

Well-being and pressures of daily life in two West Bank villages—Exploring context and history

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Interest in the well-being of people exposed to long-term violence and conflict has tended to focus on measurable effects of acute traumatic events, while attention to the pressures of their daily living context is relatively new. Using qualitative and quantitative data from a 2005 survey of all female family caretakers in 2 neighbouring Israeli-occupied West Bank villages ($n = 820$), we explored the associations of demographic, health-related and contextual factors with reported pressures and WHO-5 well-being index scores. The final model explained 17.8% of the variance with negative associations between health-related factors (“back-aches,” “stomach aches” “psychological illness in the family”) and family-related factors (“male head of household aggressive”, “male head of household physically violent”) and the WHO-5 well-being index scores. We found positive associations between socio-economic factors (“standard of living”; “number of rooms”) and village-related factors (“residency in village A/B”) and the WHO-5 well-being index score. Exploring the daily living context of villages A and B illuminated how the impact of historical and political events differed, even in villages that are geographically close. The paper lends support to calls for including politics and history in research on well-being in contexts of long-term violence and conflict.

Keywords: Wellbeing; Daily life pressures; Palestinian; Context; History; Mixed methods.

Over the past two decades, mental health research on Palestinians has shifted from a focus on exposure to trauma induced by political violence as a predictor for individual pathology to attention to contextual factors influencing resilience and well-being (e.g., Barber & Schluterman, 2009; Afana, Pedersen, Ronsbo, & Kirmayer, 2010; Giacaman et al., 2011). This trend is part of the broader debate on whether or not mental health research in conflict settings should focus only on trauma or instead consider the contribution of “daily stressors” some of which may or may not be associated with the conflict (de Jong et al., 2001; Miller & Rasmussen, 2010; Steel, Silove, Bird, McGorry, & Mohan, 1999). Unfortunately, the dichotomous notions of “conflict” and

“post-conflict” are not as clear-cut as the terms suggest. Many of the world’s current conflicts can be characterised as long-term and protracted with periodic flare-ups of violence of varying intensity. In these situations, the population’s mental health may be influenced by their exposure to traumatic violence, general insecurity related to the unresolved conflict or both; Palestine is a good example of this.

For at least a century, Palestinians have lived with long-term political instability. At the end of the Ottoman Empire, the country came under a British Mandate. This was followed in 1948 by the establishment of Israel, which led to the longest-lasting refugee problem in the world. Palestinians endured the 1967 military occupation

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of the Gaza Strip and the West Bank (including East Jerusalem), until the eruption of the first Intifada in 1987. International efforts to initiate a peace process in the early 1990s were superseded by the secretly negotiated Oslo Accords between the Palestinian Liberation Organisation and Israel, and the establishment of a Palestinian Authority in the occupied territories in 1994. However, ensuing negotiations failed to reach a final peace settlement, and a second Intifada erupted in the early 2000s. In 2002, Israel began to erect a physical barrier to prevent the population of the West Bank from entering Israel.

In this prolonged state of political instability, both exposure to traumatic events and general lack of human security have affected Palestinian mental health and well-being. Leaning and Arie (2001) conceptualise human security as: basic needs (shelter, food, water and safety), psychosocial factors (sustainable sense of home and constructive social and family networks) and acceptance of the past and a positive grasp of the future. All three concepts are pertinent for explicating Palestinian mental health (Batniji et al., 2009; Ziadni et al., 2011). Recent Palestinian research has reframed the mental health paradigm to focus on the broader framework of social justice, quality of life, human rights and human security (Giacaman et al., 2011). A systematic literature review on the psychological aspects of the Israeli–Palestinian conflict acknowledges that most studies do not consider possibly relevant factors such as income, discrimination and social inequality, and suggests that a within-group variation analysis can help to understand predictors of well-being (Ayer et al., 2017).

Research on mental health in countries in protracted conflict is steadily producing evidence of the importance of contextual stressors, resilience factors and coping mechanisms (Betancourt, McBain, Newnham, & Brennan, 2014; Panter-Brick, Eggerman, Gonzalez, & Safdar, 2009). The question of *how affected populations describe and perceive mental health and psychosocial problems in humanitarian settings* remains high on the list of research priorities (Tol et al., 2011). A UK research group on “Wellbeing in Developing Countries” suggests that research on well-being in developing [sic] countries must involve working together with interdisciplinary country teams using mixed methods (McGregor, 2006).

