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Political Violence, Health, and Coping Among Women in the West Bank

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Palestinian women; political violence; war trauma; chronic stress; posttraumatic stress; resilience; proactive coping; religious support

In 2002, the World Health Organization (WHO) released a document in recognition of violence as a major public health issue, the first World Report on Violence and Health. In it, they defined violence as “the intentional use of physical force or power, threatened or actual...that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation” (WHO, 2002). The rather broad definition of violence put forth by the World Health Organization reflects a move within general violence research to recognize that violence not only causes injury and death, but also poses fundamental burdens on the quality of life of individuals and collectives (Krug, Mercy, Dahlberg, & Zwi, 2002; WHO, 2002). This report highlighted the far-reaching implications of political violence, among other types of violence.

Political violence is the deliberate use of power and physical force in attempts to achieve political goals, resulting in threats to the physical and psychological health of individuals and populations (WHO, 2002). Political violence, as outlined by the WHO, includes acts of a physical, psychological, or sexual nature that are used to harm or intimidate populations; examples include the use of assassinations, psychological torture, and rape as tools of war and political repression (Farwell, 2004; United Nations Action Against Sexual Violence in Conflict, 2010; Zwi & Ugalde, 1989). The WHO definition of political violence also includes deprivation, or the deliberate denial of basic needs (food, healthcare, education) and human rights (freedom of speech, freedom of association) for specific populations (International Committee of the Red Cross; ICRC, 1949; UNESCO, 2006; UNESCO: International Program for the Development of Communication; IPDC, 2012; United Nations Population Fund, 2007).

What qualifies as exposure to political violence varies in the research literature, although it is typically conceptualized as a range of acts of violence and repression that occur during wars, armed conflicts, dictatorships, and military occupations (Zwi & Ugalde, 1989). Examples include witnessing or experiencing shootings or aerial bombardments; being

displaced; being deprived of livelihood or essential goods and services; being under curfew; being detained, incarcerated, or tortured; and having one's home demolished (Basoglu, Livanou, & Crnobaric, 2005; Clark et al., 2010; de Jong, K. et al., 2002; Dubow et al., 2010; Farwell, 2004; Giacaman, Shannon, Saab, Arya, & Boyce, 2007; Hobfoll, Hall, & Canetti, 2012).

In recent decades, there has been an expanded effort to examine how the variety of acts within political violence affects the health of civilian populations. Exposure to political violence leads to a range of mental health problems and disorders, including posttraumatic stress disorder (PTSD), depression, and anxiety (Basoglu et al., 2005; Carballo et al., 2004; deJong, 2003; Giacaman, Shannon, et al., 2007; Klaric, Klaric, Stevanovic, Grkovic, & Jonovska, 2007; Punamäki, 1990; Tol et al., 2010; WHO, 2001). Although estimates about the mental health effects of political violence vary (likely because of variations in contextual factors, such as rates of pre-existing mental disorders and the quality of postconflict recovery environments, as well as variations in methodological factors such as sampling or recall periods (Rodin & van Ommeren, 2009)), conclusions from major international studies and organizations indicate that between one-third to one-half of people exposed to the trauma caused by mass stressors such as disasters and political violence will endure some type of mental distress (de Jong, Komproe, & Van Ommeren, 2003; WHO, 2001). DeJong et al.'s (2003) epidemiological study of people exposed to political violence in Algeria, Cambodia, Ethiopia, and Palestine ($n=3048$), for instance, found the prevalence of mental disorders (including PTSD, mood disorders, and anxiety disorders) was between 27.8% and 62.3%.

Researchers have also begun to document the relationships between exposure to political violence among populations such as refugees, asylum seekers, and torture survivors. Findings suggest that experiences of political violence are connected to a variety of physical health symptoms, such as pain, backaches, loss of appetite, asthma and weakness and sleeplessness (Burnett & Peel, 2001; Cairns & Wilson, 1991; Punamäki, Qouta, & Sarraj, 2010; Wright et al., 2010). For instance, one study of over 2,000 Kuwaiti adults found that, after adjusting for SES, smoking, BMI, and air pollution, participants who were exposed to trauma from war and occupation were 2 times more likely to report asthma than participants reporting no stressors from war (Wright et al., 2010). Biological stress response theories may help explain the connections between extreme and prolonged stress, such as that experienced within political violence, and health. According to these theories, stressors trigger responses from the body that initially are adaptive. Over time, however, and particularly when facing chronic stress, the body is unable to respond and regulate that stress, resulting in an accelerated progression of disease (Cohen, Janicki-Deverts, & Miller, 2007; McEwen, 2000, 2007; Roelofs & Spinhoven, 2007).

While research within the topic of health and resilience within political violence is clearly growing, there are a few key ways that this literature could be expanded. First, scholarship of the consequences of political violence for physical health is a relatively new area. Second, and related to this first area, is the fact that there is far more research on political violence and resilience among children than there is for adult populations (see, e.g., Betancourt & Khan, 2008; Elbedour, ten Bensel, & Bastien, 1993). There is a need for more information

about political violence, coping, and both physical and mental health within adult populations in general, and among women in particular, as a range of evidence suggests that women's health might suffer disproportionately within political violence (Al Gasseer, Dresden, Keeney, & Warren, 2004; Berman, Giron, & Marroquin, 2009; United Nations Research Institute, 2005). Studies from Palestine specifically, where this study took place, have found that in the face of political violence, women are more at risk than men for somatic disorders and symptoms of poor physical health (Punamaki, Komproe, Qouta, Elmasri, & de Jong, 2005); mental health problems (Lev-Wiesel, Al-Krenawi, & Sehwal, 2007; Qouta, Punamaki, & Sarraj, 1998); and less resilient trajectories overall (Hobfoll, Mancini, Hall, Canetti, & Bonanno, 2011).

