children, my wife, and I, and I am also responsible for my sister, this is considered a small, simple family in Palestinian society. When your salary is 3000 shekels and the government is unable to provide it due to a financial deficit, and you are unable to provide the basic requirements for your home like gas and electricity, this reduces thinking about intimate relationships, for example, conversations and family gatherings, because the focus is occupied with the essential or fundamental things, let me say. If the mother is not happy and the children are not happy, so even the simplest arguments turn into big problems, and all of this is because of other pressures. I see these as simple problems or simple topics, but there is something more important, and because of it, we cope with these problems in this way.

Gender roles. According to the narratives of some participants, gender roles have emerged as a risk factor for GBV perpetration. Having stereotypes for the roles of males and females in society puts additional pressure on them, as they feel responsible to fulfill these roles. If they are unable to do so, they may feel frustrated and resort to aggressive behavior. Additionally, this expectation of specific roles leads partners to become aggressive towards each other when they fail to fulfill these duties.

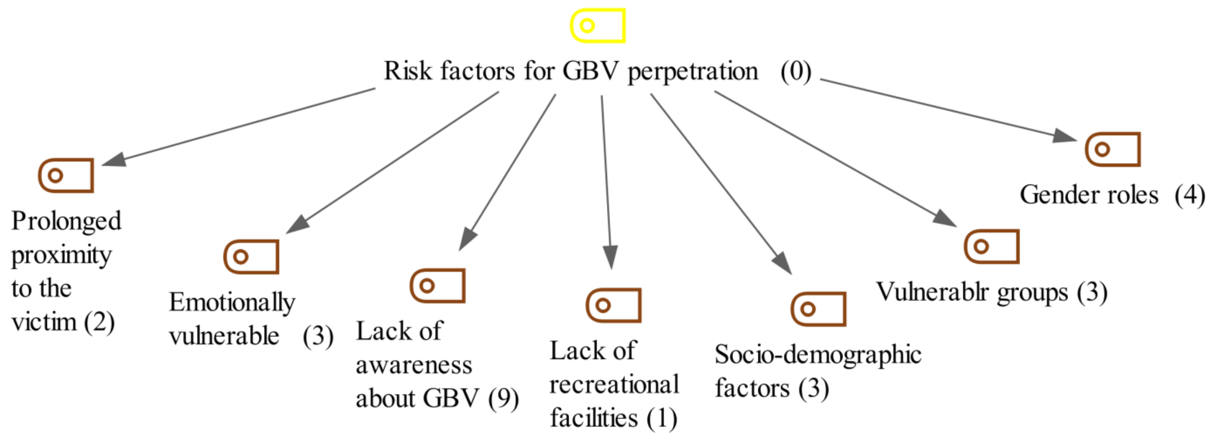
Regarding this, J.A., a 37-year-old married man from Illar village, mentioned: “My wife is not an irresponsible person. Why would I get angry at her? On the contrary, she takes care of my mother, even more than I do.”

Furthermore, A.A., a 36-year-old married man from Tulkarm, stated:

> When I came back home and realized that I could not meet the basic needs of my family, my wife or my child did not understand this, and they had the right to expect me to provide everything for them. However, due to stress, I started to yell, my voice rose, and I ended up hitting my wife.

Figure 14

Data-Driven Module for the Fourth Theme



Note: The main theme is in yellow colour, the subthemes in yellow colour.

Figure 14 presents an overview of the fourth theme and its corresponding subthemes. This theme included seven subthemes: Gender roles, socio-economic factors, vulnerable group, lack of recreational facilities, lack of awareness about GBV, emotional vulnerability, and prolonged proximity to the victim. Content analysis showed that lack of awareness about GBV was the most prevalent subtheme among all those identified within this theme.

Theme 5- "Protective factors against GBV"

On the contrary of the risk factors of GBV, another theme has emerged from the analysis; "protective factors against GBV." According to the participants' narratives, these factors help them manage their mental distress and avoid aggression. The following subthemes discuss these protective factors in detail.

Cognitive-behavioral coping. Some of the participants reported adopting several cognitive-behavioral strategies, such as behavioral activation; engaging in activities like exercising, taking showers, reading, working, spending time alone, writing, and talking to friends. Additionally, participants used problem-solving techniques, improved their communication skills, and worked on enhancing their self-control. Some strategies were specifically related to women's roles, such as avoiding the perpetrator, knowing how to deal with him when he is angry, and helping their husbands by recognizing and addressing their psychological struggles.

A.J., a 50-year-old married man from Nour-shams camp, stated:

> I might go out of the house, take a walk, or relax by sleeping. I might take a shower, or start thinking about something else, another topic I mean, because if we stay stressed, we harm ourselves and those around us.

In the previous quotation, the participant mentions some strategies he adopts when becoming angry to avoid reflecting his feelings on others, specifically his family members.

In addition, A.A., a 36-year-old married man from Tulkarm, said:

> The greatest credit goes to my wife, and regardless of how, you want me to tell you how she helped me. I can tell you that she dealt with me the way you are dealing with me now, as a participant, or call it whatever you want. That's how she treated me. Sure, sometimes she would get angry, and sometimes she wouldn't be pleased, but there were things she understood better than I did, things I couldn't notice. Based on what she would say, I would change my behavior, but I would not tell her; I kept it to myself. I remember there was not a single time I drove without getting into a fight with two or three people on the street. But now, I see the mistakes clearly and can control myself better.

Through the words of this participant, he described how his wife helped him deal with his anger issues. He also described how he helped himself by considering what his wife was saying and working on improving his self-control.

Socio-demographic factors. In some of the narratives, the participants mentioned several socio-demographic factors that help reduce the probability of being aggressive. These factors include older age, good financial status, and being educated.

> A.A., a 36-year-old married man from Tulkarm, mentioned: " '[10]Alhamdulillah', my financial situation has improved, and this has helped me. But, I consider it as a secondary factor."
>
> While, R.A., a 45-year-old married man from Hebron stated: "The older a person gets, the more they understand others." Also, he added elsewhere: "My family has not changed because I am educated and aware of what is happening. I do not take out my emotions on my wife or children."

Shared trauma. Some of the participants mentioned that even when they felt inclined to behave aggressively toward their families, they were able to prevent themselves. They could understand their family members' feelings and relate to their emotions and struggles, especially since they shared the same trauma.

In this regard, R.A., a 45-year-old married man from Hebron, stated: "In our household, we support each other, knowing that this is an occupation, and we expect everything from Israelis, so it does not affect our home." While, J.A., a 37-year-old married man from Illar mentioned:

> When I was in prison, I did not care, my mom and dad were talking to me, but was starting to fight with them easily. But after I got out of the prison and saw how they

[10] Alhamdulillah means thanks God.

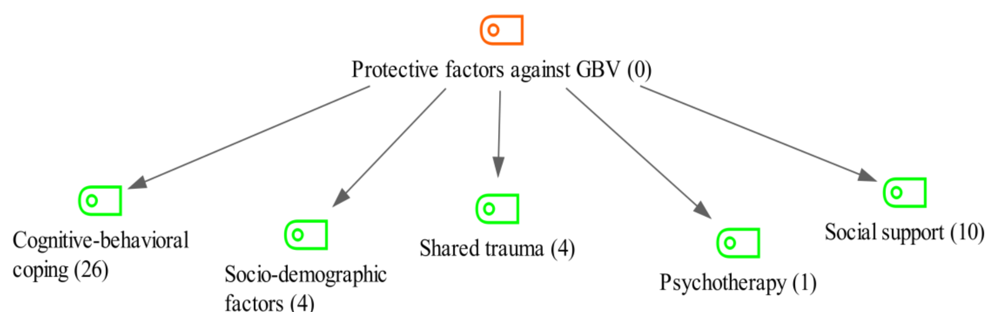
suffered, honestly, they are strong, especially my mom. My dad was someone who did not want any trouble with people. If anyone came to talk about something, my mom would face them. So, now, whatever she asks or says ‘[11]Kilmatha ma betsier tintein’.

Psychotherapy. One of the participants mentioned that after therapy he became much better and that he can control his anger now. He said: “I entered psychotherapy, and this helped a lot” (B.H., a 40-year-old divorced man from Hebron).

Social support. It emerged as the fifth and final subtheme under the theme of protective factors against GBV. Some participants emphasized the significant role of social support from family, wives, and friends in improving their mental health and preventing aggressive behavior. B.H., a 40-year-old divorced man from Hebron, stated: “For me, the most important thing I think about when I'm upset like this is talking to my friends and ‘[12]bafish Qalbi’.” In addition, R.A., a 40-year-old married man from Nour-shams camp, said: “When I get angry, my wife calls my friend and tells him, 'Come and see R.A., he is losing his mind,' then I calm down after talking to him for a few words."

Figure 15

Data-Driven Module for the Fifth Theme



Note: The main theme is in orange colour, the subthemes in green colour.

[11] Kilmatha ma betsier tintein means that he does not say no to her. Whatever she says is considered as a must.
[12] bafish Qalbi means to express his emotions and talks about things that suffocate him.

Figure 15 summarizes the emerged subthemes from the fifth theme, "protective factors against GBV". The content analysis showed that cognitive-behavioral coping was the most frequent subtheme compared to the other subthemes.

3.3.5.3 Results from mental health care providers' interviews

Theme 1- "Political trauma"

The first theme identified from the TCA of mental health care providers (MHCPs) is political trauma. MHCPs described the various symptoms reported by their clients, both male and female, following exposure to politically traumatic events. These symptoms are categorized into four subthemes; emotional, behavioral, cognitive, and physical symptoms. The subsequent subthemes provide an in-depth discussion of these symptoms.

Physical symptoms. MHCPs noted that their clients reported various physical symptoms after experiencing political traumatic event, including excessive sweating, loss of appetite, heart palpitations, insomnia, and nausea. For instance, a female social worker with twelve years of experience, FI., stated: "They experience sweating, heart palpitations, and nausea, and I have had more than one person come to me with these symptoms." Meanwhile, SW, a female psychologist with over six years of experience in the field, added: "Women's symptoms were more related to emotions, such as eating disorders."

In the first quotation, the social worker noted that among the most common symptoms reported by her clients as a reaction to trauma are sweating, heart palpitations, and nausea. However, in the second quotation, the psychologist indicated that women tend to exhibit more emotional symptoms or symptoms primarily related to emotional processes, such as eating

disorders. It is worth noting that when she mentioned "eating disorders," she likely meant the loss of appetite rather than a diagnosed eating disorder.

Behavioral symptoms. The second subtheme that emerged from the current theme is behavioral symptoms. The MHCPs mentioned that clients, particularly males, frequently exhibited these symptoms. According to some MMHCPs, these symptoms included avoidance behavior, social withdrawal, and hyperarousal. The narratives of MHCPs revealed that reactions to trauma varied. Some clients reported engaging in avoidance behaviors, such as avoiding anything that might remind them of the traumatic events. Others began to withdraw socially and isolate themselves. Additionally, some clients exhibited hyperarousal symptoms, feeling as if they were constantly on edge, becoming overly sensitive and excessively aware of their surroundings. As a result, they often expressed these feelings through aggression and intense anger outbursts.

In this regard, SW, a female psychologist with over six years of experience in the field, said: “Whether people living in areas that are always tense or those living in areas with fewer events, I noticed that we had trauma symptoms, such as avoidance behaviors.” this regard, SW, a female psychologist with over six years of experience in the field, said: “Whether people are living in areas that are always tense or in areas with fewer events, I noticed that we had trauma symptoms, such as avoidance behaviors.” In this quote, the psychologist highlighted that her clients were reporting trauma symptoms regardless of whether they lived in areas with high political tension or areas with less intense political events. By using the word "we," the psychologist referred to her clients and may be to herself, possibly indicating that she is Palestinian or that she also experiences trauma symptoms.

In addition, BS., a male psychologist working in the field for more than eighteen years, stated: “You are talking about an unusual family environment. When this family has been exposed to such an event, you find or feel that they are constantly irritated, and this makes them always tense and having problems.” In this quote, the psychologist explains how some families who experienced political traumatic events usually become irritated and on edge. The whole atmosphere in the home often feels intense, and at any time, they may behave aggressively.

While, EB., a female psychologist working in the field for more than fourteen years, said: “Some of them develop communication and social relationship problems because they feel that they couldn't protect themselves and their children, so they start isolating themselves.” This psychologist stated that some of her clients usually started to isolate themselves as a trauma reaction, possibly because they felt helpless or ashamed that they couldn’t protect themselves or their children from the traumatic event.

Cognitive symptoms. According to the narratives of MHCPs, some of their clients reported experiencing cognitive symptoms characterized by distraction, difficulties in concentrating, memory problems, as well as re-experiencing symptoms such as flashbacks, nightmares, overthinking about the incident, and intrusive thoughts.

EB., a female psychologist with over fourteen years of experience in the field, described the symptoms reported by her clients after experiencing political traumatic events: “The symptoms vary; some people experienced disturbing nightmares, and had flashbacks, which are indicative of trauma. While others experienced difficulty concentrating, and distraction that resulted in their inability to make decisions and solve problems.” While, SW., a female psychologist with over six years of experience in the field, added: “Some individuals exhibited excessive thinking related to the event.”

In the previous quotations, the psychologists discussed how their clients' cognition was affected following exposure to traumatic events. Some clients reported becoming distracted and excessively preoccupied with the event, hindering their ability to make decisions or solve daily problems. Others experienced re-experiencing symptoms, such as vivid flashbacks and nightmares about the traumatic event.

Emotional symptoms. The fourth subtheme that emerged from the current theme is emotional symptoms. MHCPs discussed how some of their clients reported experiencing anxiety, depression, panic attacks, emotional numbness, feelings of frustration, and feelings of fear as a result of being exposed to a political traumatic event/s whether directly or indirectly.

FI., a female social worker, working in the filed for more than twelve years, stated:

> I want to tell you that 60% of people are affected by trauma, especially children, and there is also a significant percentage coming from young adults. They develop cases of panic attacks and anxiety disorders just by hearing the sound of the military plane, for example.

According to FI, based on her experience with clients, she found that 60% of them developed trauma symptoms, mainly anxiety and panic attacks. The majority of these symptoms were reported by children and young adults.

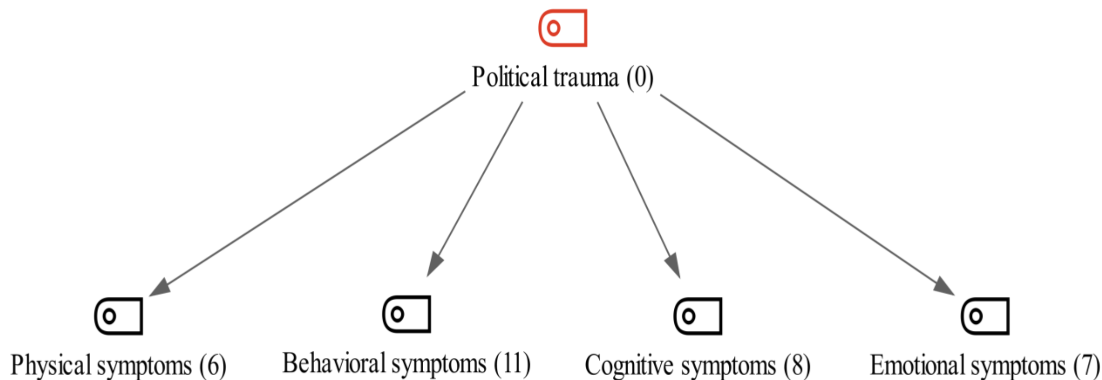
Furthermore, SW, a female psychologist with over six years of experience in the field, said: “For women, the symptoms they exhibit were more related to emotions like feelings of fear, frustration, or depressive symptoms.” In this quotation, the psychologist indicated that women tend to exhibit symptoms primarily related to emotions, such as symptoms of depression and fear. In contrast, men are more likely to display behavioral symptoms rather than emotional ones.

Moreover, SH., a female psychologist working in the field for more than 10 years, mentioned: “Some people have experienced emotional numbing, which they call adaptation, but

I call it emotional numbing." In this quotation the psychologist talked about some of her clients became numbed and not feeling anything after being to the political traumatic event.

Figure 16

Data-Driven Module for the First Theme



Note: The main theme is in red colour, the subthemes in black colour.

Figure 16 summarizes the first theme that emerged from the analysis of mental health care providers' interviews, which is called 'political trauma.' The subthemes under political trauma are physical symptoms, behavioral symptoms, cognitive symptoms, and emotional symptoms. Content analysis of the subthemes revealed that behavioral symptoms were the most frequent subtheme compared to the others.

Theme 2- "Political trauma and GBV"

The second theme that emerged from the TCA is 'political trauma and GBV.' This theme describes how MHCPs explained GBV in the context of political trauma. Specifically, it details how clients of MHCPs with trauma symptoms began to exhibit violence towards others, primarily their partners, regardless of gender. Additionally, it describes how females with trauma symptoms were at risk of experiencing violence. The followed subthemes explains this in depth.

Political trauma and GBV victimization. According to the narratives of MHCPs, women with political trauma are at greater risk of GBV victimization. When women suffer from these symptoms, they often experience functional impairments, such as an inability to meet their responsibilities, leading to increased aggression from males. Additionally, when these women are irritable and on edge, they may become aggressive towards their husbands, which can, in turn, provoke aggression from their husbands.

KA., a male psychologist working in the field for more than 15 years, said:

> The woman is part of society and follows the violent events caused by the occupation. Even if she does not witness them or isn't directly exposed to them, she sees them on television or social media. The scenes she watches are violent and she is directly affected by them. This impacts the woman's psyche, causing her to react differently towards her husband, and she becomes more vulnerable to experiencing violence from him.

In this quotation, the psychologist stated that when women are exposed to political violence, they may start to behave differently, often becoming angry with others. As a result, others, mainly their husbands, may not understand or tolerate this behavior, leading them to act aggressively towards the women.

Furthermore, MN., a female psychologist with more than twenty years of experience, mentioned based on her experience with her clients:

> If a woman is suffering from trauma and this affects her daily performance and role, any failing in meeting her responsibilities may increase the blame on her and impact her relationship with her children. Consequently, this can make her more vulnerable to violence, which significantly affects her mental health because it increases the blame on her.

According to MN., when women were unable to meet their responsibilities, especially towards their children, due to trauma symptoms, they became more vulnerable to experiencing GBV.

Political trauma and GBV perpetration. This subtheme elucidates that individuals, regardless of gender, may become aggressive towards others when they experience trauma following exposure to political violence.

In this regard, SW, a female psychologist with over six years of experience in the field, said:

> In some cases the violence was directed from women towards men, it was because women considered that the duty of the man is to protect them. In certain moments, women would become angry and resentful towards men because, for example, they were unable to protect them or their son who had martyred. Women might also recall previous family conflicts and bring them up as a result of the incident.

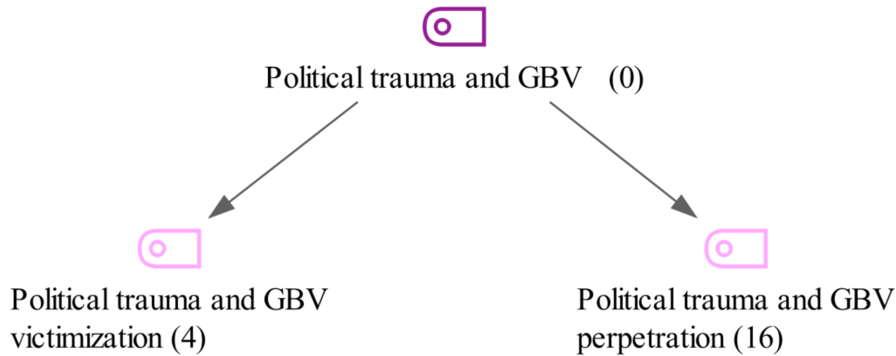
According to this quotation, when men were unable to fulfill their culturally imposed role of protecting women, and when women began to feel insecure as a result, they tended to manifest this insecurity through aggressive behavior towards men.

On the other hand, FI., a female social worker, working in the filed for more than twelve years, stated: “When a man is suffering from psychological trauma, it affects his work. Men, when they lose their jobs, tend to focus more on women, becoming more aggressive towards them.” While, BS., a male psychologist, working in the field for more than eighteen years, added by saying: “When a man is subjected to violence, he feels that his dignity has been affected and he has been humiliated. From a desire to regain a sense of control, he may lean towards abusing women.”

Based on the experiences of MHCPs with their clients, it was observed that when men feel humiliated as a trauma response, they may resort to violence against women in an attempt to regain a sense of control. Furthermore, when men's mental health is affected due to exposure to political violence, they may exhibit functional impairments, such as losing their jobs, which could lead to increased aggression towards women.

Figure 17

Data-Driven Module for the Second Theme



Note: The main theme is in purple colour, the subthemes in pink colour.

As illustrated in figure 17, the second emerged theme from TCA is 'political trauma and GBV,' featuring two subthemes: 'political trauma and GBV victimization' and 'political trauma and GBV perpetration.' Content analysis revealed that the subtheme 'political trauma and GBV perpetration' was more frequently mentioned than 'political trauma and GBV victimization.'

Theme 3- "Psychological impact of GBV"

MHCPs in the study identified various psychological impacts of GBV on Palestinian females. These include anxiety, depression, traumatic stress symptoms, obsessive-compulsive disorder (OCD) symptoms, psychosomatic symptoms, aggression, feelings of insecurity, and low self-perception.

