

# Sick or Sad? Supporting Palestinian Children Living in Conditions of Chronic Political Violence

Yoke Rabaia

Institute of Community and Public Health, Birzeit University, Birzeit, Palestine

Mahasin F. Saleh

Department of Social Sciences, Bethlehem University, Bethlehem, Palestine

Rita Giacaman

Institute of Community and Public Health, Birzeit University, Birzeit, Palestine

*In this article we reflect on the relatively recent emphasis on Palestinian children's mental health and well-being in the context of exposure to chronic warlike conditions, as we position this trend within the larger framework of the generations-long history of political turmoil and suffering. We describe how a process that started with no attention to psychosocial health of children in relation to exposure to dispossession, expulsion, occupation, repression and military attacks, proceeded with a focus on presumed mental disorders, and the more recent approach of designing context appropriate and community-based psychosocial interventions. © 2014 John Wiley & Sons Ltd and National Children's Bureau*

**Keywords:** Children, mental health, occupied Palestinian territory, social suffering, trauma.

## Introduction — Palestinian history: protracted conflict with periods of low and high intensity

Palestinians, old or young, living in historical Palestine, in refugee camps in neighbouring countries, or in the Palestinian *diaspora*, have grown up with a national narrative of historical loss. The eldest among them may still speak about growing up in the time of the British mandate (1923–1948), with the struggle against the British authorities and the growing worries about the influx of European Jewish colonists. Others may remember what Palestinians generally refer to as the *nakba* (catastrophe), when in the aftermath of the Second World War and the mass migration of Jewish Holocaust survivors to Palestine, Israel was established and recognised by the main powers of the international community. An estimated 700 000 Palestinians, or about two-thirds of the population at the time, fleeing the violence, insecurity and fighting, subsequently found themselves to be refugees behind closed borders. Until this day many of the families in refugee camps in Lebanon, Jordan, Syria and the occupied West Bank and besieged Gaza Strip hold on to the keys of their long-lost homes in what is now Israel. Although the United Nations General Assembly had as early as December 1948 passed a resolution stipulating that Palestinian refugees should be allowed to return to their homes (UN resolution 194), the 'earliest practicable date' for this event has still not arrived, even 65 years, a lifetime, and three generations later.

A second catastrophe, also referred to as the *naksa* (*setback*) by Palestinians, occurred in 1967, when the remaining territories of historical Palestine (the Gaza Strip and the West Bank of the Jordan River, respectively, administered by Egypt and Jordan) came under Israeli

occupation. Again hundreds of thousands of Palestinians became refugees, between a third and half of them for the second time. Palestinians who became refugees in the 1960s continue to tell their children and grandchildren how they lost their country and their home.

Although the first Palestinian uprising against the Israeli military occupation, the *intifada* of 1987–1991, led to an increase in the international recognition and understanding of the injustice suffered by Palestinians, an initially internationally facilitated peace process ended abruptly with a secretly negotiated deal between Israel and the Palestinian Liberation Organization in Oslo in 1993. This deal resulted in the ‘return’ of PLO officials and their families to the West Bank and the Gaza Strip as well as the establishment of a Palestinian Authority (PA). However, the deal failed to guarantee the return or right to compensation of the rest of the 1948 and 1967 Palestinian refugees, many of them still living in refugee camps in the neighbouring countries. Palestinian parents of today tell their children about how they grew up during the first *intifada*, the commercial and school strikes, the collective action undertaken and the collective punishments which were endured at the time.

Contrary to international perceptions the Palestinian people remain subject to Israeli and international control regarding their national borders, democratic processes and economic development. The Palestinian refugee problem remains unresolved and Palestinians from the West Bank and the Gaza Strip can only access ‘their capital East Jerusalem’ with hard to acquire Israeli-issued permits. Resistance to this status quo has led to Israeli demonstrations of its military might, with the re-occupation of West Bank cities in 2002, the 3-week war against the Gaza Strip at the end of 2008 and most recently the 8-day assault on the Gaza Strip in November 2012. Rather than through an intensive full-time military occupation, Israel now continues its domination over the West Bank and Gaza Strip population by way of control of external borders, military checkpoints and closure of roads inside the West Bank, a ‘separation barrier’, also called the Apartheid Wall by Palestinians, armed settlers and the regular, but poorly reported incarceration of Palestinian political activists, largely men, but also women and children. It is essential to note, that since 2000 over 8000 Palestinian children have been detained, arrested and prosecuted by the Israeli military (Save the Children Sweden and East Jerusalem YMCA Rehabilitation Program, 2012). The widespread and systematic abuses in Israel’s juvenile military courts and detention facilities do not meet international juvenile justice standards as outlined in the Convention on the Right of the Child and the UN Convention Against Torture (Defence for Children International Palestine (DCI-Palestine), 2012; UNICEF, 2013). Unfortunately, the support of the international community to Israel is guaranteed with a continued policy of non-intervention, despite Israel’s ongoing violation of international law. This is the context in which Palestinian children in the West Bank and Gaza Strip are growing up.