Responding to the need for more information about the effects of political violence on the physical and mental health of adult women, this study focused on the effects of political violence among Palestinian women in the West Bank, testing the hypothesis that reports of rates of lifetime and past 30-day exposure to political violence exposure would be related to reports of poorer physical and mental health. The West Bank is well known for its history of protracted conflict and ongoing Israeli occupation of civilian areas (for historical timeline of the conflict and an analysis of its relationship to health see, for instance, Giacaman et al. (2009) and other articles in the 2009 Lancet series on health in Palestine). Acts within the Israeli occupation of the West Bank include control of the movement of populations along roads through hundreds of checkpoints, roadblocks and closed areas; home demolitions; arrests and detainments; and an 8-meter high, 436-mile long separation wall consisting of concrete sections and gates that deprive people of their ability to move and conduct daily activities such as work, socializing and accessing medical care (Giacaman, Shannon, et al., 2007; International Court of Justice, 2004; Israeli Committee Against Home Demolitions; (ICAHD, 2012; Jubran, Al Faqih, Nafe, Khalili, & Barghouthi, 2005; Medecins du Monde, 2005; United Nations Office for the Coordination of Humanitarian Affairs; UN-OCHA; Occupied Palestinian Territories; oPt; 2011).

Despite the grim evidence of the effects of political violence on health, people tend to cope effectively with the stress and function better than might be expected, therefore exhibiting substantial resilience in the face of political violence (Summerfield, 1999). The term resilience is often used to describe ongoing processes of recovery from adversity caused by internal traits, skills, or strategies; resources activated within environments; or other protective factors (Bogar & Hulse-Killacky, 2006; Fraser, Kirby, & Smokowski, 2004; Masten, Best, & Garmezy, 1990). Scholars have increasingly suggested that resilience is not the exception, but part of the normal course of development within trauma (Bonanno, 2004).

Analyses of protective factors—variables that lessen risk or promote well-being— can help establish when and under which conditions individual resilience can develop (Herrenkohl, 2011; Werner, 1995). Protective factors are often conceptualized as moderators of risk and are analyzed within regression models. In these models, the goal is to determine if a hypothesized protective factor interacts with a risk factor to alter the direction or strength of an outcome, like PTSD or depression (Baron & Kenny, 1986; Cohen, 2003; Frazier, Tix, & Barron, 2004). There is growing indication that internal and external resources such as a proactive approach to problem solving, support from family and religious sources, and

political or civic engagement help people cope with, and therefore demonstrate resilience, in the face of political violence. Compared to studies among youth, however, much less is known about resilience in the face of political violence for adults. In examining the relationship between political violence and health among women in the West Bank, this study also therefore set out to explore resilience by testing if the relationship between political violence and health differs based on two areas of coping: how women approach problems or challenges and how women access resources within their environments.

The term *proactive coping* has been used to describe approaches to problem solving in which people appraise challenges in ways that are positive and future-oriented (Greenglass, 2002; Schwarzer, 2002). Research among children and proactive coping within political violence demonstrates that possessing agency, determination, a future orientation, and skills in planning, strategizing, and problem solving all offer protection to children in the face of political violence (Berk, 1998; Cortes & Buchanan, 2007; Farwell, 2001). Although the literature is slight on the role of proactive coping among adults faced with political violence, the research that does exist points toward the protective effects of engaged and self-reliant coping styles, active rebuilding after conflict, and a sense of hope and optimism (Hernández, 2002; Hooberman, Rosenfeld, Rasmussen, & Keller, 2010; Shalhoub-Kevorkian, 2006).

In addition to the internal resource of a proactive, self-reliant coping style, the literature on stress and coping in general suggests that accessing resources, or social support, helps people to effectively manage stress (Finfgeld-Connett, 2005; Langford, Bowsher, Maloney, & Lillis, 1997; Seeman, Singer, Ryff, Dienberg Love, & Levy-Storms, 2002). Social support encompasses both emotional support (i.e., comfort and encouragement) to individuals and instrumental support (i.e., tangible goods and services, money, information). It appears that use of social support is an essential strategy for building resilience for populations facing political violence (Hobfoll, Johnson, et al., 2012; Masten & Obradovic, 2008; Punamäki et al., 2005; Punamäki, Komproe, Qouta, El-Masri, & de Jong, 2005; Ungar, 2011).

Within the somewhat limited studies of political violence and resilience among adult populations, findings point to the buffering effects of support from organizational sources, particularly political and religious organizations. The strength of leadership and the closely related instrumental and emotional support from political and religious organizations appear to help ease the burdens and hasten recovery within contexts of political violence (Nuwayhid, Zurayk, Yamout, & Cortas, 2011). As well, the internal support from religion (i.e., religious conviction or faith) may be protective against the harmful effects of political violence. Religiosity appears to build strength in the face of political violence, even though it may represent a more passive form of coping (Barber, 2001; Eggerman & Panter-Brick, 2010). Support from family may also be a vital resource for coping with the experiences within political violence. For those affected by political violence, the shared resource of the family offers both emotional solace and informational and logistical assistance (Eggerman & Panter-Brick, 2010; Khamis, 1998).

Finally, while the evidence is somewhat conflicting on the topic, some research has found that political and civic engagement may be protective within conflict situations in some situations and for some individuals, perhaps because of the corresponding increase in

feelings of empowerment, purpose, and dignity (Barber, 2001; Jones & Kafetsios, 2005; Khamis, 1998; Nguyen-Gillham, Giacaman, Naser, & Boyce, 2008; Qouta, Punamaki, & El Sarraj, 1995; Srour, 2005). This research, however, primarily focuses on youth, although there is some indication that political participation increases quality of life for adults within contexts of political violence (Giacaman, 2007).

In line with the evidence about the potential for specific ways of coping to build resilience in the face of political violence, we hypothesized six variables would function as moderators of the effects of political violence, to buffer or weaken its effects on physical and mental health outcomes (Baron & Kenny, 1986). These variables are: proactive coping; self-reliance; reliance on political, family, and religious support; and political or civic engagement.

Design and Method

The project is part of a collaborative research project between a researcher based in the United States and staff from the Palestinian Medical Relief Society (PMRS), one of the oldest and largest healthcare NGOs in Palestine. After exploring several potential areas of collaboration, the research team arrived at a shared overall goal to guide this project: to enhance mental health and community-building programs for women by better understanding women's experiences of political violence, trauma, and resilience.