Anxiety, depression, and traumatic stress. According to the narratives of MHCPs, the most prevalent psychological impact of GBV on their female clients includes emotional symptoms characterized by depression, anxiety, and traumatic stress. These clients often feel helpless and believe the abuse will never end, leading them to socially isolate and withdraw. Additionally, they frequently experience anxiety due to the unpredictability of the perpetrator's behavior. Traumatic symptoms also emerge, marked by feelings of guilt, as they blame

themselves because they think that they are the reason of being abused. This is coupled with self-destructive behaviors, where they neglect self-care and feel undeserving of it.

SM., a male clinical supervisor in psychology, working in the field for over sixteen years, said:

> Women who are subjected to violence, and from the cases that come to my mind, they developed self-destructive behaviors and they see themselves as undeserving of self-care, leading to clear self-neglect. We also observe many symptoms of depression, particularly characterized by feelings of helplessness. Additionally, we frequently see psychosomatic symptoms because some of these women do not have the time or opportunity to withdraw and isolate themselves due to their responsibilities, and thus, the issues manifest in their bodies.

Furthermore, SE., a female social worker, working in the field for over fifteen years, stated: “Women experience anxiety and stress.” While, BS., a male psychologist, working in the field for more than eighteen years, added: “The woman starts to think that she is the guilty, and begins to blame herself.”

Aggression. According to MHCPs, they stated that some of their female clients started to project violence onto others after being abused, mainly on their children. Which means that they may start to be aggressive with another vulnerable group such as their children.

SE., a female social worker, working in the field for over fifteen years, mentioned: “The woman starts to project her anger onto her children or onto other people.” Furthermore SM., a male clinical supervisor in psychology, working in the field for over sixteen years, stated: “The women become violent, it means that the women who are subjected to violence become violent themselves, and from the cases that come to my mind now, they became violent toward their children.”

According to the quotations of MHCPs, the cycle of violence is so clear, in which the abuse and violence is recurring and escalating over time.

Feeling insecure. Female clients reported through the narratives of MHCPs that they feel insecure. They do not expect the violence against them to stop, as political violence is difficult to halt. Consequently, they perceive that their condition will not change, and they anticipate continued abuse from males. Additionally, they feel insecure because the person who is supposed to protect and support them is abusing them, leading to a loss of feeling secure.

BS., a male psychologist, working in the field for more than eighteen years, said: “The most important thing that a woman loses is her sense of security, it means that she stops feeling safe.” Moreover, KA., a male psychologist working in the field for more than 15 years, stated when asked him how GBV affects Palestinian females: “They feels insecure, and they believe that this situation will not end, along with the ongoing occupation, which make them see that there is no solution to their problem.”

Low self-perception. MHCPs described how their clients, the victims of violence, lost confidence in themselves and developed low self-concept and low self-esteem to the extent that they began to believe they deserved the abuse.

SM., a male clinical supervisor in psychology, working in the field for over sixteen years, stated: “Self-esteem and self-concept become low, which means that they reach a point where they see themselves as deserving this violence.” Also, BS., a male psychologist, working in the field for more than eighteen years, added: “The most important thing is that all of this affects her self-confidence and self-esteem.”

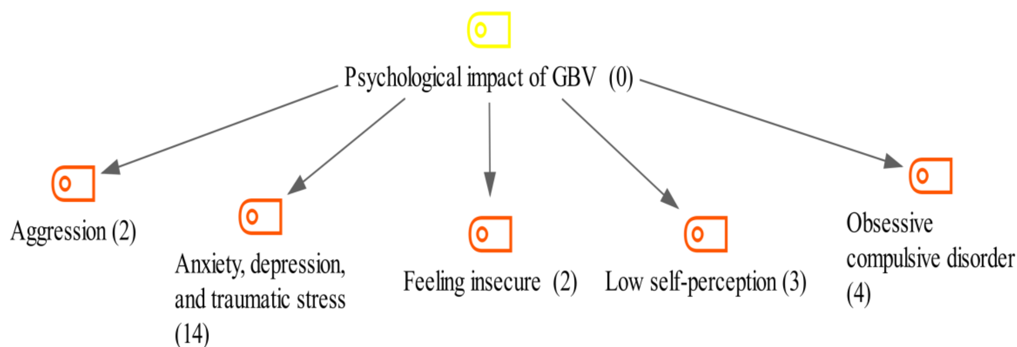
Obsessive compulsive disorder symptoms. OCD symptoms were noted by some MHCPs as a reaction to abuse in some of their clients, although it is not a common psychological outcome. Additionally, they observed that psychosomatic symptoms were more prevalent among

clients who lacked opportunities to express their feelings and distress or to isolate themselves and process their emotions. As a result, these clients began to exhibit psychosomatic symptoms.

In this regard, SW, a female psychologist with over six years of experience in the field, said: "it is possible for women to develop obsessions, but it is very rare." In addition, KH., a male clinical supervisor in psychology, working in the field for over thirty years, stated: "Women sometimes express their emotions less verbally, so you notice that they have higher physical symptoms than other individuals or groups."

Figure 18

Data-Driven Module for the Third Theme



Note: The main theme is in yellow colour, the subthemes in orange colour.

In conclusion, Palestinian females' exposure to violence negatively affects their mental health. This impact is characterized by anxiety, depression, traumatic stress symptoms, obsessive-compulsive disorder symptoms, being aggressive with others, feelings of insecurity, and low self-perception. Content analysis revealed that the most frequent psychological impact is anxiety, depression, and traumatic stress symptoms.

Theme 4- "Risk factors of GBV against females"

In the narratives of MHCPs, several factors were identified as contributing to GBV against Palestinian females. These factors will be discussed in depth in the following subthemes.

Addictions. One psychologist identified drug addiction as a risk factor for abusing females. He stated, when asked about the factors contributing to violence against women, "Drug addiction" (KH., a male clinical supervisor in psychology with over thirty years of experience).

Cultural factors. According to the narratives of MHCPs and their experience in the field, they identified the patriarchal system, societal and cultural gender roles, stigmatization of female victims of violence, and societal exclusion of some families as risk factors for GBV against females.

The patriarchal system is characterized by male dominance and victim-blaming, where men are often given the benefit of the doubt in cases of abuse, and the female victims are blamed, accused of provoking the abuse as a justification for males' aggressive behavior. Furthermore, identified gender roles are also a risk factor; when individuals cannot fulfill their culturally imposed roles—due to political violence or trauma—males may become aggressive to regain a sense of control. If females fail to perform roles such as childcare, males may blame them and exhibit aggression. Moreover, when there is no equality in gender roles, this might lead to perpetrate violence against women.

In this regard, KA., a male psychologist working in the field for more than 15 years, stated:

> Our society is patriarchal. When the woman comes to her family's home beaten and bleeding, her family tells her that it's her fault, saying 'Who knows what you said to him?' They make her feel guilty. Even when she goes back to her husband's house, she doesn't return with specific conditions, she goes back with no dignity; she goes back even more broken, and the feelings of injustice are even greater.

Furthermore, SW, a female psychologist with over six years of experience in the field, said: “There are other factors related to gender discrimination. The imbalance in roles between the wife and the husband; there is no equity in the distribution of responsibilities.”

Stigmatization of female victims of violence, as they ask her to tolerate and accept the abuse as they consider her as the reason of the abuse, and also telling her that being abused is something to be ashamed about it, and they don’t deal with her as a victim. KA., a male psychologist working in the field for more than 15 years, stated:

> In our culture, it is not common for women to seek help from relevant institutions because ultimately, they feel they will have to return to their husbands, and they do not want to scandalize themselves. When we offer women consultations, promising them protection and a dignified life, and legal follow-up, they completely refuse. They say, 'I just want to vent, then I will leave because I know this will remain confidential with you, and I am coming without my husband's permission anyway.' So, societal culture prevents them from turning to institutions that could protect them.

On the other hand, societal exclusion of the family societal exclusion of families occurs when certain households are marginalized and not embraced by the broader community, including their extended family or neighbors. This exclusion may stem from factors such as their financial situation or behaviors that do not align with societal norms. According to MHCPs, this exclusion is considered as a risk factor for GBV against females, as SE., a female social worker, working in the field for over fifteen years, said while mentioning the factors contributing to GBV: “Social factors like being socially excluded.”

Lack of support. According to the narratives of MHCPs, the lack of support from family, friends, and specialized institutions is considered a risk factor for the continuation of violence against females. Perpetrators know that there will be no one to stop them, while women keep going back to perpetrators because they don’t have any other alternative or someone to turn to for support.

SW, a female psychologist with over six years of experience in the field, said: "Lack of support that involves the absence of protection or support from both the family and the community." Moreover, KA., a male psychologist working in the field for more than 15 years, added:

> The most significant thing is that when there is no one providing support, it means when the family is emotionally impoverished and their communication skills are weak due to their culture or upbringing. This lack of what we call emotional warmth means that women miss out on many things; they have an oppressive husband and no warmth or support.

While as an example of lack of support from institutions, SW, a female psychologist with over six years of experience in the field, mentioned: "The woman's inability to access protection services."

Political violence. The general political situation, including experiences of political violence endured by males, as described in the narratives of MHCPs, can have significant impacts. For example, being imprisoned can lead to feelings of anxiety and disorientation upon release, which may contribute to aggressive behavior towards one's wife. Similarly, sustaining injuries from the Israeli army, resulting in the inability to work and subsequent job loss, can exacerbate frustrations, leading to aggression towards the wife and other family members.

MN., a female psychologist with more than twenty years of experience, mentioned:

> When a woman has a family member, whether her husband or son, who is injured, the burden of care falls on her. If the husband is unable to work due to his injury, and as we know, unemployed individuals tend to remain at home, this exacerbates their frustrations and can lead to increased domestic violence. Thus, the woman becomes more vulnerable to violence in this situation.

Socio-demographic factors. The last subtheme emerged from current theme is socio-demographic factors, as it includes social and demographic factors that contribute to violence against women, or to the continuation of violence against females. These factors included the larger size of the family, where increased responsibilities fall upon the mother as the family

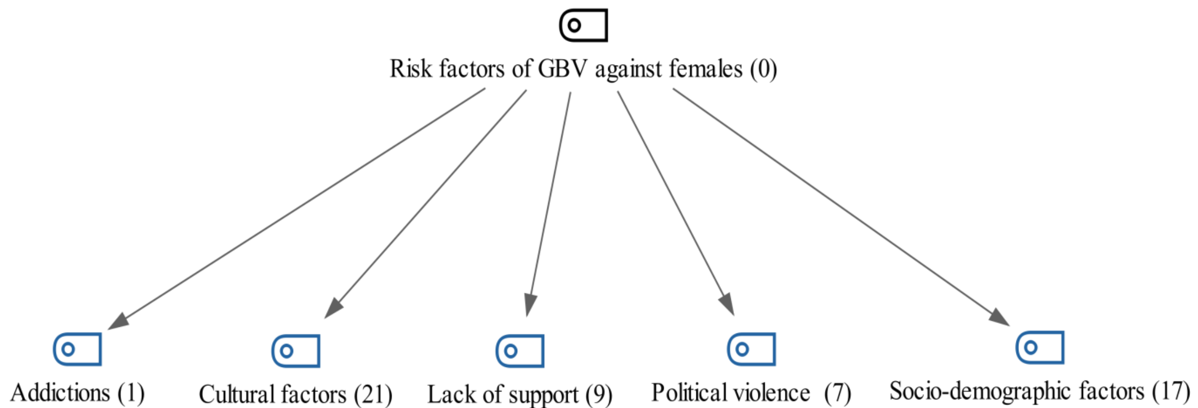
grows. With this expansion comes heightened financial needs, placing both parents under significant pressure, often resulting in aggressive behavior towards women. High rates of unemployment and poverty are additional factors contributing to gender-based violence. The financial strain on families primarily affects males, particularly when they lose their jobs due to injuries sustained, for example, from incidents involving the Israeli army or due to closures enforced by Israeli authorities, which restrict their access to work. This often leads to increased aggression towards women stemming from frustration and anger. Furthermore, when women are unable to work due to high unemployment rates, they struggle to attain financial independence, leaving them dependent on the perpetrator and unable to break free from the cycle of abuse.

Extended families and population density are additional risk factors. When families reside with extended relatives, the household becomes densely populated, resulting in increased responsibilities and reduced privacy for all members. This heightened pressure makes females more susceptible to abuse.

FI., a female social worker, working in the filed for more than twelve years, stated when explaining the factors contributing to GBV against females: “The number of family members, especially large families, as it increases responsibility and financial burden, and this significantly impacting women.” While MN., a female psychologist with more than twenty years of experience, said: “poverty and unemployment.” Furthermore, She added elsewhere another factor by saying: “population density and extended families.”

Figure 19

Data-Driven Module for the Fourth Theme



Note: The main theme is in black colour, the subthemes in blue colour.

Figure 19 summarizes the fourth theme, 'Risk factors of GBV against females.' MHCPs mentioned several factors that can be considered as a risk factors for GBV against females in the Palestinian context. These factors are addictions, cultural factors, lack of support, political violence, and socio-demographic factors. Furthermore, the content analysis showed that the subtheme "cultural factors" is more frequent than the other subthemes.

Theme 5- "Protective factors against GBV"

In contrast to the risk factors for GBV, another theme that emerged is protective factors against GBV. MHCPs discussed factors that may help females stop violence against them, reduce it, or cope with it. Several subthemes stemmed from current theme including, cognitive-behavioral coping, mental health services, physical and mental health status, psychological resilience, raising awareness about GBV and its impact and gender roles, religiosity, self-perception, social support, and socio-demographic factors. The researcher discussed these factors in depth in the subsequent subthemes.

Cognitive-behavioral coping. This subtheme explains the cognitive-behavioral strategies that MHCPs described to help females cope with or stop violence against them. These strategies include problem-solving techniques, characterized by a female's tendency to find a solution for her situation and think about how to address the problem and the abuse or factors leading to it. Another strategy is good communication skills; MHCPs emphasized the crucial role of how females communicate with males, noting that poor communication skills may heighten the risk of abuse. Additionally, showing assertive behavior towards the perpetrator was identified as an important strategy. This involves saying no to violence or deciding to divorce and leave a toxic relationship. Some MHCPs noted that females who exhibited assertive behavior often could stop the violence. Other coping strategies included participating in entertaining and debriefing activities.

SM., a male clinical supervisor in psychology, working in the field for over sixteen years, stated:

> It's very important to be assertive, to know her boundaries well, and to maintain her dignity sufficiently. We can see all types of examples; we see women who are able to say no and withdraw from the relationship, and others who are not.

Furthermore, FI., a female social worker, working in the filed for more than twelve years, said:

> Despite the negative aspect of violence, sometimes a woman finds herself searching and discovering her strengths. She may start working at home or initiate a project to support her husband. In other words, she tries to find any alternative to change the situation and support herself. For many women, suffering becomes the starting point of their lives.

In addition, EB., a female psychologist with over fourteen years of experience in the field, described:

> Women need psychological debriefing and recreational activities. When I work with groups and we engage in stress-relieving activities, you really feel the difference. Women feel like they have accomplished something significant.

In the first quote, the psychological supervisor emphasizes the significance of assertive behavior among women to halt violence directed at them. He stressed the importance of women understanding their boundaries to prevent others from overstepping them.

In the second quote, the social worker observed how some of her clients, coming from families affected by political violence, experienced shifts in their financial stability due to men losing their jobs or facing financial hardship. Despite this adversity, the women in these families were actively engaged in efforts to support their male counterparts and improve their financial circumstances. This proactive engagement was observed by the social worker as a potential means to mitigate or reduce instances of violence against women within these households.

While, in the third quote, the psychologist emphasized the importance of participating in recreational and debriefing activities. Despite their simplicity, she noted that women truly valued these activities and found them very beneficial.

Integrated support services. MHCPs emphasized the significance of offering a range of services not only to female victims of violence but also to entire families, particularly those impacted by political violence. They stressed the necessity of providing comprehensive support to victims, including mental health, physical health, legal, and protection services. Additionally, they underscored the importance of establishing specialized institutions with trained staff to address the needs of this population effectively. Furthermore, they highlighted the importance of institutions considering the genuine needs of Palestinian victims of violence, rather than imposing services based on non-national perspectives.

In this regard, A.A., a male project manager of mental health program, and a psychologist with over twenty years of experience, said:

> Training and qualifying workers who deal with victims of violence, whether at the level of institutions providing psychological or social services, are crucial. It is important to stress the importance of the services offered at the police and judicial levels. Additionally, the presence of governmental rehabilitation centers is vital. Moreover, it is important to train personnel, especially within feminist institutions, as currently, what we mostly see are slogans rather than any professional and systematic approach towards dealing with victims of violence.

Furthermore, MN., a female psychologist with more than twenty years of experience, mentioned:

> Initially, we must prioritize the physical and psychological health of individuals who have experienced or been exposed to violence by the occupation. This helps to mitigate the effects or consequences of trauma, along with intervening with the family as a whole.

Physical and mental health status. According to MHCPs, they emphasized the crucial role of maintaining good mental and physical health to mitigate the impacts of GBV on females. They explained that females with good mental and physical health are more likely to be able to resist and stop violence compared to those with poor mental or physical health.

MN., a female psychologist with more than twenty years of experience, said: “When the woman is psychologically empowered, she might be able to change man’s attitudes toward her, and the way how he deals with her.” Moreover, KH., a male clinical supervisor in psychology with over thirty years of experience, added: “Additionally, her good health condition supports her.”

Psychological resilience. High levels of psychological resilience were described as helping females overcome and manage the various stressors they experience.

A.A., a male project manager of mental health program, and a psychologist with over twenty years of experience, said:

> We have psychological resilience, which we often see in the Palestinian community. For example, we receive the wife of a prisoner who also has a son detained and, at the same time, faces difficult economic conditions and experiences violence, regardless of the source. We might sit with her for about 45 minutes, and probably she will be crying and talking about her difficult living conditions. However, when we administer a measurement scale, it shows that her level of distress is moderate or less. How can this be explained? It is due to her high psychological resilience.

The above-mentioned quote highlights the importance of psychological resilience in enabling females to cope with the hardships they face in their lives, including being victims of violence.

Raising awareness. The MHCPs emphasized the importance of raising awareness about GBV, including identifying practices that are considered aggressive. They found that some women were unaware they were being abused and did not recognize certain behaviors as aggressive. Additionally, they highlighted the need to raise awareness about the mental health outcomes of both political violence and GBV. They stressed the importance of educating the public about gender roles in Palestinian society and the need to change them. Furthermore, they noted the significance of addressing attitudes toward females in Palestinian society, which still adheres to a patriarchal system.

SW, a female psychologist with over six years of experience in the field, mentioned: "The most important thing is the personal factor, that the woman has to be aware that any state of violence, regardless of its cause, is abnormal." Furthermore, KH., a male clinical supervisor in psychology with over thirty years of experience, added:

> We need to raise awareness about the structure and function of the family. The family is not just a structure where the husband works, the wife cooks, and the children study. The family has an emotional meaning, where everyone is for the one and the one is for the family. This is something we need to raise awareness about in the Palestinian society. For example, the child needs to understand that he should help his mother and father.

Religiosity. HCPs emphasized the significant role of religion and religiosity in reducing the likelihood of violence towards women. They noted that adherence to Islamic religious

principles in interactions with women serves as a preventive measure against violence. Additionally, religious practices were highlighted for their positive impact on mental health, with some clients finding peace through religious engagement.

In this regard, SW, a female psychologist with over six years of experience in the field, mentioned:

> One of the other factors that protect women from being exposed to violence is religion, as religion can prevent someone from practicing violence. And for men, they may practice violence due to a psychological crisis, but if the upbringing they were raised on is based on religious values, then they will understand more the necessity of respecting women.

While KH., a male clinical supervisor in psychology with over thirty years of experience, said: “Religious factors are important because many women find solace and comfort in practicing religious rituals.”

Self-concept. Self-concept emerged as a subtheme of protective factors against GBV. According to the MHCPs, it is crucial for women to be self-aware and understand their strengths. Additionally, having a positive self-esteem is essential. Women with a strong self-concept and high self-esteem would be more able to decrease, stop, or cope with violence. When they are aware of their strengths, they are more likely to find solutions to how to stop the abuse. Furthermore, with good self-esteem, they are less likely to accept the abuse and more inclined to refuse it.

SM., a male clinical supervisor in psychology, working in the field for over sixteen years, stated: “The personal strength of a woman and her self-esteem can potentially influence or change a man's negative attitudes toward her, and may change his way of dealing with her.”

Social support. Support from family, friends, neighbors, society, and institutions emerged as a protective factor against GBV. When women receive support from others, it can assist them in stopping the violence. For instance, their family can intervene by communicating

with the perpetrator and asking him to stop the violence. Moreover, family and friends can provide them with a place to stay for women seeking to leave the perpetrator, or they may encourage her to file a police report and support her in doing so. Additionally, support from others enhances their mental health by allowing them to share their feelings. On the other hand, social support for males who have been exposed to political violence was found to decrease the likelihood of them becoming aggressive towards others.

SM., a male clinical supervisor in psychology, working in the field for over sixteen years, stated when asking him about factors that may help in stopping victims of violence or helping them to cope: “Another factor is social support from family, friends, or neighbors.”

Socio-demographic factors. MHCPs mentioned several socio-demographic factors that can assist females in coping with or halting abuse. These factors include having children, obtaining education, being employed (which implies financial independence), and the financial status of the family.