### The international community's interest in Palestinians' mental health

Given this long history of loss and the absence of a state, Palestinians not only got used to expecting and dealing with the reality of living in political, economic and human insecurity, but the situation also compelled them to take care of each other. Until today, family bonds are strong and supportive, often across borders. Many families have members who have out-migrated and who provide financial support when needed and a safe haven in case of emergency. On the ground in times of crises or need, neighbours and communities help each other, and as testified to recently by Jones and Lavalette (2011) ‘magnificent welfare projects’ are carried out by unqualified people.

International (Western) attention to the Middle East has traditionally been favourable to the Israeli state, with little attention for Palestinians. This began to change by the end of the 1980s with the news broadcast images of the first *intifada* (uprising) which highlighted the

plight of the Palestinians in the West Bank, including East Jerusalem and the Gaza Strip. Although a series of hijacks of international airplanes in the 1970s had portrayed Palestinians as 'terrorists', this perception began to change at the time of the first intifada when children armed with bare rocks and sling shots were seen fighting Israeli tanks and bullet fire. The sheer numbers of Palestinian civilians, including children, shot and injured by Israeli rubber bullets and live fire, reversed the image of Palestinians as perpetrators to another extreme, one of Palestinians as victims of violence. The violent and oppressive nature of Israel's military occupation of Palestinian territory with house demolitions, deportations, curfews, mass arrests, torture and humiliation, affecting old and young could no longer be denied.

Research publications about the question of how exposure to the violence of the Israeli military occupation affected Palestinian children began to appear during and after the first intifada. During the period 1989–2006, at least 20 articles on the subject were published in international academic journals. These articles provided quantitative analyses of the association of exposure to violence with mental health outcomes in Palestinian children and adolescents. Negative outcomes included measurements of fears; aggression; favourable attitudes of war; Post Traumatic Stress Disorder; pessimistic future orientations; attitudes towards peace negotiations; psychological symptoms; poor psychological adjustment; personality and behavioural changes; behavioral problems; neuroticism; low self-esteem; concentration, attention and memory problems; risk taking; negative perception of parenting; psychological adjustment problems; emotional disorders; depression; anxiety; mood disorders; somatoform disorders; psychological symptoms; antisocial behaviour; depression. In about a quarter of the articles there is some attention for positive outcomes, such as positive coping styles; personal growth; social integration; peace potential; social competence; civic and religious involvement; identity; orientation towards others, and active coping (Barber and Schluterman, 2009). It must be assumed that these studies were conducted with the best intentions and possibly to a certain extent with the objective of providing the international community with evidence of the negative (mental health) impact of Israel's actions on Palestinian children. However, the focus on pathological symptoms, such as PTSD symptoms, depression, mood and other mental health disorders, created the impression that young Palestinians exposed to violence had become 'mentally ill', and thus 'needed' and 'had the right to treatment' (according to the Convention on the Rights of the Child, Article 23, the dissemination of treatment approaches internationally). The question of how Palestinians had managed to maintain their mental health throughout their long history of dispossession and episodes of lower and higher intensity violence received markedly less interest.

### **Mental disorders in need of medical treatment and therapy.....?**

Those who are mentally ill indeed have a right to treatment. The problem with estimates of mental illness derived from population research based on the prevalence symptoms rather than clinical diagnoses by professionals is that such estimates tend to turn out unrealistically high. Moreover, it has been convincingly argued that the measures used are relevant to clinical practice and should not be used to assess prevalence at the population level (Horwitz and Wakefield, 2007).

