

Domestic Violence And Its Relationship To Mental Health And Post-Traumatic Symptoms In Pregnant Women In Hebron

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Abstract:

The study aimed to identify domestic violence and its relationship with mental health and post-traumatic symptoms among pregnant women in Hebron. To achieve this, a correlational descriptive approach was used. The study population consisted of all pregnant women in the city of Hebron. The researcher developed a scale for psychological violence and a scale for post-traumatic symptoms, along with the General Health Questionnaire (GHQ-28). The three scales were applied to a sample of 335 pregnant women from Hebron. Ultimately, the findings were: The results showed that the level of domestic violence against pregnant women in Hebron was high. The percentage of women who experienced violence among the women participating in the study was 78.8%. The results also revealed that 42.7% of the women who faced violence experienced it more than six times, indicating a significant frequency of violence. The results indicated that the level of domestic violence was moderate, with an arithmetic mean of 3.29 and a standard deviation of 1.35. The findings showed that the level of mental health among pregnant women in Hebron was low, with a mean score of 2.60. The results regarding post-traumatic stress symptoms, as detailed in Table 17 in the previous section, indicate that the level of post-traumatic stress symptoms was moderate, with a mean score of 3.29. The results exhibited a strong inverse relationship with statistical significance at the significance level of 0.001 between domestic violence and mental health, with domestic violence explaining and accounting for 84.5% of the decline in mental health. The results indicated a strong, statistically significant positive relationship between domestic violence and post-traumatic stress symptoms, and this relationship explains 84.0% of the occurrence of post-traumatic stress symptoms in pregnant women.

The study also showed that there were statistically significant differences between the mean ranks of the respondents' estimates regarding the level of domestic violence and its relationship with mental health and post-traumatic stress symptoms among pregnant women in Hebron, from their perspective, according to a set of demographic and social variables (the nature of the wife's work, the nature of the husband's work, blood type, age of the wife, age of the husband, number of pregnancies, educational level of the husband, and number of family members). On the other hand, the results showed no statistically significant differences in the post-traumatic stress symptom scale related to the educational level of the pregnant woman.

Based on the results of the study, the following recommendations were formulated: It is recommended to establish specialized units to detect domestic violence cases early during pregnancy, and to provide psychological support and legal advice to affected women. These units should be part of the primary care system, not secondary services, and should operate confidentially and efficiently to ensure the protection of pregnant women and enhance their sense of security.

Keywords: violence, domestic violence, health, mental health, post-traumatic stress disorder, pregnant women

Introduction:

Family is the foundation of society, responsible for raising children, developing their physical and social abilities, and instilling values and morals that reflect the culture of the community. Despite its importance, some families struggle to fulfill these roles, leading to

an unstable home environment. Domestic violence is one of the most serious signs of failure in a family's role as a safe haven that provides support and protection, especially for pregnant women in a conservative society like Hebron. Its dangers become even greater during pregnancy—a period when women need the most psychological and physical care. Domestic violence weakens the mental health of pregnant women and triggers symptoms of post-traumatic stress disorder (PTSD) due to continuous exposure to trauma within the very household that should be a place of safety.

Domestic violence is not limited to direct physical assault; it also includes control and dominance between partners, aiming to subjugate and weaken the victim. It manifests in various forms—physical, psychological, sexual, and economic (Azouq & Qasid, 2020). Studies in the Palestinian context highlight a strong link between these types of abuse and the deterioration of women's mental health, particularly pregnant women. For instance, a study on women in Gaza (Thabet et al., 2015) found that psychological, physical, and sexual violence were associated with high levels of depression, anxiety, and post-traumatic stress disorder (PTSD) symptoms. Similarly, local research (Bdier & Mahamid, 2021; Guido et al., 2023) confirmed that gender-based violence correlates positively with psychological distress—such as anxiety, depression, and stress—and negatively with well-being and quality of life.

The effects of domestic violence become even more severe for pregnant women due to the physiological and psychological changes that accompany pregnancy. According to the World Health Organization (WHO, 2021), 50% of abused women experience symptoms of depression, compared to only 20% of non-abused women. Additionally, 70% of survivors suffer from PTSD-like symptoms even years after the violence has stopped (Fernández et al., 2021). Domestic violence also weakens self-confidence and reinforces feelings of helplessness and guilt (Karakurt et al., 2015), further compromising mental health during a critical period like pregnancy.

On the other hand, declining mental health—such as depression or personality disorders—can increase a woman's vulnerability to domestic violence (APA, 2019; NIMH, 2020). Studies (e.g., PMC, 2018; WHO, 2021) indicate that psychological stress and mental disorders heighten the risk of domestic violence, creating a vicious cycle between abuse and weakened mental health.

This dynamic is especially dangerous for pregnant women in Hebron's conservative society, where cultural and economic factors shape patterns of violence and influence the likelihood of reporting abuse or seeking support.

The importance of this study stems from its focus on a sensitive and often neglected issue: the relationship between domestic violence and the mental health of pregnant women in the city of Hebron. This group is experiencing a critical psychological and physical phase, making them more vulnerable to domestic violence. The research contributes to shedding light on the psychological dimensions of violence, such as depression, anxiety, low self-esteem, and symptoms of post-traumatic stress disorder, within a conservative social environment that may conceal manifestations of violence and fail to provide adequate protection for victims. The study also highlights the importance of addressing violence as a public health issue, not just a social issue. The lack of local research that systematically links different types of domestic violence to the mental health of pregnant women in the Palestinian context, particularly in the city of Hebron, makes this study both important and necessary.

Thus, this study aims to examine the interactive relationship between various forms of domestic violence and mental health indicators—depression, anxiety, self-esteem, and post-traumatic stress symptoms—among pregnant women in Hebron. The goal is to provide scientific data that supports the design of intervention programs tailored to the unique needs of this vulnerable group within their social context.

Methodology:

In line with the study's objective of exploring the relationship between domestic violence and the level of mental health among pregnant women in the Hebron Governorate, the researcher adopted a descriptive correlational approach, given its analytical capacity to study the relationships between psychological and social variables without intervening in experimental control. This approach enabled the examination of the effect of the independent variable, domestic violence, on the dependent variables, namely mental health and symptoms of post-traumatic stress disorder (PTSD), within a scientific framework that takes into account the cultural and social specificities of the local community. This methodological approach also enabled the use of standardized measurement tools appropriate to the nature of the phenomenon under study, enhancing the accuracy and objectivity of the results. This approach is appropriate for the nature of the study, which aims to explain the relationships between psychological and social phenomena, away from abstract theoretical generalizations, with a focus on providing an in-depth understanding of the psychological effects resulting from domestic violence in the context of pregnancy. This contributes to building a knowledge base that can be used to develop appropriate psychological and social interventions.

Study Population:

The study population consists of all pregnant women residing in the city of Hebron, according to statistical data issued by the city's Health Directorate, which indicates that their number reached () pregnant women during the study period. This population was chosen due to its direct connection to the research topic, which aims to investigate the relationship between domestic violence and the level of mental health among pregnant women. This enhances the reliability of the results and ensures their applicability to the target group within the local context.

Study Sample:

The study sample consisted of (335) pregnant women from the city of Hebron, who were selected from among the visits to clinics specializing in maternity follow-up during the data collection period, using the available sample method, which ensures direct access to the target group. A set of inclusion criteria were adopted, most notably that the participant be actually pregnant, a resident of the city of Hebron, in addition to her ability to understand the content of the questionnaire and agree to participate. Conversely, anyone who did not meet these conditions, or who did not complete the questionnaire completely, was excluded. The measurement tools were distributed in paper form within the clinics, and all questionnaires were returned after completion, with a recovery rate of (100%), which enhances the reliability of the results and the validity of the statistical processing. Table (1) presents the demographic characteristics of the participants.