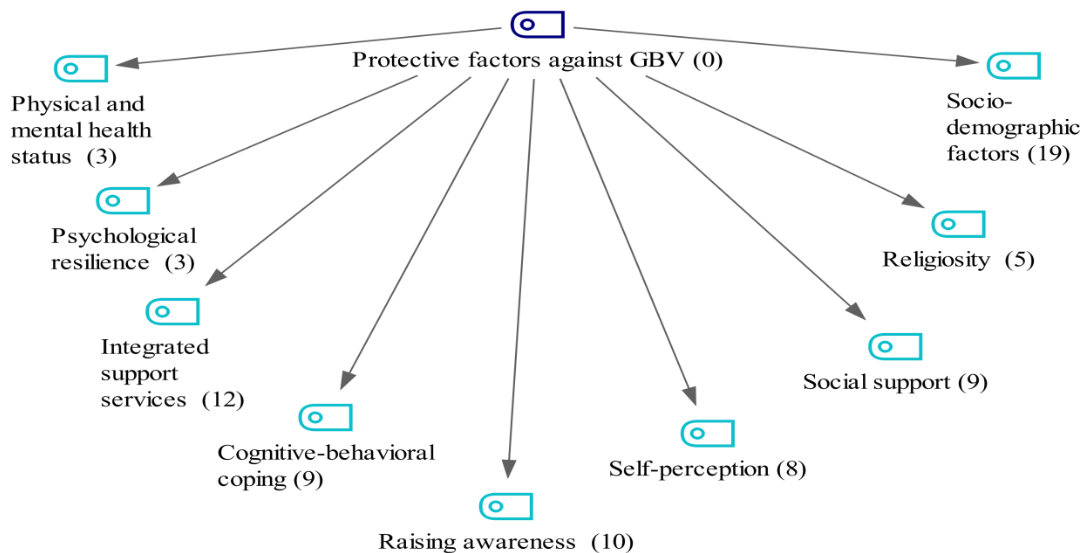
The good financial status of the family leads to a more stable family situation and alleviates pressure, particularly for the man, regarding meeting the family's needs. Furthermore, when a woman is educated, it helps her become more self-aware and recognize her strengths, providing her with the opportunity to work and achieve financial independence, thereby preventing the man from exerting control over her. Additionally, having children is considered a factor that helps women cope, as they focus on raising their children and are motivated to keep living

In this regard, A.A., a male project manager of mental health program, and a psychologist with over twenty years of experience, said: “The children give her motivation in the sense that she says, 'I want to raise my children and see them succeed.” Furthermore, SM., a male clinical

supervisor in psychology, working in the field for over sixteen years, said: "From the economic side, if the woman is financially empowered, this helps her."

Figure 20

Data-Driven Module for the Fifth Theme



Note: The main theme is in dark blue colour, the subthemes in light blue colour.

Figure 20 summarizes the fifth theme that emerged from the analysis of mental health care providers' interviews, which is called 'protective factors against GBV.' The subthemes under protective factors against GBV are physical and mental health status, psychological resilience, integrated support services, cognitive-behavioral coping, raising awareness, self-perception, social support, religiosity, and socio-demographic factors. Content analysis of the subthemes revealed that socio-demographic factors were the most frequent subtheme compared to the others.

3.3.6 Preliminary discussion of the results

The aim of this study was to understand GBV victimization and perpetration in light of political trauma in the Palestinian context from the perspectives of females, males, and mental

health care providers by adopting grounded theory as a research technique. The results yielded the emergence of five themes and twenty-five subthemes from the analysis of MHCPs' interviews; seven themes and thirty subthemes from the analysis of females' interviews; and five themes and eighteen subthemes from males' interviews.

The first shared theme that emerged from both the interviews of females and males is political violence, as both groups mentioned exposure to political violence, whether indirectly or directly. Direct exposure, for example, is characterized by the loss of loved ones, demolition of their own houses, being injured as a result of being shot by Israeli soldiers, being arrested, and being humiliated at checkpoints. An example of indirect exposure to political violence is seeing these events on the news or hearing about them from others. In contrast, political violence emerged as a subtheme of the main theme "risk factors for GBV" from MHCPs' interviews. They did not describe the events in depth but talked about political violence in general, saying, for example, ‘violence from occupation.’

The findings of the first theme align with previous studies conducted in the Palestinian context. Palestinians have been found to endure numerous traumatic events due to the Israeli military occupation. These events include losing loved ones, sustaining physical injuries, experiencing attacks on family members or friends, and facing immediate life-threatening situations (El-Khodary et al., 2020; Giacaman et al., 2007; Punamäki et al., 2001). Additionally, Palestinians have been subjected to land invasions and confiscations, house evictions, demolitions, detentions, physical abuse, and murder as a result of the prolonged military occupation (Mahamid & Veronese, 2021; Mahamid et al., 2023).

The second shared theme that emerged from the interviews of the three groups is political trauma and GBVThis theme described the trauma reactions to being exposed to political violence

and how the participants connected these symptoms or reactions to GBV victimization or perpetration. Specifically, females and MHCPs discussed how these symptoms led to both GBV victimization and perpetration by both males and females. In contrast, males connected these symptoms to their aggressive behavior toward females or GBV perpetration.

The trauma reactions, which are the subthemes, differed in each group. From the perspective of females, the trauma reactions were characterized by avoidance, fear, anxiety, stress, hyperarousal, negative changes in emotions and feelings, and re-experiencing. While according to males, the trauma reactions were characterized by fear, anxiety, feelings of humiliation, and traumatic stress, which included irritability, insomnia, avoidance, re-experiencing, negative emotions, emotional numbing, and feelings of guilt.

On the other hand, ‘MHCPs connected political trauma to GBV, and they detailed the outcomes, which were categorized into four subthemes: behavioral, cognitive, emotional, and physical symptoms. The behavioral symptoms included avoidance, social withdrawal, and hyperarousal. Cognitive symptoms included distraction, difficulties in concentrating, memory problems, re-experiencing symptoms such as flashbacks, nightmares, overthinking about the incident, and intrusive thoughts. Emotional symptoms included anxiety, depression, panic attacks, emotional numbness, feelings of frustration, and feelings of fear. Physical symptoms included excessive sweating, loss of appetite, heart palpitations, insomnia, and nausea.

These findings are supported by previous studies. A review of twenty-four studies from Palestine found that anxiety disorders and PTSD are the most prevalent mental health issues, linked to various risk factors such as the Israeli occupation and low quality of life (Marie et al., 2020). Furthermore, Sousa (2013), found that exposure to political violence correlated positively with PTSD among Palestinian women in the West Bank. Additionally, exposure to political

trauma is correlated with PTSD and major depression among Palestinians in Gaza Strip, West Bank, and East Jerusalem, with PTSD being more prevalent among women. Increased exposure to traumatic events heightens vulnerability to PTSD and major depression (Canetti et al., 2010). Furthermore, war-related quality of life is associated with depressive symptoms and hopelessness among Palestinians in the West Bank (Mahamid et al., 2022), and political violence is positively correlated with post-traumatic stress symptoms in this region (Mahamid et al., 2023).

By refereeing to emotional theories, this can be explained by the fact that psychological comorbidities may develop when individuals are unable to emotionally cope with or adapt to traumatic events (Suveg & Zeman, 2004).

Results also agreed with the findings of previous studies which indicated that PTSD symptoms and depression increase the risk of IPV and GBV perpetration/victimization in the Palestinian context (Breet et al., 2019; Gilbar et al., 2021). This can be attributed to PTSD-related symptoms, such as irritability and anger, which may undermine emotional intimacy, foster maladaptive dependency patterns, or encourage aggressive behaviors, thereby increasing the likelihood of perpetrating GBV (Breet et al., 2019; Gibbs et al., 2018). Moreover, PTSD and depression can distort women's perceptions of assault risk, making them less inclined to take protective actions. These conditions also heighten women's vulnerability, making them more susceptible to violence and potential targets for perpetrators (Machisa et al., 2021).

Furthermore, types of GBV victimization emerged as a theme from females’ interviews, whereas types of GBV perpetration emerged as a theme from males’ interviews. In contrast, MHCPs did not specify types of perpetration or victimization in their narratives. As subthemes, females mentioned three types of violence they were exposed to; physical, sexual, and

psychological/emotional violence. Males, on the other hand, mentioned two types of GBV perpetration; physical and psychological violence.

This aligns with Jewkes et al. (2017), who examined the conflict experiences of men and women from the general population of Bougainville, Papua New Guinea. They explored perceptions of the lasting impact of conflict and its associations with significant health and development issues on the islands, such as mental health problems and violence against women. Their findings revealed that the perceived long-term impact of conflict was linked to the perpetration of rape and physical and/or sexual partner violence in the past year.

In the Palestinian context, the findings of a study by Sousa et al. (2018) supported our results. According to Sousa's study, the most prevalent form of intimate partner violence (IPV) was control, with 38% of respondents indicating that their husbands had restricted their independent behavior on various occasions. Emotional or psychological abuse was also common: 23.5% of women reported being insulted, yelled at, or sworn at by their husbands; 21.8% experienced ridicule or accusations of failure; 13.9% reported that their friends were insulted; and 11% faced threats of physical harm. Child abuse was the next most frequent form of abuse, with nearly 20% reporting that their husbands had either beaten or threatened to beat the children at least once. Furthermore, 13.9% of respondents said their husbands had thrown, smashed, hit, or kicked something; 10% reported physical attacks; 6% reported attacks with harmful objects; and 2% indicated that their husbands had threatened or used lethal weapons against them or had strangled them at least once.

Another theme that emerged only from females' interviews is multi-dimensional GBV perpetration. Females talked about being abused by different groups, including males, females,

and society. Specifically, females mentioned that they were abused by males, other females, and local societies, institutions, or figures.

Despite the fact that men are more likely than women to perpetrate violence against women (Fleming et al., 2015), but still women can be violent toward each other. In our study, it's crucial to acknowledge that perpetrators reside in a context marked by prolonged occupation. Within this environment, women may have already experienced political violence and its psycho-social effects, potentially leading them to behave aggressively.

In addition, females and MHCPs shared another theme; the psychological impact of GBV. As a result of experiencing GBV, females mentioned suffering from several mental health outcomes, including addictive behavior, anxiety, depression, feelings of humiliation, low self-perception, and traumatic stress symptoms characterized by intrusion, feeling sad, feeling guilty, feeling hopeless, and social withdrawal. According to MHCPs, the mental health outcomes included aggression, anxiety, depression, feeling insecure, low self-perception, obsessive-compulsive disorder, and traumatic stress symptoms including helplessness, social withdrawal, feelings of guilt, and self-destructive behaviors.

The current findings are in line with those reported by Haj-Yahia (2000), who observed that battered and abused women in the West Bank exhibited high levels of anxiety and depression, along with low self-esteem. Similarly, the results align with Veronese et al. (2023), who found that GBV was associated with stress, anxiety, and depression among Palestinian women in the West Bank. Additionally, Thabet et al. (2015) discovered a positive association between domestic violence and anxiety, depression, and PTSD among women in the Gaza Strip.

According to learned helplessness theory, continuous exposure to violent events leads women to feel powerless to change their situation, resulting in decreased motivation, low self-

esteem, and depression (Seligman, 1975). From the perspective of stress and coping theory, violence is a significant stressor that necessitates coping mechanisms. When women adopt negative coping strategies or maladaptive behaviors, and lack social support, this can worsen their mental health problems (Lazarus & Folkman, 1984).

Moreover, the results yielded two additional themes shared by all three groups. The first one is risk factors of GBV. In addition to political violence and political trauma, females, males, and MHCPs mentioned several factors. From the perspective of females, cultural gender roles, lack of assertive behavior, lack of knowledge about GBV and their rights, lack of problem-solving techniques, lack of social support, political groups, and socio-economic factors characterized by poverty and unemployment were mentioned as risk factors that increase their vulnerability to abuse. According to the males, being emotionally vulnerable, gender roles, lack of awareness about GBV, lack of recreational facilities, prolonged proximity to the victim, socio-economic factors (poor financial status, larger family size, and type of work), and being part of a vulnerable group were found to heighten the risk of being aggressive toward females. MHCPs narrated that addiction behaviors in males, cultural factors such as the patriarchal system, lack of support from family, friends, or institutions, and socio-demographic factors characterized by larger family size, high rates of unemployment, poverty, extended families, and population density also contributed to the risk.

In contrast to the risk factors, females, males, and MHCPs mentioned several factors that can protect females from exposure to violence and its negative effects on their mental health. These factors include cognitive-behavioral coping strategies such as showing assertive behavior, engaging in debriefing activities, and adopting problem-solving techniques; feelings of empathy; financial and self-empowerment in females; receiving and having access to mental health

services; religiosity; social support; sharing the trauma; socio-demographic factors (older age, good financial status, being educated, having children); good physical and mental health; psychological resilience; good self-perception; raising awareness about GBV, including identifying practices that are considered aggressive and understanding the gender roles of both genders, as well as being aware of the mental health outcomes of both political violence and GBV.

Results are in harmony with the findings of different researches. A systematic review by Murphy et al. (2023) of 77 studies on violence against women and girls (VAWG) in conflict and natural disaster contexts identified key risk factors for male perpetration and female victimization. These include poverty, economic strain, substance abuse among men, exposure to violence, shifting gender dynamics in unequal gender norm environments, and lack of social support. Conflict-specific factors such as displacement, insecurity, overcrowding in camps, militarization, loss of family members, and property destruction also correlate with increased VAWG prevalence.

Attitudinal factors, such as beliefs justifying IPV and adherence to traditional gender roles, along with behavioral factors like alcohol consumption by women and their partners and frequent gambling by partners, further contribute to risk (Cao et al., 2023).

Mojahed et al. (2022) examined IPV risk factors in Arab countries through an ecological framework, finding that early marriage, lower education levels among women, and unemployment of women or their partners increase the likelihood of IPV. Political violence exposure also emerged as a risk factor for male-to-female IPV.

Ghoshal et al. (2023) reviewed 32 studies on IPV in low- and middle-income countries, identifying increased risk factors such as women under 45, male partners' substance dependence, prior abuse history, and acceptance of wife-beating by either partner.

Moreover, the results are consistent with several studies conducted in the Palestinian context. Social support has been found to be a protective factor against depression, anxiety, and stress among Palestinian women who experienced GBV (Veronese et al., 2023). Education and economic independence are also considered important protective factors against IPV among Palestinian women (Baloushah et al., 2019; Haj-Yahia & Clark, 2013). In addition, Abu-Lughod (2010) explored coping mechanisms and adaptation strategies among women who experienced GBV in a Palestinian refugee camp in Jordan. The study found that hope and religious resources were commonly used coping mechanisms against stressors among the study participants.

3.3.6.1 Conceptual models of the study

This study adopted an exploratory mixed-method approach, with the qualitative phase leading the quantitative one. Based on the results from the qualitative study and the findings from previous literature (see Chapter One), two conceptual models have emerged to be tested in the subsequent quantitative study.

Figure 21

The conceptual effect of GBV resulting from political traumatic events and symptoms on mental health distress and outcomes, and the mediating roles of self-concept, healthy and unhealthy coping

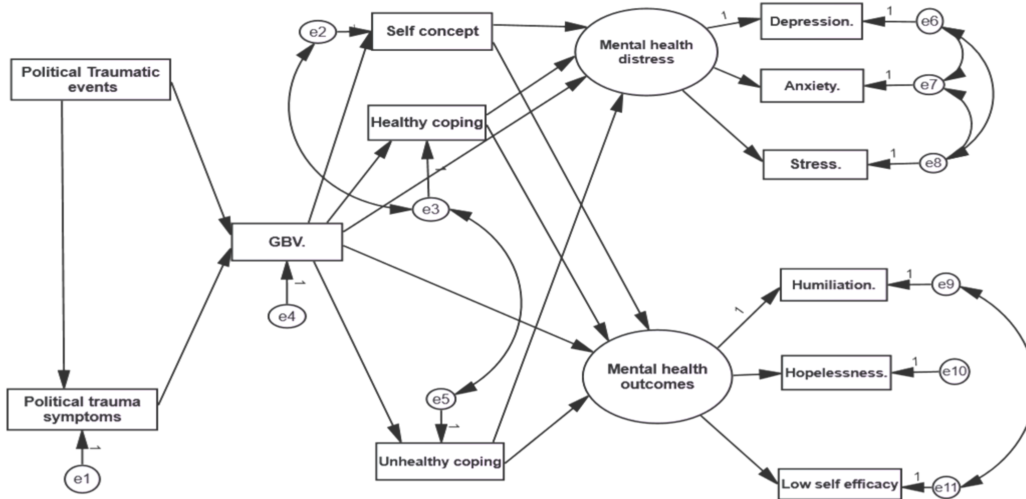
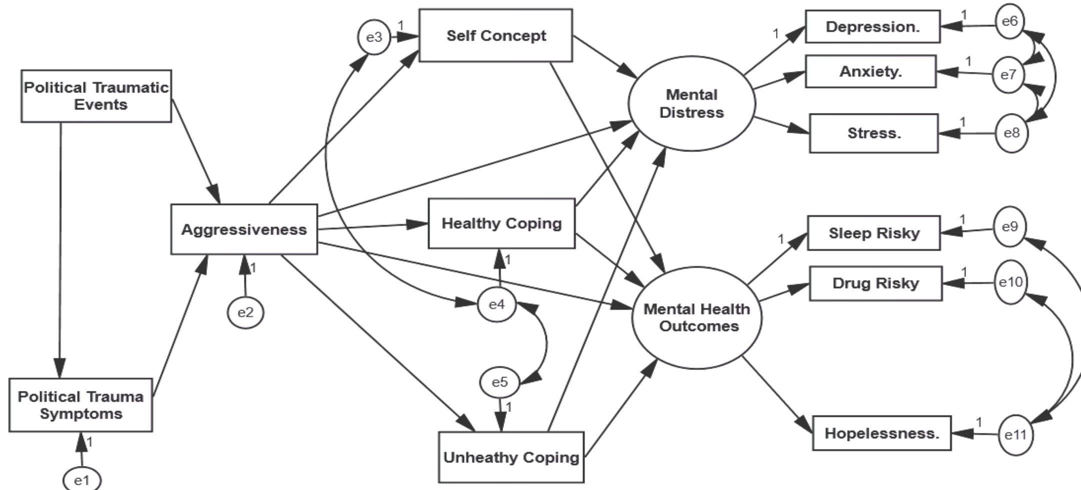


Figure 22

The conceptual effect of aggressiveness resulting from political traumatic events and symptoms on mental health distress and outcomes, and the mediating roles of self-concept, healthy and unhealthy coping



CHAPTER FOUR

The quantitative assessment

4.1 The quantitative study

The previous study aimed at understanding GBV victimization and perpetration in the Palestinian context from the perspective of females, males, and MHCPs. Based on the results of thematic content analysis of the qualitative study, and the previous literature (see Chapter One), two conceptual models (see Chapter Three) have emerged to be tested in this study. So, this study aimed to quantitively assess the relationships between political traumatic events, political trauma symptoms and GBV, and between GBV and mental health outcomes (humiliation, hopelessness, and low self-efficacy) and distress (depression, anxiety, and stress), and whether self-concept, healthy coping, and unhealthy coping mediated the relationship between GBV, mental health outcomes and distress among Palestinian females. The second aim was to assess the relationship between Political traumatic events, political trauma symptoms and aggressiveness, and between aggressiveness and mental health outcomes and distress, and whether self-concept, healthy coping, and unhealthy coping mediated the relationship between aggressiveness, mental health outcomes (sleep risky behaviors, drug use, and hopelessness) and distress (depression, anxiety, and stress) among Palestinian males.

Accordingly, the hypotheses of current study were: Political trauma symptoms related to political traumatic events would be positively associated with GBV victimization among Palestinian females *(H1)*; GBV related to political trauma symptoms would be positively associated with mental health outcomes (humiliation, hopelessness, and low self-efficacy) and mental health distress (depression, anxiety, and stress) among Palestinian females *(H2)*; self-concept, healthy coping, and unhealthy coping would mediate the association between GBV and

mental health outcomes (humiliation, hopelessness, and low self-efficacy) and mental health distress (depression, anxiety, and stress) among Palestinian females *(H3)*; political trauma symptoms would be positively associated with aggression among Palestinian males *(H4)*; aggressiveness related to political trauma symptoms would be positively associated with mental health outcomes (sleep risky behaviors, drug use, and hopelessness) and mental health distress (depression, anxiety, and stress) among Palestinian males *(H5)*; self-concept, healthy coping, and unhealthy coping would mediate the association between aggression and mental health outcomes (sleep risky behaviors, drug use, and hopelessness) and mental health distress (depression, anxiety, and stress) among Palestinian males *(H6)*; socio-demographic factors characterized by residency, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members, would predict GBV victimization among Palestinian females *(H7)*; socio-demographic factors characterized by residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members, would predict aggression in Palestinian males *(H8)*; there would be a significant differences between females and males on study variables (political traumatic events, political trauma symptoms, self-concept, depression, anxiety, stress, healthy coping, unhealthy coping, hopelessness) *(H9).*

4.1.1 Participants and procedures

The current study involved 1038 Palestinian adults: 371 males and 667 females (see table 4). Participants' age ranged from 18 to 70 years old (M = 28.32, SD = 11.37). 46.1% resided in urban areas, 92.9 % in rural areas, while 11.1% were from internally displaced camps. Of the participants, 94.3% resided in the West Bank of Palestine, and 5.7% were from East Jerusalem. Regarding academic degree, 17.9% of participants had a graduate degree, 63.7% had an

undergraduate degree, and the remainder 18.4% obtained a high school degree. Concerning participants' marital status, 62.1% were single, 34.8% were married, 1.2% widows, and 1.9% were divorced. Moreover, 51.9 of participants were employed, of which 72.4 % were full-timers, and 27.6 were part-timers, and the remainder 48.1% were unemployed. Participants' monthly income in Shekel ranged from 1000 to 10000 (M = 3791. 27, SD = 2097.47). The number of family members among participants ranged from 3 to 13 (M = 5. 86, SD = 2.01). Inclusion criteria required participants to be Palestinian adults (both females and males) aged 18 years or older; possess proficiency in reading and speaking Arabic; and have experienced at least one political traumatic event, either directly or indirectly.