For example, a Gaza-based study of children who lost their homes found that 54 per cent had severe PTSD scores and 33.5 per cent were moderate (Qouta and others, 2003). Another study estimated PTSD rates in children in Gaza as 41 per cent with moderate to severe PTSD symptoms, while 72.8 per cent reported at least mild intensity symptoms (Thabet and Vostanis, 1999). Rates for other populations in situations in conflict include a study of Rwandan youth immediately following the genocide which found probable PTSD rates of 54 per cent

to as high as 100 per cent (Neugebauer and others, 2009), while a comparison study of children in Kurdistan and Kurdistan children exiled in Sweden cited PTSD prevalence rates of 32.3 per cent and 11 per cent respectively (Ahmad and others, 2008).

A more critical problem arises when interventions forego clinical diagnoses and people who have been exposed to traumatic events are 'treated' on the basis of their exposure to the event as has happened in interventions designed around compulsory psychological debriefing of victims of traumatic events in an attempt to prevent 'worse mental problems'. Considerable amounts of funding and effort on this type of intervention provided no measurable positive effect in preventing or decreasing PTSD, anxiety or depression and there is 'some suggestion that it may increase the risk of PTSD and depression' (Rose and others, 2009).

In the occupied Palestinian territory (oPt), an example of the provision of psychological treatment to victims of 'major life events or consequences of the conflict' was an intervention provided to a sample ( $N = 1773$ ) of children and adults (with a 6:4 proportion), who had been referred to an international medical aid providing organisation by local mental health and counselling personnel or by beneficiaries talking about the programme to friends or neighbours. The 'patients' presented with a variety of complaints, of which the most prevalent were *fear* (20.5%) and *sadness* (16.4%). Over 50 per cent of the 'patients' received individual therapy and over one-third received family therapy; the remainder had carer/child dyad therapy. A published evaluation speaks of 80 per cent improvement after the therapy (Gaboulaud and others, 2010). A critical reading of the article, however, raised a variety of issues, from questions about the validity of the diagnoses to the actual attribution of the 'improvement' of the 'patients' to the therapy (Rabaia and others, 2010). Such questions need to be asked. Only through careful evaluation can we learn about the appropriateness and effectiveness of psychological or psychosocial interventions. In practice, however, many of the interventions, especially those in the form of time-limited projects funded by external donors, are evaluated through the log frame/logic model format, which is usually more concerned with counts and outputs (how has the money been spent) than outcome (did the output achieve the intended result) and which tends to coincide with the end of the intervention, when the money is spent and little time or opportunity is available to use the lessons learned for amending or adapting the intervention. This lack of evaluation integrity negatively impacts programme sustainability and also often involves the one-time use of outside expertise instead of drawing upon local experts or embarking on a long-term cooperation between local and international partners.

### **Illness in need of therapy, or: *sadness and fear in need of structural change?***

There is no doubt that Palestinian children have been exposed to many violent events and it is likely that this exposure has affected them, and that they may display some or all of the symptoms that correspond to the diagnostic symptoms associated with mental ailments such as PTSD, anxiety, depression and mood disorders. The question is, however, whether displaying these symptoms necessarily means that children suffer a mental illness or disorder, requiring a form of specialised 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. Defining human conditions into treatable disorders is a relatively new trend, covering not only fear and sadness but also other illnesses or 'syndromes' relating to behaviour, a psychic state, or a bodily condition, that were previously not considered as medical problems. Some analysts point at the coinciding of this new trend with the expansion of the medical services and the pharmaceutical industry, but patients' interest groups also play a role (Conrad, 2007).

The transformation of normal sorrow to depressive disorder in modern psychiatry, specifically, has been described by Horwitz and Wakefield, in 'The Loss of Sadness' (2007). They explain that part of the problem lies in the expanded use of the Diagnostic and Statistical Manual of Mental Disorders from a manual to help practitioners with the diagnosis of the ailment of their individual patients, to using the symptomatic criteria as the basis for the development of instruments measuring the 'prevalence' of ailments in a population. It must be recognised, however, that there is a major difference between the people seen by practitioners for clinical diagnosis and the people counted in surveys: the person seen by the practitioner has actually decided (or it has been decided for him or her) that he or she requires professional help. Others, exposed to the same traumatic experience may display the same symptoms without actually needing or wishing for professional help. Cultural and societal norms, as well as the meaning ascribed to the 'traumatic' event, ultimately shape the reactions of the individual victims, whether or not they seek help and their expectations of recovery (Summerfield, 2004; Young, 1995). Horwitz and Wakefield explain that the conflation of normal sadness and depressive disorder leads to overestimates of both the severity and the prevalence components of disability ratings. (p. 215)