Table 1: Demographic characteristics of the participants

Variable	levels variable	Frequency	Percent%
wife's work	Housewife	66	19.7
	Student	43	12.8
	Employee	136	40.6
	Unemployed	22	6.6
	Other	68	20.3
Total		335	100.0
husband's work	Worker	82	24.5
	Employee	127	37.9

	Freelancer	54	16.1
	Unemployed	41	12.2
	Other	31	9.3
Total		335	100.0
blood type	O-	40	11.9
	O+	82	24.5
	-A	29	8.7
	A+	50	14.9
	B-	28	8.4
	B+	31	9.3
	AB-	34	10.1
	AB+	41	12.2
Total		335	100.0
Wife's age	18 thru 20	18	5.4
	21 thru 30	182	54.3
	31 thru 40	116	34.6
	41 thru 50	19	5.7
Total		335	100.0
Husband's age	20 thru 30	110	32.8
	31 thru 40	148	44.2
	41 thru 50	64	19.1
	51 thru Highest	13	3.9
Total		335	100.0
Number of pregnancies	Once	74	22.1
	Twice - Three times	180	53.7
	More than three times	81	24.2
Total		335	100.0
Wife's educational level	High school or less	107	31.9
	Diploma	155	46.3
	Bachelor's	64	19.1
	Postgraduate studies	9	2.7
Total		335	100.0
Husband's educational level	High school or less	146	43.6
	Diploma	119	35.5
	Bachelor's	55	16.4
	Postgraduate studies	15	4.5
Total		335	100.0
Number of family members	lowest thru 3	128	38.2
	4 thru 7	193	57.6
	8 thru 10	13	3.9
	11 thru Highest	1	.3
Total		335	100.0

Data Collection

Data were collected using a questionnaire consisting of three main scales: the first scale measured domestic violence, the second measured mental health, and the third measured symptoms of post-traumatic stress disorder (PTSD). The first section included demographic data for the participants. The questionnaire was distributed using a paper-based method, with visits to clinics that monitor pregnant women in the city of Hebron

directly distributed to pregnant women attending these clinics. The final sample consisted of (335) pregnant women who met the conditions for participation in the study.

Study Tool:

Description of the Measurement Tool: To understand the nature of the relationship between domestic violence, mental health, and post-traumatic symptoms among pregnant women in Hebron, a study tool was developed in the form of a questionnaire based on previous literature and guidance from specialists in the field. The questionnaire consisted of four main sections:

Section One: Preliminary demographic data, which included personal and social variables aimed at identifying the general characteristics of the study sample, such as: the nature of the wife's work, the nature of the husband's work, blood type, age of the wife, age of the husband, number of pregnancies, educational level of the wife, educational level of the husband, and the number of family members.

Section Two: Measurement of domestic violence, which consisted of 24 items distributed across two dimensions; the first for measuring physical violence which includes 11 items, and the second for measuring psychological violence which includes 13 items. These items aimed to determine the extent and frequency of various patterns of violence that a pregnant woman may be exposed to within her family environment.

Section Three: Measurement of mental health, which contained 28 items based on the General Health Questionnaire (GHQ-28), with the items distributed across four main dimensions: somatic symptoms (7 items), anxiety and sleep disturbances (7 items), social functioning (7 items), depression and negative feelings (7 items). These items aimed to monitor the various psychological aspects that may be affected by domestic violence in the context of pregnancy.

Section Four: Post-traumatic symptoms, which contained 15 items divided into three dimensions: the first dimension comprised 5 items to measure re-experience symptoms, the second dimension contained 5 items to measure avoidance, and the third dimension included 5 items to measure negative changes in thinking and mood.

Psychometric properties of the scale:

Validity of the scale:

The researcher used two types of validity, the first of which was the validity of the arbitrators, by presenting the questionnaire to a group of (10) arbitrators, with the aim of ensuring the suitability of the measuring tool for what it was prepared for and the soundness of the wording of the paragraphs. There was agreement among them on the validity of the measuring tool, its readability, and its suitability for the Palestinian environment. With some necessary modifications.

On the other hand, the construct validity of the study tool was verified using a statistical analysis method based on calculating the correlation coefficients between the scores of each item and the total score of the domain to which it belongs, in order to ensure the extent to which the items represent the theoretical concept they measure. The researcher conducted an analysis of the inter-item correlation matrix, as illustrated in tables (2 to 7), where the results showed that all correlation coefficients were positive and statistically significant at the level of ($\alpha \leq 0.05$), indicating a strong internal consistency among the items within each domain of the tool. This consistency is an indication that the items measure interrelated and integrated aspects within the assumed structure of the target domain, whether in the aspect of domestic violence, mental health, or symptoms of post-traumatic stress disorder.

The construct validity was also supported by the multi-table analysis (2, 3, 4, 5, 6, and 7), which showed agreement between the items and the total score across different dimensions, further enhancing the tool's validity in measuring the theoretical concepts related to the study topic. These results indicate that the tool possesses an appropriate level of construct validity, accurately reflecting the psychological and social dimensions associated with domestic violence and its impact on pregnant women in the Hebron governorate, ensuring the reliability of the results and enhancing its interpretive capacity in the local research context.

First: Validity of the Domestic Violence Measurement Tool:

Table 2: Results of Spearman's Rank-Order Correlation for the correlation matrix of the items of the study tool with the total score for each domain, specifically for the second section (Domestic Violence).

Ite m	Correlatio n Coefficien t	Sig. (2- tailed)	Ite m	Correlatio n Coefficien t	Sig. (2- tailed)	Ite m	Correlatio n Coefficien t	Sig. (2- tailed)
Domestic violence								
						Physical violence		
1	**0.813	.000	5	**0.924	.000	9	**0.759	.000
2	**0.885	.000	6	**0.893	.000	10	**0.865	.000
3	**0.922	.000	7	**0.819	.000	11	**0.901	.000
4	**0.886	.000	8	**0.893	.000			
Psychological violence								
1	**0.843	.000	6	**0.857	.000	11	**0.891	.000
2	**0.788	.000	7	**0.875	.000	12	**0.905	.000
3	**0.822	.000	8	**0.886	.000	13	**0.902	.000
4	**0.830	.000	9	**0.839	.000			
5	**0.793	.000	10	**0.902	.000			

* Statistical significance at the level of ($\alpha \leq 0.05$).

** Highly statistically significant at the level of ($\alpha \leq 0.01$).

The data in Table (2) indicate the results of a correlation analysis using Spearman's rank coefficient. This analysis aimed to verify the construct validity of the domestic violence measurement tool, specifically in the second section related to physical and psychological violence. The results showed that all items had a positive and highly statistically significant correlation with the total score for each domain. Correlation coefficients ranged between (0.759 and 0.924) for physical violence, and between (0.788 and 0.905) for psychological violence. All items were statistically significant at the ($\alpha \leq 0.01$) level.

These results reflect a high level of internal consistency between the items, indicating that the tool effectively and coherently measures the dimensions of domestic violence, as theoretically assumed. This consistency is a strong indicator of construct validity, as the high correlation coefficients indicate that the items belong to a unified conceptual structure and contribute to accurately measuring the targeted phenomenon. Accordingly, it can be said that the measuring tool used in the study has a high degree of validity and is suitable for measuring the level of domestic violence among pregnant women in the city of Hebron within the local context of the study.

To verify the internal consistency validity of the domains, the researcher calculated the correlation coefficients between the score of each section of the tool and the overall score of the tool. Table (3) illustrates this:

Table 3: Results of Spearman's Rank-Order Correlation for the correlation matrix of the overall score of the domestic violence domains with the overall score of the tool.

Variables	Spearman correlation coefficient	value (sig.)
Physical violence	**0.968	.000**
Psychological violence	**0.939	.000**

* Statistical significance at the level of ($\alpha \leq 0.05$).

** Highly statistically significant at the level of ($\alpha \leq 0.01$).

The data in Table (3) indicate that all domains of domestic violence are strongly and statistically significant correlated with the total score of the instrument. The correlation coefficient between the domain of physical violence and the total score of the instrument was (0.968**), and between the domain of psychological violence and the total score was (0.939**), both at a significance level of (0.000**).