The aim of this study was to increase the understanding of contextual factors affecting the mental health of people suffering from long-term political adversity using Palestine as an example. We used an existing quantitative and qualitative data set collected in two villages in the north West Bank that we refer to as village A and village B. Village A is located at about 10 km from the Israeli separation barrier and has retained its agricultural land, while the population of village B has lost most of its agricultural land and the barrier has become the de facto northern border of village B. The data were collected by the Institute of Community and Public Health of Birzeit University and

the Community Based Rehabilitation (CBR) Program as a 2005 needs assessment for psychosocial interventions. The CBR programme selected these villages to determine the psychosocial support needs of populations affected in disparate ways by the local political context and surveyed the female heads of households in the two villages.

Quantitative data were obtained from survey data on demographics, respondent physical and mental health and the social and socio-economic factors related to her household. The survey also included an open question (qualitative data) in which female family caretakers were asked whether or not they suffered from “*dughutar*” (literally “pressures”—the closest local expression for the Western concept of “stress”) and if yes, to describe the pressures. Researchers in this case learned from the respondents’ words rather than imposing words and a perspective on them (Spradley, 1979). This helps the researcher to identify a range of local conceptualizations of distress (Rasmussen, Keatley, & Joscelyne, 2014).

The original 2005 study team summarised the narrated causes of pressure into 100 summary codes. In this study in 2017, we re-coded these summary codes into five categories of perceived pressures. Adding the re-coded data to the quantitative data set, we explored associations between: (a) the individual and contextual variables, and perceived pressures; (b) perceived pressures and WHO-5 well-being index scores and (c) contextual and demographic variables, and the WHO-5 well-being index scores while correcting for the impact of perceived pressures on well-being. Our conceptual model (Figure 1) differs from other models linking stressors to well-being since it considers that both individual characteristics (including health indicators) and household/contextual variables may (directly or indirectly) influence well-being and perceived pressures. The model explicitly accounts for the role of contextual variables in explaining well-being. Our study also takes into account that the associations between individual and contextual variables and perceived pressures and well-being may differ between villages. By comparing the results between two villages, the study examines the political and socio-economic factors that may explain within-group variation of perceived pressures and well-being in a population (Ayer et al., 2017).

METHODS

We conducted a secondary analysis of a 2005 needs assessment survey of female heads of households in two neighbouring West Bank villages including qualitative and quantitative data on experiencing “pressures” and well-being. CBR field workers, trained by Birzeit University researchers, had conducted the original survey. Data had been coded and entered into SPSS files by a local social research organisation, supervised by

