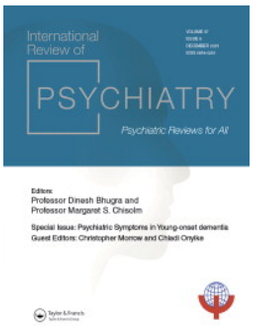

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RESEARCH ARTICLE

Gaza: rethinking and decolonizing mental health responses in humanitarian emergencies

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ABSTRACT

Longstanding armed conflicts generate distinctive psychological wounds, transforming collective bonds and reconfiguring individuals' perceptions of identity, security, and trust, enduring. The occupied Palestinian territories exemplify this violence, as prolonged occupation has produced deep, systematic, and foreseeable psychological consequences. Standard humanitarian mental health models—largely rooted in Western diagnostic paradigms—often risk individualizing and depoliticizing suffering structurally and collectively produced. Drawing on liberation psychology, decolonial mental health, and human rights approaches, this article reframes Palestinian distress as a rational response to systemic violence, displacement, and precarity. It synthesizes existing research on the psychological consequences of recurrent large-scale violence while emphasizing culturally rooted protective factors such as family cohesion, community solidarity, and *sumud*. The paper critically examines humanitarian MHPSS systems which, despite their importance, may inadvertently reproduce epistemic and operational hierarchies and marginalize local knowledge. A central contribution is the articulation of practical strategies for decolonizing MHPSS, grounded in field-based collaboration. These include locally led program design, reciprocal training and supervision models, culturally anchored approaches, ethical positionality, and sustained support for Palestinian practitioners navigating dual roles as caregivers and affected civilians. It concludes with directions for sustainable, justice-oriented mental health systems, arguing that meaningful healing requires structural change rooted in solidarity—not solely clinical intervention.

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Introduction

Protracted armed conflicts, extending over decades and generations, leave unique psychological scars, often altering the social fabrics of a people and reshaping one's very sense of self, safety and trust into the world. The occupied Palestinian territories come as the epitome of deep-rooted armed conflicts, causing profound consequences on the mental health and psychosocial well-being of its civilian population. Decades of scholarship have shown how Palestinian mental health is shaped by protracted displacement, military occupation, and recurrent large-scale violence (Giacaman et al., 2009; Marie et al., 2016; Thabet & Vostanis, 2011). Since late 2023, the scale of destruction in Gaza—including the collapse of health services, unprecedented civilian casualties, and the mass displacement of families—has brought renewed international attention to the psychological consequences of such conditions (GCMHP, 2024; Human Rights Watch, 2025). As humanitarian actors increasingly describe the crisis as a mental health emergency, critics have argued that the translation of wartime suffering into bounded psychiatric diagnosis can obscure causes of distress that are structurally and politically produced, and thus limit both ethical and effective responses (Kirmayer, 2012; Summerfield, 1999).

This article draws on a synthesis of peer-reviewed literature, practitioners' reflections, and insights from collaborative discussions with Palestinian colleagues.

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Combining field-based narratives with empirical research aligns with contemporary calls in global mental health to broaden what counts as evidence, particularly in politically charged or structurally constrained settings (Helbich & Jabr, 2022; Patel et al., 2018). This methodological stance reflects not only a practical reality of working in restricted environments but also an epistemological commitment to centring lived experience and community knowledge, respecting local forms of meaning-making, and acknowledging the limitations of external humanitarian perspectives.

Humanitarian mental health interventions remain largely grounded in Western diagnostic frameworks, emphasizing individual pathology, symptom reduction, and short-term psychosocial support (Mills, 2014; Watters, 2010). While these approaches can be valuable, they often risk depoliticizing and pathologizing survival by individualizing distress rather than recognizing it as a predictable consequence of chronic exposure to coercive contexts - occupation, dispossession, and collective loss - that define everyday life (Kohrt & Mendenhall, 2016; Summerfield, 2004). Liberation psychology and decolonial mental health frameworks argue that psychological wellbeing cannot be disentangled from the realities and structural conditions that produce harm (Helbich & Jabr, 2022; Martín-Baró, 1996). In the Palestinian context, this means acknowledging how instability, movement restrictions, fragmentation, loss, lack of protection and safety, and systemic precarity shape emotional and social worlds. The rapidly shifting structural and social landscape in Palestine further constrains data collection, reducing the capacity of research to fully capture the breadth and complexity of these intersecting determinants.