The study sample was obtained by using the snowball sampling technique in both the West Bank and East Jerusalem of Palestine. The study was conducted between May 2023 and October 2023, and was carried out following APA ethical principles of psychologists and code of conduct (American Psychological Association, 2010). After obtaining the ethical approval from the Ethical Board of An-Najah National University, Nablus, Palestine (Ref:Med.Sep.2022/37), on September 25th, 2022, the researcher started collecting the data via two modes; online and in-person.

Through the in-person mode and prior to obtaining consent, participants were informed about the study's objectives and the sensitive nature of the questions of the self-report questionnaires. They were assured that only researchers would have access to the data. Furthermore, the participants were aware that they could decline to fulfill the questionnaires (or to answer any specific items) and that they were able to withdraw from the study at any time. In-person data recruiting was done in a different comfortable places around the West Bank

(Tulkarm, Jenin, Nablus, Qalqilyah, Hebron, Ramallah, Bethlehem, and Salfit) and East Jerusalem, in which a team of research assistants helped in collecting the data.

While in the online mode, the researcher created online sheet containing all measures used in the study by using Google forms. This sheet started with the title and aims of the study. Then the researcher shared the link of the Google form sheet on social media platforms (Facebook and Instagram) in order to collect the data.

The majority of the participants were collected in presence, as 247 of the participants (190 females and 57 males) were collected via online, and 791were collected in presence.

Table 4.

Demographic characteristics of study sample (N=1038)

Characteristics	Number	Percent (%)
Gender		
Male	371	35.7
Female	667	64.3
Total	1038	100.0
Place of residence		
Urban areas	478	46.1
Rural areas	445	42.9
Internally displaced camps	115	11.1
Total	1038	100.0
Region		
West Bank	979	94.3%
East Jerusalem	59	5.7%
Total	1038	100%
Academic degree		
Graduate	186	17.9
Undergraduate	661	93.7
High school	191	18.4
Total	1038	100%
Marital status		
Single	645	62.1

Married	361	34.8
Widow	12	1.2
Divorced	20	1.9
Total	1038	100%
Employment status		
Employed	539	81.9
Unemployed	499	48.1
Total	1038	100%

4.1.2 Measures

The research instruments used in this research were translated from English to Arabic and reviewed for content validity and inclusiveness. Ten experts in psychological counseling, Arabic language, and clinical psychology reviewed the research tools; based on the revision committee's feedback, minor modifications were made. After completion, the translated drafts of the questionnaires were back-translated into English by an independent expert in translation. The translated versions were then pilot-tested with 200 participants and further refined for clarity according to their feedback.

Demographic variables questionnaire: This instrument's variables included residency, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members.

Exposure to Political Violence Scale (EPVS): The EPVS (Haj-Yahia, 2005) examines 49 acts of political violence, which reflect experience with psychological abuse, physical violence, sexual abuse (as a direct victim), and witnessing of such violence (as an indirect victim) committed by the Israeli army and police as well as by Israeli settlers against family members and relatives. Participants were requested to answer the question about each act using a

dichotomous measure: no = 0 or yes = 1. Cronbach's alpha value of the EPVS, as used in females' study was .90, while in the males' study was .91.

Trauma scale specific to Palestinian context (PCSTS)**:** The PCSTS is a self-report measure developed by Mahamid et al. (2023), comprising 32 items designed to test traumatic symptoms among Palestinian adults. The scale consists of 32 items under five subscales: The re-experiencing trauma, avoidance and numbing, hyperarousal, somatic symptoms, and psychological symptoms. PCSTS is a five-point Likert scale (always = 5, mostly = 4, sometimes = 3, rarely = 2 and never = 1). A score of 1–1.8 suggests no trauma symptoms, while a score of 1.81–2.6 indicates mild trauma symptoms, 2.61–3.40 indicates moderate trauma symptoms and 3.41–4.2 indicates high trauma symptoms. Finally, a score of 4.21–5 suggests severe trauma symptoms. Cronbach's alpha value of the PCSTS, as used in both females' and males' studies, was .92.

Violence Against Women Questionnaire (VAWI): The VAWI developed by the World Health Organization (2005) consists of behavior-specific items related to (a) psychological violence, such as insults, belittling, constant humiliation, intimidation, threats of harm, and threats to take away children (e.g., insulted me in a way that made me feel bad about myself), (b) and physical violence, such as slapping, hitting, kicking, and beating (e.g., hit me with his/her fist or with some other object that could have hurt me). The items of sexual violence sub-scale were excluded due to cultural restrictions. For each question, respondents were asked whether they had experienced specific acts of violence during the past year and earlier in life. The questionnaire's five-point response format ranges from 0 (never) to 4 (always) (García-Moreno et al., 2005). Cronbach's alpha value of the VAWI, as used in this study, was .89.

The Coping Orientation to Problems Experienced Inventory (Brief-COPE): It was developed by Carver (1997), comprises 28 self-report items designed to assess both situational coping strategies (how individuals cope with specific stressful events) and dispositional coping strategies (how individuals typically cope with stress in everyday life). This instrument encompasses three main coping strategies: Behavioral coping, emotional coping, and avoidant coping, with 14 coping subscales, each containing two items. Respondents rate their use of coping responses on a four point Likert scale (1 = I usually don't do this at all; 2 = I usually do this a little bit; 3 = I usually do this a medium amount; 4 = I usually do this a lot). In this study, the inventory was divided into two sub-scales, as the first sub-scale consisted of the healthy coping strategies, while the second sub-scale consisted of the unhealthy coping strategies. Cronbach's alpha values of the Brief-COPE, as used in females' study, were .88 and .87 respectively, while in males' study were .87 and .86 respectively.

The Personal Self-Concept Questionnaire (PSC): The PSC initially contained 22 items when it was first introduced by Goñi Palacios (2009). Subsequent revisions by Goñi et al. (2011) resulted in a final version with 18 items aims to measure personal perceptions regarding Self-fulfillment (6 items), Honesty (3 items), Autonomy (4 items), and Emotional self-concept (5 items), each rated on a Likert-type scale with five response options ranging from totally disagree to totally agree (Goñi et al., 2011). The original version of the questionnaire demonstrated an internal consistency with a reliability coefficient of .834 (Palacios et al., 2015), while the Cronbach's alpha value of females' and males' studies were .92 and .90 respectively.

***Depression, Anxiety and Stress Scale (DASS-21)*:** The DASS 21 is a 21 item measure designed to test symptoms of depression, anxiety and stress. Individuals are required to mention the presence of symptoms during the previous week to complete the test. Items of scale scored

from 3 (most of the time during the last week or very high) to 0 (did not happen to me during the last week). The main goal of DASS is to evaluate the symptoms of anxiety, depression, and stress. Consequently, the DASS is not only a measure to assess the symptoms of anxiety, depression, stress among patients; it also allows measuring patient response to the treatment plan. All items of the scale are indicated by letters to which items belong; A (anxiety), D (depression), and S (stress). The total score of each group (Anxiety, Depression, and Stress) should be multiplied by two (Gomez, 2016). Cronbach's alpha values of the DASS, as used in females' study, were .93, .94 and .90 respectively, while in males' study were .91, .93 and .92 respectively.

***The Beck Hopelessness Scale (BHS)*:** The BHS is a 20 item self-assessment instrument to measure hopelessness. Respondents are asked to evaluate each of the 20 statements and decide whether they describe their attitude in the previous week (including the assessment day). Nine items are inversely scored to prevent acquiescence. After inversion of the positively worded items, a sum score is calculated. The total score can range from 0 to 20, indicating the number of items endorsed in hopelessness (Kliem et al., 2018). Cronbach's alpha value of the BHS, as used in females' and males' studies, were .91and .93 respectively.

***Humiliation Inventory (HI)*:** The Humiliation Inventory (HI) measures humiliation along two subscales: fear of humiliation and cumulative (Hartling & Luchetta, 1999). This 32-item scale is divided into four sections, the first of which assesses how much participants believe themselves to have been affected by particular experiences ("Throughout your life how seriously have you felt harmed by being ridiculed?"). The second section measures how fearful participants are of being humiliated ("At this point in your life, how much do you fear being harassed?"). The next section attempts to measure participants' concerns over experiencing

humiliation ("At this point in life, how concerned are you about being discounted as a person?"). The last section consists of only two items, which assesses participants worries ("How worried are you about being viewed by others as incompetent?"). All 32 items are measured on a five-point Likert scale, ranging from one ("Not at all") to five ("Extremely") (Asmari et al., 2022). Cronbach's alpha value of the HI, as used in females' study, was .92.

The Short Scale for Measuring General Self-Efficacy Beliefs (ASKU)**:** It is a concise 3-item scale designed to evaluate general self-efficacy expectations, in which each item rated on a Likert-type scale with five response options ranging from does not apply at all to applies completely (Beierlein et al., 2013). It demonstrates strong reliability, with McDonald's omega ranging from 0.81 to 0.86, and has been validated effectively. The mean ASKU score is derived by summing the scores from the responses and calculating the average. Cronbach's alpha value of the HI, as used in this study, was .93.

The Health Risk Behaviors Inventory (HRBI): It is a brief self-report questionnaire that was developed by Irish (2011) to assess individual's health risk behaviors. HRBI measures seven health risk behaviors: physical inactivity, unhealthy diet, insufficient sleep, direct and indirect exposure to cigarette smoke, illicit drug use, risky sexual behaviors, and risky drinking behavior. In this study only the insufficient sleep and illicit drug use subscales were used in the male's study. The insufficient sleep subscale contained 10 items, while the illicit drug use subscale contained 9 items. Items were scored on a five-point Likert scale ranging from never true to always true. Cronbach's alpha value of both subscales, as used in this study, was .90.

The Aggression Questionnaire (AGQ)**:** It is a self-report questionnaire that was developed by Buss & Perry (1992) to assess to what extent participants engaged in aggressive behaviors toward others. It consists of 28 items examining four elements of violence: physical

violence (8 items), verbal violence (5 items), anger (7 items), and hostility (8 items). Example items were: “I tell my friends openly when I disagree with them” and “I have trouble controlling my temper.” Responses were based on a five-point Likert scale ranging from 1 (very much disagree) to 5 (very much agree). Cronbach’s alpha value of the AGQ, as used in the males’ study, was .88.

4.1.3 Data Analysis

Structural equation modeling (SEM) was conducted to test the conceptual models of our study, where GBV was identified as a predictor, self-concept, healthy coping, and unhealthy coping as mediating variables, and mental health distress (stress, anxiety, and depression), and mental health outcomes (hopelessness, humiliation, and low self-efficacy) as outcome variables in the first model, while in the second model, aggressiveness was identified as a predictor, self-concept, healthy coping, and unhealthy coping as mediating variables, and mental health distress (stress, anxiety, and depression), and mental health outcomes (sleep risky behaviors, drug risky behaviors, and hopelessness) as outcome variables. We also calculated descriptive statistics for our study variables. Moreover, Person Correlation Coefficient was used to test the significance of correlations among study variables. Normed fit index (NFI), non-normed fit index (NNFI), root mean square error of approximation (RMSEA), standardized root mean square (SRMR), and comparative fit index (CFI) were tested. The thresholds for good fit were as follow: RMSEA0.94, CFI>0.95. Lastly, we set a P value at 0.001. We tested our conceptual models (Fig. 23 and 24) using AMOS25 software for data analysis.

In addition, stepwise multiple regression analysis was conducted to predict GBV and aggressiveness through demographic variables (residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members) in step

1, and political traumatic events and political trauma symptoms were specified as independent variables in step 2. Finally, independent samples t-test was used to test the significance of differences between females and males on study variables. Descriptive statistics, correlations, and regression analysis were conducted using the Statistical Package for Social Sciences (SPSS.25) software for data analysis.

4.1.4 Results

4.1.4.1 Females' data

Descriptive statistics related to political traumatic events, political trauma symptoms, GBV, self-concept, depression, anxiety, stress, healthy coping, unhealthy coping, Hopelessness, humiliation, low self-efficacy as shown in table 5. Participants reported high scores on self-concept, healthy coping, and smoking risky behaviors. Moreover, participants reported Moderate scores on political traumatic events, political trauma symptoms, and GBV. Finally, participants reported average scores on depression, anxiety, stress, unhealthy coping, hopelessness, humiliation, low self-efficacy. Regarding internal consistency, the tools of the current study indicated a high level of reliability on Cronbach's Alpha Formula; scores ranged from .94 (*Anxiety*) to .87 (*Unhealthy coping*).

Table 5.

Descriptive statistics for research variables (N= 667)

Variable	Mean	S.D	Min	Max	Range	Skewness	Kurtosis	Reliability
Political traumatic events	1.23	.20	1.00	2.00	1.00	1.09	1.14	.90
Political trauma symptoms	3.10	.82	1.00	5.00	4.00	-.21	-.14	.92
GBV	1.60	.78	1.00	5.00	4.00	1.71	2.76	.89
Self-concept	3.42	.51	2.11	4.94	2.83	.18	-.27	.92
Depression	2.10	.69	.86	4.00	3.14	.47	-.02	.93

Anxiety	2.04	.68	.86	4.00	3.14	.49	-.01	.94
Stress	2.28	.64	1.00	4.00	3.00	.34	.15	.90
Healthy coping	2.61	.59	1.00	4.00	3.42	-.56	.28	.88
Unhealthy coping	2.13	.51	.58	4.00	3.00	.13	.56	.87
Hopelessness	1.23	.21	.85	1.95	1.10	.87	-.13	.91
Humiliation	2.06	.85	1.03	5.00	4.13	.99	.68	.92
Low self-efficacy	2.04	.79	1.00	5.00	4.00	.42	-.27	.93

Results of the correlational analysis are mentioned in Table 6. Specifically, political traumatic events positively correlated with political trauma symptoms (r =.42, $p < .01$), GBV (r =.42, $p < .01$), depression (r =.16, $p < .01$), anxiety (r =.20, $p < .01$), stress (r =.12, $p < .05$), unhealthy coping (r =.13, $p < .05$), hopelessness (r =.19, $p < .01$), humiliation (r =.12, $p < .05$), and negatively correlated with self-concept (r = -.32, $p < .01$). Political trauma symptoms positively correlated with GBV (r =.25, $p < .01$), depression (r =.24, $p < .01$), anxiety (r =.30, $p < .01$), stress (r =.26, $p < .01$), unhealthy coping (r =.17, $p < .01$), hopelessness (r =.17, $p < .01$), humiliation (r =.17, $p < .01$), and negatively correlated with self-concept (r =-.18, $p < .01$). GBV positively correlated with depression (r =.23, $p < .01$), anxiety (r =.24, $p < .01$), stress (r =.15, $p < .01$), unhealthy coping (r =.18, $p < .01$), hopelessness (r =.31, $p < .01$), humiliation (r =.28, $p < .01$), and negatively correlated with self-concept (r =-.22, $p < .01$). Depression positively correlated with anxiety (r =.74, $p < .01$), stress (r =.80, $p < .01$), healthy coping (r =.15, $p < .01$), unhealthy coping (r =.38, $p < .01$), hopelessness (r =.25, $p < .01$), humiliation (r =.34, $p < .01$), and low self-efficacy (r =.16, $p < .01$). Anxiety positively correlated with stress (r =.76, $p < .01$), healthy coping (r =.16, $p < .01$), unhealthy coping (r =.36, $p < .01$), hopelessness (r =.17, $p < .01$), humiliation (r =.33, $p < .01$), and low self-efficacy (r =.11, $p < .05$). Stress positively correlated with healthy coping (r =.24, $p < .05$), unhealthy coping (r =.39, $p < .01$), hopelessness

(r =.10, $p < .05$), humiliation (r =.34, $p < .01$), and low self-efficacy (r =.15, $p < .01$). Healthy coping positively correlated with unhealthy coping (r =.59, $p < .01$), and negatively correlated with hopelessness (r =-.27, $p < .01$). Unhealthy coping positively correlated with hopelessness (r =.12, $p < .05$), humiliation (r =.29, $p < .01$) and low self-efficacy (r =.11, $p < .05$). Hopelessness positively correlated with humiliation (r =.20, $p < .01$) and low self-efficacy (r =.20, $p < .01$). Humiliation positively correlated with low self-efficacy (r =.28, $p < .01$). Finally, self- concept negatively correlated with depression (r = -.32, $p < .01$), anxiety (r = -.27, $p < .01$), stress (r = -.26, $p < .01$), unhealthy coping (r = -.26, $p < .01$), hopelessness (r = -.49, $p < .01$), humiliation (r = -.31, $p < .01$), and low self-efficacy (r = -.40, $p < .01$), and positively correlated with healthy coping (r =.15, $p < .01$).

Table 6.

Correlations among study variables (N= 667)

Measures	*1*	2	3	4	5	6	7	8	9	10	11	12
Political traumatic events	*1*	.42**	.42**	-.17**	.16*	.20**	.12*	.03	.13*	.19**	.12*	-.01
Political trauma symptoms		1	.25**	-.18**	.24**	.30**	.26**	.05	.17**	.17**	.17**	.008
GBV			1	-.22**	.23**	.24**	.15*	-.06	.18**	.31**	.28**	.05
Self-concept				1	-.32**	-.27**	-.26**	.15*	-.26**	-.49**	-.31**	-.40**
Depression					1	.74**	.80**	.13*	.38**	.25**	.34**	.16*
Anxiety						1	.76**	.16*	.36**	.17*	.33**	.11*
Stress							1	.24**	.39**	.10*	.34**	.15*
Healthy coping								1	.59**	-.27**	.08	-.05
Unhealthy coping									1	.12*	.29**	.11*
Hopelessness										1	.20**	.20**
Humiliation											1	.28**
Low self-efficacy												1

*Correlation is significant at the 0.05 level (2-tailed) **

*Correlation is significant at the 0.01 level (2-tailed) ***

In table 7, we tested simultaneous multiple regression analysis to predict GBV through demographic variables (Residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members) in step1. While demographic variables (Residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members) with political traumatic events and political trauma symptoms were used to predict GBV in sept2. Our findings revealed that GBV predicted by residency (β = .12; ** $p < .05$) in favor of residents of the Palestinian internally displaced camps (M; camp residents = 1.92, rural regions = 1.62, urban regions = 1.54), marital status (β = .18; ** $p < .01$) in favor of divorced women (M; single =1.52, married = 1.74, widow = 1.84, divorced = 2.15), political traumatic events (β = .37; ** $p < .01$), and Political trauma symptoms (β = .08; ** $p < .05$).

Table7.

Simultaneous multiple regression analysis for variables predicting GBV (N= 667)

Variable	B	SEB	*β*	R2
Step1				
Residency	.15	.04	.12*	
Place of residence	.04	.12	.01	
Academic degree	-.05	.05	-.03	.05
Income	.28	.01	-.06	
Marital status	.23	.06	.18**	
employed/ unemployed	-.19	.17	-.14	
Type of work	.03	.11	.04	
Family members	.01	.01	.02	

Step2				
Residency	.09	.04	.07*	
Place of residence	.02	.11	.07	
Academic degree	-.01	.05	-.01	
Income	-.03	.01	-.03	
Marital status	.21	.05	.16**	.21
employed/ unemployed	-.07	.16	-.05	
Type of work	.03	.10	.04	
Family members	.01	.01	-.01	
Political traumatic events	1.44	.15	.37**	
Political trauma symptoms	.08	.03	.08*	

*** P < .01; *p < .05*

In table 8, Chi-square test was implemented to test the significance of difference in frequencies between females who encountered GBV and those who did not. Results of Chi-square test indicated that out of 626 female respondents, 215 reported they encountered several types of GBV.

Table 8.

Results of Chi-square test for the differences in GBV encounters (N= 626)

Experienced GBV	Observed N	Expected N	Residual	df	Chi-square	Sig
Yes	215	313	98	1	61.36	.000***
No	411	313	-98			
Total	626					

C

hi-square test (see table 9) was employed to test the significance of differences in frequencies of

types of GBV encountered by Palestinian women. Results of Chi-square test indicated that out of 620 female respondents, 30 women encountered physical GBV, 111 women experienced psychological GBV, 4 women encountered sexual GBV, 56 encountered both physical and psychological GBV, 1 woman experienced both psychological and sexual GBV, 15 women encountered all types of GBV, and finally 403 women did not encounter any type of GBV.

Table 9.