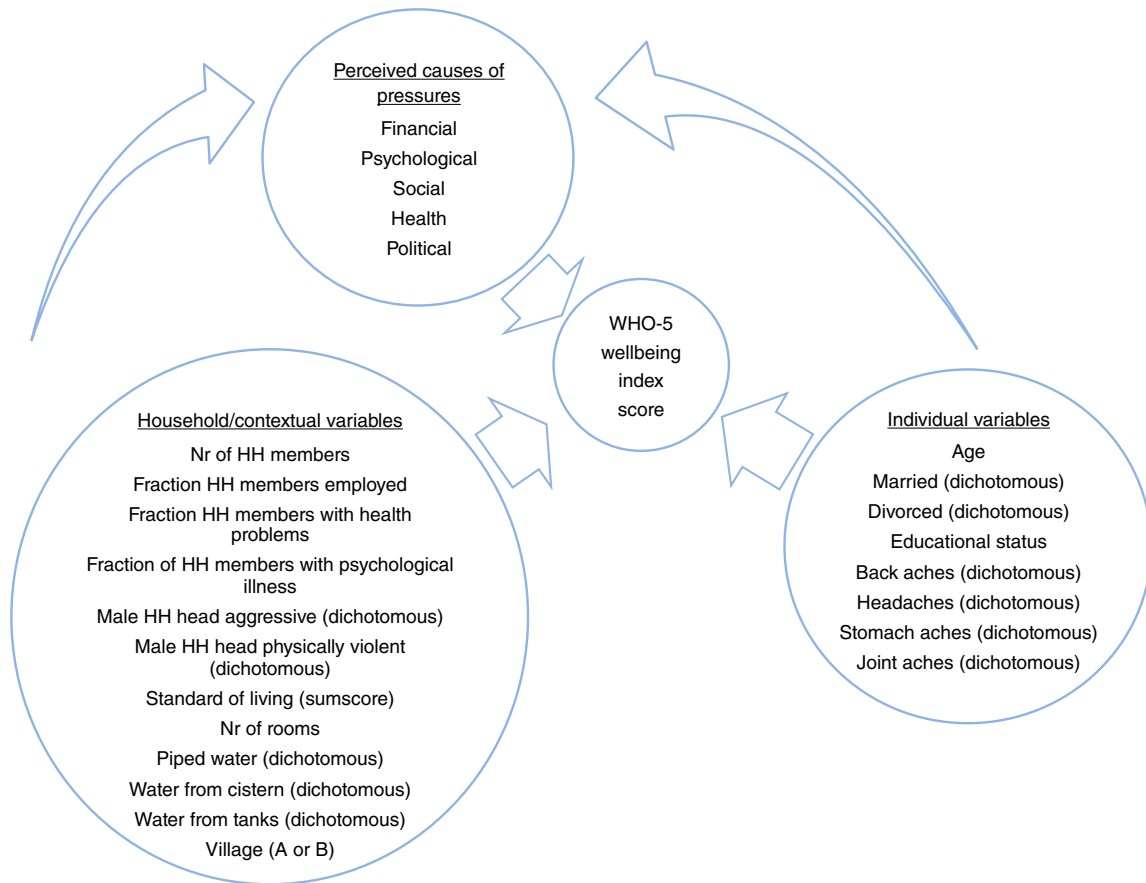


Figure 1. Conceptual model: Individual and household/contextual variables (including residency in village A or B) hypothesized to impact the WHO-5 well-being index score either directly or through the pathway of perceived pressures (abbreviation used: Nr = Number, HH = Household).

Birzeit University. Ethical approval for the study had been obtained from the Birzeit University Research Ethics Committee.

SURVEY POPULATION

The 2005 survey included all female heads of households present in villages A and B. The CBR programme officers had formally approached the mayors of the two villages and explained the survey objectives. The village councils approved of the study and encouraged the villagers to cooperate (zero non-response). However, 20 households in village A (7.2%) could not be included in the survey since these families had temporarily moved to the Jordan Valley for seasonal agricultural work. Field research continued until all households had been visited and questionnaires completed, which yielded a total of 820 completed questionnaires (258 for village A and 562 for village B).

DATA

Survey results provided four types of data included in our secondary analysis. First was socio-demographic data for

the survey respondents and family members. Second was historical and political contextual data including refugee status (UN card) and availability of water resources (piped; cistern or purchase of tank fills) to the families. Third was culture-specific data from 100 short summaries in Arabic of answers to the open question “Do you suffer from pressures (*dughutat*)” and if yes, what causes the pressures you experience?.” Fourth was data from the respondents’ scores on the WHO-5 well-being index including five questions widely used to measure subjective well-being on a 0–100 scale (Topp, Ostergaard, Sondergaard, & Bech, 2015). To support the discussion of the statistical analysis we also used Birzeit University’s unpublished initial 2006 report, which included a thorough description of the geographic, demographic and political settings of the two villages (Giacaman et al., 2006).

PROCEDURES

The first author translated the original 100 summarised descriptions of “pressures” from Arabic to English and re-coded them into five main categories: financial

