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Mental Health in the Occupied Palestinian Territories

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Without Abstract

Our writing was completed before the beginning of the genocide in Gaza after October 7, 2023. Yet, the ongoing assault has confirmed and magnified our concerns, producing collective, intergenerational, cumulative, and colonial trauma on a scale aimed at the very erasure of Palestinian existence.

This temporal positioning is crucial, as it makes clear that our reflections foreshadowed conditions that have since escalated into systematic destruction, forced displacement, and genocidal violence that dismantles every dimension of Palestinian life.

Synonyms

Human insecurity; Liberatory framework; Palestine; Structural violence

Definition

An increasing number of scholars are challenging existing, colonial perspectives on understanding mental health. The framework we adopt in this entry offers an alternative approach applied in the context of the decades-long and violent Israeli colonial occupation of Palestinian territories.

Introduction

In this entry, we review some of the conditions that impact Palestinians living in the occupied Palestinian territories (OPT), examine existing approaches to understanding their mental health, and propose a liberatory approach to addressing improvements therein. Any effort to understand the health of the Palestinian population must start with at least basic awareness of the geography and some historical facts.

The OPT covers the West Bank (including Palestinian East Jerusalem) and the Gaza Strip. There are approximately five million Palestinians who live in the OPT, approximately two million of whom live in the Gaza Strip, an area 41 km (25 mi) long and 6–12 km (3.7–7.5 mi) wide, with a total area of 365 km^2 (141 sq mi). Hence, the Gaza Strip is one of the most overpopulated geographic areas in the world. In addition, the Gaza Strip has been placed under movement restrictions since the early 1990s, and has been enduring an intensified chronic siege since 2007, imposed by Israel and Egypt (https://www.ochaOPT.org/theme/gaza-blockade). The West Bank is an area including 5655 km^2 of land (2183 sq mi), although Palestinians live and/or are allowed entry into only portions of that area with the rest under the control of the Israeli military. In 2002, the government of Israel approved the building of a wall inside and around the West Bank, with entry and exit tightly controlled by the Israeli authorities. The area is further divided by the ongoing illegal construction and development of more than 200 Israeli colonies (settlements) inside the West Bank to house Israeli citizens, which as of this writing number 600,000 (https://www.btselem.org/topic/settlements). The West Bank is also separated by hundreds of Israeli army checkpoints, some of them permanent, others shifting, sometimes called flying checkpoints. The result is ongoing chronic distress, insecurity, and uncertainty about how long it will take to go from one place to another, what roads are closed, and what risks come from daily activities. These geographic realities create ongoing and shifting control mechanisms over the Palestinian population and hourly reminders of the reality of Israeli occupation (see Peteet, *2017*).

Besides basic understanding of current geopolitical realities, basic knowledge of at least three historical events is critical: (1) the *Nakba*: the Arab word for catastrophe and which reflects the mass expulsion of hundreds of thousands of Palestinians from their homes and land during the creation of the state of Israel in 1948, without any ability to return to the land they owned and with the confiscation of all Palestinian wealth held in banks that operated in the newly created state of Israel (see Mitter, *2014*); (2) the Six-Day War of 1967, which resulted in Israel occupying the West Bank and the Gaza Strip, two areas where many dispossessed and dispersed Palestinian refugees of the Nakba had settled, with an approximately additional 180,000 Palestinians becoming refugees in neighboring countries (United Nations, *1967*); and (3) the 2007 (to present) Israeli land, air, and sea blockade of Gaza, which followed the removal of 25 Israeli settlements in 2005 -thus removing all Israeli citizens from the area- and the subsequent electoral victory of Hamas (an occupation resistance organization whose power base is in the Gaza Strip). The blockade has been described by the secretary-general as “a continuing collective penalty against the population in Gaza” (A/HRC/28/45, para. 70). A 2017 report detailed that the blockade dropped agricultural exports out of the Gaza Strip from a height of 1802 truckloads in 2005 to 41 in 2016, and 1500 truckloads of