The difference in patients wishing diagnosis and treatment and people exposed to traumatic experiences, is clarified when we examine a survey conducted immediately after the 3-week Israeli assault on the Gaza Strip end 2008-beginning 2009. When asked to whom adult respondents in a randomly selected sample would turn if they wanted to talk to someone about their worries, only 1 per cent said they would turn to a professional, versus 24 per cent who would not talk to anyone, 59 per cent to a family member and 22 per cent to a friend (UNFPA and FAFO, 2009). That 3-week Israeli operation including airstrikes and a ground offensive against civilian and lightly armed Palestinians resulted in more than 1400 Palestinian versus 13 Israeli casualties. The world was shocked and the international humanitarian networks were quick to appear on the scene, with the intention of helping the Palestinian population deal with the physical and mental recovery of this, yet another, traumatic experience. International trainers of the Mental Health and Psychosocial Support working group led by WHO and UNICEF were flown in to conduct a workshop in Ramallah to clarify the Inter-Agency Standing Committee (IASC) group guidelines to the international and local relief workers of the various organisations and institutions working in psychosocial and mental health all over the West Bank and the Gaza Strip. The IASC guidelines are specific to mental health and psychosocial support in emergencies and point out that a multi-layered system should be developed to help a variety of groups with an emphasis of concurrent implementation. In the manual, a pyramid depicts the bottom layer as 'basic services and security', then, respective layers include 'community and family supports', 'focused non-specialized services', and 'specialized services' (Inter-Agency Standing Committee (IASC), 2007, 2008). It is important to note that the directives for the largest layer of the pyramid focusing on basic services and security include the following: 'The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs'. This should be implemented through 'advocacy and provision of advice to states on bringing national legislation, policies, programmes and practices into line with international law and standards' (Inter-Agency Standing Committee (IASC), 2008, p. 19) as well as 'advocacy for compliance with international law and standards, and with customary laws consistent with international standards' (p. 21). This makes a lot of sense when the emergency relates to an internal problem, where the state should protect all its citizens. However, the question is whether this guideline applies also to the Palestinian situation, where it is not the Palestinian Authority that has the control over the bottom layer of the pyramid, but rather Israel, the occupying power and to a certain extent also the international

community, which fails to enforce UN resolutions. A focus on the dynamics between the trainers and the trainees at the workshop illuminates this issue.

As is often the case in workshops, the interaction between trainers and trainees can provide an opportunity for mutual learning. In this case, throughout the time of the workshop, participants referred to the fact that Palestinian relief workers and Palestinian people in general have become used to Israeli repressive and powerful aggression. They pointed at the recurring and cumulative nature of Israeli assaults against the population and their long-term experience in dealing with these crises. However, the trainers were not particularly interested in reacting to this point, as they concentrated on delivering the training according to their own guidelines. It was towards the end of the training when a young woman stood up and asked if she might speak. She said her English was not so good and she asked permission to make her point in Arabic. Language can be a barrier when international and local organisations try to work together. By requesting to speak in Arabic, the young woman made it clear that what she wanted to say was particularly important to her. She then reiterated the point that had been made earlier about the fact that the organisations and relief workers have become quite used to humanitarian crises and they know how to react. However, that was not the main point she wanted to make, she posed a question to the trainers. She said, 'we try to help people as good as we can, and that is appreciated, but sometimes people get angry when they see that we are supported by or connected to international agencies. They ask us why we don't tell these organisations to make the international community force Israel to stop the aggression against Palestinians. They ask us why we have to endure these aggressions time after time'. And the young Palestinian relief worker said: 'We do not know how to answer that question ....' (Personal observation of first author).

The protracted and long-term character of the Middle East conflict and the interest of international agencies in the plight of Palestinians and their children have eventually led to a huge number of psychosocial initiatives in the oPt. Psychosocial workers have become experienced professionals in a population, which in itself has become used to periodic crises and hardship.

### 'Modesty' as a keyword for interventions (in the absence of structural political change)

Aid agencies have complied willingly as their agenda has expanded almost annually to deliver not just growth, but empowerment of women, environmental protection, good governance, and peace, all within a declining resource base. As they contemplate this massive, and often contradictory, list of tasks it is worth reflecting on the advice on one health official. Asked whether he had any advice for others planning rehabilitation interventions in conflict affected countries, he answered as follows:

Yes, be modest in your objectives to ensure that priorities are set according to needs.

Wise words.