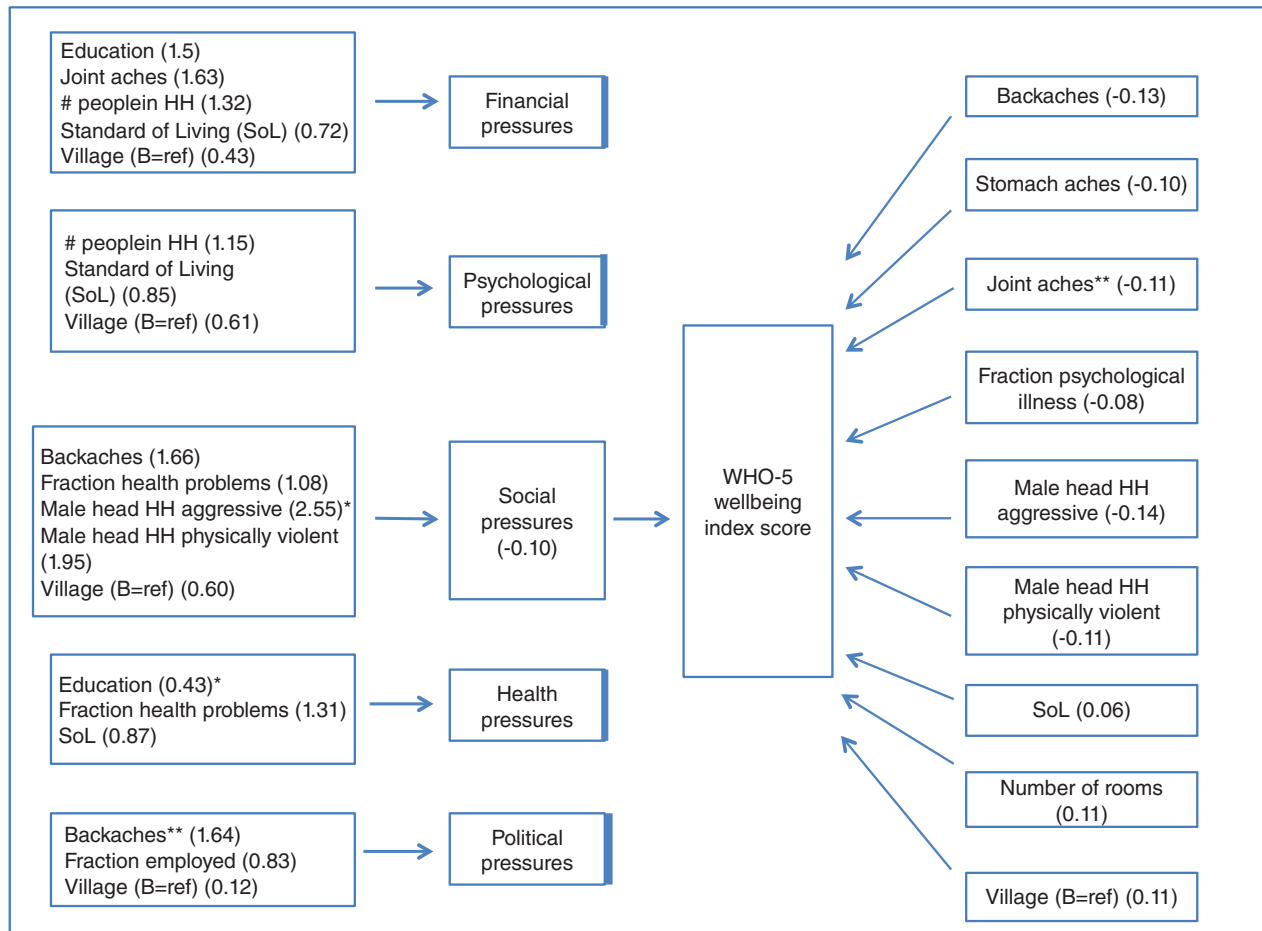


Figure 2. Schematic overview of significant associations found between individual and contextual variables, pressures and WHO-5 well-being index scores. Boxes on the left contain odds ratios for variables found to be significantly associated with perceived pressures. Only social pressures were found to be associated with WHO-5 well-being index score with a standardised regression coefficient included in the corresponding box. Boxes on the right contain standardised regression coefficients for individual and contextual variables that were found to be associated with WHO-5 well-being index score after correction for perceived pressures. * Only significant for village A. ** Only significant for village B.

($n = 14$), psychological ($n = 26$), social ($n = 42$), health ($n = 5$) and political ($n = 13$). An Arabic/English fluent bilingual university colleague reviewed both the translation and the re-codes to achieve consensus. Whenever a specific summarised description contained elements of two or more types of pressure, the description was counted for each type. For example, the summary “Loneliness + not getting pregnant + people’s talk” was coded in the new categories under “psychological,” “social” and “health.” (Scales and re-codes of pressures are available in File S1, Supporting Information).

STATISTICAL ANALYSES

Contextual and pressure variables were compared between the two villages using independent sample t -tests and chi-square tests. Associations between contextual variables and pressures were tested by means of logistic regression analyses performed separately

for financial, psychological, social, health and political pressures. For each pressure, a two-step procedure was used. Associations between contextual variables and perceived pressure were first tested univariately. Only the contextual variables with a p value less than .10 in the univariate analysis were included in a multivariable logistic regression analysis using a backward elimination procedure.

Associations between perceived pressures and contextual variables and the dependent variable, WHO-5 well-being index score, were tested using linear regression. A two-step procedure was used so the first step associations could be tested univariately. In the second step, a multivariable model was built from a model containing only the five new pressure categories. The model was then expanded with contextual variables associated with the WHO-5 well-being index score using a forward selection of contextual variables with $p < .10$ in univariate analysis. These analyses were performed for the whole

TABLE 1
Comparison of demographic and contextual variables, reported pressures and well-being scores between the two villages