garments to 36, thus completely destroying its economic infrastructure (Visualizing Palestine, *2017*). More broadly, the Israeli authorities have also choked off the population by refusing entry to basic goods, including medicines, gas for electricity, cement and other necessities for (re)building, and by cutting off 85% of its fishing waters in the Mediterranean, among other punitive measures. Palestinians in the Gaza Strip are rarely permitted to leave by Israel, even for emergency medical reasons, and the layers of approvals and permits to leave make the process uncertain and defeating. In 2018, the UN Special Rapporteur for Human Rights in the OPT concluded that "with an economy in free fall, 70 per cent youth unemployment, widely contaminated drinking water and a collapsed health care system, Gaza has become 'unliveable'" (United Nations, *2018*).

With these minimal essentials as background, the exploration of factors that shape the mental health of Palestinians in the OPT is now situated in context. There is a growing public health, medical, and social-psychological literature developing to describe the mental health of Palestinians under Israeli occupation and to understand some of the primary factors affecting it. Not surprisingly, chronic exposure to violence consistently emerges as a primary determinant of mental health deficits. Next we briefly address some of the exposures to violence that Palestinians endure; then challenge existing frameworks for understanding mental health in chronic warlike conditions and a settler colonial context.

Exposure to Violence

Exposure to violence is a well-known cause of mental health deficits (Giacaman et al., *2007b*; Tol et al., *2010*), and the rates of such exposure in the OPT are striking. A small sampling of recently published studies begins to demonstrate this. For example, El Khodary and Samara's (*2020*) sample of 1029 children and adolescents (ages 11–17) living in the Gaza Strip revealed that 90% reported witnessing or hearing shelling by tanks, artillery, or military planes. Another study (Wagner et al., *2020*) found that 70% of the 2481 Palestinian youth living in the West Bank or East Jerusalem witnessed one of the following types of violence: directly witnessed beating of close relative; directly witnessed killing of close relative or friend; witnessed shooting of close relative or friend by rubber/plastic or real bullets; or directly witnessed a close relative/friend's house closure or demolition. Moreover, 69% reported the murder of a close relative or friend or the Israel military detention of a close relative. Finally, 100% of a subsample of 99 college-aged youth in the Gaza Strip reported exposure to one or more episodes of war (e.g., bombardment by drones and aircraft, shelling by tanks and navy, and gunfire from snipers; Manzanero et al., *2016*). Tens of other studies confirm these levels of exposure and link them to reports of distress, mental suffering, and ill-being (Barber et al., *2016a*; Giacaman et al., *2011*), in addition to the standard biomedical assessments, such as post-traumatic stress disorder, depression, and other mental health–related sequelae among Palestinians (e.g., for review, see Khamis, *2000*, *2008*; Thabet et al., *2014*). However, standard measures and report of exposure to violence fall short of capturing the experience of life under Israeli occupation. To better do so requires data and reports that capture (more closely) the nuances and invisible effects of violence on people in the OPT.

One way to access these nuances is via access to the biweekly "Protection of Civilians" reports from the branch of the United Nations Office for Humanitarian Affairs with oversight over the OPT (OCHA, *2020*). Two reports for the first and second half of June, 2020, identify the following across the West Bank and the Gaza Strip:

- An 8-month-old baby boy, who needed heart surgery at an Israeli hospital, was not allowed to exit from the Gaza Strip and died.
- Israeli forces injured 146 Palestinians, including 9 children, in multiple clashes across the West Bank. Twenty-nine of those injuries came at weekly demonstrations held in the village of Kafr Qaddum. Of those injured, 73 were treated for tear-gas inhalation, 56 were hit by rubber-coated metal bullets, 10 were physically assaulted, six were hit with live ammunition, and one was hit by a tear-gas canister.
- Israeli forces carried out 245 search-and-arrest operations and arrested 346 Palestinians across the West Bank (an average of 11 Palestinians arrested each day). Israeli law allows the Israeli authorities to detain or arrest Palestinians without established cause, and hold them without trial for 6 months at a time, renewable with approval of the court, and this can go on for marked lengths of time. Between January 2015 and July 2017, 2441 extensions were submitted to courts (averages to more than 2 per day); 75% of requests were approved without amendments or limitations (B'tselem, *2017*).
- In the Gaza Strip, on "at least" 61 occasions, Israeli forces opened fire near Israel's perimeter fence around the Strip and off the coast. No injuries were reported.
- Twenty Palestinians were injured, hundreds of olive trees (on Palestinian farmland) were set on fire, and 16 vehicles vandalized by assailants believed to be Israeli settlers.
- Ninety-one Palestinian-owned structures were demolished or seized in the West Bank due to the lack of Israeli-issued building permits (which are almost never provided, making any building or repair nearly impossible unless done without a permit), displacing (making homeless) 120 people, including many children, and affecting over 370.

This list of incidents come from only 1 month (June, 2020). It is not an unusual month in any way. In fact, in many ways, it would be considered a calm month in terms of violence. These data do not include periods of major Israeli assaults against Palestinians in the OPT. For example, the Israeli military killed over 250 Palestinians, and injured another 36,143 during demonstrations in the Gaza Strip dubbed the "Great March of Return" (GMR), which calls for the Israeli authorities to lift the long-term illegal blockade on the Strip and allow Palestinian refugees to return to their villages and towns inside Israel. These weekly demonstrations lasted approximately 20 months (from March 30, 2018 to the end of 2019) and occurred inside the Strip, at fences that separated the Strip from Israel. Of those injured, 22% or 7951 people were shot with live ammunition, resulting in over 1200 cases of long-term rehabilitation and 156 limb amputations. The UN report summarizing these injuries (United Nations, *2020*) also noted that "in 2020, an estimated 10,400 people [in the Gaza Strip] will suffer severe mental health problems in connection to the GMR demonstrations, and nearly 42,000 people will have mild to moderate problems. These figures include over 22,500 children".

Palestinians in the Gaza Strip also suffered greatly during an Israeli military assault in 2014 that lasted 51 days, and resulted in the killing of 2251 Palestinians, including 551 children (OCHA, *2014*). The sustained military attack (while exits from the Strip were closed) included over 6000 air raids (averaging 120 per day, or 5 per hour), and involved 5000 tonnes of munitions dropped on one of the most densely populated areas in the world. Not surprisingly, these attacks resulted in injury to 11,231 Palestinians, including 3436 children, and the damage or destruction of over 18,000 housing units, 73 medical facilities, and 66 schools. A UN report identified several violations of international human rights law during the assault, including the following report of Israel's demolition of entire buildings (one of many such incidences): "On 29 July at around 7.30 a.m., an Israeli aircraft dropped an aerial bomb on the Al Dali building in Khan Younis, where the Abu Amr, Breikah, Al-Najjar and

Mu'ammar families lived. The strike resulted in the complete destruction of the Al Dali building and serious damage to adjacent buildings. At least 33 people inside the house were killed, including 18 children and 6 women. In addition, the damage caused by the attack to adjacent houses reportedly killed one member of the Al-Ramlawi family, a girl aged 9, and a member of the Abu Sitta family. Another 21 people were injured, including 4 children, several of them critically" (A/HRC/29/CRP.4, p. 41; see also, OHCHR, *2014*).

The experience of violence in the West Bank – with its constant presence of Israeli military, and settlers, at Israeli army checkpoints – is of a different nature. The violence of occupation is not the result of the suffocation from a blockade or major military assaults, but of routinized hourly and daily violence through arrests, individual and collective humiliations, control, ongoing attacks on dignity, and other forms of human insecurity (e.g., Amro & Giacaman, *2012*; Giacaman et al., *2007a*; McNeely et al., *2014*).