This article proceeds from the premise that Palestinian distress must be understood not solely as individual trauma but as collective, intergenerational social suffering (Das et al., 2000; Giacaman, 2018). Existing studies from Gaza, the West Bank, and East Jerusalem document elevated levels of anxiety, depression, and post-traumatic symptoms among children, adolescents, and adults (Mahamid et al., 2021; Thabet et al., 2008). At the same time, communities demonstrate forms of coping, solidarity, and *sumud*—steadfastness—that function as protective and meaning-making practices (Giacaman, 2020; Wispelwey & Jamei, 2020). These dimensions rarely figure in conventional clinical assessments, yet they are central to understanding how people navigate and resist ongoing instability.

Accordingly, this article has three aims: (1) to synthesize evidence on the psychological consequences of prolonged occupation and structural precarity; (2) to critically examine how humanitarian mental health models may inadvertently reproduce depoliticizing or individualizing narratives and (3) to propose a practical liberation-oriented, decolonial approach grounded in local leadership, community agency and culturally anchored forms of care.

In doing so, this paper contributes to broader debates in global mental health, trauma studies, and ethical humanitarian practice by reframing Palestinian psychological distress through structural, collective, and rights-based lenses.

Psychological impact of occupation

The prolonged military occupation of Gaza, the West Bank, and East Jerusalem produces widespread and predictable psychological distress across Palestinian communities. In Gaza, prior to 2023, over two million residents lived under protracted blockade conditions, nearly half under 18 years of age, and a majority originating from refugee populations displaced in previous decades (Filiu, 2014; Khalidi, 2020; Roy, 2016). Recurrent armed assaults between 2008 and 2023 have exposed children and adults to direct violence, loss of property, and disruptions to education, healthcare, and social life (Amnesty International, 2011; CARE, 2025; United Nations, 2021). Gazan children born in 2007 are now *'six-wars old.'* Even before the most recent escalation, studies documented high levels of post-traumatic stress, anxiety, depression and behavioral difficulties among children, adolescents, and adults, indicating the cumulative and intergenerational effects of chronic exposure to conflict (Coldiron et al., 2013; Diab et al., 2023; Thabet et al., 2014, 2015).

Distress in this context is a predictable outcome of chronic political violence, siege, displacement, and deprivation, reflecting structural determinants rather than sole individual pathology. At the individual level, children and adults experience traumatic stress, chronic uncertainty, grief, somatic symptoms, panic and pervasive anxiety (Altawil et al., 2008; Diab et al., 2023; Heszlein-Lossius, 2019; Khamis, 2008). When children witness airstrikes or home demolitions, parents' protective capacity is compromised, further amplifying the psychological impact (Qouta & El-Sarraj, 2004). Parental approaches to discussing past trauma, however, can mitigate this effect: children whose parents communicate openly about prior violence show lower rates of PTSD and distress, without increased psychological harm (Dalgaard et al., 2019). Furthermore, structural violence and economic oppression have been found to produce several

deleterious effects on individuals, including human insecurity, poor psychological wellbeing and quality of life, existential suffering, humiliation, injuries to dignity, and feelings of life being experienced as 'on hold'(Hammad & Tribe, 2020).

In 2023, before the onset of hostilities, 30 psychologists, social workers, psychiatrists and psychiatric nurses in Gaza were interviewed regarding common mental health diagnoses and issues (Diab et al. 2023). The most prominent topic discussed was the impact of the blockade on quality of life, mental health, and social problems. Diab et al. recorded several idioms used to describe psychological harm, such as suffocation (makhnogeen), imprisonment (masjoneen), isolation (maa'zoleen), hopelessness (fesh amal), feelings of being lost (tayheen), pressure (madghoteen), fear (khayfeen) and worry (galganeen). Common reasons for those feelings included disruption of education, displacement, feeling suffocated and neglected due to the blockade, economic anxiety, dependence on foreign aid due to recurring assaults and attacks on infrastructure, and military occupation. Diab et al. additionally reported rising suicidality, addiction and aggression among children, highlighting the intensity of cumulative exposure to violence.