The above quotation entails the last lines in the conclusion of Joanna Macrae's book 'Aid-Recovery? – The crisis of AID in chronic political emergencies (Macrae, 2001).

In the face of the ultimate fallacy of developmental and emergency aid for recovery in chronic political emergencies, strengthening the resilience of the population with a keen eye for priorities in relation to needs, and extreme modesty in the formulation of objectives, may be a wise alternative to more grandiose, but seldom sustainable, interventions.

Arafat and Boothby (2003) indicate that Palestinian children 'continue to exhibit resilience, as is evidenced by their enduring sense of self-efficacy and optimism about their own future. A majority of them continue to feel that they can improve their own lives by developing academically, as well as personally and socially' (p. 45). And a comparative study of

the effects of exposure to violence between Palestinian and Bosnian adolescents found that Palestinian adolescents were protected by the fact that they understood the conflict and their place in it, in contrast to the Bosnian adolescents who more often saw their experience as unworthy and regrettable and felt not engaged in the conflict (Barber, 2008).

Rather than considering social suffering an illness that needs to be 'cured' it is the issue of collective and cumulative exposure to Israeli aggression and the international communities condoning of it, that needs to be addressed. These issues are the root cause of their suffering. In the mean time, paying more attention to the historical and sociopolitical context in relation to social work (Lavalette and Ioakimidis, 2011) and qualitative research into children's own perspectives of their experience suggest an alternative school of thought in relation to children's exposure to violence. Such an interdisciplinary approach would challenge the portrayal of children exposed to political violence as victims (Gilligan, 2009) and would illuminate a population's collective experience in coping with international aggression and neglect, the availability of family and community support, children's own individual and collective coping mechanisms and their resilience (Barber and Schluterman, 2009; Nguyen-Gillham and others, 2008). Interventions following this approach tend to focus more on psychosocial support than biomedical or psychotherapy, with more attention to the identification and strengthening of community-based resources, the development of creativity and the enhancing of life-skills. The Community Based Rehabilitation (CBR)'s youth group programme in the villages in the north of the West Bank, is one such example based in the oPt. It focuses on 'youth as strategy' for rehabilitation, community and youth development work in places where there are few opportunities and services for young people, in terms of employment as well as leisure. This long-standing programme, which started in 2004 as a 'research to action' project between the local Palestinian Birzeit University and a local Palestinian NGO, the Medical Relief Society, is a generative and empowering model which brings youth together and provides a forum for exploration and understanding of their own issues and challenges as well as those in their communities. The youth groups work with CBR workers learning and supporting community disability interventions and activities, while at the same time developing their own social projects based on community need and group capacity (Giacaman and others, 2011; Rabaia and others, 2010).

### Empirical evidence?

One of the reviewers of an earlier version of this paper mentioned that the authors might not have the empirical data to support their argument. We would like to use this important critique to make an equally important point. The authors are based at Birzeit University, a local Palestinian educational establishment, which is starving for funds, and unable to self-finance any research activity. For over 10 years, two of the authors have undertaken research into the psychosocial health and the strengthening of resilience of young people in their own society, each project painstakingly designed, fund raised for, and implemented with minimal staff and local resources, albeit with the unwavering moral support of many and professional support of some international colleagues. Several of the findings of those research projects have been used to support the argument of this article, specifically the qualitative research which highlighted the resilience of young people exposed to traumatic experiences (Nguyen-Gillham and others, 2008), and the long-term intervention research cooperation with the CBR programme (Rabaia, 2013). The latter process illuminates the importance of working with local resources to support young people to help themselves and others in a sustainable way (strengthening resilience). This type of intervention is very different from the short-term intervention projects that are designed and implemented by international NGOs, based on the two assumptions that, firstly, children exposed to political

violence must experience psychological 'trauma' and that, secondly, they will recover through short-term interventions, which are assumptions that the authors and other colleagues continue to question (Gilligan, 2009; Pupavac, 2001; Summerfield, 1999). To strengthen the above-mentioned youth group project, the academic partners (the authors) have repeated the cycle of design, fund-raise, implementation and reporting on the intervention five times over this 10-year period. Here we do not speak about flying in Western professional trainers to 'impose an intervention' to strengthen resilience. Birzeit University is part of Palestinian society; the researchers themselves have been exposed to the same traumatic experiences as the young people they work with. The study of these researchers, including this article, is in itself part as well as evidence of the resilience of the society and must be recognised as such.