Results of Chi-square test for the differences in types of GBV (N=620)

GBV types	Observed N	Expected N	Residual	df	Chi-square	Sig
Physical	30	88.6	-58.6	6	1401.05	.000***
Psychological	111	88.6	22.4			
Sexual	4	88.6	-84.6			
Physical & psychological	56	88.6	-32.6			
Psychological & sexual	1	88.6	-87.6			
All types	15	88.6	-73.6			
None	403	88.6	314.4			
Total	620					

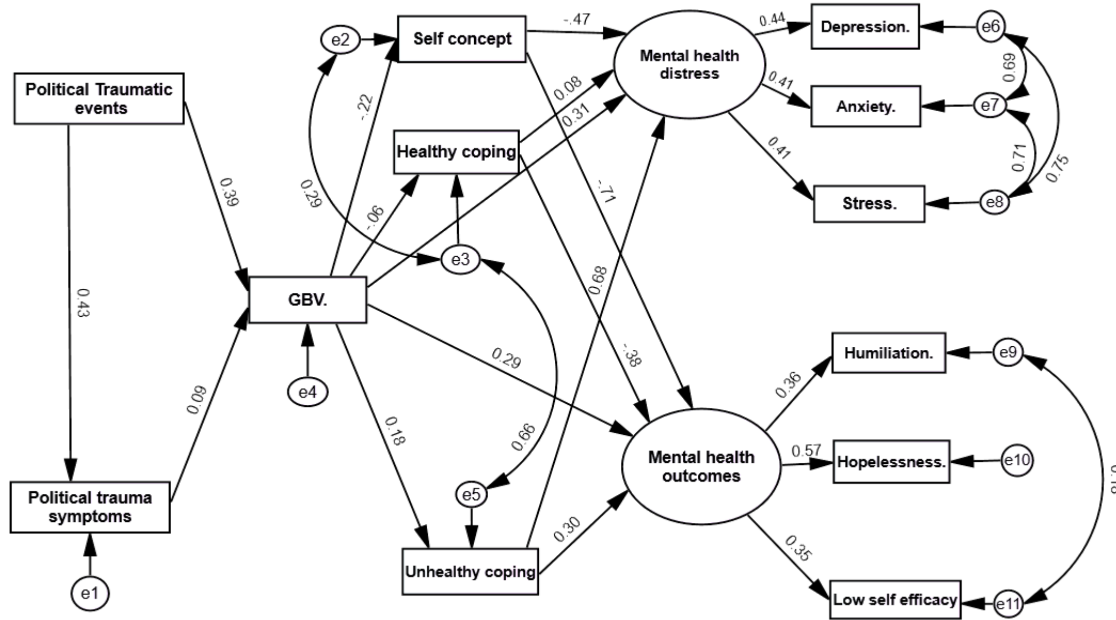
Structural equation model (SEM)

Table 10 and Figure 23 display the outcomes of the path analysis, with GBV as a predictor, self-concept, healthy coping, and unhealthy coping as mediating variables, and mental health distress (stress, anxiety, and depression), and mental health outcomes (hopelessness, humiliation, and low self-efficacy) as outcome variables tested across the sample (N=667). The findings of our study showed that self-concept, healthy coping, and unhealthy coping mediated

the relationship between GBV, mental health distress, and mental health outcomes with a good fit for the data ($\chi2_{(42)}$ =79.08; p =.000; GFI=.97; AGFI=.96; RMSEA=.04; NFI=.98; CFI=.97).

Figure 23.

SEM for the effect of GBV resulting from political traumatic events and symptoms on mental health distress and outcomes, and the mediating roles of self-concept, healthy and unhealthy coping.



Analysis of the paths between political traumatic events and GBV showed a positive effect ($\beta_{M,\ Y}$ = .43; $p < .01$). Moreover, a positive effect in path analysis was also established between political trauma symptoms and GBV (βM, Y =.09; $p < .05$). Results of path analysis between GBV and mental distress showed a positive effect, stress (βM, Y =.21; $p < .01$), anxiety (βM, Y =.22; $p < .01$), and depression (βM, Y =.23; $p < .01$), and a positive effect was found in path analysis between GBV and mental health outcomes, hopelessness (βM, Y =.30; $p < .01$), humiliation (βM, Y =.19; $p < .01$), and low self-efficacy (βM, Y =.18; $p < .01$).

In addition, Results of path analysis between self-concept and mental distress showed a negative effect, stress (βM, Y =-.19; $p < .01$), anxiety (βM, Y =-.19; $p < .01$), and depression βM, Y =-.19; $p < .01$). and a negative effect was found in path analysis between self-concept and mental health outcomes, hopelessness (βM, Y =-.40; $p < .01$), humiliation (βM, Y = -.25; $p < .01$), and low self-efficacy (βM, Y = -.24; $p < .01$). Results of path analysis between healthy coping and mental health outcomes showed a negative effect, hopelessness (βM, Y =-.21; $p < .01$), humiliation (βM, Y = -.14; $p < .05$), and low self-efficacy (βM, Y = -.13; $p < .05$).

Moreover, Results of path analysis between unhealthy coping and mental distress showed a positive effect, stress (βM, Y =.27; $p < .01$), anxiety (βM, Y =.28; $p < .01$), and depression βM, Y =.30; $p < .01$). and a positive effect was found in path analysis between unhealthy coping and mental health outcomes, hopelessness (βM, Y =.17; $p < .01$), humiliation (βM, Y =.11; $p < .05$), and low self-efficacy (βM, Y =.11; $p < .05$).

Finally, regarding the mediation hypothesis, the model produced the standardized total effect of GBV on depression (βX, M =.23; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.21; $p < .01$), and unhealthy coping (βX, M, Y =.30; $p < .01$), and a statistically significant direct effect of GBV on total mental health distress (βX, Y, M =.30; $p < .01$).

The model yielded a standardized total effect of GBV on anxiety (βX, M =.22; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.19; $p < .01$), and unhealthy coping (βX, M, Y =.28; $p < .01$). and a statistically significant direct effect of GBV on total mental health distress (βX, Y, M =.30; $p < .01$). Also, the model yielded a standardized total effect of GBV on stress (βX, M =.21; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M,

Y =-.24; $p < .01$), and unhealthy coping (βX, M, Y =.27; $p < .01$). and a statistically significant direct effect of GBV on total mental health distress (βX, Y, M =.30; $p < .01$).

The model revealed a standardized total effect of GBV on hopelessness (βX, M =.30; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.40; $p < .01$), healthy coping (βX, M, Y =-.21; $p < .01$) and unhealthy coping (βX, M, Y =.17; $p < .01$). and a statistically significant direct effect of GBV on total mental outcomes (βX, Y, M =.29; $p < .01$). Furthermore, the model indicated a standardized total effect of GBV on low self-efficacy (βX, M =.18; $p < .01$), this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.24; $p < .01$), healthy coping (βX, M, Y =-.13; $p < .05$) and unhealthy coping (βX, M, Y =.10; $p < .01$), and a statistically significant direct effect of GBV on total mental outcomes (βX, Y, M =.29; $p < .01$). Finally, the model revealed a standardized total effect of GBV on humiliation (βX, M =.19; $p < .01$), this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.26; $p < .01$), healthy coping (βX, M, Y =-.14; $p < .01$) and unhealthy coping (βX, M, Y =.11; $p < .01$), and a statistically significant direct effect of GBV on total mental health outcomes (βX, Y, M =.29; $p < .01$).

Table 10.

Results of SEM analysis for conceptualized model (N = 667)

Endogenous variables	**Exogenous variables**	**Standardized regression weights (β)**	***P***	**Indirect effect *(p)***	**Standardized total effect *(p)***
GBV	Political traumatic events	.43	*<.01*	----	.42(*p<01*)
GBV	Political trauma symptoms	.09	*<.05*	----	.09(*p<05*)
Self-concept	GBV	-.22	*<.01*	----	-.22(*p<01*)
Healthy coping	GBV	-.06	*<.05*	----	-.06(*p<05*)
Unhealthy coping	GBV	.18	*<.01*	----	.18(*p<01*)
Mental health distress	GBV	.30	*<.01*	----	.53(*p<01*)
Mental health outcomes	GBV	.29	*<.01*	----	.53(*p<01*)
Mental health distress	Self-concept	-.47	*<.01*	----	-.47(*p<01*)

Mental health outcomes	Self-concept	-.71	*<.01*	----	-.71(*p<.01*)
Mental health distress	Healthy coping	.08	*<.05*	----	.08(*p<.05*)
Mental health outcomes	Healthy coping	-.37	*<.01*	----	-.37(*p<.01*)
Mental health distress	Unhealthy coping	.67	*<.01*	----	.67(*p<.01*)
Mental health outcomes	Unhealthy coping	.30	*<.01*	----	.30(*p<.01*)
Depression	Self-concept			-.28(*p<.01*)	
	Unhealthy coping			.39(*p<.01*)	
Anxiety	Self-concept			-.26(*p<.01*)	
	Unhealthy coping			.36(*p<.01*)	
Stress	Self-concept			-.24(*p<.01*)	
	Unhealthy coping			.34(*p<.01*)	
Hopelessness	Self-concept			-.17(*p<.01*)	
	Healthy coping			-.07(*p<.05*)	
	Unhealthy coping			.07(*p<.05*)	
Humiliation	Self-concept			-.42(*p<.01*)	
	Healthy coping			-.18(*p<.01*)	
	Unhealthy coping			.18(*p<.01*)	
Low self-efficacy	Self-concept			-.38(*p<.01*)	
	Healthy coping			-.16(*p<.01*)	
	Unhealthy coping			16(*p<.01*)	

4.1.4.2 Males' data

Descriptive statistics related to political traumatic events, political trauma symptoms, self-concept, depression, anxiety, stress, healthy coping, unhealthy coping, Hopelessness, sleep risky behaviors, drug use risky behaviors, and aggression as shown in table 11. Participants reported high scores on self-concept. Moreover, participants reported Moderate scores on political traumatic events , Political trauma symptoms, drug use risky behaviors, healthy coping, and hopelessness. Finally, participants reported average scores on depression, anxiety, stress,

sleep risky behaviors, aggression and unhealthy coping. Regarding internal consistency, the tools of the current study indicated a high level of reliability on Cronbach's Alpha Formula; scores ranged from .93 (*Stress*) to .86 (*Unhealthy coping*).

Table 11.

Descriptive statistics for research variables (N= 371)

Variable	Mean	SD	Min	Max	Range	Skewness	Kurtosis	Reliability
Political traumatic events	1.34	.25	1.00	2.00	1.00	.37	-.59	.91
Political trauma symptoms	2.98	.97	1.00	5.00	4.00	-.05	-.64	.92
Self-concept	3.32	.49	2.17	5.00	2.83	.74	.21	.90
Depression	2.07	.65	1.00	4.00	3.00	.28	-.16	.93
Anxiety	1.92	.68	.86	4.00	3.14	.44	-.21	.91
Stress	2.15	.64	1.00	4.00	3.00	.17	-.01	.92
Sleep risk behaviors	2.65	.56	1.40	4.70	3.30	.30	.29	.90
Drug use risky behaviors	2.88	.25	2.11	4.33	2.22	.80	.34	.90
Aggression	2.67	.71	1.29	4.43	3.14	.20	-.68	.88
Healthy coping	2.42	.65	1.00	4.00	3.00	-.19	.00	.87
Unhealthy coping	2.05	.61	1.00	4.00	3.00	.55	.56	.86
Hopelessness	1.31	.22	1.00	1.95	1.10	.22	-.94	.93

Results of the correlational analysis are mentioned in Table 12. Specifically, political traumatic events positively correlated with political trauma symptoms (r =.39, $p < .01$), depression (r =.29, $p < .01$), anxiety (r =.29, $p < .01$), stress (r =.22, $p < .01$), sleep risky behaviors (r =.13, $p < .05$), dug use risky behaviors (r =.19, $p < .01$), aggression (r =.27, $p < .01$), healthy coping (r = -.13, $p < .05$), unhealthy coping (r =.19, $p < .01$), hopelessness (r =.16, $p < .01$), and negatively correlated with self-concept (r =-.13, $p < .01$). Political trauma symptoms positively correlated with depression (r =.36, $p < .01$), anxiety (r =.41, $p < .01$), stress (r =.33, *p*

$< .01$), sleep risky behaviors (r =.08, $p < .05$), dug use risky behaviors (r =.15, $p < .01$), aggression (r =.44, $p < .01$), healthy coping (r =.07, $p < .05$), unhealthy coping (r =.24, $p < .01$), hopelessness (r =.23, $p < .01$) , and negatively correlated with self-concept (r =-.37, $p < .01$). Depression positively correlated with anxiety (r =.77, $p < .01$), stress (r =.79, $p < .01$), sleep risky behaviors (r =.17, $p < .05$), dug use risky behaviors (r =.06, $p < .05$), aggression (r =.30, $p < .01$), healthy coping (r =.21, $p < .01$), unhealthy coping (r =.37, $p < .01$), hopelessness (r =.31, $p < .01$). Anxiety positively correlated with stress (r =.75, $p < .01$), sleep risky behaviors (r =.12, $p < .05$), dug use risky behaviors (r =.11, $p < .05$), aggression (r =.27, $p < .01$), healthy coping (r =.18, $p < .01$), unhealthy coping (r =.42, $p < .01$), hopelessness (r =.30, $p < .01$).

Stress positively correlated with sleep risky behaviors (r =.13, $p < .05$), dug use risky behaviors (r =.12, $p < .05$), aggression (r =.25, $p < .01$), healthy coping (r =.28, $p < .01$), unhealthy coping (r =.37, $p < .01$), hopelessness (r =.18, $p < .01$). Sleep risky behaviors positively correlated with dug use risky behaviors (r =.07, $p < .05$), aggression (r =.09, $p < .05$), unhealthy coping (r =.13, $p < .05$), hopelessness (r =.23, $p < .01$). Drug use risky behaviors positively correlated with aggression (r =.20, $p < .01$), unhealthy coping (r =.11, $p < .05$), and hopelessness (r =.17, $p < .01$). Aggression positively correlated with healthy coping (r= .07, $p < .05$), unhealthy coping (r =.26, $p < .01$), and hopelessness (r =.25, $p < .01$). Healthy coping positively correlated with unhealthy coping (r =.72, $p < .01$), and negatively correlated with hopelessness (r =-.13, $p < .05$). Finally, unhealthy coping positively correlated with hopelessness (r =.21, $p < .01$).

Table 12.

Correlations among study variables (N= 371)

Measures	*1*	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*
Political traumatic events	*1*	.39**	-.13*	.29**	.29**	.22**	.01	.11*	.27**	.13*	.19**	.16**
Political trauma symptoms		1	-.37**	.36**	.41**	.33**	.08*	.15*	.44**	.07*	.24**	.23**
Self-concept			1	-.37**	-.35**	-.26**	-.19**	-.18**	-.36**	.07*	-.30**	-.50**
Depression				1	.77**	.79**	.17**	.06*	.30**	.21**	.37**	.31**
Anxiety					1	.75**	.12*	.11*	.27**	.18**	.42**	.30**
Stress						1	.13*	.12*	.25**	.28**	.37**	.18**
Sleep risk behaviors							1	.07*	.09*	.04	.13*	.23**
Drug use risky behaviors								1	.20**	.02	.11*	.17**
Aggression									1	.07*	.26**	.25**
Healthy coping										1	.72**	-.13*
Unhealthy coping											1	.21**
Hopelessness												1

*Correlation is significant at the 0.05 level (2-tailed) **
*Correlation is significant at the 0.01 level (2-tailed) ***

In table 13, we tested simultaneous multiple regression analysis to predict aggressiveness through demographic variables (residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members) in step1. While demographic variables (residence, place of residence, academic degree, income, marital status, employed/ unemployed status, type of work, and family members) with political traumatic events and political trauma symptoms were used to predict aggressiveness in sept2. Our findings

revealed that aggressiveness predicted by academic degree (β = .11; ** $p < .05$), in favor of high school holders (M; graduate degree holders = 2.47, BA holders = 2.69, high school holders = 2.76), political traumatic events (β = .14; ** $p < .05$), and Political trauma symptoms (β = .39; ** $p < .01$).

Table13.

Simultaneous multiple regression analysis for variables predicting aggressiveness (N= 371)

Variable	B	SEB	β	R2
Step1				
Residency	.02	.05	.02	
Place of residence	-.20	.16	-.06	
Academic degree	.12	.05	.11*	.09
Income	.16	.01	.02	
Marital status	.10	.07	.09	
employed/ unemployed	-.22	.13	-.14	
Type of work	.11	.07	.14	
Family members	.04	.01	.01	
Step2				
Residency	.05	.04	.05	
Place of residence	-.10	.14	-.02	
Academic degree	.12	.05	.11*	
Income	.07	.01	.06	
Marital status	.04	.06	.03	.30
employed/ unemployed	-.08	.12	-.05	
Type of work	.08	.06	.10	
Family members	.01	.01	.04	
Political traumatic events	.39	.14	.14*	

Political trauma symptoms	.28	.03	.39**

*** P < .01; *p < .05*

In table 14, Chi-square test was implemented to test the significance of difference in frequencies between males who encountered GBV and those who didn't. Results of Chi-square test indicated that out of 344 male respondents, 152 reported they encountered several types of GBV.

Table 14.

Results of Chi-square test for the differences in GBV encounters (N= 344)

Experienced GBV	Observed N	Expected N	Residual	df	Chi-square	Sig
Yes	152	172	20	1	4.65	.0**
No	192	172	-20			
Total	344					

** P < .01*

Chi-square test (see table 15) was employed to test the significance of differences in frequencies of types of GBV encountered by Palestinian men. Results of Chi-square test indicated that out of 342 male respondents, 33 men encountered physical GBV, 68 men experienced psychological GBV, 2 men encountered sexual GBV, 43 encountered both physical and psychological GBV, 8 women encountered all types of GBV, and finally 187 men did not encounter any type of GBV.

Table15.

Results of Chi-square test for the differences in types of GBV (N=342)

GBV types	Observed N	Expected N	Residual	df	Chi-square	Sig
Physical	34	57	-23	5	406.52	.000***
Psychological	68	57	11			
Sexual	2	57	-55			
Physical & psychological	43	57	-14			
All types	8	57	-49			
None	187	57	130			
Total	342					

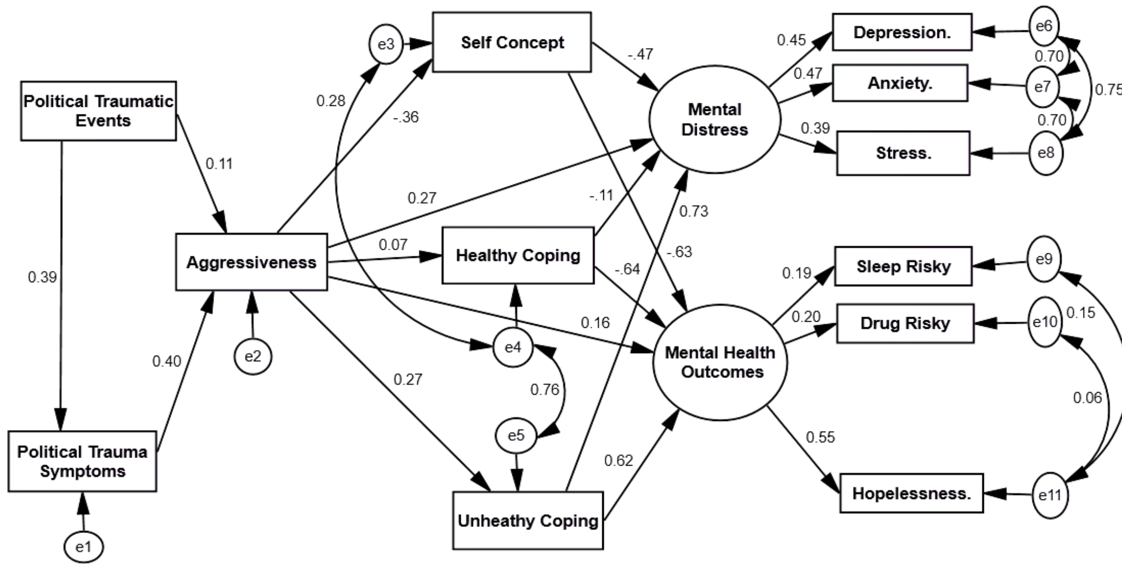
*** *P < .001*

Structural equation model (SEM)

Table 16 and Figure 24 display the outcomes of the path analysis, with aggressiveness as a predictor, self-concept, healthy coping, and unhealthy coping as mediating variables, and mental health distress (stress, anxiety, and depression), and mental health outcomes (sleep risky behaviors, drug risky behaviors, and hopelessness) as outcome variables tested across the sample (N=371). The findings of the current study showed that self-concept, healthy coping, and unhealthy coping mediated the relationship between aggressiveness, mental health distress, and mental health outcomes with a good fit for the data ($\chi2_{(41)}$ =54.13; p =.000; GFI=.98; AGFI=.97; RMSEA=.03; NFI=.97; FI=.98).

Figure 24.

SEM for the effect of aggressiveness resulting from political traumatic events and symptoms on mental health distress and outcomes, and the mediating roles of self-concept, healthy and unhealthy coping.