At the collective level, ongoing occupation and repeated military operations have fragmented social fabrics, disrupted safety nets and produced intergenerational grief. Psychological suffering manifests as chronic collective exhaustion, anticipatory and ongoing mourning, political weariness, and erosion of identity (Das et al., 2000; Giacaman, 2020). Somasundaram parallelly describes the profound transgenerational impact of collective trauma on a group's identity, social cohesion and further ability to trust, and how these consequences should inform the use of community level interventions (Somasundaram, 2014). The Gaza Community Mental Health Program (GCMHP) reported widespread despair, psychological numbness, loss of appetite, anger, night terrors, and intense fear among adults, while children increasingly exhibit bedwetting, phobias, sleepwalking, nightmares, and heightened attachment to caregivers (GCMHP, 2024). Many children are forced to assume adult responsibilities, such as procuring food, standing in aid queues, or securing water, and at least 19,000 children were orphaned or left without a caregiver as of 2024 (GCMHP, 2024; Human Rights Watch, 2024).

At the developmental level, chronic exposure to violence, deprivation, and instability disrupts children's education, socialization, and developmental trajectories (Assaf, 2005; Mahamid et al., 2021). In Gaza, Save the Children (2022) reported that 80% of children experience high levels of emotional distress, with 84% feeling fearful, 78% grieving, and 79% exhibiting bedwetting. Similarly, War Child (2024) found that 96% of children felt death was imminent, 87% displayed severe fear, 79% suffered nightmares, and 49% expressed a wish to die, alongside pervasive withdrawal, hopelessness and aggression. These data underscore the developmental burden of living under siege, where daily survival eclipses normal childhood experiences.

In the West Bank and Jerusalem, children face similar, additional stressors, including property destruction, detention of family members, and direct threats from military operations. PTSD is most frequently observed among children aged 15 and younger and is significantly associated with witnessing murder, property loss or violent arrests (Espié et al., 2009). The imprisonment of fathers is particularly deleterious, as children who witness these detainment processes exhibit higher levels of PTSD and psychological distress (Shehadeh et al., 2015). Psychological consequences among Palestinian children are widely documented, as they constitute nearly half of the Palestinian population.

Despite these challenges, resilience and culturally rooted protective factors persist. Family cohesion, community support, faith, political socialization, and engagement in collective practices, alongside the culturally specific concept of *sumud* (steadfastness), contribute to psychological coping and a sense of agency (Giacaman, 2020; Jabali et al., 2024; Wispelwey & Jamei, 2020). For Palestinians, '*Sumud* is a central component of resilience and provides a meta-cognitive framework which Palestinians use to interpret, cope and respond to ongoing injustice and traumatic experiences, engendering a sense of purpose and meaning. It is 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 a determination to remain on the land' (Hammad & Tribe, 2021). Moreover, parental guidance, intergenerational storytelling, and communal mobilization reinforce identity, solidarity, and purpose, highlighting the interplay between coping strategies and psychological adaptation.

Taken together, these findings illustrate that Palestinian distress is not merely a reaction to discrete traumatic events, but a structured, cumulative response to chronic exposure to political violence, deprivation, and occupation. Understanding mental health in this context requires attention to individual, collective, and developmental dimensions, as well as culturally meaningful and contextually informed approaches, such as

sumud, that support coping, well-being, and community cohesion.