The Institutional Review Board at the University of Washington approved all study procedures. Staff from PMRS oversaw and approved of each step of the study, including the consent processes, tools, and plans for data collection and analysis. PMRS staff also provided assistance with and approval of the accuracy for the translation of materials. Staff in PMRS clinics did the consent processes and collected the surveys, as described below. Surveys were collected in 2007 and 2008 from adult Palestinian women in eight districts in the West Bank. The total sample size was 122. Respondents were recruited from Birzeit University and from general health and women's clinics belonging to PMRS and to the Palestinian Ministry of Health. Staff at these locations approached the potential participants with a prepared script that explained the study and its potential benefits and risks. Participants were recruited if they met the criteria of being a Palestinian woman over the age of 18. In a few instances, staff allowed participants who did not meet these criteria to fill out surveys (including several males who were in the clinic waiting rooms and who wanted to fill out surveys, although they were informed the study was focused on women). These surveys were not included in our analyses. Those approached to participate in the study were told it was strictly voluntary and that declining to take part will not affect their services in any way. Those who agreed to participate were consented following a standard script. Per data sharing agreements, data belongs jointly to the entire research team. Sample demographics are presented in Table 1. Average age of participants was 33.42. Most participants were married (66.1%); 29.8% were single. Most participants who listed their educational level ($n=87$ out of our total N of 122) had completed at least some university (64.4%). However, for over 10% of the population (11.5), the highest level of education was primary school¹. Most study participants lived in a village (66.9%); 28.8% lived in a town, and only 4.2% lived in a refugee camp (although this does not necessarily mean that the same percentage of the study population was refugees; in the West Bank, roughly one in five

refugees resides in camps, and urban areas have a larger proportion of refugees than nonrefugees (United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), 2011).

Measures

The survey tool consists of nine constructs and 150 questions. Professional translators in the West Bank translated the survey from English into Arabic; PMRS staff verified this translation. Survey development took 1 year and included consultation with a diverse international pool of experts in the fields of trauma, resilience, the Israeli/Palestinian conflict, and mental health. The process of survey development included a focus group with Palestinians from the West Bank who were living temporarily in Seattle, Washington. Participants in this focus group pilot tested the survey and gave input on the items, the translation, the time required for completion, and ethical or emotional issues regarding the survey. So as to develop a sufficiently broad and detailed measure of political violence, focus group participants were asked to list the most influential experiences Palestinians in the West Bank encounter under the occupation. These answers were analyzed against those items in the survey and some modifications were made. The entire research team (PMRS staff and the U.S.-based researcher) agreed on the final survey instrument, and several PMRS staff members checked the accuracy of the final translation.

Political violence

The survey tool includes a 30-item index of exposure related to political violence. The tool includes questions about experiences within political violence that deprive people of the ability to move about and conduct activities of daily life (such as exposure to checkpoints, having to change plans for school, wedding, or travel because of the occupation, or having interrupted access to health care because of the occupation). The tool also includes acts that directly threaten physical and psychological well-being, such as home demolitions, witnessing or experiencing arrest or detainment, and being the victim of beatings or strip-searching by Israeli police or military. A few measures of political violence already exist, including The Harvard Trauma Questionnaire (HTQ), which has been used in Lebanon (Saab, Chaaya, & Doumit, 2003), Kosovo (Morina & Ford, 2008), and Palestine (Punamaki et al., 2005); the Afghan War Experiences Scale (Miller, Omidian, & Quraishy, 2006); and other location-specific indices, such as those used in the former Yugoslavia (Basoglu et al., 2005) and Sri Lanka (de Jong, K., et al., 2002). These existing measures, along with measures developed within Palestine (Quota, et al. 2005, Giacaman et al., 2007, Al-Krenawi, et al., 2007), were used to gather ideas for measurement of political violence. The research group ultimately chose to create a new measure specific to the aspects of the conflict in the West Bank in an attempt to focus more on chronic stressors of living under occupation and less on items reflecting active fighting. Examples of items include proximity to the wall (prompted by Boushieh, 2006), number of times people must pass through checkpoints in 1 month, loss of income, loss of access to land, and loss of access to family because of Israeli closure policies.

¹This could reflect generally high levels of education within our sample, as the Palestinian Central Bureau of Statistics (2013) reports that, in 2008, 7.5% of women in the West Bank had an educational level of a Bachelor's degree or above.

Within the 30-item tool, there is a variety of questions related to experiences of political violence. For this analyses, we constructed two separate indices with distinct items that represented lifetime experiences and experiences within the past month. The index of lifetime occurrences consisted of dichotomous (yes/no) responses to 12 items; for a full list of items and their frequencies, see Table 2. Cronbach's alpha for this index is .745. Distinct items were used for occurrences within the last month; the seven items that measured experiences in the previous 30 days were used for our second index. Table 3 provides the full list of items and the descriptive statistics for this measure. Cronbach's alpha for this index is .809. Both of indices of political violence were positively skewed, so log transformations were applied to both of them to normalize the distribution²; a natural logarithm (LN) was applied to the last month measure. A base-10 log transformation with the addition of a constant (2) was used with the lifetime measure, because of problems with negative and zero values when we tried to apply the natural logarithm (McDonald, 2009).

Outcome measures

Outcome measures included one measure of physical health and four measures of mental health. We used the SF-12, version 2, an abbreviated version of the SF-36 (Ware, Kosinski, & Keller, 1996). The SF-36 has been widely used to assess health, and its use has been validated with Arab populations (Al Sayah, Ishaque, Lau, & Johnson, 2012; Sabbah, Drouby, Sabbah, Retel-Rude, & Mercier, 2003). The SF-12, like the SF-36, measures eight concepts, or subdomains, of health; for this study, we used the subdomain scales of physical health (General Health Perception or GH) and mental health (MH). General Health Perception (GH) is one item that asks respondents to rate their general health on a 5-item Likert scale from poor to excellent, with higher scores indicating better general health perception. The use of a single-item measure of self-reported health status is a simple and effective way to measure health; several international studies have shown self-perceived health status is related to mortality and a variety of physical conditions, including pain and delayed recovery from illness (Benyamini & Idler, 1999; Bowling, 2005; Emmelin et al., 2003; Idler & Benyamini, 1997; Jylha, 2009; Mäntyselkä, Turunen, Ahonen, & Kumpusalo, 2003). Previous research has used the General Health (GH) subdomain to investigate the effects of political violence (Eisenman, Gelberg, Liu, & Shapiro, 2003; Hobfoll, Hall, et al., 2012). The mental health subdomain (MH) of the SF-12 includes two items (how often have you felt calm and peaceful? and how often have you felt depressed or downhearted?); each question used a 5-item Likert scale with choices from *none of the time* to *all the time*. Higher scores on the MH subdomain scale indicate better mental health. The mental health scale was correlated with our other two mental health measures: distress ($-.583, p=.000$) and PTSD ($-.351, p=.000$).