These results reflect a high degree of internal consistency among the components of the instrument, demonstrating its construct validity and its ability to measure the targeted phenomenon in a coherent manner. It can be concluded that the items associated with each domain work in harmony to measure the level of domestic violence against pregnant women in the city of Hebron, enhancing the reliability of the instrument in the local research context"

Secondly: Validity of the mental health measurement tool:

Table 4: Results of Spearman's Rank-Order Correlation for the correlation matrix of the study tool items with the total score for each domain, specifically for the second section (mental health).

Item	Correlation Coefficient	Sig. (2-tailed)	Item	Correlation Coefficient	Sig. (2-tailed)	Item	Correlation Coefficient	Sig. (2-tailed)
Mental health								
Physical symptoms			anxiety, sleep disorders			social performance		
1	**0.898	.000	1	**0.907	.000	1	**0.932	.000
2	**0.873	.000	2	**0.869	.000	2	**0.885	.000
3	**0.899	.000	3	**0.905	.000	3	**0.907	.000
4	**0.860	.000	4	**0.980	.000	4	**0.890	.000
5	**0.891	.000	5	**0.980	.000	5	**0.921	.000
6	**0.892	.000	6	**0.883	.000	6	**0.924	.000
7	**0.909	.000	7	**0.924	.000	7	**0.915	.000
Depression and negative emotions								
1	**0.927	.000	4	**0.892	.000	7	**0.880	.000
2	**0.864	.000	5	**0.902	.000			
3	**0.911	.000	6	**0.903	.000			

* Statistical significance at the level of ($\alpha \leq 0.05$).

** Highly statistically significant at the level of ($\alpha \leq 0.01$).

The data in Table (4) indicate the results of the Spearman correlation coefficients between the items of the mental health measurement tool and the total score for each dimension of the tool, to verify the validity of internal consistency. The results showed that all items had a positive and highly statistically significant correlation with the total score for each domain. Correlation coefficients for the physical symptoms dimension ranged between (0.860** and 0.909**), for the anxiety and sleep disturbances dimension between (0.869** and 0.980**), for the social functioning dimension between (0.885** and 0.932**), and for the depression and negative emotions dimension between (0.864** and 0.927**), all at a significance level of (0.000**).

These high correlation values reflect strong evidence of construct validity, indicating that the items coherently and interconnectedly measure the various dimensions of mental health as theoretically defined. Accordingly, it can be said that the measurement tool used has a high degree of validity and is suitable for measuring the level of mental health among pregnant women in the city of Hebron, which enhances the reliability of the study results and confirms the soundness of the tool's conceptual structure.

To verify the internal consistency validity of the domains, the researcher calculated the correlation coefficients between the score of each section of the instrument and the total score of the instrument, and Table (5) illustrates this.

Table 5: Results of Spearman's Rank-Order Correlation for the correlation matrix of the total score of the family health domains with the total score of the instrument.

Variables	Spearman correlation coefficient	value (sig.)
Physical symptoms	**0.929	.000
Anxiety and sleep disturbances	**0.945	.000
Social performance	**0.936	.000
Depression and negative feelings	**0.926	.000

* Statistical significance at the level of ($\alpha \leq 0.05$).

** Highly statistically significant at the level of ($\alpha \leq 0.01$).

The data in Table (5) indicate strong and statistically significant correlations between scores on each domain of mental health and the total score of the instrument, reflecting the internal consistency of the instrument's construction. The correlation coefficient between the domain of physical symptoms and the total score of the instrument was (0.929**), between the domain of anxiety and sleep disturbances (0.945**), between the domain of social functioning (0.936**), and between the domain of depression and negative emotions (0.926**), all at a significance level of (0.000).

These high values indicate that the items associated with each domain work harmoniously to measure the general concept of mental health, enhancing the validity of the instrument in measuring the relationship between domestic violence and mental health among pregnant women in the city of Hebron. This indicates that the instrument has a high degree of internal consistency and is suitable for use in a local research context to achieve the study's objectives.

Thirdly: Validity of the post-traumatic stress disorder measurement tool:

Table 6: Results of Spearman's Rank-Order Correlation for the correlation matrix of the study tool items with the total score for each domain, specifically for the second section (post-traumatic stress disorder).

Item	Correlation Coefficient	Sig.	Item	Correlation Coefficient	Sig.	Item	Correlation Coefficient	Sig.
post-traumatic stress disorder								
Symptoms of re-experiencing			Avoidance			Negative Changes in Thinking and Mood		
1	**0.914	.000	1	**0.577	.000	1	**0.936	.000
2	**0.884	.000	2	**0.892	.000	2	**0.893	.000
3	**0.925	.000	3	**0.867	.000	3	**0.940	.000
4	**0.898	.000	4	**0.858	.000	4	**0.918	.000
5	**0.905	.000	5	**0.881	.000	5	**0.940	.000

* Statistical significance at the level of ($\alpha \leq 0.05$).

** Highly statistically significant at the level of ($\alpha \leq 0.01$).

The data in Table (6) indicate the results of the Spearman correlation coefficients between the items of the PTSD measurement tool and the total score for each dimension of the tool, to verify internal consistency. The results showed that all items had a positive and highly statistically significant correlation with the total score for each domain. Correlation coefficients for the "Re-experiencing" dimension ranged between 0.884** and 0.925**, for the "Avoidance" dimension between (0.577** and 0.892**), and for the "Negative Changes in Thinking and Mood" dimension between (0.893** and 0.940**), all at a significance level of (0.000**).

These high correlation values reflect strong evidence of construct validity, indicating that the items coherently and interconnectedly measure the dimensions of PTSD as theoretically defined. Accordingly, it can be said that the measurement tool used has a high degree of validity and is suitable for measuring the level of post-traumatic stress disorder among pregnant women in the city of Hebron, which enhances the reliability of the study results and confirms the soundness of the conceptual structure of the tool.

To verify the internal consistency validity of the domains, the researcher calculated the correlation coefficients between the score of each section of the instrument and the total score of the instrument, and Table (7) illustrates this.

Table 7: Spearman's Rank-Order Correlation results for the total score of the PTSD symptom domains with the total score of the instrument

Variables	Spearman correlation coefficient	value (sig.)
Re-experiencing symptoms	**0.947	.000
Avoidance	**0.948	.000
Negative changes in thinking and mood	**0.944	.000

* Statistical significance at the level of ($\alpha \leq 0.05$).

** Highly statistically significant at the level of ($\alpha \leq 0.01$).

The data in Table (7) indicate strong and statistically significant correlations between the scores of each domain of PTSD symptoms and the total score of the instrument, reflecting the internal consistency of the instrument's construction. The correlation coefficient between the "Re-experiencing" domain and the total score of the instrument was (0.947**), between the "Avoidance" domain (0.948**), and between the "Negative Changes in Thinking and Mood" domain (0.944**), all at a significance level of (0.000). These high correlation values strongly indicate that the items associated with each domain work together to measure the psychological symptoms associated with PTSD, enhancing the validity of the instrument in measuring these symptoms among pregnant women in the city of Hebron. Accordingly, it can be said that the instrument has a high degree of internal consistency and is suitable for use in psychological studies aimed at understanding the relationship between domestic violence and mental health in the local context"

Reliability of the measurement tool: To verify the reliability of the study tool, the researcher relied on internal consistency, one of the most common and accurate methods for measuring reliability in psychological and social studies. The reliability coefficient was calculated using Cronbach's Alpha, a statistical indicator that reflects the degree of consistency between the tool's items within a single domain. This indicator is used to determine the extent to which the items measure the same hypothesized dimension. High Cronbach's Alpha values indicate a high level of internal consistency, enhancing the tool's reliability in measuring the targeted concepts.