Analysis of the paths between political traumatic events and aggressiveness showed a positive effect ($\beta_{M,\ Y} = .27$; $p < .01$). Moreover, a positive effect in path analysis was also established between political trauma symptoms and aggressiveness (βM, Y =.40; $p < .05$). Results of path analysis between aggressiveness and mental distress showed a positive effect, stress (βM, Y =.24; $p < .01$), anxiety (βM, Y =.12; $p < .05$), and depression (βM, Y =.28; $p < .01$), and a positive effect was found in path analysis between aggressiveness and mental health outcomes, hopelessness (βM, Y =.28; $p < .01$), drug use risky behaviors (βM, Y =.10; $p < .05$), and sleep risky behaviors (βM, Y =.09; $p < .05$).

In addition, Results of path analysis between self-concept and mental distress showed a negative effect, stress (βM, Y =-.12; $p < .01$), anxiety (βM, Y =-.12; $p < .01$), and depression

βM, Y =-.21; $p < .01$). and a negative effect was found in path analysis between self-concept and mental health outcomes, hopelessness (βM, Y =-.34; $p < .01$), drug use risky behaviors (βM, Y = -.13; $p < .05$), and sleep risky behaviors (βM, Y = -.12; $p < .05$). Results of path analysis between healthy coping and mental health outcomes showed a negative effect, hopelessness (βM, Y =-.35; $p < .01$), drug use risky behaviors (βM, Y = -.13; $p < .05$), and sleep risky behaviors (βM, Y = -.12; $p < .05$).

Moreover, Results of path analysis between unhealthy coping and mental distress showed a positive effect, stress (βM, Y =.28; $p < .01$), anxiety (βM, Y =.34; $p < .01$), and depression βM, Y =.33; $p < .01$). and a positive effect was found in path analysis between unhealthy coping, and mental health outcomes, hopelessness (βM, Y =.34; $p < .01$), drug use risky behaviors (βM, Y =.13; $p < .05$), and sleep risky behaviors (βM, Y =.12; $p < .05$).

Finally, regarding the mediation hypothesis, the model produced the standardized total effect of aggressiveness on depression (βX, M =.28; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.22; $p < .01$), and unhealthy coping (βX, M, Y =.33; $p < .01$), and a statistically significant direct effect of aggressiveness on total mental health distress (βX, Y, M =.62; $p < .01$).

The model yielded a standardized total effect of aggressiveness on anxiety (βX, M =.29; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.22; $p < .01$), and unhealthy coping (βX, M, Y =.34; $p < .01$), and a statistically significant direct effect of aggressiveness on total mental health distress (βX, Y, M =.62; $p < .01$).

Also, the model yielded a standardized total effect of aggressiveness on stress (βX, M =.24; $p < .01$). However, this effect was composed of a statistically significant indirect effect via

self-concept (βX, M, Y =-.28; $p < .01$), and unhealthy coping (βX, M, Y =.28; $p < .01$), and a statistically significant direct effect of aggressiveness on total mental health distress (βX, Y, M =.62; $p < .01$).

The model revealed a standardized total effect of aggressiveness on hopelessness (βX, M =.28; $p < .01$). However, this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.34; $p < .01$), healthy coping (βX, M, Y =-.35; $p < .01$) and unhealthy coping (βX, M, Y =.34; $p < .01$), and a statistically significant direct effect of aggressiveness on total mental outcomes (βX, Y, M =.50; $p < .01$).

Furthermore, the model indicated a standardized total effect of aggressiveness on drug use risky behaviors (βX, M =.10; $p < .05$), this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.12; $p < .05$), healthy coping (βX, M, Y =-.12; $p < .05$) and unhealthy coping (βX, M, Y =.12; $p < .05$), and a statistically significant direct effect of aggressiveness on total mental outcomes (βX, Y, M =.50; $p < .01$).

Finally, the model revealed a standardized total effect of aggressiveness on sleep risky behaviors (βX, M =.10; $p < .05$), this effect was composed of a statistically significant indirect effect via self-concept (βX, M, Y =-.12; $p < .05$), healthy coping (βX, M, Y =-.12; $p < .05$) and unhealthy coping (βX, M, Y =.11; $p < .01$), and a statistically significant direct effect of GBV on total mental outcomes (βX, Y, M =.50; $p < .01$).

Table 16.

Results of SEM analysis for conceptualized model (N = 371)

Endogenous variables	Exogenous variables	Standardized regression weights (β)	*P*	Indirect effect *(p)*	Standardized total effect (*p*)
Aggressiveness	Political traumatic events	.11	$<.05$	----	.27($p<.01$)
Aggressiveness	Political trauma symptoms	.40	$<.01$	----	.40($p<.01$)
Self-concept	Aggressiveness	-.36	$<.01$	----	-.36($p<.01$)
Healthy coping	Aggressiveness	.07	$<.05$	----	.07($p<.05$)
Unhealthy coping	Aggressiveness	.26	$<.01$	----	.26($p<.01$)
Mental health distress	Aggressiveness	.27	$<.01$	----	.62($p<.01$)
Mental health outcomes	Aggressiveness	.15	$<.01$	----	.50($p<.01$)
Mental health distress	Self-concept	-.47	$<.01$	----	-.47($p<.01$)
Mental health outcomes	Self-concept	-.63	$<.01$	----	-.63($p<.01$)
Mental health distress	Healthy coping	-.10	$<.05$	----	-.11($p<.05$)
Mental health outcomes	Healthy coping	-.64	$<.01$	----	-.64($p<.01$)
Mental health distress	Unhealthy coping	.72	$<.01$	----	.34($p<.01$)
Mental health outcomes	Unhealthy coping	.62	$<.01$	----	.72($p<.01$)
Depression	Self-concept			-.21($p<.01$)	
	Unhealthy coping			.33($p<.01$)	
Anxiety	Self-concept			-.22($p<.01$)	
	Unhealthy coping			.34($p<.01$)	
Stress	Self-concept			-.18($p<.01$)	
	Unhealthy coping			.28($p<.01$)	
Hopelessness	Self-concept			-.34($p<.01$)	
	Healthy coping			-.35($p<.05$)	
	Unhealthy coping			.34($p<.05$)	
Drug use risky behaviors	Self-concept			-.12($p<.05$)	
	Healthy coping			-.13($p<.05$)	
	Unhealthy coping			.12($p<.05$)	
Sleep risky behaviors	Self-concept			-.12($p<.05$)	
	Healthy coping			-.12($p<.01$)	
	Unhealthy coping			.11($p<.01$)	

4.1.4.3 Females and Males Data

In table 17, The significance of differences between males and females in political traumatic events, political trauma symptoms, self-concept, depression, anxiety, stress, healthy coping, unhealthy coping, hopelessness, smoking risky behaviors, drug use risky behaviors, and

sleep risky behaviors were examined using independent samples t-test. Results of independent samples t-test showed significant differences between males and female in traumatic experiences in favor of males (M; Females = 1.23, Males = 1.34). While significant differences were noted between males and females in political trauma symptoms in favor of females (M; Females = 3.10, Males = 2.98). Significant differences were noted between males and females in self-concept (M; Females = 3.42, Males = 3.32), in favor of female respondents. Moreover, female participants reported more anxiety compared with male participants (M; Females = 2.04, Males = 1.92). The results also showed significant differences between males and females in stress (M; Females = 2.43, Males = 2.25), in favor of females. Female participants reported more healthy coping compared with male participants (M; Females = 2.61, Males = 2.42). Significant differences were observed between males and females in unhealthy coping (M; Females = 2.13, Males = 2.05), in favor of females. Male participants reported more hopelessness compared with female participants (M; Females = 1.23, Males = 1.31).

Table17.

Differences between males and females according to study variables (N=1038)

Dependent variable	Independent variables	N	M	SD	t-value	df	Sig
Political traumatic events	Males	371	1.34	.25	7.31	1036	.000***
	Females	667	1.23	.20			
Political trauma symptoms	Males	371	2.98	.97	-2.10	1036	.000***
	Females	667	3.10	.82			
Self-concept	Males	371	3.32	.49	-3.01	1036	.02*
	Females	667	3.42	.51			
Depression	Males	371	2.07	.65	-.64	1036	.52
	Females	667	2.10	.69			

Anxiety	Males	371	1.92	.68	-2.63	1036	.00**
	Females	667	2.04	.69			
Stress	Males	371	2.25	.59	-4.42	1036	.000***
	Females	667	2.43	.62			
Healthy coping	Males	371	2.42	.65	-4.87	1036	.000***
	Females	667	2.61	.59			
Unhealthy coping	Males	371	2.05	.61	-2.27	1036	.02*
	Females	667	2.13	.51			
Hopelessness	Males	371	1.31	.22	6.18	1038	.000***
	Females	667	1.23	.21			

4.1.5 Preliminary discussion of results

The main two aims of this study were to assess the association between political traumatic events, political trauma symptoms and GBV, as well as the association between GBV and mental health outcomes (humiliation, hopelessness, and low self-efficacy) and distress (depression, anxiety, and stress). Additionally, the study aimed to examine whether self-concept, healthy coping, and unhealthy coping mediate the relationship between GBV, mental health outcomes and distress among Palestinian females. The second aim was to assess the association between Political traumatic events, political trauma symptoms and aggressiveness, as well as the association between aggressiveness and mental health outcomes and distress. The study also sought to test whether self-concept, along with healthy and unhealthy coping strategies, mediate the association between aggressiveness, mental health outcomes (sleep risky behaviors, drug use, and hopelessness) and mental distress (depression, anxiety, and stress) among Palestinian males.

By addressing the first aim, the results demonstrated a positive effect between political traumatic events, political trauma symptoms and GBV. Also, a positive effect was detected between GBV

and mental health outcomes (humiliation, hopelessness, and low self-efficacy), and between GBV and mental distress (depression, anxiety, and stress). Moreover, a negative effect was found between self-concept, healthy coping and mental distress (depression, anxiety, and stress), as well as between self-concept, healthy coping and mental health outcomes (humiliation, hopelessness, and low self-efficacy) among Palestinian females. Conversely, a positive effect was found between unhealthy coping and mental distress (depression, anxiety, and stress), and between unhealthy coping and mental health outcomes (humiliation, hopelessness, and low self-efficacy) among Palestinian females. Finally, self-concept, healthy coping, and unhealthy coping mediated the relationship between GBV, mental health outcomes and mental distress.

While by addressing the second aim, the results demonstrated a positive effect between political traumatic events, political trauma symptoms and aggressiveness. Also, a positive effect was detected between aggressiveness and mental health outcomes (sleep risky behaviors, drug use, and hopelessness), and between aggressiveness and mental distress (depression, anxiety, and stress). Moreover, a negative effect was found between self-concept, healthy coping and mental distress (depression, anxiety, and stress), and between self-concept, healthy coping and mental health outcomes (sleep risky behaviors, drug use, and hopelessness) among Palestinian males. Additionally,, a positive effect was found between unhealthy coping and mental distress (depression, anxiety, and stress), and between unhealthy coping and mental health outcomes (sleep risky behaviors, drug use, and hopelessness) among Palestinian males. Finally, self-concept, healthy coping, and unhealthy coping mediated the association between aggressiveness, mental health outcomes and mental distress.

4.1.5.1 Political traumatic events, political trauma symptoms and GBV victimization

In agreement with prior research (Canetti et al., 2010; Mahamid et al., 2022; Mahamid et al., 2023), a positive relationship was found between exposure to traumatic events and political trauma. Importantly, consistent with prior studies (Breet et al., 2019; Gilbar et al., 2021), the findings of the current study supported the first hypothesis, which proposed a positive association between political trauma resulting from political traumatic events and GBV victimization, as a positive relationship was found between political trauma related to political traumatic events and GBV victimization among the study sample.

Accordingly, Palestinian females exposed to political violence began to exhibit trauma symptoms, which, in turn, increased the risk of experiencing GBV. One possible explanation could relate to social approach, which suggests that trauma symptoms emerge due to environmental stressors (Maercker & Hecker, 2016). As Palestinian females live in a context with various environmental stressors due to the Israeli occupation, they may be at risk of developing mental health disorders, including PTSD. While, as an explanation for the relationship between political trauma and GBV victimization, is that trauma-related symptoms, such as irritability and anger, can undermine emotional intimacy, foster unhealthy relationship dynamics, and lead to behaviors that increase vulnerability to GBV victimization (Breet et al., 2019; Gibbs et al., 2018). Additionally, PTSD and depression can distort women's perceptions of assault risk, making them less likely to take protective measures. These conditions heighten women's vulnerability, making them more susceptible to violence and more likely to be targeted by perpetrators (Machisa et al., 2021).

4.1.5.2 GBV, mental health outcomes, and mental distress

The current findings confirmed the second hypothesis, and replicate prior research showing a positive relationship among females between experiencing GBV and negative mental health outcomes and distress (Haj- Yahia, 2000; Thabet et al., 2015; Veronese et al., 2023). This result can be explained by the fact that exposure to violence is considered as a stressful event that requires coping mechanisms to cope with. When females lack such coping mechanisms or adopt negative coping strategies, they become more vulnerable to mental distress such as stress, depression, and anxiety (Lazarus & Folkman, 1984). While With the continuation of violence and the inability to stop it, especially when this violence is rooted in exposure to political violence and the ongoing Israeli occupation, females may feel helpless and hopeless about changing their situation and stopping the violence against them. This sense of helplessness can hinder their self-efficacy (Seligman, 1975).

Furthermore, women feel humiliated when they realize that males perceive them as an inferior gender, hold them in contempt, and see them as unworthy (Fattore & Mason, 2020). Also, Palestinian females may feel humiliated because, despite their ability to deal with the stressors and challenges they face due to restrictions related to the occupation and its impact on their quality of life, they are still seen as unworthy by males.

4.1.5.3 Self-concept, healthy coping, and unhealthy coping as factors influencing mental health outcomes of GBV

The results showed a negative association between mental health outcomes, mental distress, self-concept and healthy coping, while a positive relationship was found between unhealthy coping, mental health outcomes and mental distress. Thus, the third hypothesis was confirmed. These findings on the relationship between self-concept, healthy coping, and the

negative mental health outcomes of GBV are consistent with prior research (Abu-Lughod, 2010; Baloushah et al., 2019; Haj-Yahia & Clark, 2013; Magalhães et al., 2022; Veronese et al., 2023). While the results regarding the relationship between unhealthy coping and the negative mental health outcomes of GBV, were consistent with previous research by (Cao et al., 2023; Ghoshal et al., 2023; Magalhães et al., 2022).

Individuals with a positive self-concept tend to experience fewer psychological problems because their well-developed sense of self helps them manage uncertainty and mental distress. From an epistemic perspective, a solid self-concept reduces psychological entropy—essentially the mental confusion that comes from uncertainty about oneself (Hirsh et al., 2012). This clarity about who they are allows them to better process and integrate self-related information, maintain a sense of continuity and meaning in their lives, and make sense of past experiences (Klein & Lax, 2010).

From a practical standpoint, individuals with a positive self-concept are able to predict, regulate, and navigate social relationships. They tend to seek interactions that confirm their self-perception or engage in behaviors that reinforce how they see themselves, which further stabilizes their self-concept and reduces psychological distress (Swann, 2005). This alignment between their self-perception and their social interactions contributes to their overall mental well-being.

Individuals who possess a healthy self-concept, characterized by a clear and integrated understanding of themselves, tend to experience higher life satisfaction, stable self-esteem, and fewer negative emotions. This well-developed self-knowledge enables them to react less defensively in situations that threaten their sense of self and promotes greater mindfulness. The belief in having integrated self-knowledge—understanding internal processes in a coherent and

unified manner—is linked to lower levels of anxiety, depression, and perceived stress, along with higher self-esteem, subjective well-being, self-compassion, mindfulness, autonomy, competence, relatedness, and self-control (Jankowski et al., 2022). This comprehensive self-awareness and self-integration make individuals less vulnerable to mental distress, as they can better navigate life's challenges with resilience and clarity.

While as an explanation for the results on the association between healthy and unhealthy copings with mental health distress; is that individuals who engage in healthy coping strategies are less vulnerable to mental health distress because these strategies not only help to reduce stress but also support long-term emotional and psychological adaptation. Unlike unhealthy coping strategies, which may provide temporary relief but ultimately hinder long-term well-being, healthy coping fosters resilience, enabling individuals to better manage and overcome challenges. This sustained ability to adapt and cope in the face of stress reduces the likelihood of experiencing ongoing mental health problems (Delhom et al., 2018).

As a theoretical explanation, individuals who adopt healthy coping strategies, such as problem-focused coping, tend to experience fewer mental health problems because they actively address the root causes of their stress. By rationally evaluating the situation, considering the factors involved, and using their capacity to solve the problem, they modify the stress-inducing circumstances, reducing their psychological distress. In contrast, emotion-focused coping, which centers on alleviating emotional distress without addressing the underlying issue, may offer temporary relief but doesn't resolve the stressor, potentially leading to the development and persistence of their mental distress (Lazarus & Folkman, 1986). In other words, individuals adopting unhealthy coping strategies often turn to unhealthy behaviors such as substance use and

avoidance. These behaviors minimizing the severity or impact of stressful events and failing to engage in proactive problem-solving techniques (Magalhães et al., 2022).

4.1.5.4 Political traumatic events, political trauma symptoms, and aggressiveness in males

In agreement with prior research (Canetti et al., 2010; Hall et al., 2015; Mahamid et al., 2022; Mahamid et al., 2023; Steel et al., 2009), a positive relationship was found between exposure to traumatic events and political trauma. Importantly, consistent with prior studies (Bahati et al., 2022; Begić & Begić, 2001; Breet et al., 2019; Gibbs et al., 2021; Gillikin et al., 2016; Goessmann et al., 2019; Hellmuth et al., 2012; Sousa et al., 2018; Zedan & Haj-Yahia, 2023), the fourth hypothesis proposed a positive relationship between political trauma related to political traumatic events and aggressiveness in males. The findings confirmed this hypothesis by demonstrating a positive relationship was found between political trauma related to political traumatic events and aggressiveness among Palestinian males.

Accordingly, Palestinian males exposed to political violence began to exhibit trauma symptoms, which, in turn led to aggressive behavior toward females. This can be explained by emotional theories which propose that PTSD can emerge when individuals have difficulty coping with or adapting to traumatic experiences (Suveg & Zeman, 2004). People with rigid beliefs before the trauma are especially at risk—those with inflexible positive beliefs may see these beliefs challenged, while those with rigid negative beliefs may see them reinforced (Park et al., 2014). Additionally, negative evaluations of one's own or others' reactions to trauma, along with responses to early trauma symptoms, can interact with these pre-existing beliefs, heightening feelings of ongoing threat and inadequacy that contribute to chronic PTSD. and so, Palestinian males may struggle to emotionally cope with the continuous trauma, leading to persistent symptoms of PTSD. Those with rigid pre-trauma beliefs are particularly vulnerable; for instance,

rigid positive beliefs about safety and justice can be shattered by the ongoing violence, while rigid negative beliefs about the world may become more entrenched. Additionally, the continuous nature of political violence can result in constant negative assessments of one's own reactions, others' responses, and the overall situation. These negative evaluations can reinforce existing beliefs of pervasive threat and incompetence. Consequently, the ongoing violence exacerbates feelings of insecurity and helplessness, contributing to the development and persistence of PTSD in affected individuals.

While, one possible explanation for the relationship between political trauma and aggressiveness, is that trauma symptoms can alter perceptions of cues and reduce inhibitions, leading to increased aggression (Machisa & Shamu,2018). Moreover, trauma-related symptoms, such as irritability and anger, may raise the likelihood of perpetrating GBV by undermining emotional intimacy, fostering maladaptive dependency patterns, or promoting aggressive behaviors (Breet et al., 2019; Gibbs et al., 2018). Another explanation, is that trauma symptoms in males can induce a type of gender role stress known as a narcissistic masculine wound (Gilbar et al., 2019). This wound involves feelings of inadequacy and worthlessness, which, coupled with societal pressures, may result in increased aggressive behavior.

4.1.5.5 Aggressiveness, mental health outcomes, and mental distress

The current findings supported the fifth hypothesis of the study, which propose a positive relationship between aggressiveness related to political trauma ,negative mental health outcomes and mental distress among Palestinian males. Also, our findings are consistent with the limited existing research indicating that violence against women imposes a mental health burden on perpetrators. In a study examined the relationship between IPV perpetration and poor mental health among Nigerian young adults, the results showed that IPV perpetration was associated

with feeling worthless, sadness, and alcohol use among the study sample (Stark et al., 2020). And so, the vast of research concentrated on exploring poor mental health as a risk factor for aggressiveness or violence against women, rather than on the negative mental health outcomes of perpetrating violence.

When individuals become aggressive with others and perpetrate violence this affect their relationship with others negatively specifically when they are partners, and leads to relationship breakdowns, divorce, with accompanying negative effects such as loss of housing; personal distress including fear, depression, stress, anxiety, stress, and drug use (Capaldi et al., 2005).

In the Palestinian context, which is characterized by a collectivistic society, an individual exhibiting aggressive behavior may experience deterioration in relationships, leading to loss of social support. This loss can negatively impact the individual's mental health, as social support is a crucial protective factor in collectivistic cultures. Additionally, the lack of accessible mental health services contributes to the persistence and chronicity of mental health issues. The stigma associated with psychotherapy further exacerbates this problem, particularly for males who may be less likely to seek help for their aggressive behavior. As a result, untreated aggressive behavior, compounded by psychosocial and environmental stressors, can lead to the development of more severe mental health disorders. Furthermore, Palestinian females suffer not only from political violence but also from violence inflicted by males who may be their fathers, husbands, or others, leading to the development of not only negative feelings such as guilt and shame in male perpetrators but also maladaptive behaviors and mental health issues.