Liberation psychology, decolonial mental health & human rights frameworks

Palestinian mental health has historically been approached through a predominantly biomedical lens, often imposed by international organizations, which neglects the socio-political determinants underpinning collective suffering (Helbich & Jabr, 2022). While Palestinians may experience mental health difficulties directly related to occupation, their normative reactions to systemic injustice and chronic oppression are frequently pathologized (Helbich & Jabr, 2022; Rabaia et al., 2019). Trauma-focused frameworks dominate humanitarian and research discourse, recognizing certain types of distress like fear and shock, yet often overlooking social suffering, political anger and daily contextual stressors like checkpoints, limiting understanding of distress as a rational response to structural oppression (Meari, 2015; Summerfield, 1999; Veronese & Kagee, 2025). Studies often rely on quantitative approaches to measure trauma, with dichotomous scales merely translated to Arabic without cultural adaptation, while overlooking lived experience and socio-political nuances that cannot be captured through scales (Helbich & Jabr, 2022; Makkawi, 2009; Rabaia et al., 2019; Summerfield, 1999).

Situating Palestinian mental health within liberation psychology, decolonial thought, transformative justice, community psychology and human rights frameworks enables a more comprehensive understanding of distress, resilience, and agency under occupation and settler colonialism. These frameworks highlight how communities engage in resistance, resilience and struggles for justice and dignity, reframing psychological well-being as inseparable from collective freedom and self-determination. They also provide conceptual tools to critique the ways in which Western NGOs and international aid often impose trauma models that individualize, psychologize and depoliticize suffering, while undermining grassroots organizations, inadvertently reproducing colonial power hierarchies (Helbich & Jabr, 2022; Makkawi, 2017).

Liberation psychology, as developed by Ignacio Martín-Baró and building on Paulo Freire, frames distress as a rational response to oppression rather than as pathology (Martín-Baró, 1994; Freire, 1970). It emphasizes *conscientization*, or critical awareness, whereby individuals and communities examine the socio-political conditions producing harm and develop collective agency (Fox, 2008; Helbich & Jabr, 2022). In Palestine, this perspective emphasizes the political nature of psychological suffering, encouraging interventions that recognize both communal experiences and the collective strategies people employ to survive and resist structural violence. Martín-Baró's work underscores the ethical responsibility of mental health professionals to participate in transformative practices rather than solely administering symptom-focused care. Applied to Palestine, liberation psychology emphasizes practices of bearing witness, preserving memory through reclaiming narrative, and resisting erasure. Distress in this context is a *testimony* to conditions of domination, not a sign of individual pathology.

Decolonial mental health frameworks critique the epistemic violence inherent in Western diagnostic paradigms, which often frame survival under occupation as pathological (Helbich & Jabr, 2022; Makkawi, 2009). Trauma and PTSD are not neutral medical discoveries but socially and politically produced constructs at the intersection of psychiatric (scientifically rooted) and human rights (morally rooted) discourse (Makkawi, 2017; Summerfield, 1999). Western interventions frequently marginalize indigenous idioms of distress, reducing politically grounded anger, humiliation, and systemic oppression to individual symptoms (Meari, 2015). Decolonial approaches advocate for re-centering local knowledge, emphasizing structural determinants, and integrating collective narratives into mental health care.

Frantz Fanon complements these perspectives by illustrating how racialized subjugation and colonial domination shape psychological experience, particularly through the 'epidermalization of inferiority' (Jabr & Berger, 2021). Fanon emphasizes that psychiatric concepts must be interpreted through lived, sociopolitical realities, offering a critical lens for understanding mental health under occupation (Fanon, 1952). Similarly, Nyowe's synoptic theory emphasizes the interplay between cultural identity and mental health, arguing that mental well-being cannot be adequately understood without considering the lived experiences of individuals within their specific socio-cultural contexts (Nyowe, 2022). In Palestine, practices such as sumud—steadfastness—reflect anticolonial subjectivity, resilience, and agency, linking mental well-being to collective struggle for liberation and moral purpose (Jabr, 2018; Meari, 2015). It offers Palestinians a meta-cognitive framework for interpreting and responding to injustice and trauma and cultivates a sense of agency through actions aimed at safeguarding well-being, dignity and identity. Sumud embodies everyday resistance and the ethical commitment to maintain life and dignity under prolonged oppression.

Human rights frameworks further contextualize psychological suffering as inseparable from structural violence. Exposure to imprisonment and risk of arbitrary detention, home demolitions, restrictions on movement, and economic deprivation are not only political injustices but direct determinants of mental health (Veronese & Kagee, 2025). Transformative justice praxis, as outlined by Atallah and Masud (2021), situates healing within accountability, community cohesion, and the restoration of dignity, highlighting the interdependence of individual, familial, and societal well-being.