This analysis was applied to all domains of the tool, including the Domestic Violence Scale, the Mental Health Scale, and the Post-Traumatic Stress Disorder Symptoms Scale, to ensure the accuracy and stability of the results across various dimensions. This step is essential in studies addressing psychological and social phenomena, as it ensures that the tool is not affected by external factors or unsystematic fluctuations, but rather measures concepts consistently and objectively:

First: Reliability of the domestic violence measurement tool:

Table 8: Results of Cronbach's Alpha coefficient for the reliability of the domestic violence measurement tool

Statement	N	N of Items	Cronbach's Alpha
Physical violence	335	11	0.980
Psychological violence		13	0.982
Domestic violence		24	0.989

The data in Table (8) indicate the reliability coefficient (Cronbach's alpha) results for the Domestic Violence Measurement Tool. The results demonstrated a high level of internal consistency between the tool's items. The reliability coefficient for the physical violence domain reached 0.980, and for the psychological violence domain reached 0.982, while the reliability coefficient for the total score of the Domestic Violence Tool reached 0.989, based on a sample of (335) participants.

These high Cronbach's alpha values reflect a high degree of reliability, indicating that the tool measures the targeted concepts consistently and reliably. This indicates that the Domestic Violence Measurement Tool enjoys strong reliability at the overall construct level, which supports its use in in-depth studies requiring accurate and reliable tools to

measure psychological and social phenomena among pregnant women in the city of Hebron.

Secondly: Stability of the Psychological Health Measurement Tool:

Table 9: Results of Cronbach's Alpha Coefficient for the Stability of the Psychological Health Measurement Tool

Statement	N	N of Items	Cronbach's Alpha
Physical symptoms	335	7	0.982
Anxiety and sleep disturbances		7	0.983
Social performance		7	0.984
Depression and negative feelings		7	0.984
Mental health		28	0.995

The data in Table (9) indicate the reliability coefficient (Cronbach's alpha) results for the mental health measurement tool. The results demonstrated a high level of internal consistency among the tool's items. The reliability coefficient for the physical symptom's domain reached 0.982, for anxiety and sleep disturbances (0.983), for social functioning (0.984), and for depression and negative emotions (0.984). The reliability coefficient for the total score of the mental health tool reached 0.995, based on a sample of (335) participants.

These high Cronbach's alpha values reflect a high degree of reliability, indicating that the tool measures the targeted concepts consistently and reliably across various domains. This indicates that the mental health measurement tool enjoys strong reliability at the overall construct level, which supports its use in in-depth psychological studies that require accurate and reliable tools to measure psychological dimensions among pregnant women in the city of Hebron.

Third: The reliability of the post-traumatic stress disorder symptom measurement tool:

Table 10 :Results of Cronbach's Alpha Coefficient for the Stability of the Post-traumatic stress symptoms Measurement Tool

Statement	N	N of Items	Cronbach's Alpha
Re-experiencing symptoms	335	7	0.973
Avoidance		7	0.903
Negative changes in thinking and mood		7	0.981
Post-traumatic stress symptoms		28	0.984

The data in Table (10) indicate the reliability coefficient (Cronbach's alpha) results for the PTSD symptom measurement tool. The results demonstrated a high level of internal consistency among the tool's items. The reliability coefficient for the "Re-experiencing" domain reached 0.973, for the "Avoidance" domain (0.903), and for the "Negative Changes in Thinking and Mood" domain (0.981). The reliability coefficient for the total PTSD score was 0.984, based on a sample of (335) participants.

These high Cronbach's alpha values reflect a high degree of reliability, indicating that the tool consistently and reliably measures PTSD symptoms across various domains. This indicates that the measurement tool has strong reliability at the overall construct level, enhancing its suitability for use in in-depth psychological studies aimed at understanding the psychological impact of domestic violence on pregnant women in the city of Hebron.

Correction of the Measurement Tool:

First: Correction of the Domestic Violence Measurement Tool:

The items of the measurement tool were constructed according to a five-point scale with the following weights assigned to the items in the domestic violence measurement tool: (Very high degree: five points, High degree: four points, Moderate degree: three points, Low degree: two points, very low degree: one point). This five-point scale was applied to all items, and to determine the estimates of the sample individuals and ascertain the degree of domestic violence, the range was calculated ($5-1 = 4$), which was then divided by (5) to obtain the correct length of the cell ($4/5 = 0.80$). After that, this value was added to the lowest value in the questionnaire (or the beginning of the questionnaire, which is one point) to determine the upper limit of this cell. Thus, the lengths of the cells became as follows:

Table 11: Correction Keys for the Domestic Violence Measurement Tool.

Mean	Score range
1.80 – 1.00	Very low
2.60 – 1.81	Low
3.40 – 2.61	Moderate
4.20 – 3.41	High
5.00 – 4.21	Very high

Second: Validation of the mental health measurement instrument:

Given that the mental health measurement tool adopted in this study is based on the GHQ-28 scale, whose items are formulated in a negative way that reflects psychological and physical symptoms (such as anxiety, insomnia, poor performance, and depressive feelings), a coding correction was adopted to reverse the direction of the scores, with the aim of standardizing the logic of statistical interpretation within the tables and analyses. A five-point Likert scale was applied to the items of the instrument on the following scale: Always = 1, Often = 2, Sometimes = 3, Somewhat = 4, Never = 5). To ensure that higher scores reflect a higher level of mental health, item coding was reversed so that high values indicate an improvement in mental health, while low values indicate the presence of negative symptoms to varying degrees. To interpret the arithmetic averages resulting from the responses, the categorization shown in Table 9 below was adopted :

Table 12: Correction keys for the Mental Health Measurement Tool

Mean	Score range
1.80 – 1.00	Very low
2.60 – 1.81	Low
3.40 – 2.61	Moderate
4.20 – 3.41	High
5.00 – 4.21	Very high

The very low score in Table (9) indicates a very low level of mental health and a very high prevalence of symptoms, while a low score indicates a low level of mental health and a high prevalence of symptoms, a Moderate score indicates an average level of mental health and a Moderate prevalence of symptoms, a high score indicates a high level of mental health and a low prevalence of symptoms, and a very high score indicates a very high level of mental health and a very low prevalence of symptoms.

Third: Correcting the tool for measuring post-traumatic symptoms:

The paragraphs of the post-traumatic stress disorder (PTSD) symptom measurement tool were constructed according to a five-point scale, and the weights were given to the paragraphs in the domestic violence measurement tool as follows: (very high: five points, high: four points, medium: three points, low: two points, very low: one point). This five-point scale was applied to all paragraphs, and to identify the sample members' estimates and determine the degree of domestic violence, according to the arithmetic mean value, the range was calculated ($5-1 = 4$), then divided by (5) to obtain the correct cell length ($4/5 = 0.80$), and then this value was added to the lowest value in the questionnaire (or the beginning of the questionnaire, which is the correct one) to determine the upper limit of this cell, and thus the length of the cells became as follows:

Table 13: Correction Keys for the Domestic Violence Measurement Tool.

Mean	Score range
1.80 – 1.00	Very low
2.60 – 1.81	Low
3.40 – 2.61	Moderate
4.20 – 3.41	High
5.00 – 4.21	Very high

Study Variables: -

- ***Independent variable:*** domestic violence.
- ***Dependent variable:*** mental health, post-traumatic symptoms.
- ***Mediating variables:*** nature of the wife's job, nature of the husband's job, blood type, age of the wife, age of the husband, number of pregnancies, educational level of the wife, educational level of the husband, and number of family members.

Steps for implementing the study:

1. Educational literature, previous studies, and consultations with experts and specialists were reviewed. The study population was then identified and a study tool was developed to enable the researcher to implement this study.
2. The validity of the study tool was verified by presenting it to a group of expert judges from various Palestinian universities.
3. The tool was applied to the study sample, randomly selected from (335) pregnant women. The study tool was followed by a set of guidelines and instructions to assist respondents in completing it.
4. The questionnaires were collected and serially numbered for computer entry. The tools were then corrected, the data was transcribed, and the data was entered into special forms using the statistical program (Statistical Package for the Social Sciences (SPSS) to analyze the data and extract the results.

Study Limitations:

Objective Limitations: The study is limited to examining domestic violence and its relationship to mental health and post-traumatic stress symptoms among pregnant women in the city of Hebron.

Timeframe: The study was conducted in 2025.

Study Sample Limitations: The study was limited to a random sample of Pregnant women in Hebron.

Methodological Limitations: The researcher relied on the descriptive correlational approach.