Mental Health in Palestine

Given these conditions, it should come as no surprise that studies demonstrate exceptionally high rates of post-traumatic stress disorder, depression, and other measures of psychological distress within Palestinian communities (for review, see Ayer et al., *2017*; Madianos et al., *2011*). Unfortunately, measures that easily lend themselves to comparisons across populations are constructed to smooth over contextual experiences of trauma and violence and, as such, are often inappropriate for understanding the distinctive experience of Palestinians. Many of these analyses unintentionally risk contributing to the ongoing erasure of the particular conditions that shape Palestinian trauma (i.e., an oppressive and violent military occupation and colonization), ignoring culturally and contextually specific components of ongoing trauma, and overlooking aspects of survival, endurance, and resistance to injustice that Palestinians reflect. Put another way, the problem with analyses that take a traditional lens to understanding mental health is that they often ignore the essential realities that are most responsible for the lived experience of Palestinians under occupation (see Giacaman, *2018a*) – one of chronic violations of basic human rights and of subjugation to ongoing efforts toward colonial domination (Masocha & Robinson, *2017*).

Broadly speaking, the notion of mental illness has been equated for centuries with the psychiatric discourse of contention and segregation as a mean of social reproduction (Horn, *2020*), and reflects Eurocentric masculine oppressive domination of colonizers over oppressed social classes, indigenous populations, marginalized women, and discriminated/dehumanized minorities (Fanon, *1970*; Foucault, *1988*). Indeed, colonizing powers have used Western psychiatric discourse (e.g., PTSD) to minimize dissent and reproduce forms of control and surveillance under the label of mental illness and maladaptation (Joseph, *2015*). Mental health services are organized and focused on ensuring and perpetuating the social and political order (Foucault, *2006*). As a result, the oppressed are reduced from "desiring being" (seeking for justice, dignity, freedom, and redemption) to "obedient and sentient victimized beings" (Goodchild, *1996*). A growing number of local and international NGOs operating in the field of mental health in the OPT elevate this type of risk of psychiatrizing the Palestinian suffering and resistance (Boyden, *2003*; Makkawi, *2017*; Marie et al., *2016*), thereby diverting the scientific and public attention from the essential realities of structural (and physical) violence and injustice to more governable and reductionist definitions of mental illness, trauma, and post-trauma.

A true understanding of mental health in the OPT is bound to a dark history of subjugation and colonization (Basaglia & Ongaro, *2018*; Giacaman, *2018a*, *b*). Yet, research and international aid-informed interventions are mainly focused on individual symptoms and syndromes, most often underestimating or totally neglecting the practical knowledge and directions provided by indigenous mental health providers and practitioners. Native Palestinian thinking and knowledge about mental health and well-being are excluded from international discussions on the matter, often criticized for being insufficiently scientific, while instruments developed in the Western world and without any nuance to the realities facing Palestinians under occupation are celebrated and used to help shape policy. Indeed, both anecdotal narratives (Shani, *2017*) and social scientific research depict Palestinian society as mentally sick, corrupted by antisocial behaviors (Thabet et al., *2015*), domestic violence (Heath et al., *2013*), and an epidemic of post-traumatic syndromes (El-Khodary & Samara, *2020*; Khamis, *2008*). The natural result of such work may be to devote energies and propose systems that treat such illness. Indeed, it is undeniable that any society enduring the stress and trauma that face Palestinians in the OPT will face ills. The question, as Rabaia, Saleh, and Giacaman (*2014*, p. 175) correctly asked in summarizing symptoms of mental distress among Palestinian children in the OPT, is "whether displaying these symptoms necessarily means that children suffer a mental illness or disorder, requiring a form of specialized treatment, or alternatively, whether the fear and sadness associated with exposure to political violence are normal reactions which will diminish with time and support from family and community, and ultimately require a sociopolitical resolution as opposed to a medical one?".