Variable	Village A (n = 258)(%)	Village B (n = 562)(%)	Chi-square	p Value
UN card	24	56	$\chi^2 = 72.2$ (df = 1)	<.001
Education				
Elementary	43	40	$\chi^2 = 10.967$ (df = 3)	.012
Preparatory	27	19		
Secondary	20	29		
Post secondary	11	12		
Marital status				
Not married	.4	1.1		.817 ^a
Married	92	91		
Divorced	.4	.7		
Widowed	7	8		
Piped water	78	0.7	$\chi^2 = 560.401$ (df = 1)	<.001
	M (SD)	M (SD)	T	p Value
Age	38 (14)	40 (14)	-1.6 (df = 818)	.118
Number of members in household (HH)	6.4 (3.1)	5.5 (2.1)	4.4 (df = 818)	<.001
Number of employed/Number of HH members	.19 (.15)	.20 (.14)	-0.23 (df = 818)	.819
Number of ill/Number of HH members	.20 (.23)	.27 (.25)	-3.8 (df = 818)	<.001
Number of psychological illness/Number of HH members	.02 (.08)	.03 (.10)	-1.4 (df = 818)	.172
Number of rooms in the house	3.2 (1.4)	3.6 (1.3)	-3.2 (df = 816)	.002
Standard of living	3.9 (2.0)	4.4 (2.0)	-3.1 (df = 815)	.002
WHO-5 well-being index score	55.6 (25.4)	50.4 (25.5)	2.7 (df = 817)	.007
Respondent reports of pressures	%	%	Chi-square	p Value
No pressures	22.5	12.5	13.491 (df = 1)	<.001
Financial	61	86	4.202 (df = 1)	.025
Psychological	66	72	3.205 (df = 1)	.044
Social	23	34	10.754 (df = 1)	.001
Health	21	22	0.16 (df = 1)	.489
Political	3	22	48.274 (df = 1)	<.001

^ap Value for Fisher's exact test.

sample including an indicator for the village (A or B) as a contextual variable. Next, analyses were performed separately for village A and B. The normality of residuals from multivariate regression models were checked by means of QQ-plots. All analyses were performed in SPSS version 22 using a two-sided significance level of .05.

RESULTS

Missing values were scarce (< 0.4% missing data) for the majority of independent variables and dependent variables. However, 10.1% of the respondents (9.3% in village A and 10.4% in village B) had missing values for the independent variables "Male head of HH physically violent" and "Male head of HH aggressive". Missing values were mainly due to female HH being unmarried, divorced or widowed. For married women, the missing value rate was only 1.6% (1.7% in village A and 1.6% in village B). Multivariate models were fitted on respondent complete data only (89.9%) and were restricted to the sub-population of women who were married at the time of the 2005 needs assessment.

Table 1 reveals several significant differences in independent variables, reported pressures and well-being scores between the two villages. Village B had a higher proportion of UN-refugee cardholders. Fewer villagers in village B had access to piped water and the average household size was smaller compared to village A. Respondents from village B reported a higher proportion of people with illness in their households and had lower WHO-5 well-being index scores, despite having a higher average number of rooms in the house and standard of living compared to village A.

The proportion of respondents who reported they did not suffer from pressures at all was found to be lower in village B compared to that of village A. The respondents in village B were more likely to report pressures related to financial, psychological, social and political issues, compared to village A respondents.

Results of the univariate logistic regression analyses with pressures as outcomes are available in File S1. Table 2 shows the final multivariate models for the reported pressures of both the combined population and each village separately.

TABLE 2
Results of multivariate logistic regression analyses with pressures as outcomes

A multivariate logistic regression was used with backward elimination. Only predictors with $p < .10$ in the univariate analyses were included in the multivariate analyses

	Combined			Village B			Village A		
	OR	95% CI	p Value	OR	95% CI	p Value	OR	95% CI	p Value
Financial pressures									
Education									
Illiterate/elementary/preparatory (ref)	1.00								
Secondary/diploma/bachelors	1.50	(1.03, 2.18)	.035						
Joint aches									
Never or rarely (ref)	1.00								
Sometimes or a lot	1.63	(1.14, 2.33)	.007						
Number of people in household (per person increase)	1.32	(1.22, 1.43)	<.001	1.41	(1.26, 1.57)	<.001	1.22	(1.10, 1.35)	<.001
Standard of living (per unit increase)	0.72	(0.66, 0.80)	<.001	0.72	(0.64, 0.81)	<.001	0.75	(0.64, 0.87)	<.001
Village (B = reference)	0.43	(0.30, 0.62)	<.001						
Psychological pressures									
Number of people in household (per person increase)	1.15	(1.07, 1.24)	<.001	1.18	(1.07, 1.30)	.001	1.12	(1.02, 1.23)	.023
Standard of living (per unit increase)	0.83	(0.76, 0.91)	<.001	0.81	(0.74, 0.90)	<.001			
Village (B = reference)	0.61	(0.43, 0.87)	.006						
Social pressures									
Backaches									
Never or rarely (ref)	1.00			1.00			1.00		
Sometimes or a lot	1.66	(1.19, 2.31)	.003	1.73	(1.19, 2.52)	.004	2.01	(1.08, 3.74)	.03
Fraction with health problems (per 10% increase)	1.08	(1.01, 1.16)	.02						
Male head of HH aggressive									
Never or rarely (ref)							1.00		
Sometimes or a lot							2.55	(1.13, 5.77)	.02
Male head of HH physically violent									
Never or rarely (ref)	1.00			1.00					
Sometimes or a lot	1.95	(1.26, 3.00)	.002	2.19	(1.28, 3.75)	.004			
Village (B = reference)	0.60	(0.42, 0.87)	.006						
Health pressures									
Education									
Illiterate/elementary/preparatory (ref)							1.00		
Secondary/diploma/bachelors							0.43	(0.19, 0.98)	.045
Fraction with health problems (per 10% increase)	1.31	(1.22, 1.40)	<.001	1.29	(1.19, 1.41)	<.001	1.36	(1.19, 1.55)	<.001
Standard of living (per unit increase)	0.87	(0.80, 0.96)	.004	0.86	(0.77, 0.97)	.010			
Political pressures									
Backaches									
Never or rarely (ref)				1.00					
Sometimes or a lot				1.64	(1.10, 2.44)	.02			
Fraction employed (per 10% increase)	0.83	(0.71, 0.97)	.016						
Village (B = reference)	0.12	(0.06, 0.26)	<.001						