The 10-item distress scale (Kessler's 10, or K-10) is used in health surveys by governments in the United States and Canada as well as by the World Health Organization (Kessler et al., 2002). Kessler's-10 measures distress symptoms in the prior 4 weeks on a scale of 10 to 50, with higher scores representing higher distress. Items include feeling tired "for no good reason," nervous, depressed, worthless, and "so restless that you could not sit still."

²All analyses were re-run with nontransformed variables; results were similar to those reported here using the transformed variables.

Cronbach's alpha for this scale is .889. The distress scale was skewed so a natural log transformation was applied to it.

We investigated PTSD symptoms, rather than diagnostic criteria (Nemiah, 1995; North, Suris, Davis, & Smith, 2009), responding at least in part to the ongoing controversy around the use of PTSD as a measure (Johnson & Thompson, 2008; Mezey & Robbins, 2001; North et al., 2009; Summerfield, 2001). Symptoms of posttraumatic stress disorder symptoms were assessed with the 4-item Primary Care PTSD screen (PC PTSD), a brief screening tool for PTSD symptoms (Prins et al., 2004; $\alpha=.854$). The symptomology of PTSD is a widely used outcome measure in research on political violence in general (Basoglu et al., 2005; Johnson & Thompson, 2008; Lopes Cardozo, Vergara, Agani, & Gotway, 2000), as well as in Palestine specifically (Afana, Dalgard, Bjertness, Grunfeld, & Hauff, 2002; Hobfoll et al., 2011; Khamis, 1993; Punamäki, Qouta, & Sarraj, 2010).

Coping factors

Measured coping factors that were hypothesized to interact with political violence in the predication of health include: proactive coping; self-reliance; reliance on political, family, and religious support; and political or civic engagement. We used the Proactive Coping subscale of the Problem Solving Inventory (PSI; Greenglass & Schwarzer, 1998; $\alpha=.768$). This subscale includes 14 items, including "I like challenges and beating the odds" and "I try to pinpoint what I need to succeed."

For self-reliance and reliance on political, family, and religious support, we used a coping scale that was developed by Khamis (2000) in Palestine; it assesses use of coping resources and social support across both problem-focused (i.e., gathering information) and emotion-focused (i.e., aimed at emotional regulation through processes like seeking support) domains (Finfgeld-Connett, 2005; Langford et al., 1997; Lazarus, 2000). Examples include: "I seek information from political organizations"; "I seek moral support from my family"; "I pray."

Exploratory Factor Analysis with oblique rotation (which allows the factors to correlate) was used on the full 33-item scale; the pattern matrix was used to examine loadings (Costello & Osborne, 2005). We retained items that loaded .4 or higher. Using the scree plot and a comparison of 4 and 5 factor tables, we determined that four factors were optimal (Costello & Osborne, 2005). These included: reliance on self; reliance on political support; reliance on family; and reliance on religious support. Factor scores for each of the four factors are presented in Table 2. Measured scales were constructed from the items within each factor. Cronbach's alphas for the scales were as follows: reliance on self ($\alpha=.775$), reliance on political support ($\alpha=.922$), reliance on family support ($\alpha=.744$), and reliance on religious support ($\alpha=.583$). Log transformations were applied to the variables because of problems with distribution.

We used a one-item measure of political or civic engagement scored on a Likert scale of 1-4 with response categories of *strongly disagree*, *disagree*, *agree* or *strongly agree*: "I am actively involved in movements, activities or organizations in order to help my country/my people." This measure was conceived of as a proxy for asking outright if people were politically active, because people might be reluctant to report political activity for fear of

retribution; it also served to open up this type of question to encompass activities for common good that people might not define as “political activity.”

Analyses

For the first step in our analysis, we examined the relation between lifetime and past 30-day political violence to physical and mental health. We then investigated interactions between the two measures of political violence and the previously mentioned protective factors: proactive coping; self-reliance; reliance on political, family, and religious support; and political or civic engagement. As suggested by Frazier et al. (2004), variables were first centered around their means. These centered variables were used to create interaction terms. The order of entry in the multiple regression models was: (1) past 30-day or lifetime political violence; (2) protective factor; (3) political violence and protective factor interaction (Frazier et al., 2004). For those equations with significant interaction effects, we plotted our results and tested the significance of the slopes (Frazier et al., 2004; Holmbeck, 2002) using Mod-Graph I, an Excel-based moderation plotting software program (Jose, 2008). All analyses were re-run using the original (nontransformed) variables, and there were no new significant results. Results reported here are using the transformed variables.

Results

Table 3 shows lifetime occurrences of political violence. About half of our study sample reported they had lost income because of the occupation. Almost one-fourth reported their ability to access health care suffered because of the occupation. Almost one in five had been strip-searched by Israeli forces, and 27.5% reported they had been threatened by Israeli forces. Table 4 shows the rates of seven acts of political violence in the past month. A quarter of all participants reported that they had been prevented from visiting family at least once in the past 30 days during the occupation. A similar number reported they had seen a house or business demolished in the last 30 days. Seventy percent of the study population reported they had to pass through a checkpoint at least once in the past 30 days, with 15.6% responding they had to do this 10 or more times in the past 30 days.

Table 5 shows the correlations between experiences of political violence and the mental health and health outcomes. Both past 30-day and lifetime measures of political violence were positively correlated with PTSD symptoms at around .30 ($p < .01$). Neither measure of political violence was related to distress, nor to General Health Perception (GH) and Mental Health (MH), as assessed with the SF-12.

Tests of variable interactions showed that, for PTSD symptoms and distress, there were no significant interactions between political violence and proactive coping, any of our subscales of coping (reliance on self, reliance on political support, reliance on family support, and reliance on religious support), or political or civic engagement. There were several significant interactions for the two outcomes from the SF-12: General Health Perception (GH) and Mental Health (MH). For those interaction tests that were significant, Tables 6-8 show the results of the regression equations for political violence on health (including the interaction tests for coping and political violence). As seen in Tables 6 and 7, where results are shown for the regressions of lifetime and past-month political violence on General

Health (respectively), and described in more detail below, a few of our coping variables (proactive coping, political or civic engagement, and reliance on self) significantly interacted with political violence to affect General Health in a counter intuitive direction, acting as risk, not protective, factors. Of all coping variables tested, only reliance on religious support emerged as a significant protective factor; it significantly interacted with past-month political violence to protect both General Health and Mental Health. Table 8 presents the significant results of the regression equation for past-month political violence on the SF-12 measure of Mental Health.