Liberatory Approach to Mental Heath

A liberatory and decolonized approach to understanding the Palestinian experience (Qato, *2020*; Makkawi, *2017*) recognizes the historical and political determinants of social suffering in Palestine and can provide a necessary reframing of mental distress therein. Consistent with the psychology of liberation perspective (Martìn-Barò *1994*), psychological trauma and related symptoms are understood within the framework of ongoing Palestinian dispossession and abuse, rather than the phenomenological surface of a sick society. In fact, when the public spaces for expressing a collective pain are reduced or eliminated, the only outlet for social suffering is through the expression of individualized symptoms, emergent as a reparation of historical and multigenerational collective burdens. These expressions are impossible to understand without first identifying and analyzing the conditions that create those traumatic realities, then focusing on the structural violence that turns the "abnormal" in most Western and colonizer contexts into the "normal" within deeply colonized and subjugated communities (Martìn-Barò & Martin-Baro, *1994*). Ultimately, a full understanding of mental health issues in the OPT necessitates the recognition "that the individual's wellbeing is to a large extent an outcome of ongoing occupation, oppression, repression, and exploitation" (Makkawi, *2017*, p. 84). Consistent with that approach, Giacaman (2018, p. 23) makes the following case:

> Our journey in the process of investigating the effects of war on health has revealed the need for a reframing of the causes and health consequences of exposure to political violence by placing the concept of suffering at the core of the health paradigm, and by adding a political domain as the ultimate determinant of population health. This reframing is essential to really understand what war does to people. It is also essential to guide relief operations and humanitarian assistance, and to support initiatives intended to mitigate the effects of war on health. For too long, Palestinians have been the recipients of aid in response to their plight, a

> plight that seems to have no end in sight. Yet, what Palestinians really need is first and foremost a recognition of the injustice that befell them when with the Balfour Declaration the British decided to give a land they did not own to people coming from elsewhere, and when the United Nations agreed to partition Palestine despite the severe injustice to Palestinians this entailed, with the consequent creation of a tragedy that continues to this day: "the question of Palestine". Palestinians do not want charity, medications and therapies to help them withstand injustice. While it is true that humanitarian assistance and relief operations are needed in times of chronic crises, those must be coupled with a serious attempt at resolving the root causes of ill-health, which, in the Palestinian case, requires a sociopolitical resolution: justice, freedom, sovereignty, and self-determination before good health and peace can be achieved.

The commitment to shift the scholarly analysis of Palestinian health toward a liberatory approach with a sociopolitical center is critical. It also requires reliance on constructs and measures that are indigenous to the Palestinian experience. Toward that end, Giacaman (*2018b*, p. 13) speaks of the "wounds inside" as "the invisible traumas of war that, cumulatively and over the life course, can lead to visible and diagnosable diseases". The cumulative and ongoing exposure to systematic violence in contexts characterized by war and political violence gradually shift those internal wounds to physical and psychological disease and, ultimately, to death (Giacaman, *2018b*, *2019*). This analysis moves us from a binary approach that is focused on presence versus absence of psychopathology to one that places Palestinians and other victims of wars on a continuum between "ease" and "disease".

Individuals' location on that continuum varies according to several dimensions of violence and suffering, including humiliation, deprivation, and other forms of human insecurity (Batniji et al., *2009*). Giacaman and colleagues (*2009*) began utilizing the notion of "human *insecurity*" to analyze the conditions of Palestinians living under occupation based on Learning and Sam's (*2001*) reflections on human *security* (for review, see Giacaman, 2018). Learning and Sam (*2001*) argued that "if minimal material inputs can be guaranteed and if efforts can be made to shore up basic social coping capacities, societies will be more stable and less prone to fragmentation, violence and atrocity" (p. 4).

Human insecurity in the Palestinian context may be direct (e.g., rocket fire or home demolitions) or indirect (e.g., restrictions on movement that lead to poverty) and can be assessed on three dimensions (Batniji et al., *2009*): (1) insecurity at home (e.g., sustainable sense of home and safety); (2) insecurity in the community (e.g., a network of constructive social or family support); and (3) insecurity about the future (e.g., uncertainty). Ziadni et al. (*2011*) followed up this analysis by identifying displacement and imprisonment, armed clashes, house evictions, and demolitions as types of direct threats reported by Palestinians to their felt security. Whereas, sieges, checkpoints, as well as curfews resulting in health and economic losses were reported as indirect threats that undermine felt security (Ziadni et al., *2011*).