### Measuring the outcome of psychosocial health interventions

In the continuing absence of a political solution addressing the root cause of their suffering, Palestinians continue to experience a flurry of psychosocial programming. This article highlights the importance of doing no harm, enhancing local resources and long-term commitment. All too often, it is programme frameworks and processes which come in the way of a locally relevant approach.

It is important to acknowledge that children do not live in a laboratory; they live in a dynamic world. There are influences on psychosocial health which are not directly related to the 'trauma' of the trauma-based interventions, but more to the pressures of daily life, for example the effects of sudden loss of income, through job loss of a parent or situations occurring when donor countries are unhappy with internal Palestinian political developments and decide to withhold their support to the PA. Contextual phenomena related to the prolongation of an unsolved problem, the absence of a state structure that can be held accountable, and the ensuing lack of human security for Palestinians are all factors that influence psychosocial health not only of the children, but of the whole family. Psychosocial project assessment frameworks are generally derived from biomedical and individualistic models utilising 'objective' indicators of psychosocial health — often developed elsewhere — which may or may not be relevant and appropriate for culture and context. The assessment is based on the assumption of the temporality of a 'traumatic event', while structural factors related to the historical, sociopolitical and economic context are often neglected.

The complexity of the concept of psychosocial health and its intricate link to meaning, culture and context require collaboration between local and international researchers that builds on the expertise that is brought in by each of the partners and that needs to be based on mutual respect and interest in learning from and with each other. In mental health, what is understood in some cultures has no meaning in others. This is not an issue of finding the right word in translation, or semantics, it is about a way of being, of living, of reacting to stress and trauma linked to a mindset where meaning, culture and context are of the essence. Indeed, this is precisely why a more sensitive and effective engagement with local professionals and researchers may well take psychosocial health programming in the oPt to a better direction.

### Acknowledgements

We like to acknowledge our dear colleague Viet Nguyen-Gillham, who is no longer with us. Without her mentorship we would not have been able to write this article.

## References

- Ahmad A, Von Knorring AL, Sundelin-Wahlsten V. 2008. Traumatic experiences and post-traumatic stress disorder in Kurdistanian children and their parents in homeland and exile: an epidemiological approach. *Nordic Journal of Psychiatry* 62: 457–463.
- Arafat C, Boothby N. 2003. *Psychosocial Assessment of Palestinian Children*. Secretariat of the National Plan of Action for Palestinian Children (NPA) and Save the Children. Occupied Palestinian territory (oPt): Save the Children: Jerusalem.
- Barber BK. 2008. Contrasting portraits of war: youths' varied experiences with political violence in Bosnia and Palestine. *International Journal of Behavioral Development* 32: 298–309.
- Barber BK, Schluterman JM. 2009. An overview of the empirical literature on adolescents and political violence. In *Adolescents and War – How Youth Deal with Political Violence*. Barber BK (ed.). Oxford University Press: Oxford; 35–61.
- Conrad P. 2007. *The Medicalisation of Society*. The Johns Hopkins University Press: Baltimore.
- Defence for Children International Palestine (DCI-Palestine). 2012. Bound, blindfolded and convicted: children held in military detention. Author: Ramallah, occupied Palestinian territory (oPt). Available at [http://www.dci-palestine.org/sites/default/files/report\\_0.pdf](http://www.dci-palestine.org/sites/default/files/report_0.pdf) [Accessed 28 March 2013].
- Gaboulaud V, Reynaud C, Moro MR, Roptin J, Lachal C, Brown V, Baubet T. 2010. Psychological support for Palestinian children and adults: an analysis of data from people referred to the Medecins Sans Frontieres programme for behavioural and emotional disorders in the occupied Palestine territories. *Intervention* 8: 131–142.
- Giacaman R, Rabaia Y, Nguyen-Gillham V. 2011. *Under Fire: Doing Research in Warlike Conditions*. Harpelle RN, Muirhead B (eds.). Wilfrid Laurier University Press: Canada.
- Gilligan C. 2009. 'Highly vulnerable'? Political violence and the social construction of traumatized children. *Journal of Peace Research* 46: 119–134.
- Horwitz AV, Wakefield JC. 2007. *The Loss of Sadness – How Psychiatry Transformed Normal Sorrow into Depressive Disorder*. Oxford University Press: New York.
- Inter-Agency Standing Committee (IASC). 2007. *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. IASC: Geneva.
- Inter-Agency Standing Committee (IASC). 2008. *Mental Health and Psychosocial Support: Checklist for Field Use*. IASC: Geneva.
- Jones C, Lavalette M. 2011. "Popular social work" in the Palestinian West Bank: dispatches from the front line. In *Social Work in Extremis: Lessons for Social Work Internationally*. Lavalette M Ioakimidis V (eds.). The Policy Press: Bristol; 15–30.
- Lavalette M, Ioakimidis V. (eds.). 2011. *Social Work in Extremis: Lessons for Social Work Internationally*. The Policy Press: Bristol.
- Macrae J. 2001. *Aiding Recovery? The Crisis of Aid in Chronic Political Emergencies*. Zed Books: London.
- Neugebauer R, Fisher PW, Turner JB, Yamabe S, Sarsfield JA, Stehling-Ariza T. 2009. Post-Traumatic stress reactions among Rwandan children and adolescents in the early aftermath of genocide. *International Journal of Epidemiology* 38: 1033–1045.
- Nguyen-Gillham V, Giacaman R, Naser G, Boyce W. 2008. Normalizing the abnormal: Palestinian youth and the contradictions of resilience in protracted conflict. *Health and Social Care in the Community* 16: 291–298. DOI:10.1111/j.1365-2524.2008.00767.x.
- Pupavac V. 2001. Therapeutic governance: psychosocial intervention and trauma risk management. *Disasters* 25: 358–372.
- Qouta S, Punamäki RL, El Sarraj E. 2003. Prevalence and determinants of PTSD among Palestinian children exposed to military violence. *European Child and Adolescent Psychiatry* 12: 65–72. DOI:10.1007/s00787-003-0328-.
- Rabaia Y. 2013 (forthcoming). Reflections on a psychosocial project. Paper presented at 'Cultural Psychiatry & Global Mental Health' a conference to mark the farewell of Joop de Jong as Professor of Cultural & International Psychiatry at the VU University in Amsterdam, May 31st.