Research Tool Limitations: Methodological limitations: The researcher relied on the descriptive correlational approach. Research tool limitations: The study relied on the domestic violence questionnaire prepared by the researchers, after verifying its validity and standardization, the mental health questionnaire (GHQ-28), and the post-traumatic stress symptoms questionnaire prepared by the researcher.

Statistical Analysis:

To analyze the data, the researcher used the Statistical Package for the Social Sciences (SPSS) employing the following statistical treatments:

1. Descriptive statistics were used to extract frequencies, percentages, means, and standard deviations of the sample individuals and their responses to the tools.
2. Cronbach's alpha reliability coefficient was used to calculate the reliability of the tool, and Spearman's Rank-Order Correlation was used to confirm the nature of the relationship between the study variables and to verify construct validity.

Analysis of Study Results

First: Answering the Study Questions:

Question 1: What is the level of domestic violence among pregnant women in the city of Hebron?

First: The percentage of women in the study sample who were subjected to domestic violence, and the number of assaults:

To determine this, frequencies and percentages were extracted, as shown in Table (10).

Table 14: The rate of domestic violence among the study sample members

Variable	levels variable	Frequency	Percent%
Were you subjected to any form of physical violence by your current partner during pregnancy?	No	71	21.2
	Yes	264	78.8
Total		335	100.0
Approximately how many times has this physical violence occurred during your current pregnancy?	Once	13	3.9
	Twice	43	12.8
	3-5 times	65	19.4
	6-10 times	97	29.0
	More than 10 times	46	13.7
Total		264	100.0

The data in Table (14) indicate that a large percentage of the sample had been subjected to some form of physical violence by their current partner during pregnancy. Of the total sample of (335) participants, (78.8%) answered "yes," compared to (21.2%) who answered "no." This percentage is a worrying indicator of the prevalence of domestic

violence during pregnancy, necessitating urgent therapeutic and preventive interventions at both the health and social levels.

Regarding the frequency of physical violence during pregnancy, the results showed that a large percentage of women were exposed to violence repeatedly. (19.4%) were exposed to it three to five times, (29.0%) were exposed six to ten times, and (13.7%) were exposed more than ten times. This means that more than half of the participants (54.6%) were exposed to violence three or more times during their current pregnancy. These findings indicate that physical violence was not a one-off incident in most cases, but rather a recurring and chronic phenomenon, reflecting a stressful social reality that requires deeper study and multidimensional interventions to protect pregnant women and promote their psychological and physical health.

Second: Manifestations of Domestic Violence Against Pregnant Women?

To identify the most prevalent manifestations of domestic violence against pregnant women, arithmetic means and standard deviations were extracted, as shown in Table (15):

Table 15: Arithmetic means and standard deviations of manifestations of domestic violence against pregnant women, in descending order

Ranking	Items	Mean	Std. Deviation	Score range
1.	I am forced to do hard labor.	3.72	1.235	High
2.	I am violently pushed or shaken.	3.69	1.219	High
3.	I am constantly threatened with a weapon (knife or gun).	3.67	1.184	High
4.	I am slapped or punched.	3.58	1.226	High
5.	I am constantly subjected to hair pulling.	3.55	1.167	High
6.	I am denied necessary health care.	3.40	1.268	Moderate
7.	My husband intentionally hurts me in the abdominal area.	3.26	1.511	Moderate
8.	My husband kicks me while I am pregnant.	3.19	1.488	Moderate
9.	I am intentionally burned by my husband.	3.12	1.519	Moderate
10.	I am hit with a tool or solid object (such as a stick, belt, pan, etc.).	3.11	1.508	Moderate
11.	My husband strangles me for the most trivial reasons.	3.06	1.500	Moderate
Physical violence		3.26	1.38	Moderate
1.	.3	3.50	1.520	high
2.	My husband isolates me from visiting my family and relatives.	3.48	1.506	high
3.	He constantly threatens me with divorce.	3.42	1.460	high
4.	My husband becomes angry when I socialize with the neighbors.	3.39	1.460	Moderate
5.	The children are often subjected to verbal abuse, insults, humiliation, and mockery by the father.	3.38	1.502	Moderate

6.	He deliberately insults me in front of my children with obscene language.	3.34	1.455	Moderate
7.	My husband imposes his opinion on our children's future.	3.33	1.464	Moderate
8.	The father interferes in the choice of friends the children have and allows them to play with them.	3.32	1.461	Moderate
9.	My husband takes all my salary.	3.28	1.456	Moderate
10.	The father threatens to evict the children from the house.	3.24	1.517	Moderate
11.	My husband trivializes one of the children's illnesses.	3.17	1.583	Moderate
12.	The father withholds his children's allowance.	3.15	1.558	Moderate
13.	I treat him with contempt.	3.05	1.630	Moderate
Psychological violence		3.31	1.364	Moderate
Domestic violence among pregnant women in Hebron		3.29	1.35	Moderate

The results of Table (15) indicate that the level of domestic violence against pregnant women in the city of Hebron is widespread and moderate. The overall average level of violence was (3.29) with a standard deviation of (1.35), which is classified as a "high" level. This reflects a disturbing reality in the family environment during pregnancy, a sensitive stage from a health and psychological perspective. This gives these results a particularly dangerous character.

When analyzing the manifestations of physical violence, it becomes clear that pregnant women are exposed to direct and painful practices, most notably being forced to perform hard work with an average of (3.72), being violently pushed or shaken violently (3.69), and being constantly threatened with the use of sharp or firearms (3.67). Other practices also appeared, such as beating, punching, hair pulling, and denial of healthcare, all of which are indicators of deliberate neglect of women's health during pregnancy. The average level of physical violence was (3.26), which is classified as a "high" level, with high standard deviations exceeding (1.20) in most cases. Paragraphs, indicating a significant variation in the degree of exposure to violence among participants, reflecting the differences in family circumstances from one case to another. Psychological violence recorded a higher mean of (3.31) with a standard deviation of (1.364), which is classified as a "moderate-high" level. However, some of its manifestations were at the forefront of the most common indicators, such as social isolation, humiliation in front of children, and threats of divorce, in addition to controlling family relationships and educational and financial decisions. These practices are invisible to the naked eye, but they leave deep and long-lasting psychological effects. Their recurrence reflects an authoritarian pattern within the marital relationship and indicates the presence of chronic psychological pressure within the family. The standard deviations revealed a variation in the participants' perception of the seriousness of these practices, which may be linked to cultural factors that influence the interpretation of indirect violence. When these results are linked to the previously mentioned finding that (78.8%) of pregnant women in the sample were exposed to domestic violence, and that more than half of them were exposed to it repeatedly, ranging from three to more than ten times, it becomes clear that violence is not an isolated or temporary phenomenon, but rather represents a cumulative pattern

within marital relationships, linked to psychological, social, and cultural factors, and reflects a flaw in family concepts related to the marital and educational role.

Question 2: What is the level of mental health among pregnant women in the city of Hebron?

To answer the previous question, arithmetic means and standard deviations were extracted for the level of mental health among pregnant women in the city of Hebron, the arithmetic means were calculated based on the scale correction in the section on mental health scale correction mentioned above, as shown in Table (16).