A significant interaction was found for lifetime exposure to political violence and proactive coping in the prediction of general health ($B = -6.391$, $\beta = -.319$, $p = .005$). Overall, the variables accounted for about 13% of the variance in general health, $F(3, 77) = 3.979$, $R^2 = .134$, $p = .011$. Tests of the slopes reflecting the association between lifetime political violence and general health for those with low and high coping showed they each are significantly different from 0. As scores on political violence increased, general health declined for those with high proactive coping, $t(76) = -3.749$; B (for the simple slope test) = -30.517 ; $p < .001$. For those with low proactive coping, general health improved as levels of political violence increased, $t(76) = 5.727$; B (for the simple slope test) = 46.545 ; $p < .000$.

Political or civic engagement also significantly moderated the relationship between lifetime political violence and general health ($B = -25.153$, $\beta = -.244$, $p = .021$), with the full model accounting for about 6% of the variance in general health overall, $F(3, 88) = 1.864$, $R^2 = .060$, $p = .142$. The corresponding simple slope tests showed that slopes for both high and low reliance on self were significantly different from 0. As scores on lifetime political violence increased, there was a general decline in health for those with high involvement, $t(87) = -72.753$; $B = -27.775$; $p < .000$; for low involvement, reports of general health improved as political violence increased, $t(87) = 854.192$; $B = 31.617$; $p < .000$.

Finally, reliance on self significantly moderated the relationship between lifetime political violence and general health in an unexpected direction ($B = -184.682$, $\beta = -.247$, $p = .028$), with the full model accounting for about 7.5% of the variance in general health overall, $F(3, 77) = 2.064$, $R^2 = .074$, $p = .112$. The corresponding simple slope tests showed that slopes for both high and low reliance on self were significantly different from 0. As scores on political violence increased, there was a general decline in health for those with high reliance on self, $t(76) = -91.378$; $B = -20.438$; $p < .000$; for low reliance on self, reports of general health improved as political violence increased, $t(76) = 166.974$; $B = 37.346$; $p < .000$. Reliance on self also was a significant moderator of the relationship between general health and political violence in the past month ($B = -110.262$, $\beta = -.235$, $p = .034$); $F(3, 84) = 2.214$, $R^2 = .075$, $p = .092$ (see Table 7). For high scores on reliance on self, as political violence increased, general health declined, $t(83) = -13.580$; $B = -5.686$; $p < .000$; for low scores on reliance on self, increased political violence was related to improved reports of general health, $t(83) = 69.307$; $B = 28.812$; $p < .000$.

Reliance on religious support was the only significant protective factor that emerged in these analyses. For people who highly relied on religious support, as political violence in the past month increased, general health improved; similarly, for those who highly relied on

religious support, as levels of past month political violence increased, mental health improved (see table 8; $B = 93.071$, $\beta = .245$, $p = .026$; $B = 71.737$, $\beta = .240$, $p = .029$, respectively). Each of these two final regression models predicted about 5-6% of the variance in general health, $F(3, 89) = 1.738$, $R^2 = .055$, $p = .165$; $F(3, 91) = 1.935$, $R^2 = .060$, $p = .129$. Tests of slopes reflecting the association between past-month political violence and general health showed that slopes for both high and low reliance on religious support were significantly different from 0. As past-month political violence increased, high reliance on religious support was related to improved health, $t(88) = 39.830$; $B = 16.761$; $p < .000$, and low use was related to declining health, $t(88) = -51.614$; $B = -21.365$; $p < .000$. As past month political violence increased, high reliance on religious support was also related to improved mental health, $t(90) = 16.906$; $B = 7.114$; $p < .000$, and low use of religious support was related to a decline in mental health, $t(90) = -35.806$; $B = -22.272$; $p < .000$.

Our measure of reliance on religious support included both reliance on religiosity (e.g., “prays”; “believes what has happened is fate”) and reliance on religious institutions (e.g., “seeks information and advice from religious people”; “participates in religious activities”). Therefore, it was not strictly a measure of faith, but also a measure of reliance on religious institutions and organized activities. This nuance became an important point of consideration when evaluating the results of this study and led us to complete one more final set of post-hoc analyses with separate measures of “active religious support” (participates in religious activities, seeks information and advice from religious people, seeks help from religious group; $\alpha = .598$) and “passive religious support” (prays, believes what happened is fate; $\alpha = .411$). New regression equations were set up in the manner described in our methods section for these two separate measures of religious support. Active religious support was a significant protective factor for both General Health Perception and Mental Health within the equations run with political violence in the past month ($B = 60.878$, $\beta = .288$, $p = .006$; $B = 40.449$, $\beta = .244$, $p = .020$, respectively). Tests of slopes reflecting the association between past-month political violence and both general health and mental health showed that slopes for both high and low reliance on active religious support were significantly different from 0. Passive religious support was not a significant moderator of political violence.

Discussion

This study focused on examining rates of political violence, the correlations between political violence and physical and mental health, and the possible interactions between a variety of coping strategies and physical and mental health.

Somewhat surprisingly, we did not find bivariate correlations between either of our political violence variables and distress, or between political violence and the General Health Perception (GH), or the Mental Health (MH) measure from the SF-12 (MH). We did, however, find significant bivariate relationships between political violence and PTSD symptoms. These findings are consistent with those of other studies conducted in Palestine (Khamis, 2000; Punamäki, 1990) and elsewhere (de Jong, 2003; de Jong, Ford, Kam, et al., 2008; de Jong, Ford, Lokuge, et al., 2008; Tol et al., 2010). Regarding the relationship between political violence variables and PTSD symptoms, there is strong evidence in

literature about political violence that PTSD symptoms follow a dose-response pattern, with rates rising in relation to the number of traumatic experiences (Johnson & Thompson, 2008; Lopes Cardozo et al., 2000). Our data contribute to this evidence, as rates of PTSD symptoms rose in relation to both the number of experiences of political violence women endured in their life (reflected in the lifetime measure) and the frequency of various events of political violence they experienced in the prior 30 days.