Financial pressures

In the combined village population, financial pressures were more likely to be reported by respondents with a secondary education, joint aches and a higher number of people in the household. Financial pressures were less likely to be reported by people with a higher standard of living. After correction for these variables, respondents in village A were still less likely to perceive financial pressures compared to those of village B. Separate multivariate analyses for village A and B revealed a higher

number of people in the household and lower standard of living as main factors associated with a higher probability of reporting financial pressures in both villages.

Psychological pressures

In the combined population of the villages, psychological pressures were more likely to be reported by respondents with a higher number of people in the household, and less likely by respondents with a higher standard of living. Psychological pressures were much more likely to be

reported by respondents suffering from headaches and joint aches, and when corrected for other predictors, were reported slightly less often with increasing age. After correction for these variables, respondents in village A were still less likely to report psychological pressures compared to those of village B. In both villages, psychological pressures were more likely to be reported by respondents with a higher number of people in the household. Lower standard of living was found to be associated with reporting of psychological pressures in village B, but not in village A.

Social pressures

In the combined population of the two villages, social pressures were more likely to be reported in association with backaches when the household included more people with health problems, and when the male head of household was reported to be physically violent. After correction for these variables, respondents in village A were still less likely to report social pressures compared to village B. In village A, respondents were more likely to report social pressures when the male head of household was reported to be aggressive, whereas physical violence by the male head of household was dropped from the multivariate model in the backward elimination procedure. An association between backaches and reporting of social pressures was found in both villages.

Health pressures

In the combined population respondents were more likely to report health pressures when there were more people with health problems in the household and less likely to perceive health pressures when the household had a higher standard of living. In village A, but not B, we found that respondents with a higher education were less likely to experience health pressures. In village A, the standard of living did not appear in the final model.

Political pressures

In the combined population respondents were less likely to report political pressures when more household members were employed. After correction for these variables, respondents of village A were still less likely to report political pressures. In village B, but not A, reported political pressures were associated with more backaches. Since only a very few respondents in village A reported political pressures, no associations were found with any independent variable.

WHO-5 well-being index

Results of the univariate linear regression analyses relating WHO-5 well-being index scores to contextual

variables and reported pressures are available in File S1. Univariate analyses showed significant negative associations between all types of reported pressures and the WHO-5 well-being index score in the combined sample. In village A, only reported health pressures were found to be associated with a lower WHO-5 well-being index score, whereas in village B all pressures, except political, were associated with lower WHO-5 well-being index scores. Table 3 shows the results of the multivariate analyses. In the combined population of the two villages, reported social pressures were found to be negatively associated with the WHO-5 well-being index score. No other type of reported pressure was found to be associated with a WHO-5 well-being index score when corrected for the other types of pressures and contextual variables. In the combined population of the two villages, backaches and stomach aches were negatively associated with the WHO-5 well-being index score. Psychological illness in the household, male head of household aggressiveness and physical violence were all negatively associated with WHO-5 well-being index scores in the combined population. Standard of living and number of rooms were associated with a higher WHO-5 well-being index score. Corrected for these factors, living in village A rather than village B was still associated with a better WHO-5 well-being index score. In village B, joint aches were negatively associated with the WHO-5 well-being index score, whereas backaches were not included in the final multivariate model. Adjusted *R*-squared for multivariate models that included the contextual variables together with the pressures were 17.8% for the combined sample, 18.3% for village B and 11.4% for village A compared to 6.2, 6.6 and 2.3%, respectively, for the multivariate model including only the five new categories of pressures.