An important and increasingly recognized aspect of human insecurity for Palestinians is the experience of routinized humiliation (Giacaman et al., *2007a*). Indeed, Barber et al. (*2016b*) found that humiliation experiences (including being shot at, kicked, verbally abused, having homes searched, and witnessing others being humiliated) occurred frequently among Palestinians and was associated with idiomatic signs of distress such as "feeling broken or destroyed", depressed, traumatized, or insecure. This notion of feeling of being "broken inside" and "destroyed" reflected a psychological and emotional experience of cumulative exhaustion across different domains; including restrictions to freedom of movement, absorbing political pressure, and living with military violence. By stripping Palestinians of their basic rights to human security, to resistance to occupation, to freedom of movement, and to other basic needs, and by creating layers of uncertainty

about essential aspects of life and safety, Israeli military occupation and related policies and military violence across decades and generations have placed Palestinians increasingly on the disease end of Giacaman's (2018) ease-disease continuum.

A consequence of ongoing humiliation, and a factor that has been shown to be associated with diminished health in the OPT (Barber et al., *2016b*; Khatib & Armenian, *2010*), is the loss of dignity. In the chain of the Palestinian suffering – from the macro-, social, and political levels to the micro-, personal, and emotional ones – the daily aggression to both individual and collective dignity has been identified as a crucial determinant of psychological functioning and social well-being, as well as a direct consequence of daily humiliations that Palestinians must endure in the OPT (Batniji, *2012*). Israeli authorities control and surveil the whole territory vertically (airspace, ground, and underground), and the international aid system stresses and enforces already existing inequalities, victimizing and diminishing the indigenous knowledge on resilience and resistance (Giacaman, *2019*). In this space, responsibilities between oppressors and oppressed run the risk of being strategically ambiguated, and the root of the illness can deftly switch from the occupation and the structures that brutally maintain or expand it to the subjects of that colonization. It can also obscure the agency of Palestinians to overcome and to achieve.

Resilience

As the Western assumptions of suffering, vulnerability, and pathology have been revised in the Palestinian context under the umbrella of the political domain, psychological functioning and adaptation to hardships and resilience in such a context are also concepts that require to be critically rethought in the same light (Giacaman, *2019*). In fact, the benefits of individuals' ability to adapt to hardships (as resilience is conceptualized) are challenged when such "hardships" include systematic and ongoing violation of basic human rights. Indeed, "adaptation" can easily turn into willing subjugation to the violence of colonization and oppression, and efforts to increase resilience may unintentionally promote comfort with deeply problematic structures of violence. As such, indigenous mental health providers who refuse to be agents of acquiescence to the status quo may appropriately refuse to engage in resilience exercises that "help" Palestinians "adapt" to abnormal, deeply destructive, and violent living conditions (Giacaman et al., *2009*).

Instead, one might imagine a sociopolitical approach to Palestinian well-being which emphasizes the importance of providing agency to Palestinians in their efforts to tear down oppressive structures that maintain or further advance their colonization (e.g., Barber et al., *2014*). Toward that effort, Veronese and colleagues have focused on raising the agentic capabilities of Palestinian women (Veronese et al., *2018*, *2019a*), children (Veronese et al., *2018*, *2019b*, *2020b*; Veronese & Cavazzoni, *2019*), and adults (Veronese et al., *2020c*) to position themselves as active and politically informed social actors fully capable of creating change. The agentic attitude and steadfastness of Palestinians in confronting Western colonization can be summarized with the Arabic idiomatic expression of "*Sumud*"; the Palestinian individual and collective perseverance in resistance against the occupation. *Sumud* contributes to fostering a sense of coherence (comprehensibility, manageability, and meaningfulness; Antonovsky, *1974*; Veronese et al., *2020a*) and personal growth (Afana et al., *2020*) among Palestinians, generating health and psychological wellness. In their review of growing research on *Sumud* among Palestinians, Hammad and Tribe (*2020*, p. 6) describe *Sumud* as "both a value and an action that manifests via individual and collective action to protect family and community survival, wellbeing, dignity, Palestinian identity and culture, and to remain