Palestinian community psychology, as developed by Makkawi (2009, 2015) and later discussed by Antunes Da Costa and Mendes (2025), operationalizes these concepts at the grassroots level, emphasizing culturally grounded interventions, indigenous knowledge systems, and participatory approaches. This paradigm rejects institutionalized, Western-imposed frameworks in favor of collective healing strategies, embedding psychological support within social transformation and anti-colonial struggle. The work of Samah Jabr (2019) further advocates for integrating collective trauma, social justice, and community-led narratives to understand distress holistically.

By integrating liberation psychology, decolonial mental health, and human rights perspectives, these models reframe Palestinian distress as a rational, contextually grounded response to occupation, highlighting the inseparability of psychological well-being from justice, dignity and collective agency. These frameworks collectively challenge dominant Western paradigms, offering conceptual tools to align mental health interventions with the lived realities of Palestinians and the broader struggle for self-determination.

Humanitarian aid & power dynamics

The many layers and complexities involved in humanitarian work may not always be visible to the distant observer. From rigorous needs assessments and in-depth contextual research to negotiating access, establishing trust, and building community acceptance, organisations navigate a delicate balance between managing risks and addressing the most urgent needs. Yet, humanitarian practice is deeply entangled in political constraints and fraught with ethical dilemmas. The question of neutrality remains one of the most significant challenges—the principle that aid should be provided without any political alignment (Healy, 2021). The delivery of emergency MHPSS in protracted conflicts is often framed as neutral, technical and universally applicable; yet consistently collides with political realities and highlights the moral responsibilities that cannot be ignored amid atrocities. In Palestine, these interventions operate within a landscape marked by structural violence, and repeated mass displacement. As a result, even well-intentioned psychosocial programs can inadvertently reproduce unequal power dynamics, marginalize local expertise, and depoliticize the very suffering they aim to address. Understanding how humanitarian mental health systems function—and where they fall short—is essential for developing ethical, context-sensitive support grounded in local agency and rights.

As service providers to inherently vulnerable populations, humanitarian organizations must remain accountable for power dynamics and epistemic hierarchies, even more so when it comes to supporting the mental health of people who have been living under occupation for decades. Humanitarian systems tend to position international organizations as primary actors and Palestinians as beneficiaries rather than partners. This asymmetry shapes which needs are prioritized, how services are organized, and which forms of knowledge count as legitimate. Evidence from Lebanon—mirroring Palestinian realities—demonstrates that international NGOs and UN agencies often hold disproportionate decision-making power due to their funding access, perceived expertise, and institutional credibility (Lokot et al., 2024). Local organizations are frequently included only at the consultation or implementation stage, with limited influence over agenda-setting. Language barriers and reporting systems designed around donor requirements rather than local priorities also reinforce these power imbalances. Moreover, organizations often secure funding more easily when aligning with Western biomedical models, incentivizing interventions that privilege external paradigms over Palestinian knowledge and lived experience (Helbich & Jabr, 2022). Western psychological models, assessment tools and therapeutic standards often override local conceptualizations of distress, coping, and care. Such aid models can inadvertently reinforce dependency by centering international actors as indispensable providers and obscure the expertise and leadership that already exist within Palestinian institutions, families and community networks.

As previously mentioned, a recurring critique within global mental health is the tendency to treat trauma as a discrete psychological event detached from its political determinants. This raises fundamental questions about who has the authority to define trauma and whose narratives are legitimized or

sidelined. In Palestine, without acknowledging the realities of occupation, blockade and systematic violence, humanitarian care risks becoming merely palliative in the face of structural harm. The efforts to address the MHPSS needs of Palestinians cannot exist in a vacuum and must be situated within the reality of the health sector on the ground, which is severely limited by security threats resulting from occupation and militarized presence. Adopting a stance of 'clinical neutrality' ignores the decisive impact this presence has in shaping the healthcare needs and service delivery in the region. The Palestinian health sector is profoundly shaped by structural constraints: destruction of hospitals, restrictions on movement of patients and providers, and Israeli control over essential resources including fuel, water, and medicines (Batniji et al., 2009). Research also shows strong links between exposure to military and settler violence and increased depression-like symptoms among Palestinian youth—even when the exposure is indirect (Giacaman et al., 2007).