4.1.5.6 Self-concept, healthy coping, and unhealthy coping as factors influencing mental health outcomes of aggressiveness

The results showed a negative relationship between mental health outcomes, mental distress and self-concept and healthy coping, while a positive relationship was found between unhealthy coping, mental health outcomes and mental distress. Thus, the sixth hypothesis was confirmed. To our knowledge, no study has yet examined the mediating roles of self-concept, healthy coping, and unhealthy coping in the relationship between aggressiveness and negative mental health outcomes among perpetrators of violence.

As an explanation for how self-concept can mediate the relationship between aggressive behavior and negative mental health outcomes among violence perpetrators, is that, perpetrators often have high self-expectations and a strong moral self-concept, viewing themselves as loyal and trustworthy. To protect this self-image, they may engage in self-deception and moral absolutism, which helps them justify their violent behavior and avoid immediate psychological distress. While this defense mechanism temporarily shields them from the worst effects, it can lead to more severe mental health issues over time as the internal conflict between their actions and self-perception builds up (Cunha et al., 2023).

In other words, violence perpetrators often have a poor self-concept that is obscured by unrealistic self-expectations and moral absolutism. They maintain a distorted self-image by justifying their violent behavior through self-deception. While this helps them avoid immediate psychological distress, it doesn’t address the underlying issues. Over time, the conflict between their aggressive actions and their idealized self-concept can lead to more severe mental health problems, as the strain of maintaining this poor self-concept accumulates.

While healthy coping strategies can mediate the relationship between aggressive behavior and mental health outcomes by influencing how individuals manage stress and emotional responses. According to Carver et al. (1989), healthy coping techniques, such as problem-solving and seeking social support, help address the underlying causes of aggression and regulate emotions, thereby reducing the risk of developing mental health issues. These strategies act as a buffer, preventing aggressive behavior from leading to severe psychological distress. On the contrary, unhealthy coping strategies, such as avoidance and substance abuse, exacerbate the relationship by failing to address the root causes of aggression and leading to maladaptive behaviors, which can worsen mental health outcomes. Thus, healthy coping serves as a mediator that can diminish the negative impact of aggressive behavior on mental health, while unhealthy coping tends to amplify it.

4.1.5.7 GBV victimization predicted by socio-demographic factors among Palestinian females

According to our results, GBV victimization was predicted by residency factor in favor of females reside in internally displaced Palestinian camps, and marital status in favor of divorced females.

Results regarding GBV predicted by residency are consistent with previous research conducted by (Al-Modallal et al., 2015; bdier & Mahamid, 2021). One explanation for this result is that Palestinian females in refugee camps endure especially challenging social and economic conditions, as many lack personal income or employment and rely entirely on men for support. Due to the higher unemployment rates in these camps compared to nearby urban areas, males experience significant stress, which can often manifest as violent behavior toward their wives or daughters (Al-Modallal et al., 2015). Furthermore, the occupation's policies and practices specifically targeting refugee camps subject men to continuous humiliation, rendering them

unable to protect or provide for their families. This sense of powerlessness can lead to frustration, often expressed as violence against those with less power, particularly women and children (Clark et al., 2010). Also, Palestinian refugee females are particularly vulnerable to violence in refugee camps due to the precarious and uncertain living conditions they face while coping with ongoing crises and conflicts. In a context where state institutions have been systematically weakened or destroyed, the absence of any alternative accountable authority leaves these females at greater risk of experiencing violence from males (Bordignon, 2014). Another possible explanation, is that violence against females is not viewed as a taboo in this context (Khawaja & Barazi, 2005).

While as a possible explanation for why divorced women are at greater risk of experiencing violence from men is the high rates of unemployment (Bordignon, 2014), which make these women financially dependent on their families. This dependence may increase the risk of violence, especially if they have children. Another possible explanation is that Palestinian culture does not accept or approve of divorce, leading to societal disapproval and blame directed toward divorced women. This cultural stigma places them at greater risk of violence, whether from their own families or their ex-husbands (Meler, 2023). Another explanation, is that divorced women find it easier and with more freedom to talk about the violence that they were exposed to than married women (Mamdouh et al., 2012).

4.1.5.8 Aggressiveness predicted by socio-demographic factors among Palestinian males

According to the study results, aggressiveness was predicted by academic degree in favor of high school diploma holders. This result aligns with previous studies demonstrating a a positive association between perpetrating violence and behave aggressively with lower education (clark et al., 2010; Tran et al., 2016; Zakar et al., 2013).

Higher education plays a critical role in the advancement of the backward societies, with benefits that extend well beyond economic calculations. It is essential in building a higher level of human capital, which is fundamental to progress in the modern world. By fostering cognitive growth and enhancing sophisticated abilities, higher education contributes to societal development. Education improves marital satisfaction and communication skills, enabling couples to discuss issues, resolve conflicts, and reason logically. These skills help in addressing and mitigating aggression, leading to healthier, more constructive relationships (Banat, 2015). Moreover, a study exploring attitudes toward Intimate Partner Violence against Women among women and men in 39 low- and middle-income countries found that men with less education are more likely to justify and perpetrate violence against women. Lower average levels of education are linked to greater gender inequality and the acceptance of violence as a strategy for resolving relationship conflicts or expressing frustration and anger (Tran et al., 2016).

4.1.5.9 Gender differences in responses to political traumatic events, including political trauma symptoms, self-concept, depression, anxiety, stress, healthy and unhealthy coping, and hopelessness

Consistent with prior research (Breslau et al., 1998; Heath et al., 2013; Wagner et al., 2020; Zona & Milan, 2011), the results of the current study revealed that Palestinian males were exposed to more political traumatic events compared with Palestinain females.

The Palestinian culture and politics create a unique environment for understanding female and male vulnerability to be exposed to political violence. During the Palestinian resistance, male heroism and sacrifice were especially valued, as is common in struggles for independence (Punamäki et al., 2005). Also, the higher odds of experiencing political violence among males may be attributed to gender differences in the environments they are exposed to or

choose to enter. This is particularly evident in conservative settings, where females may face family or social restrictions on their mobility, while males are more likely to engage in political demonstrations and violent resistance activities (Canetti et al., 2010; Wagner et al., 2020). As a result, males are perceived as the more threatening gender, making them more vulnerable to experiencing political violence, as they are often targeted because of their gender.

Supported by previous studies (Canetti et al., 2010; Heath et al., 2013; Hobfoll et al., 2011; Punamäki et al., 2005; Tolin & Foa, 2008; Wagner et al., 2020) trauma symptoms, anxiety, and stress, significant differences were found between females and males, with females showing higher levels on them, while no significant differences were observed between genders in terms of depression.

These results can be explained by the fact that Palestinian males tend to normalize exposure to violence (Wagner et al., 2020). Another explanation for the results is that, in addition to political violence, Palestinian females face social pressures, such as unequal gender norms, which subject them to additional stress (Heath et al., 2013). Also, as Palestinian females are expected to fulfill specific roles pre-defined by their cultural society, such as raising children and managing household chores. As a result, they often struggle to find time for themselves to process their feelings or seek help. Furthermore, trauma symptoms in males were associated with exposure to political violence, whereas in females, they were primarily associated with socio-political stressors rather than exposure to political violence (Canetti et al., 2010). This could explain why females exhibit greater trauma symptoms than males, as males in this study reported moderate levels of exposure to political violence.

Regarding hopelessness, Palestinian males reported more hopelessness compared with Palestinian females, consistent with findings from a previous study by (Veronese et al. 2021).

This could be because Palestinian males often struggle to meet their own needs and those of their families due to the socio-economic impact of the ongoing occupation, such as high unemployment rates (Veronese et al. 2021). In the Palestinian context, where gender roles dictate that males are primarily responsible for providing financial support, this inability to fulfill their expected role may contribute to a greater sense of hopelessness among them.

On the other hand, Palestinian females reported higher scores on both healthy and unhealthy copings compared to males within the study sample. As an explanation for the results, is that females are more likely to seek and provide social support when facing adversities, which is a healthy coping strategy that fosters resilience. This is often attributed to women's greater tendency to openly acknowledge and express their emotions, including negative ones, making them more inclined to seek help and share their experiences (Abadsa & Thabet, 2013).

However, this same emotional openness may also contribute to higher levels of unhealthy coping. Women are often more sensitive to stress and may be more affected by negative events, leading them to sometimes engage in maladaptive coping strategies, such as avoidance or rumination (Stallman et al., 2021). Additionally, the social and cultural expectations placed on women to be more emotionally attuned can result in them being more vulnerable to stress and less likely to rely on personal competence alone to manage difficulties.

Regarding the differences between females and males in self-concept, significant differences were noted between males and females in favor of female respondents. One possible explanation for this finding is that Palestinian females generally have more support available to them than males, they are also more likely to offer support to others (Helgeson, 2003). However, this role as a key support provider can also reinforce and enhance their self-concept.

The current findings indicate that Palestinian females are more resilient in managing stressors compared with Palestinian males (Veronese et al. 2021). Women's ability to support others in coping with the stressors and challenges of the ongoing occupation may enhance their resilience and self- efficacy. In contrast, males tend to experience greater feelings of hopelessness (Veronese et al. 2021). This difference highlights how the resilience of females and their supportive roles contribute to a stronger self-concept, as they are more aware of their capabilities and contributions to others compared to their male counterparts.

CHAPTER FIVE

5.1 Integrated discussion of the results

5.1.1 Integrated discussion of the results from both inquiries

As was discussed before, GBV and its negative effects on individuals and communities have attracted significant attention from sociologists, psychologists, social workers, and various local and international organizations. In the Palestinian context, several studies have examined the mental health impacts on Palestinian women who have been exposed to violence (Alhajjar, 2013; Canetti et al., 2010; Haj-Yahia, 2000; Kira et al., 2015; Sousa et al., 2014; Sousa et al., 2018; Veronese et al., 2023). However, earlier studies showed that experiencing political trauma increases the likelihood of violence against women (Heath et al., 2013; Cougle et al., 2009). Most previous studies explored the association between political violence and GBV, mainly focused on women's perspectives regarding GBV (Coker et al., 2002; Giacaman, 2010; Manjoo & McRaith, 2011; Sousa, 2013). Moreover, the majority of research in the Palestinian context used quantitative methods (Haj-Yahia, 2000; Sousa et al., 2018; Thabet et al., 2015; Veronese et al., 2023; Zedan & Haj-Yahia, 2023), with qualitative studies also often concentrating on intimate partner violence (IPV) (Sousa et al., 2018; Zedan & Haj-Yahia, 2023), which overlooks a crucial group; unmarried women.

Therefore, this study had several aims. The first one was to investigate and understand the potential role of political trauma on GBV from the perspectives and perceptions of females, males, and mental health care providers in the Palestinian context, by applying an exploratory mixed method approach; while the second one was to understand factors that can help in developing conceptual model to enhance mental health status of Palestinian females who have suffered from political trauma and gender based violence in upcoming research. More

specifically, this study sought to understand the victimization of GBV and the potential contributions of political trauma and political violence to it. Additionally, it aimed to explore how both political trauma and political violence may contribute to the perpetration of GBV by men. Moreover, this research endeavored to comprehend GBV within the Palestinian context, characterized by prolonged occupation, from the perspectives of females, males, and mental healthcare providers. It also aimed to investigate the potential risk and protective factors associated with GBV victimization among women and GBV perpetration by men.

5.1.2 Political traumatic events and political trauma symptoms among Palestinians

By addressing the first question of the qualitative study, Palestinian females and males reported being exposed to different political traumatic events, with this exposure occurred either directly or indirectly, as similarly reported by MHCPs. Direct exposure, for example, is characterized by the loss of loved ones, demolition of their own houses, being injured as a result of being shot by Israeli soldiers, being arrested, and being humiliated at checkpoints. An example of indirect exposure to political violence is seeing these events on the news or hearing about them from others. The following quotations illustrate some of the direct and indirect exposure to political traumatic events that as narrated by two of the participants. T.A., a 43-year-old married woman from Jenin camp, said:

> I've been through several events, some before the moment of arrest and others at the moment of arrest. For example, the Israeli army had been chasing me more than once. Once, I had to jump from the second floor of a building to another building onto sand just to escape from them, even though I ended up fracturing three fingers. But the important thing is, thank God, I managed to escape from them.

While, A.J., a 50-year-old married man from Nour-Shams camp stated:

> My brother was severely injured when they came to arrest him. The first time they came to the hospital, they wanted to arrest my brother. That day, they brought my father and mother in a jeep and started threatening my brother that if he didn't turn himself in, they

> would kill them. Then, they arrested him at my sister's house and took him away without any clothes on.

According to these detected sub-themes, the researcher decided to use a quantitative measure to assess both direct and indirect exposure to political traumatic events in the quantitative study. The results of this measure supported the results emerged from the qualitative study, with both females and males participants reported moderate scores on political traumatic events for both direct and indirect exposure. The findings from both studies align with previous studies conducted in the Palestinian context. Palestinians have been found to endure numerous traumatic events due to the Israeli military occupation. These events include losing loved ones, sustaining physical injuries, experiencing attacks on family members or friends, and facing immediate life-threatening situations (El-Khodary et al., 2020). Additionally, Palestinians have been subjected to land invasions and confiscations, house evictions, demolitions, detentions, physical abuse, and murder as a result of the prolonged military occupation (Mahamid & Veronese, 2021; Mahamid et al., 2023).

In addition, the participants narrated how this exposure affected their mental negatively. Mental health outcomes were mainly characterized by trauma symptoms such as (avoidance, fear, anxiety, stress, hyperarousal, negative changes in emotions and feelings, re-experiencing, feelings of humiliation, irritability, insomnia, emotional numbing, and feelings of guilt). As an example showing the negative mental health outcomes lies in M.E. words, a 40-year-old married man from East Jerusalem :"Now life is difficult, and fear controls us, especially after the Sheikh Jarrah incidents. Why the weapons and violence? We have become afraid, and I am afraid to send my children to school. It is difficult to move around Jerusalem because I am Arab, and I am afraid to walk in the streets of Jerusalem in particular."

After this result, the researcher sought to use a scale to assess trauma symptoms among the participants. The results of the quantitative study supported the results of the qualitative study, in which participants from both genders; females and males reported moderate scores on political traumatic symptoms.

These results were in line with several studies showed that there was a positive relationship between exposure to political violence and negative mental health outcomes characterized by PTSD, depression, hopelessness, and anxiety among Palestinian adults (Canetti et al., 2010; Mahamid et al., 2022; Mahamid et al., 2023; Marie et al., 2020).

5.1.3 Political trauma and GBV victimization and perpetration

Through their narrations, the participants connected negative mental health outcomes of exposure to political violence with GBV victimization or perpetration. Specifically, females and MHCPs discussed how these symptoms led to both GBV victimization and perpetration by both males and females. As outlined by M.U., a 48- year- old married woman from Balata camp, “My husband started to do some things as if unconsciously. For example, if I made a cake or dessert, he would ask me what I had made. I used to say that I made it because the kids asked for it, but his response would be, 'Take this from my face,” and SW, a female psychologist, “In some cases the violence was directed from women towards men, it was because women considered that the duty of the man is to protect them. In certain moments, women would become angry and resentful towards men because, for example, they were unable to protect them or their son who had martyred. Women might also recall previous family conflicts and bring them up as a result of the incident.”

In contrast, males connected these symptoms to their aggressive behavior toward females or GBV perpetration. As A.A., a 36-year-old married man from Tulkarm, stated:

> A while ago, I used to get excessively angry, and the main reason is not because I am naturally aggressive, but it was more like a 'Farfatet Rouh'. When I was coming back home and found myself unable to provide my family with the basic needs of life, sometimes my wife or child couldn't understand this. It is their right, for sure, that I provide them with everything. But due to the stress, I started to yell, my voice would rise, and sometimes I ended up hitting my wife. Most of the time, we were quarreling.

Accordingly, the researcher sought the importance of exploring the relationship between political trauma and GBV victimization among Palestinian females, and between political trauma and GBV perpetration in Palestinian males. The results of the quantitative study supported the results emerged from the qualitative study, in which political traumatic symptoms correlated positively with GBV victimization among Palestinian females. In other words, Palestinian females showing trauma symptoms at more risk to be exposed to violence from males. This finding to prior research conducted by (Breet et al., 2019; Gibbs et al., 2018).

Moreover, the results showed that political traumatic symptoms correlated positively with aggressiveness among Palestinian males. Which means that Palestinian males exhibiting trauma symptoms are more likely to be violent towards others, and since females are considered as a vulnerable group (Murthy & Lakshminarayana, 2006), then they are more likely to be the targeted of this aggression. This finding aligns with previous research conducted by (Bahati et al., 2022; Begić & Begić, 2001; Breet et al., 2019; Gibbs et al., 2021; Gillikin et al., 2016; Goessmann et al., 2019; Hellmuth et al., 2012; Zedan & Haj-Yahia, 2023), in which males or veterans with mental health comorbidities related to exposure to political traumatic event, were found to exhibit aggressive behavior.

5.1.4 GBV related to political trauma and its mental health outcomes on Palestinian females

Palestinian females reported exhibiting and suffering from different mental health disorders after exposure to GBV. These disorders characterized by (anxiety, depression,

traumatic symptoms, low self-esteem, low self-concept, low self-confidence, feelings of humiliation, and addictive behaviors. As a 43-year-old married woman from Nour-Shams camp, said: “I feel myself helpless; not able to do anything.” She also added, “I cry a lot, and sometimes I faint from the stress. One time, I fainted and they took me to the hospital. The doctor told me these are symptoms of a stroke.” While, M.U., a 48-year-old married woman from Balata camp, stated: “Drawing requires dignity, and I no longer feel that I have any dignity. My dignity doesn’t mean that my husband lets me go wherever I want or not; my dignity is when I speak and my husband listens to me and respects me. The respect was not there.”

Based on the results that emerged from the qualitative study, the researcher decided to examine anxiety, stress, depression, low self-efficacy, feelings of humiliation, and hopelessness as negative mental health outcomes resulting from exposure to GBV among the female participants in the quantitative phase of the project.

A positive association was found between exposure to GBV and negative mental health outcomes among the study participants, including anxiety, stress, depression, low self-efficacy, feelings of humiliation, and hopelessness. The current findings supported by the findings of prior studies conducted by (Haj-Yahia, 2000; Thabet et al., 2015; Veronese et al., 2023).

5.1.5 GBV: Risk and protective factors

This current research highlighted several factors identified as risk for both GBV victimization and perpetration. These factors differed based on the group. For females, the risk factors include cultural gender roles, lack of assertive behavior, lack of knowledge about GBV and their human rights, lack of problem-solving techniques, lack of social support, political groups, socio-economic factors characterized by poverty and unemployment. As an example, I.M., a 59-year- old widowed woman from Balata camp, reported while describing cultural

gender role as a risk factor: “If he found that his wife did not prepare anything and did not do anything, he would become nervous, scream, and slam the door.”

For males, the risk factors identified are emotional vulnerability, gender roles, lack of awareness about GBV, lack of recreational facilities, prolonged proximity to the victim, socio-economic factors (poor financial status, larger family size, and type of work), and being part of a vulnerable group were found to heighten the risk of being aggressive toward females. As an example of prolonged proximity, A.A., a 36-year-old married man from Tulkarm, said: “The target here is not the woman; the target is everyone. Sometimes, since the woman or wife is the one confronting and arguing, out of anger, you might hit her. But for me, the violence was directed at everyone”.

MHCPs noted that addictive behaviors in males, cultural factors such as the patriarchal system, lack of support from family, friends, or institutions, and socio-demographic factors characterized by larger family size, high rates of unemployment, poverty, extended families, and population density also contribute to an increased risk of GBV. As an example on addictive behaviors as a risk factor for GBV perpetration, KH., a male clinical supervisor in psychology with over thirty years of experience, stated: “Drug addiction.”

In contrast to the risk factors, females, males, and MHCPs identified several factors that can protect females from exposure to violence and its negative effects on their mental health. These factors include cognitive-behavioral coping strategies such as showing assertive behaviors; engaging in debriefing activities; and adopting problem-solving techniques; feelings of empathy; financial and self-empowerment in females; receiving and having access to mental health services; religiosity; social support; sharing the trauma; socio-demographic factors (older age, good financial status, being educated, having children); good physical and mental health;

psychological resilience; good self-perception; raising awareness about GBV, including identifying practices that are considered aggressive and understanding the gender roles of both genders, as well as being aware of the mental health outcomes of both political violence and GBV.

In this regard, I.M., a 59-year-old widowed woman from Balata camp, said: “With the help from Allah and our patience, we could overcome the difficulties.” Also, she added elsewhere, “I used to pray for Allah to be with us.” While, A.J., a 50-year-old married man from Nour-shams camp, stated: “I might go out of the house, take a walk, or relax by sleeping. I might take a shower, or start thinking about something else, another topic I mean, because if we stay stressed, we harm ourselves and those around us.” In addition, SM., a male clinical supervisor in psychology, working in the field for over sixteen years, stated: “The personal strength of a woman and her self-esteem can potentially influence or change a man's negative attitudes toward her, and may change his way of dealing with her,” and he added: “Another factor is social support from family, friends, or neighbors.”