We did not find bivariate correlations between our political violence variables and general health. This is in contrast to another study that used the general health perception (GH) outcome from the SF-12 and found a direct effect of political violence on reports of poorer general health using a comparison design with two groups: those who were exposed to political violence and those who were not exposed to political violence (Eisenman et al., 2003). Whereas we didn't find a direct effect of political violence on general health perception, there could be more to investigate regarding the question of how political violence might affect health. For instance, recent research from within Palestine found that political violence affected general health indirectly through the mediating mechanism of psychological distress (Hobfoll, Hall, et al., 2012). Other research has also found connections between mental health (and particularly PTSD) and physical health among people with histories of trauma (Munyandamutsa, Nkubamugisha, Gex-Fabry, & Eytan, 2012; Qureshi, Pyne, Magruder, Schulz, & Kunik, 2009; Weisberg, Bruce, Machan, Kessler, Culpepper, & Keller, 2002). Future research on the health effects of political violence should attend to not only if political violence affects physical health, but to the various pathways through which this relationship might occur.

At the bivariate level, there were interesting positive correlations between political violence and both political or civic engagement and reliance on political organizations. These results reflect those of Punamäki (1990), who over two decades ago in research among women in Palestine, found that the more that women were exposed to political hardships, the more they engaged in social-political activity—a coping strategy which was simultaneously individual and collective.

This study sought to determine if the relationship between political violence and health was dependent on resources women used to cope. None of our six hypothesized moderators (proactive coping; self-reliance; reliance on religious, political, and family support; and political or civic engagement) showed statistical significance for the outcomes of distress or PTSD symptoms. This may be because of a lack of statistical power; analyses of power indicated that for most of the equations we had between 70-80% power, which, while acceptable, is somewhat low (Borenstein, Rothstein, Cohen, Schoenfeld, & Berlin, 2001). We might also conclude, given this lack of findings, that the stressors of political violence may overpower the protective effects of coping practices, as other research on political violence and resilience has suggested (Hooberman et al., 2010). Another interpretation of this null finding could be that there is something that remains unaccounted for within our current analysis that is affecting the relationship between political violence and mental health. It is quite possible that there could be important protective factors that, if included in our models, would have effectively buffered the effects of political violence on mental health. In particular, as mentioned below in our limitations section, this study only measured

reliance on specific coping resources; it did not capture the quality or availability of these resources. These additional dimensions of coping have been found to be effective protective forces in other research (Eggerman & Panter-Brick, 2010; Khamis, 1998, 2000). Accordingly, if other aspects of coping resources were analyzed here, they might very well prove to build resilience against the effects of political violence.

Significant moderation effects were seen for a few variables for the SF-12 measures of general health (GH) and mental health (MH). For high levels of civic or political engagement, worse general health was reported as lifetime political violence increased. This is contrary to most literature that has examined the possible protective effects of political and civic engagement and found it to be highly protective within situations of political violence (Barber, 2001; Jones & Kafetsios, 2005; Khamis, 1998; Nguyen-Gillham et al., 2008; Qouta et al., 1995; Srour, 2005), although this question is far from resolved in the literature. For instance, at least two studies among youth (one in Palestine and one in Bosnia) found that engagement might actually increase risks for poor behavioral and mental health outcomes, or that disengagement from political processes was actually protective (Barber, 1999; Jones & Kafetsios, 2005). Scholars have suggested that the potential for political involvement as a protective factor may vary by the type of conflict and the cultural and political contexts of struggle (Barber, 2008) and alongside the relative danger that is present (Punamäki et al., 2001).

One interpretation of our finding regarding political engagement is that political engagement increases risk for poor health because of a mediation effect of political violence; it could be that, as retribution for increasing political engagement, people are increasingly targeted with political violence, which in turn causes lower rates of general health perception. An alternate interpretation that has some support in the empirical literature is that poor health outcomes actually acts as the mediator within the relationship between political violence and political engagement; one study found that people affected by political violence experience more PTSD symptoms, which in turn motivates people to become more engaged (Hobfoll, Johnson, et al., 2012). Future research should further investigate these questions of temporality regarding political violence, engagement, and health.

Surprising results were seen regarding the interaction of proactive coping and reliance on self with political violence; these two more internalized and individual forms of coping actually emerged as risk factors, whereas reliance on active religious support, a more external and social coping strategy, emerged as our only protective factor. The implications of these results will first be explored separately, and then the findings will be explored as a whole in a discussion that highlights the importance of exploring a variety of coping strategies that might alleviate the negative health sequela resulting from political violence.

Tests of interaction terms showed that, as scores of lifetime political violence increased, general health perception declined for those at higher levels of proactive coping and reliance on self. Similarly, as levels of political violence in the last 30 days rose, there was a decreased perception of general health for those with high reliance on self. The emergence of proactive coping and reliance on self as risk, rather than protective, factors contradicts the body of literature concluding that positive affect, proactive coping, optimism, and self-

efficacy seem to positively affect health (Benight & Bandura, 2004; Folkman, 1997; Greenglass, 2002). However, this finding does align with critical and nuanced evaluations of self-reliant forms of coping that propose that individualized approaches to stress management which focus the responsibility (and therefore, blame) on oneself might be a hindrance to emotional recovery within situations where one cannot actually affect the problem (Solomon & Smith, 1994).

As our results suggest, an increased reliance on oneself to change a situation that is fundamentally unchangeable by oneself alone may, in fact, pose more risk to health than having a low expectation for, and therefore lower pressure on, oneself to affect change. The idea that we must understand how various dimensions of stressors, particularly controllability, affect the usefulness of various coping strategies, certainly aligns with our findings (Folkman & Moskowitz, 2004). It makes sense that the loss of control that accompanies increased levels of political violence might particularly frustrate and disturb those who tend to put a lot of pressure on themselves to rally individual coping resources. Future research might tend to the how perceptions of controllability within political violence might affect the usefulness of more proactive, individualized coping strategies (see, e.g., Hooberman et al., 2010), as well as the role of chronic versus episodic stress within coping processes.

Reliance on religious support was the only one of our coping variables that demonstrated a statistically significant protective influence within the relationship between political violence and health. Results of the initial model, where those with high reliance on religion showed a general improvement in both physical and mental health as the levels of political violence experienced in the past month increased, aligns with what we would expect from the array of literature on political violence that demonstrates the protective influence of religion in the face of political violence.