Table 16: Arithmetic means and standard deviations for the level of mental health among pregnant women in the city of Hebron, arranged in ascending order

Ranking	Items	Mean	Std. Deviation	level of mental health	prevalence level of the symptom
1.	I feel constant physical fatigue.	2.64	1.432	Moderate	Moderate
2.	My appetite has changed or become erratic.	2.60	1.448	low	High
3.	I notice a decline in my physical performance.	2.59	1.442	low	High
4.	I no longer enjoy things that used to bring me joy.	2.59	1.547	low	High
5.	My physical activity has changed significantly (either lethargic or hyperactive).	2.54	1.512	low	High
6.	I experience headaches or body aches for no apparent reason.	2.50	1.452	low	High
7.	I quickly run out of energy when doing simple tasks.	2.50	1.490	low	High
Physical symptoms		2.57	1.401	Low	High
1.	I feel tense or anxious for no apparent reason.	2.73	1.361	Moderate	Moderate
2.	My nerves are on edge most of the time.	2.62	1.392	Moderate	Moderate
3.	I wake up early and can't get back to sleep.	2.61	1.397	Moderate	Moderate
4.	I have difficulty falling asleep or staying asleep.	2.61	1.462	Moderate	Moderate
5.	I experience sudden bouts of fear or panic.	2.61	1.444	Moderate	Moderate
6.	My ability to concentrate and think has become weaker.	2.53	1.502	Low	High
7.	I get easily upset and become more sensitive.	2.52	1.456	Low	High
Anxiety and sleep disturbances		2.60	1.36	Low	High

1.	I have difficulty completing daily tasks.	2.72	1.407	Moderate	Moderate
2.	I have difficulty making my usual decisions.	2.70	1.341	Moderate	Moderate
3.	I feel like I'm not performing well at work or school.	2.69	1.452	Moderate	Moderate
4.	My self-confidence has noticeably declined.	2.65	1.448	Moderate	Moderate
5.	I don't feel interested in others around me.	2.65	1.452	Moderate	Moderate
6.	I have difficulty dealing with daily stress.	2.59	1.483	Low	High
7.	I tend to isolate myself and avoid social interaction.	2.57	1.464	Low	High
Social performance		2.65	1.37	Moderate	Moderate
1.	I feel sad most of the time.	2.64	1.440	Moderate	Moderate
2.	I feel like life has become worthless.	2.64	1.422	Moderate	Moderate
3.	I constantly have negative thoughts.	2.63	1.408	Moderate	Moderate
4.	I've lost my sense of joy and enjoyment.	2.63	1.406	Moderate	Very high
5.	I feel like a burden to others.	2.60	1.481	Low	High
6.	I have a desire to withdraw from life.	2.47	1.539	Low	High
7.	I believe I'm insignificant and useless.	2.44	1.540	Low	High
Depression and negative feelings		2.58	1.399	Low	High
Mental Health		2.60	1.358	Low	High

Note: The scale was reverse-coded, so that low means reflect a high degree of psychological symptoms, while high means reflect an absence or low degree of symptoms.

The data presented in Table (16) indicate that the average level of mental health among pregnant women in the city of Hebron falls within the "low" classification, with an overall mean of (2.60) and a standard deviation of (1.358). This reflects a high prevalence of negative psychological symptoms. Although the apparent classification suggests a low severity of symptoms, the reverse coding of the scale shows that low values indicate a worsening of psychological symptoms, which necessitates a careful reading of the results rather than relying solely on abstract numerical indicators.

When analyzing the subdomains, the following is evident:

First: Physical symptoms: This area recorded a mean of (2.57) and a standard deviation of (1.401), classifying it within the "low" level, indicating a clear presence of physical symptoms associated with psychological stress, such as persistent fatigue, appetite disorders, decreased physical performance, and unexplained headaches. These indicators

reflect a direct impact of psychological stress on hormonal and physical balance among pregnant women, especially during a phase characterized by biological and psychological sensitivity.

Second: Anxiety and sleep disorders: The mean for this area reached (2.60) with a standard deviation of (1.36), also within the "low" classification, reflecting a high prevalence of anxiety and stress symptoms, such as difficulty sleeping, early awakening, hypersensitivity, and recurring panic attacks. These results indicate a state of increased neural excitability and mental instability, threatening the psychological and emotional safety of the pregnant woman and increasing the likelihood of psychological complications during pregnancy or after childbirth.

Third: Social performance: This area recorded a mean of (2.65) and a standard deviation of (1.37), slightly higher than the other areas but still within the "low" classification, indicating a decline in the ability to handle daily tasks, low self-confidence, a tendency towards isolation, and hesitation in decision-making. These indicators reflect a state of social withdrawal and internal pressure, which may negatively affect the quality of life and interaction with the family and community context.

Fourth: Depression and Negative Emotions: The average in this area (2.58) came with a standard deviation (1.399), which is also classified within the "low" level. It includes serious indicators such as persistent sadness, loss of pleasure, thoughts of withdrawing from life, and low self-image. This area is considered one of the most dangerous psychological indicators, as it reflects the likelihood of severe untreated depression, which necessitates urgent and targeted intervention.

These results indicate a complex psychological burden affecting the physical, emotional, social, and cognitive aspects of pregnant women in the city of Hebron and reflect a high prevalence of negative psychological symptoms in the absence of support or weak intervention. Urgent measures are required, including:

- Designing specialized psychological support and awareness programs for pregnant women
- Activating institutional intervention through specialized health and social partnerships
- Reevaluating the social environment that promotes silence and marginalizes women's suffering, especially in the context of traditional tribal patterns that consider domestic violence a private matter, which weakens chances for official intervention and increases the accumulation of psychological symptoms.

Additionally, granting absolute patriarchal authority to some husbands according to prevalent societal perceptions creates an environment that implicitly legitimizes violent behavior and marginalizes women's feelings, especially during pregnancy, which requires high psychological sensitivity. With ongoing exposure to stress and violent behaviors, psychological and physical symptoms such as sleep disturbances, anxiety, and depression worsen, as corroborated by very low values across all aspects of mental health.

Question 3: What is the level of post-traumatic stress symptoms among pregnant women in the city of Hebron?

To answer the previous question, arithmetic means and standard deviations were extracted for the level of post-traumatic stress symptoms among pregnant women in the city of Hebron, the arithmetic means were calculated based on the scale correction in the section on mental health scale correction mentioned above, as shown in Table (17).

Table 17: Arithmetic means and standard deviations for the level of post-traumatic stress symptoms among pregnant women in the city of Hebron, arranged in ascending order

Ranking	Items	Mean	Std. Deviation	level of mental health
1.	I feel intense psychological distress when I recall violent incidents.	3.47	1.474	High
2.	My heartbeat quickens when I remember my partner's abuse.	3.39	1.435	Moderate
3.	I have recurring nightmares about the violent incidents I experienced.	3.32	1.357	Moderate
4.	I feel like the violent incident is happening again (e.g., hallucinations, fugue).	3.29	1.378	Moderate
5.	I have painful memories of violent incidents, even though I try to forget them.	3.28	1.495	Moderate
Re-experiencing symptoms		3.35	1.358	Moderate
1.	I feel indifferent to things I enjoyed before pregnancy.	3.46	1.432	High
2.	I feel emotionally isolated, even from my unborn child.	3.38	1.436	Moderate
3.	I have difficulty remembering details of violent incidents.	3.32	1.405	Moderate
4.	I avoid places or people associated with violent experiences.	3.30	1.411	Moderate
5.	I avoid talking about domestic violence, even with close friends.	2.19	1.584	Low
Avoidance		3.13	1.23	Moderate
1.	I'm constantly afraid that my child will turn out to be like his father.	3.44	1.421	Moderate
2.	I constantly blame myself for being subjected to violence.	3.44	1.491	Moderate
3.	I feel unsafe even in my own home.	3.42	1.443	Moderate
4.	I have difficulty concentrating on my pregnancy (such as doctor's appointments).	3.36	1.428	Moderate
5.	EE6	3.34	1.453	Moderate
Negative changes in thinking and mood		3.40	1.394	Moderate
post-traumatic stress symptoms		3.29	1.305	Moderate

Based on the data in Table (16), the average level of PTSD symptoms among pregnant women in Hebron falls into the "average" category, with a mean of 3.29 and a standard deviation of 1.305. Although this apparent classification indicates a moderate degree of symptoms, the nature of the items and the distribution of the sub-averages reflect the presence of worrying psychological indicators that require a closer reading beyond a

mere numerical interpretation, especially given the sensitive psychological and biological stage that pregnant women experience.

First: Re-experiencing symptoms, which were moderate, with a mean of 3.35 and a standard deviation of 1.358. This dimension demonstrates that pregnant women suffer from frequent and painful flashbacks to violent experiences, whether through flashbacks, nightmares, or physical reactions. Higher-scoring items, such as "I feel intense psychological distress when recalling violent incidents" (3.47), reflect a state of emotional immersion in the traumatic event, indicating persistent activity of emotional memory and an inability to separate past from present. These symptoms may negatively impact the psychological stability of the pregnant woman and increase the likelihood of mood disorders and anxiety during pregnancy.