DISCUSSION

Evidence that exposure to war- or conflict-related traumatic events affects people's mental health is well established (Ayer et al., 2017). Our study of well-being in two Palestinian villages illustrates that a wide array of contextual and non-trauma-related variables (lower education, joint and backaches, larger household size, lower standard of living, less employment, aggression or physical violence of the male head of household, illness in the family and residence in village B) are associated with increased stress of various types. However, as predicted in the conceptual model, many of the individual and household/contextual factors were also directly associated with the WHO-5 well-being index score. It is noteworthy that only social pressures were directly associated to well-being.

A partial explanation might be that the aggressive and violent behaviour of the male head of household, which is highly associated with lower well-being, is also

TABLE 3
Standardised regression coefficients for multivariate linear regression with WHO-5 well-being index score as outcome

A multivariate linear regression was performed in SPSS. Forward selection was used to determine a model for a relationship between the WHO-5 well-being index score and predictors. Only predictors with *p* value of less than .10 were included in the multivariate regression. All five categories of pressures were included and forced to stay in the model

Predictors	Combined (N = 732)			Village B (N = 500)			Village A (N = 232)		
	Beta	95% CI	<i>p</i> Value	Beta	95% CI	<i>p</i> Value	Beta	95% CI	<i>p</i> Value
Financial pressures	-.016	(-0.10, 0.069)	.71	-.049	(-0.15, 0.047)	.32	.090	(-0.10, 0.28)	.28
Psychological pressures	-.043	(-0.13, 0.039)	.30	-.039	(-0.13, 0.054)	.41	-.10	(-0.29, 0.087)	.29
Social pressures	-.10	(-0.17, -0.034)	.003	-.14	(-0.22, -0.055)	.001	-.073	(-0.20, 0.049)	.24
Health pressures	-.050	(-0.12, 0.018)	.15	-.039	(-0.12, 0.042)	.35	-.010	(-0.23, 0.025)	.12
Political pressures	-.034	(-0.10, 0.034)	.32	-.039	(-0.12, 0.043)	.34	-.010	(-0.13, 0.11)	.86
Backaches	0						0		
Never or rarely (ref)									
Sometimes or a lot	-.13	(-0.20, -0.058)	<.001				-.20	(-0.33, -0.75)	.002
Stomach aches	0								
Never or rarely (ref)									
Sometimes or a lot	-.10	(-0.17, -0.032)	.004	-.099	(-0.18, -0.017)	.02			
Joint aches	0								
Never or rarely (ref)									
Sometimes or a lot									
Fraction with psychological illness (per 10% increase)									
Male head of HH aggressive	-.079	(-0.15, -0.004)	.04	-.10	(-0.19, -0.010)	.03			
Never or rarely (ref)	0			0					
Sometimes or a lot	-.14	(-0.21, -0.064)	<.001	-.21	(-0.29, -0.13)	<.001			
Male head of HH physically violent	0						0		
Never or rarely (ref)									
Sometimes or a lot	-.11	(-0.18, -0.036)	.003				-.15	(-0.27, -0.022)	.02
Standard of living (per unit increase)	.056	(0.019, 0.093)	.003	.098	(0.008, 0.188)	.03	.20	(0.065, 0.33)	.004
Number of rooms (per room increase)	.11	(0.036, 0.18)	.003	.11	(0.024, 0.195)	.01			
Village (B = reference)	.11	(0.045, 0.18)	.001						
Adjusted R ² (% of variance in WHO-5 well-being index score explained by model)			17.8			18.3			11.4

Based on the findings in Table 3 the final model is presented in Figure 2:

strongly associated with social pressures. Although narratives about pressures sometimes included references to traumatic events related to the military occupation (e.g., political detention, restricted movement or the separation barrier), the respondents mainly focused on their everyday financial, psychological, social and health situation.

These results reinforce the evidence of several other studies that also take daily contextual stressors into the account. For example, a study in Afghanistan had findings similar to this study and showed that stressors of poverty, physical and mental health and violence in the family were found to bear on people's resilience and suffering (Eggerman & Panter-Brick, 2010).

In an alternative conceptualization of daily contextual stressors as "unmet needs" (WHO, 2011) among Iraqi displaced people in Jordan, the population's unmet needs (e.g., in relation to "income," "living space," "food," "health") were found to have stronger correlation with mental distress than "trauma exposure." Similarly, in Nepal, Bhutanese refugees' unmet needs decreased the strength of the association of trauma exposure with mental distress (Jordans, Semrau, Thornicroft, & van Ommeren, 2012). In the Netherlands, mental health problems of Iraqi asylum seekers were not only related to adverse life events in their home country, but also to post-migration living problems, and specifically the stress of the long juridical process related to their request for a residence permit (Laban, Komproe, Gernaat, & de Jong, 2008).