These studies, however, tend to attribute the protective effects of religion to resignation and surrender that, in its acquiescence, actually built strength for adults facing political violence (Eggerman & Panter-Brick, 2010). Our results suggest, on the other hand, that for our sample at least, it was not faith or prayer that emerged as the protective aspect of religious support, but rather the institutional and organizational aspects of religion (which were highly correlated with prayer). Thus, our study adds an interesting dimension to the task of unraveling the particular mechanisms within religion that might be protective for populations suffering from political violence. In particular, our results illustrate the importance of collective and social forms of coping within the general resource of religious support. Interestingly, along with reliance on religious support, in our tests of moderation with political violence in the past month, the protective effects of reliance on political support approached significance for both General Health and Mental Health ($B = 27.966$, $\beta = .194$, $p = .092$; $B = 18.625$, $\beta = .178$, $p = .099$, respectively). In line with these findings, research has shown the importance of collective and prosocial forms of coping for both women generally, as well as for survivors of political conflict (Guribye, Sandal, & Oppedal, 2011; Wells, Hobfoll, & Lavin, 2006). Findings from our study demonstrate the importance of investigating just how support from institutions, and people's willingness and abilities to

ask for help and information from these institutions, factors into the relationship between health and political violence.

Findings about the positive influence of political and religious institutions speak to the role that organizations within people's environments might play in promoting health within the problem of political violence. Accordingly, the importance of resources in the social environment should be taken into consideration for future research and practice within areas affected by political violence. Researchers have concluded that political violence may represent so much stress that external coping resources are overloaded and possibilities for resilience are compromised (Hobfoll et al., 2011; Norris & Kaniasty, 1996). According to the idea of communal coping (Lyons, Mickelson, Sullivan, & Coyne, 1998), individuals may become increasingly aware of how the stressors of political violence affect the structures on which they've come to depend; because of this, the stressor actually becomes amplified rather than alleviated. In addition, scholars have suggested that people may perceive many problems including corruption and lack of responsiveness within political parties and organizations; this might affect the usefulness of political bodies in offering protection from the emotional effects of political violence (Giacaman et al., 2007; Khamis, 2000). In light of our results regarding the importance of religious and political organizational resources, rebuilding and strengthening institutions, and encouraging people's accessing of these resources, should be kept in mind when planning interventions regarding political violence. The need to appreciate the importance of and advocate for the protection of environmental resources within political violence is particularly important, because political violence often deliberately targets the social environment, including political and religious institutions, resources that could be central for coping (Robben, 2005; Violich, 1998).

The results of the analyses described here contribute to literature on political violence and health among adult women. However, there are several limitations that warrant attention. The relatively small sample size affected our statistical power and raised our odds of Type 2 errors, so that there may in fact be correlations and moderation effects that we were simply unable to detect. Another important caveat to our findings is that we did not consider the quality of the family, political, and religious resources that people utilized, but only measured their reliance on these resources. Other studies have shown, for instance, that the buffering quality of the family resource depends on the strength of the family (Khamis, 1998). Furthermore, because of the cross-sectional nature of the data, it is impossible to determine the direction of our findings.

Although our study has these limitations, the results provide important implications with regards to health, coping, and political violence. Results add to a considerable body of literature demonstrating the relationships between political violence and mental health (Basoglu et al., 2005; de Jong et al., 2003; de Jong, Ford, Lokuge, et al., 2008; Tol et al., 2010). We did not find first order effects for either of our political violence variables and general health perception; however, we did find that political violence interacted with several of our coping variables to affect health. Findings from this study suggest that research, advocacy, and intervention focused on political violence should attend to both physical health and mental health. Results also add some interesting dimensions to-and underscore the importance of increasing-the relatively small body of literature looking at not

only whether political violence affects physical health (Al-Krenawi, Graham, & Sehwal, 2004; Burnett & Peel, 2001; Wright et al., 2010), but also at some of the complex ways in which the relationship between political violence and physical health might occur (Hobfoll, Hall, et al., 2012).

Our findings also indicate that higher self-reliance and more proactive approaches to problem solving might not actually offer protection from the effects of political violence, and that reliance on internalized forms of coping might increase the harmful effects that political violence has on health. Programs that build empowerment and individual coping skills within contexts of political violence should attend to the conditions under which these types of coping strategies are helpful versus harmful. Our results might fit very well into the idea of *coping flexibility*, wherein different strategies are deployed based on the dimensions of the stressor (Lester, Smart, & Baum, 1994). Various forms of coping are neither intrinsically good nor bad, but rather highly dependent on the context and the characteristics of the stressor, including its controllability (Folkman & Moskowitz, 2004). In some situations, more communal forms of coping might be more adaptive to deal with the initial shock and the accompanying loss of control, and later perhaps, when the turmoil has passed, more individualized forms of coping might become more useful. Future research might take up the task of further disentangling internalized coping (including proactive coping and problem solving) from externalized coping (i.e., seeking support from institutions), and might consider how the effectiveness of strategies varies according to the chronicity and severity of the political violence, as well as the degree of perceived controllability.

Finally, in line with other research on this topic, our results demonstrate that religious support, particularly that from institutions and organized activities, may be a critical protective factor within contexts of political violence. Attention to how institutions serve as a buffering resource in the face of political violence is thus a very important avenue for research and intervention. As Almedom and Summerfield (2004) note regarding Palestine specifically, well-being in the face of political violence depends on the environments in which people live, including their social and political worlds. Results of this study indicate the importance of attending both to individual modes of coping and to resources within the social environment when working to understand and alleviate the effects of political violence.