Second: Avoidance, which scored moderately, with a mean of 3.13 and a standard deviation of 1.23. Although this dimension falls within the average classification, there is a clear disparity between items. While the item "I avoid talking about domestic violence, even with close friends" scored the lowest mean (2.19), indicating a space for expression, other items, such as "I feel emotionally isolated, even from my unborn child," scored relatively high means. This disparity reflects an internal conflict between the desire to forget and the need for confrontation, which requires psychological intervention to enhance healthy coping mechanisms and prevent emotional closure.

Third: Negative changes in thinking and mood, which scored moderately, with a mean of 3.40 and a standard deviation of 1.394. This dimension demonstrates a profound impact on self-image and overall mood. Items such as "I feel unsafe even in my home" and "I constantly blame myself for being exposed to violence" reflect high levels of anxiety and self-blame, which are indicators of a disturbance in psychological identity and sense of control. These findings point to the need to integrate psychological support programs that rebuild self-confidence and reduce feelings of guilt, especially since these symptoms may worsen in the postpartum period.

Although the overall classification of the post-traumatic stress disorder (PTSD) section and its dimensions falls within the "moderate" level, the nature of the items and the high levels of some psychological indicators, such as severe distress, isolation, and self-blame, reflect the presence of an actual psychological disorder that requires preventive and therapeutic intervention. Pregnancy represents a fertile environment for the exacerbation of psychological symptoms, making it essential to provide specialized psychological support, whether through individual sessions or group programs, to ensure the mother's psychological and physical well-being.

Question 4: Is there a relationship between domestic violence and the level of mental health among pregnant women in Hebron?

To answer the previous question, a hierarchical multiple regression analysis was used, with the aim of examining the effect of the variable of domestic violence on the level of mental health among pregnant women, then including a group of demographic variables (the nature of the wife's work, the nature of the husband's work, blood type, the wife's age, the husband's age, the number of pregnancies, the wife's education level, the husband's education level, and the number of family members) in a second stage to monitor the amount of additional variance explained in the model, and whether these variables contribute to modifying the strength of the relationship between violence and mental health. The standard entry method (Enter) was relied upon for each stage within the hierarchical model, and Table (18) shows this:

Table 18: Results of multiple linear regression analysis to determine the relationship between domestic violence, demographic variables, and the level of mental health among pregnant women in the city of Hebron.

Model	Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.	R	R Square	Adjusted R Square
	B	Std. Error						
1	Constan	5.637	.077	73.177	.000			
	Domestic violence	-.924	.022	-.919	.000	.919 ^a	.845	.845
2	Constan	6.060	.169	35.829	.000			
	Domestic violence	-.835	.025	-.831	.000			
	wife's work	-.095	.027	-.094	.000			
	husband's work	-.053	.027	-.048	.048			
	blood type	-.013	.012	-.023	.287			
	Wife's age	.006	.008	.030	.455			
	Husband's age	-.006	.008	-.036	.419			
	Number of pregnancies	-.284	.055	-5.152	.000	.934 ^b	.868	.868
	Wife's educational level	.017	.039	.010	.672			
	Husband's educational level	-.009	.037	-.006	.801			
	Number of family members	.080	.028	.087	.004			
Calculated value of "Fa" =1815.944, significant at a significance level of <0.001								
Calculated value of "Fb" =221.317, significant at a significance level of <0.001								

a: Fixed leprosy with Domestic violence

b: Constant prediction with Domestic violence, Demographic variables (nature of the wife's work, nature of the husband's work, blood type, age of the wife, age of the husband, number of pregnancies, educational level of the wife, educational level of the husband, and number of family members)

First: The relationship before entering demographic variables: The results in Table (14) showed that there is a statistically significant negative relationship between domestic violence and mental health, in the first model without the intervention of demographic variables, as the standard regression coefficient Beta for domestic violence reached (-0.831), and the significance level reached (Sig = 0.000), which is less than the approved significance level ($\alpha \leq 0.05$), and this indicates that domestic violence is a significant predictive variable that contributes to explaining the level of mental health. The adjusted (R^2) coefficient of determination was (0.845), indicating that domestic violence explains (84.5%) of the variance in the level of mental health.

Second: After introducing demographic variables:

When a set of demographic variables were included in the second model, domestic violence maintained its strong and direct effect, with a standardized regression coefficient (Beta = -0.831) and remaining statistically significant at the Sig = 0.000 level, indicating that the inclusion of other variables did not weaken the relationship between violence and mental health. The adjusted coefficient of determination increased to (Adjusted R² = 0.868), meaning that the demographic variables added only 2.3% of the additional explanation, a limited percentage, reflecting that domestic violence remains the most influential factor in the model.

Analysis of Demographic Variables

Among the demographic variables, three showed clear statistical significance:

- The nature of the wife's work (Beta = -0.094, Sig = 0.000) indicates that working women may face additional stressors that negatively impact their mental health.
- Husband's employment (Beta = -0.048, Sig = 0.048) reflects a weak but statistically significant association, and may be related to economic or social stress.
- Number of pregnancies (Beta = -0.142, Sig = 0.000) is an important indicator, as the results indicate that repeated pregnancies are associated with lower levels of mental health, perhaps as a result of accumulated physical and psychological stress.
- Number of family members (Beta = 0.087, Sig = 0.004) showed a significant positive relationship, which may indicate the role of family support in improving mental health, although this effect remains relatively limited.

Remaining variables, such as age, blood type, and education level, were not statistically significant, indicating that their impact in this context is limited and inconclusive.

$$\hat{y} = (6.060 - .835x_1 - .095x_2 - .053x_3 - .013x_4 + .006x_5 - .006x_6 - .284x_7 + .017x_8 - .009x_9 + .080x_{10})$$

Where $\hat{y}$ represents: mental health, x_1 : domestic violence, x_2 the nature of the wife's work, x_3 the nature of the husband's work, x_4 the blood type, x_5 the wife's age, x_6 the husband's age, x_7 the number of pregnancies, x_8 the wife's educational level, x_9 the husband's educational level, x_{10} the number of family members).

That is, every one-unit increase in the level of domestic violence was accompanied by a statistically significant decrease in the level of mental health by (0.835) units.

The results confirm that domestic violence is the most influential factor in deteriorating mental health among pregnant women, even after controlling for demographic variables. Although some personal and social characteristics showed a limited impact, violence remains a decisive factor, calling for targeted psychosocial interventions focused on reducing domestic violence and providing a safe and supportive environment for women during pregnancy.

Question 5: Is there a relationship between domestic violence and the level of post-traumatic stress symptoms among pregnant women in Hebron?

To answer the previous question, a hierarchical multiple regression analysis was used, with the aim of examining the effect of the variable of domestic violence on the level of post-traumatic stress symptoms among pregnant women, then including a group of demographic variables (the nature of the wife's work, the nature of the husband's work, blood type, the wife's age, the husband's age, the number of pregnancies, the wife's education level, the husband's education level, and the number of family members) in a second stage to monitor the amount of additional variance explained in the model, and whether these variables contribute to modifying the strength of the relationship between violence and post-traumatic stress symptoms. The standard entry method (Enter) was relied upon for each stage within the hierarchical model, and Table (19) shows this:

Table 19: Results of multiple linear regression analysis to determine the relationship between domestic violence, demographic variables, and the level of post-traumatic stress symptoms among pregnant women in the city of Hebron