A particularly significant finding of this study was that although the distance between the two villages is barely 10 km, there were more reported pressures and lower well-being scores in village B. Common demographic differences were not significant and the standard of living in village B was actually higher than in village A. Residence in village B also was a significant predictor for financial, psychological, social and political pressures, and a lower WHO-5 well-being index score. This variance between the two villages is hard to explain based only on individual measurements. Wind and Komproe (2017), stress the importance of multilevel research, both on the individual and community level in populations affected by an ecological disaster. Although we had no community-level statistical data, qualitative data related to the historical, political and social contexts of the two communities helped to further explore explanations for the striking variance in findings between the two villages (Giacaman et al., 2006).

Village B is located on the "Green Line" (the unofficial border between the West Bank and Israel). A much larger proportion of the village B population (refugees who had fled their homes when Israel was established in 1948, and families whose land was confiscated in 1948, 1967 and 2002) has no access to land for income through agriculture or as a financial asset, per se. Because village B's location is on the border and the population had no land to work on, when occupying forces "opened" the border

in 1967, many people from village B sought and found work in Israel. This provided them with a reasonably stable income (generally higher than village A residents earned from working their land) and may explain village B's higher standard of living until the end of the 1990s. However, access to work in Israel became severely limited with the erection of the separation barrier in 2002, which explains why village B families were experiencing considerable financial pressure (and other pressures) at the time of the survey in 2005, since those who had been accustomed to relatively stable employment now needed to be trafficked into Israel. This meant that they incurred not only great financial expense, but also endured the risk of being apprehended and detained by Israeli police. Alternatively, they could accept (if they found) work in the West Bank, but with wages much lower than in Israel. This explanation fits the Conservation of Resources theory, which proposes that psychological responses to political conflict and violence vary according to the degree of resource loss (whether personal, social or material) people have experienced; greater resource loss leads to greater psychological distress (Hobfoll, 1989). Another structural difference between the two villages supports Wind and Komproe's conclusion that cognitive social capital affects mental health at the individual level, especially for women. The population of village A belongs to four distinct clans (*hamoula*'s) representing roughly 40, 30, 17 and 13% of the population. In village B the population belongs to 28 families, who have no shared clan affiliations (Giacaman et al., 2006). People belonging to the same *hamoula* or kinship network tend to support each other in times of crisis (Joseph, 1996). The presence of this type of support may be a contributing factor village A's higher well-being and lower level of reported pressures.

LIMITATIONS AND STRENGTHS

A limitation of secondary analysis is the restriction to variables and their operationalization in the original study. Predictors were mostly socio-demographic (education, income, etc.) and somatic reports (backaches, etc.). This rather narrow set of predictors may explain the relatively lower percentages of variances explained in the regression models, as well as the absence of relationships between most pressures and well-being. However, we have capitalised on the opportunities offered by the data, which presented variables rarely found in larger international research efforts, for example, the possession of a "UN refugee card" and access to piped water. These were the variables that exposed some of the structural differences between the two villages and lay at the basis of our contextual analysis and inclusion of historical and political components in the discussion. We also took advantage of the availability of both quantitative and

qualitative data. Respondent input on experienced pressures clearly established the importance of daily contextual pressures. Given the time lapse between data collection and this secondary analysis, documentation related to some components of the needs assessment methodology—notably the original responses and the coding summarising procedures—could not be retrieved and some hindsight bias may have occurred in the analysis. Using the original responses as narrated by the female caretakers would have allowed for a more in-depth analysis, but would probably not have changed the outcome of our analysis. Qualitative data (Giacaman et al., 2006) also provided the historical, political and social supplementary detail of the villages. This helped explain findings and specifically the cumulative effect of repeated loss of resources (see Hobfoll, 1989) and well-being.

CONCLUSION

This study presents additional evidence of the importance of daily contextual stressors in the lives and well-being of people living in settings of chronic political conflict and violence. The findings revealed important variance within a very small subgroup (the two villages) of a Palestinian population, which is usually studied in cross-sectional random sample designs exploring the associations of exposure to chronic conflict and violence with well-being and mental health. Using both quantitative and qualitative data, our study explored how large political events (1948 establishment of Israel, the 1967 occupation of the West Bank and Gaza Strip and the erection of the separation barrier) may affect the resources of subgroups of a population to various degrees. Our findings support the call for more attention to daily contextual factors in the study of well-being of populations enduring chronic political conflict and violence, and for specific attention to the cumulative effects of political and historical events affecting the daily lives of these populations (Fassin, 2011). While we agree with many of our colleagues investigating the mental health of communities affected by natural and man-made disasters that these findings imply the need for community-based psychosocial support interventions, we are cautious about the limitations of such interventions in the face of larger historical and political realities.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Original scales; and Re-codes for pressures.

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