on the land" and argues that "it is a revolutionary way of being under oppressive conditions". Yet, we simultaneously acknowledge the failures of a narrative that focuses so heavily on the resilience or *Sumud* of the Palestinians. As Mourad (*2020*) reflected in the context of the celebration of Lebanese resistance after the massive explosion in the Beirut port: "Resilience romanticizes our loss and dispossession…[It] celebrates survival at the expense of justice". Any honest analysis of Palestinian mental health must acknowledge the limitations of either a resilience or a *Sumud* framework – they risk doing the precise work that Mourad calls out so powerfully.

Ultimately, a synergistic approach to human rights and public mental health foresees mental health providers as critical actors for fostering social change, and for promoting quality of life among engaged citizens who actively resist under conditions of oppression and violation of basic human rights. Moreover, at the center of this is an appreciation for the impact of *Sumud* as a defining feature of life for Palestinians in the OPT. One example of these commitments is Diab et al.'s (*2018*) three-level mental health–related intervention for victims of political oppression in the OPT. In this proposed approach, the primary level is aimed at increasing individuals' informational capital by educating them around strategies and services tied to *Sumud*, including skills for individual and collective survival. It also involves supporting people by educating them about rights and strategies for developing a sense of meaning and coherence amid chronic and changing uncertainties. The secondary level of therapy focuses on psychotherapeutic and psychological services, acting on symptoms and psychological burdens. Finally, the third level works strategically on further developing confidence in personal and community agency, identifying individualized spaces for organizing and resistance to violence and oppression. Broader efforts to advance similar frameworks across the OPT are important for honoring the Palestinians' lived experience and helping them in strengthening their agency to address the root causes of the myriad forms of human insecurities they face.

Shalhoub-Kevorkian (*2020*) echoes our call. The children in Gaza whom she interviewed articulate life in "non-breathing, non-living spaces, produced by rendering lands, bodies, and lives exterminable and disposable" (p. 126); they reflect on being caged and on the violation of sacred home and familial spaces even within that cage; they also describe the "gun to body" contexts in which they exist. Their narratives reflect a devastating and ongoing "unchilding" of Palestinian youth.

In sum, the complex and multifaceted construct of mental health in the OPT relies on the political destiny of a conflict that is shaped by the decades of a brutal military occupation (Tanous, *2022*). The Palestinian dialectic between suffering and *Sumud*, and their positioning and repositioning in the continuum between ease and disease reflect the resistance and struggle in which Palestinians exist, resist, fall, and rise. We as natives and international scholars and practitioners are called to focus more on the pathology of the bystanders and the normalization of violence rather than on the symptoms of maladaptation among the oppressed. Historical, cultural, and political realities are embodied in the experience of political violence in the OPT, and rest in what Martín-Baró (*1989*) called "psychosocial trauma"-that is, stratified experiences of extreme violence that affect individuals, and communities in their wholeness (Becker, *1995*). Understanding mental health requires that scholars avoid applying approaches and analyses that unintentionally remove agency from Palestinians and perpetuate "science-informed" and theory-driven forms of violence and oppression against individuals and collectivities (Burns & Foot, *2020*; Sapene-Chapellín, *2009*).

Cross-References

- Health and Human Rights
- Health Humanities in the Muslim Middle East
- Health in Occupied Kashmir
- Human Rights
- Indigenous Organizing
- Land Rights, Displacement and Health Communication
- Racism and Health
- Refugee Health
- Subaltern

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