- Rabaia Y, Nguyen-Gillham V, Giacaman R. 2010. Do victims of violence need psychodynamic treatment? *Intervention* 8: 143–145.
- Rose SC, Bisson J, Churchill R, Wessely S. 2009. Psychological debriefing for preventing post traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* 2002: CD000560.
- Save the Children Sweden and East Jerusalem YMCA Rehabilitation Program. 2012. The impact of child detention: occupied Palestinian territory. Available at <http://mena.savethechildren.se/PageFiles/3731/Impact%20Report%20March%2012%20EN.pdf> [Accessed 2 April 2013].
- Summerfield D. 1999. A critique of seven assumptions behind psychological trauma programmes in war affected areas. *Social Science & Medicine* 48: 1449–1462.
- Summerfield D. 2004. Cross cultural perspectives on the medicalisation of human suffering. In *Post-traumatic Stress Disorder. Issues and Controversies*. Rosen EG (ed.). John Wiley: Chichester; 233–245.
- Thabet AZ, Vostanis P. 1999. Post-traumatic stress reactions in children of war. *Journal of Child Psychology and Psychiatry* 40: 385–391.
- UNFPA and FAFO. 2009. Life in the Gaza Strip six weeks after the armed conflict 27 December 2008–17 January 2009. Available at [http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/gaza\\_six\\_weeks.pdf](http://www.unfpa.org/webdav/site/global/shared/documents/publications/2009/gaza_six_weeks.pdf) [Accessed 28 March 2013].
- UNICEF. 2013. Children in Israeli military detention: observations and recommendations. Available at [http://www.unicef.org/oPt/UNICEF\\_oPt\\_Children\\_in\\_Israeli\\_Military\\_Detention\\_Observations\\_and\\_Recommendations\\_-\\_6\\_March\\_2013.pdf](http://www.unicef.org/oPt/UNICEF_oPt_Children_in_Israeli_Military_Detention_Observations_and_Recommendations_-_6_March_2013.pdf) [Accessed 28 March 2013].
- Young A. 1995. *The Harmony of Illusions: Inventing Post-traumatic Stress Disorder*. Princeton University Press: Princeton.

Correspondence to: Yoke Rabaia, Institute of Community and Public Health, Birzeit University, P.O Box 14, Birzeit, Palestine, Tel.: +972-2-2982020/19; Fax: +972-2-2982079. E-mail: ymeulen@gmail.com

Accepted for publication 14 August 2013