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Table 1

Demographic Characteristics

	Range	Mean	
Age (<i>N</i> =91)	19-78	33.42	
Characteristic	Group	<i>N</i>	%
Marital status (<i>N</i> =121)	Single	36	29.8
	Engaged	2	1.7
	Married	80	66.1
	Other	3	2.5
Educational level (<i>N</i> =87)	None	2	2.3
	Primary school	10	11.5
	Secondary school	19	21.8
	University	56	64.4
Permanent residence (<i>N</i> =118)	Village	79	66.9
	Town	34	28.8
	Refugee camp	5	4.2

Table 2

Factor Scores for Internal and External Reliance on Coping Resources

Reliance on self	
Item	Factor score
depends on self to solve problems	.812
depends on self to solve family matters	.722
draws on past experiences to solve problems	.669
looks at positive to be grateful	.424
says things are better the way they are	.502
depends on self to make decisions	.571
depends on self for financial matters	
Reliance on political support	
Item	Factor score
seeks information from political party	.952
asks for help from members of political party	.941
seeks help from political party	.838
Reliance on religious support	
Item	Factor score
believes what happened is fate	.422
participates in religious activities	.522
Prays	.574
seeks information and advice from religious people	.582
seeks help from religious group	.378
Reliance on family support	
Item	Factor score
seeks information from family	.899
seeks social support from family	.610
seeks moral support from family	.780
seeks information from relatives	.530

Table 3Lifetime Experiences of Political Violence (“Have you ever...”) (*n*= 122)

	% responding yes (valid %)
...had your home or business demolished by Israeli forces	15.5
...been detained or arrested	13.4
...had a detention or arrest happen to a family member	20
...been beaten by Israeli forces	8.4
...been strip searched by Israeli forces	19
...been threatened by Israeli forces	27.5
...had your family separated from land due to occupation	28.3
...been separated from family due to wall, checkpoints or borders	15.7
...had your ability to access health care suffer from wall, checkpoints, or borders	24.1
...(or your family) lost income because of occupation	52.1
...had to change plans for school, wedding or travel because of occupation	47.9
Can you see the wall from your home	19

Table 4Frequency of Political Violence in Prior 30 Days (“In the past month, number of times...”) ($n= 122$)

	Percentage of respondents in each frequency				
	Never (1)	1-3 times (2)	4-6 times (3)	7-10 times (4)	Always/ 10 + times (5)
Israeli army in town	35.5	37.2	5.8	3.3	18.2
Changed plans because of worry about police or army	63.9	20.2	3.4	5	7.6
Prevented from visiting family	72.3	14.3	5	2.5	5.9
Seen a house or business demolished in real life	73.6	18.2	.8	5	2.5
Seen or heard a detention or arrest	37.3	33.9	9.3	5.1	14.4
Seen the wall	23.3	27.5	9.2	8.3	31.7
Pass through checkpoints	30	35	12.5	6.7	15.8

Table 5

Correlation Matrix

	Lifetime PV	PV past month	distress	PTSD	GH	MH	self	Political	family	religious	Pro-active coping	Political/civic engagement
Lifetime PV	1	.616***	.132	.289**	-.060	-.144	.075	.316**	.029	.262*	.039	.016
PV past month		1	.185	.329**	.073	-.043	.088	.378***	.193*	.204*	.123	.200*
distress			1	.270**	-.158	-.583***	-.066	.121	-.290**	-.005	-.054	.036
PTSD				1	-.153	-.351***	.085	.178	-.069	.160	.100	.181
GH					1	.397***	.026	-.009	.158	.032	.136	.024
MH						1	.068	-.144	.169	-.031	.116	-.071
self							1	.201*	.285**	.160	.569***	.340***
political								1	.082	.337**	.236	.529
family									1	.205*	.308**	.036
religious										1	.061	.121
Pro-active coping											1	.368***
Active Involvement												1

* $p < .05$.** $p < .01$.*** $p < .001$.

Table 6

Regression of Lifetime Political Violence on General Health Rating and the Interaction of Coping and Lifetime Political Violence

Step and variables	R ²	Overall F	B	B (standard ized)	p-value (only sig. shown)
Proactive coping					
Step 1	.004				
Political violence ever			7.328	.061	
Step 2	.041				
Political violence ever			6.199	.051	
Proactive coping			.930	.194	.084
Step 3	.134	$F(3, 77) = 3.979$			.011
Political violence ever			8.014	.067	
Proactive coping			1.367	.286	.012
Political violence X Proactive coping			-6.391	-.319	.005
Political/civic engagement					
Step 1	.000				
Political violence ever			1.793	.015	
Step 2	.000				
Political violence ever			1.837	.015	
Active involvement			.356	.015	
Step 3	.060	$F(3, 88) = 1.864$			.142
Political violence ever			1.921	.016	
Active involvement			.558	.024	
Political violence X Active involvement			-25.153	-.244	.021
Reliance on self					
Step 1	.008				
Political violence ever			10.552	.089	
Step 2	.014				
Political violence ever			9.624	.081	
Reliance on self			16.186	.082	
Step 3	.074	$F(3, 77) = 2.064$			.112
Political violence ever			8.454	.071	
Reliance on self			9.625	.049	
Political violence X Reliance on self			-184.682	-.247	.028

Table 7

Regression of Political Violence in Past Month on General Health Rating and the Interaction of Coping and Political Violence in Past Month

Step and variables	R ²	Overall F	B	B (standardized)	p-value (only sig. shown)
Reliance on self					
Step 1	.016				
Political violence past-month			8.452	.128	
Step 2	.022				
Political violence past-month			8.110	.123	
Reliance on self			14.606	.074	
Step 3	.073	$F(3, 84) = 2.214$			.092
Political violence past-month			11.563	.175	
Reliance on self			6.984	.035	
Political violence past-month X Reliance on self			-110.262	-.235	.034
Reliance on religious support					
Step 1	.001				
Political violence prior 30 days			1.889	.028	
Step 2	.001				
Political violence past-month			1.871	.028	
Reliance on religious support			.173	.001	
Step 3	.055	$F(3, 89) = 1.738$			.165
Political violence past-month			-2.302	-.034	
Reliance on religious support			8.048	.058	
Political violence past-month X Reliance on religious support			93.071	.245	.026

Table 8

Regression of Past Month Political Violence on Mental Health Rating and the Interaction of Coping and Political Violence in the Past Month

Step and variables	R ²	Overall F	B	B (standardized)	p-value (only sig. shown)
Reliance on religious support					
Step 1	.007				
Political violence past-month			−4.450	−.083	
Step 2	.009				
Political violence past-month			−3.992	−.075	
Reliance on religious support			−5.100	−.046	
Step 3	.060	<i>F</i> (3, 91) = 1.935			.129
Political violence past-month			−7.579	−.142	
Reliance on religious support			1.511	.014	
Political violence past-month X Reliance on religious support			71.737	.240	.029