Model	Unstandardized Coefficients		Standardized Coefficients Beta	t	Sig.	R	R Square	Adjusted R Square
	B	Std. Error						
1	Constan	.383	.075	5.088	.000			
	Domestic violence	.885	.021	41.765	.000	.916 ^a	.840	.839
2	Constan	-.065	.169	-.385	.701			
	Domestic violence	.821	.025	.850	32.706	.000		
	wife's work	.083	.027	.085	3.115	.002		
	husband's work	.083	.026	.079	3.133	.002		
	blood type	-.002	.012	-.003	-.124	.901		
	Wife's age	.000	.008	-.002	-.055	.956		
	Husband's age	-	.008	.000	-.006	.995		
	Number of pregnancies	4.607E-5	.055	.079	2.761	.006	.929 ^b	.863
	Wife's educational level	-.007	.039	-.004	-.190	.849		.858
	Husband's educational level	.004	.037	.003	.115	.909		
	Number of family members	-.016	.028	-.018	-.566	.572		
Calculated value of "Fa" =1744.325, significant at a significance level of <0.001								
Calculated value of "Fb" =203.519, significant at a significance level of <0.001								

a: Fixed leprosy with Domestic violence

b: Constant prediction with Domestic violence, Demographic variables (nature of the wife's work, nature of the husband's work, blood type, age of the wife, age of the husband, number of pregnancies, educational level of the wife, educational level of the husband, and number of family members)

The analysis results presented in Table (19) indicate a strong and direct relationship between domestic violence and the level of PTSD symptoms among pregnant women in the city of Hebron. Hierarchical multiple regression analysis was used to determine this relationship, with a set of demographic variables introduced in the second stage of the model to measure the extent to which they contribute to explaining additional variance in psychological symptoms, and to determine whether they affect the strength of the relationship between violence and trauma symptoms.

Discussing the results of the sixth question: Are there statistically significant differences between the ordinal medians of the sample members' estimates of domestic violence and its relationship to mental health and post-traumatic stress symptoms among pregnant women in the city of Hebron from their point of view attributed to the variables (nature of the wife's work, nature of the husband's work, blood type, wife's age, husband's age, number of pregnancies, wife's educational level, husband's educational level, number of family members)?

The results of the sixth question showed statistically significant differences between the ordinal medians of the sample individuals' estimates regarding the level of domestic violence and its relation to mental health and symptoms of post-traumatic stress disorder among pregnant women in Hebron city, from their point of view, according to a set of demographic and social variables. These variables included: the nature of the wife's work, the nature of the husband's work, blood type, the wife's age, the husband's age, the number of pregnancies, the husband's education level, and the number of family members.

These differences were clearly evident in all three measures: domestic violence, mental health, and symptoms of post-traumatic stress disorder, indicating that these variables play a significant role in shaping pregnant women's perceptions of the nature of the violence they are subjected to, as well as its psychological and traumatic impacts.

On the other hand, the results showed no statistically significant differences in the measure of post-traumatic stress disorder symptoms attributed to the educational level of the pregnant woman, suggesting that the impact of violence in this context transcends educational background and directly affects mental health regardless of the level of education.

This result reflects a rich interpretive structure that highlights the complex interaction between demographic and social factors on one hand, and pregnant women's perceptions of domestic violence and its psychological and traumatic effects on the other. The existence of statistically significant differences between the ordinal mediators for sample estimates in measures of domestic violence, mental health, and symptoms of post-traumatic stress disorder indicates that these phenomena are not understood in isolation from the social context in which the woman lives, but are shaped and vary according to her personal and familial characteristics.

The differences associated with variables such as the nature of the wife's or husband's work, the number of family members, and the ages of the spouses reflect dynamics of power, economic pressure, and levels of family interaction, all of which affect the likelihood of experiencing violence and how it is perceived and psychologically interpreted. For example, a working woman may face dual challenges between her professional and domestic roles, increasing the likelihood of family conflict, while an unemployed husband or one working under stressful conditions may exhibit more aggressive behavior as a result of tension or frustration.

The number of pregnancies and the age of the wife are indicators of accumulated experience in the marital relationship, and of the extent to which the woman is exposed to violence throughout different stages of her reproductive life, which explains the variation in her perception of violence and its psychological impacts. Additionally, the husband's educational level is often linked to the degree of awareness, emotional regulation, and respect for the partner's rights, which explains its emergence as an influencing factor in these differences.

What is notable in these results is the absence of statistically significant differences in the PTSD symptom scale based on the educational level of the pregnant woman, a paradox that carries profound scientific implications. It indicates that when violence is repeated and chronic, it creates a psychological impact that surpasses cognitive or cultural

immunity and directly affects emotional and psychological structures. PTSD does not differentiate between an educated woman and one with less education; rather, it is shaped by the intensity of the experience, its repetition, and the availability of protection and support—factors not necessarily linked to educational level.

This result can be attributed to several factors, such as the economic and social pressures associated with the nature of work that affect family dynamics and increase the likelihood of violence, as well as age differences and the number of family members, which create a more or less stress-prone and conflict-prone environment. The husband's educational level is reflected in communication styles, respect for rights, and behavior regulation, while the absence of women's education's effect on trauma symptoms highlights that violence creates a profound psychological impact that is not mitigated by knowledge, but rather requires a safe and supportive environment.

These findings reaffirm that domestic violence is not an individual or random phenomenon, but rather the result of a complex interaction between the social, economic, and cultural structures of the family. They also emphasize that the psychological response to violence, especially in the form of PTSD, is not solely linked to awareness or education but requires a deep intervention that addresses the structural roots of violence and provides the woman with the protection and support necessary for recovery.

Conclusion:

The results of this study reveal a concerning psychological and social reality suffered by pregnant women in the city of Hebron. Data indicates that domestic violence is not an isolated or sporadic phenomenon, but rather a widespread and recurrent pattern, with 78.8% of participants reporting exposure to violence, and 42.7% having experienced it more than six times. These chronic exposures, particularly the psychological forms of abuse, have become the primary factor affecting the deterioration of mental health and the emergence of post-traumatic stress disorder (PTSD) symptoms.

The study showed that the overall level of mental health among participants was low, exhibiting significant manifestations of anxiety, depression, and psychological physical symptoms. These results were strongly associated with the prevalence of domestic violence, which explained 84.5% of the variance in mental health outcomes. Furthermore, PTSD symptoms were present at a moderate level, with cognitive and emotional disturbances—such as fear, guilt, and emotional detachment—being the most prominent. The relationship between domestic violence and PTSD symptoms was statistically significant and substantial, accounting for 84.0% of the variance in symptom severity.

Additionally, the results revealed statistically significant differences in participants' perceptions of domestic violence and its psychological impact based on several demographic and social variables, including the nature of the wife's and husband's work, age, number of pregnancies, husband's education level, and family size. Notably, the education level of pregnant women did not show statistically significant differences in PTSD symptoms, suggesting that the psychological impact of violence transcends educational level and reflects a deeper emotional vulnerability.

In summary, the study highlights the urgent need to address domestic violence as a structural element affecting psychological stress among pregnant women. The findings call for integrated interventions that combine legal protection, psychosocial support, and increased community awareness to mitigate the long-term consequences of violence and enhance mothers' mental health.

Recommendations:

In light of the study results, the following key recommendations were formulated:

- It is recommended to establish specialized units to detect domestic violence cases early during pregnancy, and to provide psychological support and legal advice to affected women. These units should be part of the primary care system, not secondary services, and should operate confidentially and efficiently to ensure the protection of pregnant women and enhance their sense of security.
- Integrate periodic assessments for domestic violence into routine prenatal checkups.
- Develop a guide for healthcare workers on dealing with women affected by trauma.
- Establish specialized psychotherapy programs for post-traumatic stress disorder.
- Integrate group psychological support sessions for pregnant women affected by violence. These sessions should be conducted in a safe environment and encourage women to share their experiences, which reduces feelings of isolation and emotional detachment and enhances resilience. Sessions can include relaxation exercises, breathing techniques, and skills for dealing with painful memories.
- Launching community awareness campaigns on the effects of domestic violence during pregnancy. These campaigns focus on breaking the silence, changing societal perceptions of violence, and clarifying the relationship between psychological trauma during pregnancy and negative outcomes for the mother and fetus. This will encourage society to adopt more supportive and protective attitudes.
- Providing a 24-hour telephone or online psychological support line to allow pregnant women to express their feelings and receive immediate counseling during moments of fear or re-experiencing. This reduces the severity of symptoms and enhances a sense of security and belonging.

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