The results align with several studies conducted in the Palestinian context, which have found that social support acts as a protective factor against depression, anxiety, and stress among Palestinian women who experienced GBV (Veronese et al., 2023). Education and economic independence have also been identified as important protective factors against IPV among Palestinian women (Baloushah et al., 2019; Haj-Yahia & Clark, 2013). In addition, Abu-Lughod (2010) explored coping mechanisms and adaptation strategies among women who experienced GBV in Palestinian refugee camps in Jordan. The study found that hope and religious resources were commonly used as coping mechanisms against stressors among the study participants.

Based on the findings revealed that good self-perception and coping strategies—such as assertive behaviors, engaging in debriefing activities, adopting problem-solving techniques, and accessing mental health services—are protective factors against the negative mental health outcomes of exposure to GBV, and drawing on previous research (Abu-Lughod, 2010; Veronese et al., 2023), the researcher explored the mediating role of self-concept and both healthy and unhealthy coping strategies in the relationship between exposure to GBV and mental health distress among Palestinian females. The results showed that both healthy and unhealthy coping and self-concept mediated the relationship between GBV and mental health distress. Specifically, unhealthy coping was found to be positively associated with the negative mental health outcomes of exposure to GBV, while healthy coping and self-concept were negatively associated with these negative mental health outcomes of exposure to GBV. The unhealthy coping items assessed in the scale included self-distraction, denial behaviors, substance use, behavioral disengagement, and self-blame. This means that the results of the quantitative study supported the findings of the qualitative study as the participants mentioned assertive behavior, engaging in debriefing activities, adopting problem-solving techniques, and accessing mental health services as protective factors against GBV and its negative mental health outcomes, which are considered healthy coping strategies.

5.1.6. Theoretical, practical, and policy implications

The results of both studies contribute to theoretical knowledge accumulated on political violence and political trauma specifically in the Palestinian context. As mentioned in Kalmanowitz & Lloyd (2004) "The personal consequences of violence are interwoven with the political and can include human rights violations, repression, abductions, rape, unjustified imprisonment, intimidation, … and these can impact the civilians of a country leading to a sense

of vulnerability and helplessness and a feeling of un-safety and insecurity" (p. 58). The results of the current study showed how political violence resulted in mental health distress among Palestinian adults, particularly in the form of trauma-related symptoms.

Moreover, the results of this studies emphasize on the fact that there is no specific theory that fully accounts for all types of violence against women, due to the different and several factors associated with it (Renzetti et al., 2011). The relationship between political trauma and GBV perpetration is explained through the psychological theoretical model of PTSD and aggression that was proposed by Chemtob et al (1997). While, the relationship between political trauma and GBV victimization is explained through a medical perspective, which suggests that trauma symptoms would undermine female's abilities to stop or recognize violence against them (Iverson et al., 2022; Machisa & Shamu, 2022). Furthermore, the results of the qualitative study, indicated that socio-demographic factors may increase the risk of GBV victimization and perpetration, highlighting fact that there is no single factor or theory can fully explain GBV victimization and perpetration.

Furthermore, the results of both studies contribute to theoretical knowledge on the role of risk and protective factors in influencing the vulnerability of individuals to perpetrate or to become victims of GBV.

On understanding GBV in the Palestinian context, this study adds a new knowledge by indicating that political trauma contributed to GBV victimization and perpetration. As well as, it highlighted the importance taking into consideration single or unmarried females when studying violence against females as most of prior studies focused on studying IPV (Sousa et al., 2018; Zedan & Haj-Yahia, 2023). Most importantly, this study explored not only GBV victimization among Palestinian females in relation to political trauma, but also it explored GBV perpetration

among Palestinian males in relation to political trauma, which contributes new insights into understanding GBV within the Palestinian context, as to our knowledge most of previous literature in the Palestinian context has focused on investigating the association between political violence, rather than political trauma and GBV, predominantly from the viewpoints of females (Coker et al., 2002; Giacaman, 2010; Manjoo & McRaith, 2011; Sousa, 2013).

The practical contribution of these results will help in developing interventions to mitigate the negative impact of exposure to GBV related to political trauma on female's mental health. Additionally, they will help create preventative measures aim at reducing the frequency of violence against women linked to political trauma by addressing aggressive behaviors resulting from political trauma and violence in both males and females. Furthermore, the current findings will support the development of therapeutic and preventative interventions aim to empower both females and males psychologically, socially, and financially, while also strengthening their healthy coping strategies.

In addition, the results stresses the need for developing integrated programs and interventions, which means in order to reduce the prevalence of GBV related to political trauma, the interventions have to target both females and males, and the negative impact of exposure to political violence in both females and males.

The results of the current study can be applied in the form of encouraging the creation of workshops to raise awareness among MHCPs about the impact of mental health on GBV victimization and perpetration. These workshops should also highlight the importance of integrated interventions when dealing with individuals or families exposed to political violence and GBV. Moreover, to enhance MHCPs' knowledge about healthy coping strategies, particularly those identified in this study. Also, it is worthy to emphasize that while unhealthy

coping strategies may seem to improve mental health and coping in the short term, they are not effective long-term solutions.

Another application would be the establishment of workshops aim at raising individuals' awareness about the mental health outcomes of exposure to political violence and the influence of both political violence and political trauma on GBV victimization and perpetration. Additionally, the current findings highlight the need to form committees that include individuals directly and indirectly affected by political violence and GBV and provide them with training to raise their awareness about the impacts of political violence and trauma, as well as the importance of receiving psychotherapy.

Based on the practical implications of the study, several policy recommendations can be made to better address the mental health impacts of GBV related to political trauma. Policymakers should prioritize the development and implementation of gender-inclusive trauma interventions that cater to both females and males. These interventions should aim to mitigate the negative mental health effects of exposure to political violence and promote healthy coping strategies across all genders. Additionally, comprehensive prevention programs are needed to reduce the occurrence of GBV linked to political trauma by addressing aggressive behaviors in both males and females, which often result from such violence.

Policies should also mandate regular training and workshops for MHCPs to enhance their understanding of the impacts of political violence and GBV on mental health. These workshops should focus on the importance of integrated interventions and educate MHCPs on promoting healthy coping strategies among those affected. Moreover, public awareness campaigns should be promoted and funded to educate the broader community about the mental health

consequences of political violence and GBV, emphasizing the connection between political trauma and GBV victimization and perpetration.

To effectively address these issues, it is crucial to form multidisciplinary committees comprising mental health professionals, social workers, legal experts, and community representatives. These committees should develop and implement community-based interventions that raise awareness and provide support to those affected by political violence and GBV. Furthermore, policy support is needed for community-based workshops that raise awareness about the mental health effects of political violence and the importance of seeking psychotherapy. These workshops should also train community leaders and individuals to educate others about the impacts of political violence and the need for effective coping strategies.

In addition, integrating trauma-informed approaches across public services such as healthcare, education, and law enforcement is essential. This integration ensures that these systems are well-equipped to support individuals who have experienced political violence and GBV, recognizing trauma symptoms and responding appropriately. Finally, ongoing research and data collection on the effects of political violence and GBV on mental health should be encouraged, as this data is crucial for developing evidence-based policies and targeted interventions that effectively address the needs of those affected. By adopting these policies, policymakers can create a more supportive and effective environment for individuals impacted by political violence and GBV, ultimately promoting mental health and reducing violence in affected communities.

5.1.7. Limitations of the study

The current study has several limitations that highlight opportunities for future research into GBV victimization and perpetration, as well as related variables within the Palestinian

context. One limitation is related to generalizability. The study utilized a snowball sampling technique, and the sample size was not representative of the broader Palestinian community. Furthermore, data collection was limited to the West Bank and East Jerusalem, excluding the Gaza Strip. This omission means that GBV victimization and perpetration in Gaza were not addressed, potentially affecting the findings and their applicability to the Gaza population.

Another limitation stems from the political context in which the study was conducted. The research took place during a period of heightened political tension in the West Bank and East Jerusalem, which could have impacted participants' mental health and, consequently, the study results. Access to certain areas, such as Jenin camp, was restricted due to security concerns, prompting the researcher to involve co-researchers from these areas. Additionally, restrictions on movement and checkpoint closures in the West Bank complicated the data collection procedures. The researcher, being a holder of a Palestinian Identity card, could not access Jerusalem, leading to the use of a co-researcher from that area. The decision to collect data both in-person and online might have also influenced the results.

From a methodological perspective, not all measures used in the current study were validated within the Palestinian context. Measures such as Brief-COPE, PSC, HI, ASKU, and HRBI had not been tested for psychometric properties in Arabic within the Palestinian context, suggesting the need for validating these measures to enhance the study's validity. Lastly, the study did not explore domestic violence or IPV related to political trauma, which represents another area for potential investigation.

To conclude, future research should consider conducting longitudinal studies to gain a deeper understanding of the phenomena and the factors influencing GBV victimization and perpetration, including political violence and trauma. Experimental studies are also needed to

assess the efficacy of healthy coping strategies and self-concept in mitigating the negative mental health effects of GBV-related political trauma among Palestinian females and improving mental health among Palestinian males. Additionally, research focusing on both victims and perpetrators of violence is highly recommended.

CONCLUSION

GBV and its adverse effects on individuals and communities have gained significant attention from scholars and organizations worldwide. This study aimed to explore the complicated relationship between political trauma and GBV within the Palestinian context, addressing gaps in the existing literature by incorporating both qualitative and quantitative approaches.

The findings of this research provided valuable insights into the impact of political trauma on GBV victimization and perpetration. The qualitative component, utilizing grounded theory, revealed five major themes and numerous subthemes related to GBV from the perspectives of females, males, and mental health care providers. The findings of the quantitative analysis revealed a good fit of our two models, where GBV was identified as a predictor, self-concept, healthy coping, and unhealthy coping as mediating variables, and mental health distress (stress, anxiety, and depression), and mental health outcomes (hopelessness, humiliation, and low self-efficacy) as outcome variables in the first model, while in the second model, aggressiveness was identified as a predictor, self-concept, healthy coping, and unhealthy coping as mediating variables, and mental health distress (stress, anxiety, and depression), and mental health outcomes (sleep risky behaviors, drug risky behaviors, and hopelessness) as outcome variables.

These results contribute to the theoretical understanding of political trauma and GBV, particularly within the Palestinian context. They underscore the need for a comprehensive theoretical model that incorporates the effects of political violence on both GBV victimization and perpetration. The study findings support the psychological theoretical model of PTSD and aggression and offers new perspectives on the medical impacts of trauma on GBV victimization.

Moreover, the current findings highlight the limitations of existing theories in fully explaining GBV due to the multifaceted nature of contributing factors.

Practically, the findings emphasize the necessity of developing and implementing integrated interventions that address the negative impacts of political trauma on GBV. Effective interventions should target both females and males, focusing on reducing aggressive behaviors and enhancing healthy coping strategies. The study advocates for organizing workshops for mental health care providers to increase their awareness about the impact of political violence on GBV and the importance of integrated interventions. Public awareness campaigns and community-based workshops are also recommended to educate individuals about the mental health consequences of political violence and to promote effective coping strategies.

Policy recommendations include prioritizing gender-inclusive trauma interventions, mandating regular training for mental health care providers, and establishing multidisciplinary committees to develop community-based support systems. Integration of trauma-informed approaches across public services such as healthcare, education, and law enforcement is crucial to ensure that these systems are equipped to support individuals affected by political violence, political trauma and GBV. Continued research and data collection are essential for informing evidence-based policies and targeted interventions that address the needs of affected communities.

In conclusion, this study gets its importance as it is the first to our knowledge to explore GBV victimization and perpetration related to political trauma in the Palestinian context from the perspectives of females and males by adopting a mixed method approach. By addressing both victimization and perpetration, and exploring the mediating roles of coping strategies and self-concept, this research lays a foundation for future studies and practical interventions aimed at

mitigating the impacts of political violence and improving mental health outcomes in affected populations.

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Appendix A

Consent Form for Participation in the Qualitative Study

INFORMED CONSENT TO THE STUDY

TITLE OF THE STUDY:

UNDERSTANDING POLITICAL TRAUMA AND GENDER BASED VIOLENCE PERPETRATION: THE PSYCHOLOGICAL IMPACTS, RISKS AND PROTECTIVE FACTORS AMONG FEMALES IN PALESTINE

INFORMATION SHEET FOR PARTICIPATION

Dear Sir/Madam,

We would like to ask you to take part in a study. It is your right to be informed about the purpose and characteristics of the study so that you can decide in an informed and free way whether to take part or not. We invite you to carefully read what is reported below. The investigators involved in this project are willing to answer any questions you may have:

(Study researcher) Dana Bdair — 0592710035
(name) — (Telephone no.)

(tutor) Prof. Guido Veronese — 00393333484293
(name) — (Telephone no.)

(Co-supervisor) Prof. Fayez Mahamid — 0592924002
(name) — (Telephone no.)

What is the purpose of this study?

1. To investigate and understand the potential role of political trauma on gender based violence, from the subjective perspective of females, males, and mental health care providers in the Palestinian context, by applying a mixed method approach;
2. To understand the factors that can help in developing a model to enhance mental health status of Palestinian females who have suffered from political trauma and gender based violence in upcoming research.

How will the study be conducted?

The study is following a mixed method design; that is qualitative then quantitative. The interviewes will be conducted in the first phase with Palestinian females, males and mental health care providers, then in the second phase only females from the West Bank of Palestine will be asked to fill self-reports (questioneers) which will be chosen after analysing the data from the first phase.
The interviews will be conducted individually and face to face with the participants.

Why are we asking you to take part?

We value your experience and the challenging events that you have experienced and still experiencing as a result of living in an occupied country characterized by the ongoing political violence, and we think that your participation will illuminate our research questions. We are interested to listen your voice, your embodied experience, and your subjective perspectives.

Are you obliged to take part in the study?

Your participation is completely voluntary. Moreover, if you should change your mind and wish to withdraw, you are free to do so at any time without having to provide any explanation.

1

What are the steps required to take part in the study?
Participation in the study involves the provision of detailed information about its characteristics, risks and benefits. At the end of the information phase, you can agree to take part in the study by signing the informed consent form. Only after you have expressed your consent in writing can you actively take part in the proposed study.

What will you be asked to do?
After knowing the needed information about the study, you will be asked to answer the questions that are related to the study subject and to tell me about your experience and what do you think.

What are the possible risks and disadvantages of the study?

The participants may become distressed and emotionally provoked while completing the study. If this happen, the researcher who is a licensed mental health care provider, will be available and deal with the participant is he/ she started to show negative response. In addition all participants will be given contact information for mental health services if symptoms were to appear any time after the completion of the interviews.

What are the possible benefits that could be derived from the study?
The study does not bring direct benefits for the participants. However, the study will have a big impact on understanding and becoming aware, of the negative effect of political violence on mental health that specifically can be characterized by political trauma. And becoming aware of gender based violence concept for both females and males. Also, it will help in the exploring the techniques, mechanisms, and possible protective factors against political trauma and gender based violence perpetration.

This study will be one of the first mixed method study (qualitative and quantitative) to be done in the field of psychology that trying to understand political trauma and gender based violence perpetration in the Palestinian context from the perspective of females, males, and mental health care providers.

How is the confidentiality of the information guaranteed?
Participants privacy will be highly treated. No names or private information will be used in the reporting of the results of the research and in the published articles from the study. Also, the researcher will deal individually with the participants. And only the members of the research group will have access to the interviews.

Other important information
We inform you that the study will be conducted in line with the ethical guidelines of the American Psychological Association (APA, 2010) and the Declaration of Helsinki (2013) and it has to be approved by the An- Najah National University IRB (Protocol number 16 May.).

We thank you for your availability

DECLARATION OF THE INVESTIGATOR

I declare that I have provided the participant with complete information and detailed explanations about the nature, purposes, procedures, and duration of this research project. I also declare that I have provided the participant with the information sheet.

SIGNATURE OF THE INVESTIGATOR Date

Name of the investigator (*in capital letters)*

INFORMATION SHEET SIGNATURE

I declare that I have received information that has made it possible for me to understand the research project, including in the light of the additional clarifications requested by me. I confirm that I have been given a copy of this information document.

SIGNATURE Date

[illegible]

EXPRESSION OF INFORMED CONSENT

Participant's code ____________

I the undersigned ____

- Declare that I have received exhaustive explanations regarding the request to take part in the experimental study in question and enough information regarding the inherent risks and benefits of the study, in accordance with what is reported in the information sheet attached herewith.
- Declare that I have been able to discuss these explanations, asking all the questions that I deemed necessary and receiving satisfactory answers in that regard.
- I have also been informed of my right to withdraw from the research at any time and to have free access to the documentation regarding the trial and the assessment expressed by the Ethics Committee.

Therefore, in the light of the information with which I have been provided:

I the undersigned ____

☐	AGREE	☐	DO NOT AGREE	To take part in the study
☐	AGREE	☐	DO NOT AGREE	To audio-video recording
☐	WISH	☐	DO NOT WISH	To be informed about the results of this study. In the event you wish to be informed, indicate a contact telephone number

PLACE, DATE SIGNATURE OF THE PARTICIPANT

PLACE, DATE SIGNATURE OF THE INVESTIGATOR

Appendix B

Expert 1 – Approval and Review Comments on the Interviews Protocol

I hope this email finds you well,

I am Dana Bdair, a Palestinian PhD student at Mialno Bicocca University,

the title of my project is: *"Understanding political trauma and gender based violence perpetration: The psychological impacts, risks and protective factors among females in Palestine".*

According to your experience and contributions in the field of psychology, and according to your availability, I would like to ask you kindly if you can accept my invitation to review the questions of the project's semi-structured interviews that you can find them in the attached file,

looking to hear from you,

Thank you so much,

Best regards,
Dana Bdair

Hello Dana,

Thanks for your invitation

I attched my comments inside of the attached file

Best Regards

Sent from Mail for Windows

Title:

Understanding political trauma and gender based violence perpetration: The psychological impacts, risks and protective factors among females in Palestine

Aims of study:

- To investigate and understand the potential role of political trauma on gender based violence, from the perspective of females, males, and mental health care providers in the Palestinian context, by applying a mixed method approach;
- To have a clear idea about dimensions that can help in developing a model to enhance mental health status of Palestinian females who have suffered

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Appendix C

Expert 2 – Approval and Review Comments on the Interviews Protocol

I hope this email finds you well,

I am Dana Bdair, a Palestinian PhD student at Mialno Bicocca University,

the title of my project is: *"Understanding political trauma and gender based violence perpetration: The psychological impacts, risks and protective factors among females in Palestine".*

According to your experience and contributions in the field of human and social sciences, and according to your availability, I would like to ask you kindly if you can accept my invitation to review the questions of the project's semi-structured interviews that you can find them in the attached file,

looking to hear from you,

Thank you so much,

Best regards,
Dana Bdair

Hi Dana,

What an excellent study idea. My expertise is not in GBV, nor in qualitative methods, so consider my feedback in that light. Also, I am generally very direct in my feedback, which comes across as disrespectful or as thinking that the work is not good or important. That is not my intention in my feedback. Happy to set up a zoom call or phone call if easier, but here are my first thoughts....good luck!

Appendix D

Expert 3 – Approval and Review Comments on the Interviews Protocol

I hope this email finds you well,

I am Dana Bdair, a Palestinian PhD student at Mialno Bicocca University,

the title of my project is: *"Understanding political trauma and gender based violence perpetration: The psychological impacts, risks and protective factors among females in Palestine".*

According to your experience and contributions in the field of human and social sciences, and according to your availability, I would like to ask you kindly if you can accept my invitation to review the questions of the project's semi-structured interviews that you can find them in the attached file,

looking to hear from you,

Thank you so much,

Attached please find my comments on the document that you had sent me. These are my initial comments, based on my understanding of the material that I received from you. I guess I will be more able to present more specific and relevant comments after I receive your response to some of my comments and questions.

Needless to emphasize that you're planning to conduct a very important study. I wish you all very best success in carrying it out .

Best wishes,

Appendix E

The Questions of the Interviews With Females

❖ Socio-demographic information:

Gender:

Age:

Place of residence:

Marital status:

Educational attainment:

Employment status:

Economic status:

- Q1: Have you experienced any political violence? Can you tell me about it?
- Q2: Can you tell me how these traumatic events affected you and your family?
- Q3: How experiencing GBV affected you?
- Q4: What are the protective factors that helped you to be less vulnerable to experience GBV, or the things that enhanced your mental health?
- Q5: What do you know about GBV?

Appendix F

The Questions of the Interviews with Males

❖ Socio-demographic information:

Gender:

Age:

Place of residence:

Marital status:

Educational attainment:

Employment status:

Economic status:

- Q1: Have you experienced any political violence? Can you tell me about it?
- Q2: Can you tell me how these traumatic events affected you and your family?
- Q3: Do you think that political trauma is the only factor that affected your behaviors, or there is other factors?
- Q4: When you started to behave in an aggressive way, was it only directed toward women?
- Q5: What are the factors that helped you in order to be less violent?
- Q6: what do you know about gender-based violence?

Appendix G

The Questions of the Interviews with Mental Health Care Providers

- Socio-demographic information:

Gender:

Type of work (position):

Years of experience:

Q1: In which way do you think that political violence can be related to political trauma among Palestinian female?

Q2: Do you think that political trauma can be considered as a predictor variable for GBV among Palestinian female, and how?

Q3: How GBV related to political trauma affect Palestinian females?

Q4: What are the expected risk factors for GBV related political trauma among Palestinian females?

Q5: What are the expected protective factors against GBV related to political trauma among Palestinian females?

Q6: How do you think we can reduce the levels of GBV related to political trauma in the Palestinian context?