It is thus unavoidable to account for the social, communal, and political dimensions of suffering. Recent evidence reinforces this point. A narrative review examining the psychosocial impact of the recent escalation in Gaza found that grassroots community-based networks and initiatives—family carers, peer groups, local initiatives—played an indispensable role in providing meaningful support, fostering social cohesion, and mitigating stigma (Aqtam, 2025). These approaches were most effective when grounded in local narratives, traditional healing practices, and relational forms of care. In contrast, interventions implemented by international agencies often showed limited efficacy, constrained by insecurity, staff turnover, and their reliance on externally designed protocols (Aqtam, 2025).

To ignore these determinants of mental health is to misunderstand the nature of distress in Palestine. Occupation is not merely a context—it is a cause. Claims of neutrality, while also indispensable and central to humanitarian ethos, risk obscuring the structural conditions that produce psychological harm, ultimately limiting the effectiveness and ethical integrity of MHPSS programs. These structural limitations do not imply that humanitarian mental health work is futile; rather, they underscore the need for models that move beyond service delivery toward equitable, locally led, and politically conscious forms of partnership. Neutrality in operations need not mean neutrality in understanding; organisations can remain impartial while providing contextually aware MHPSS.

Practical decolonization in MHPSS

Decolonizing MHPSS in the occupied Palestinian territories requires moving from critique to practice—transforming how humanitarian workers collaborate, listen, and share space with local practitioners. Under occupation, repeated displacement, and military violence, mental health interventions cannot be neutral, apolitical, or detached from structural determinants. Decolonization becomes a practical ethics: a commitment to redistribute epistemic and operational power toward Palestinian agencies and the communities they serve.

Local ownership and leadership as the ethical baseline

Effective decolonization begins with local leadership—not symbolically, but structurally. Palestinian mental health professionals and community healing collectives have long produced situated theories and models of care. Contributions by *Samah Jabr, Eyad Sarraj, Nadera Shalhoub-Kevorkian, Rita Giacaman, Mohamed Makkawi and more,* provide an already established framework for understanding suffering not as an individual deficit but as the psychological imprint of collective struggle (Jabr, 2018; Makkawi, 2015; Punamäki et al., 2011; Shalhoub-Kevorkian, 2013). Self-determination in mental health is essential, not only to strengthen local ownership, but also to prevent the inadvertent reproduction of an 'occupation of the mind'—the imposition of external frameworks that dictate how suffering should be defined and treated.

For humanitarian organisations, this means in practice, co-designing and co-conceptualizing programs, co-authoring assessments, and co-leading training with local professionals—not as 'beneficiaries' but as equal producers of knowledge. It also means shifting from a logic of *capacity building* (which assumes asymmetry) to *capacity exchange*, recognizing the depth of Palestinian clinical expertise and decades of community-led MHPSS innovation. Local teams should determine funding allocations, supervision structures, and training content, thereby reshaping the decision-making landscape to reflect contextual knowledge. International actors should act as collaborators, providing resources or technical support only when requested, and consistently consider local knowledge, language and cultural norms.

During the past year of hostilities in the Gaza Strip, the authors of this article worked in close collaboration in co-designing interventions, training materials and supervision models that ensured the programs

established were aligned with expressed needs, safeguarded local ownership and worked towards sustainability through contextually grounded services. This reciprocal approach allowed an effective, culturally coherent and locally validated implementation.

Participatory, culturally grounded and context-embedded practices

Interventions must be culturally responsive and participatory, integrating cultural healing, community practices, and relational modes of care. Humanitarian encounters must be co-constructed, technical support culturally adapted and linguistically accessible, and respectful of the population's subjective and collective worlds (McMahon et al., 2020). It requires acknowledging power relations in humanitarian settings, including the implicit authority conferred on international practitioners. Training programs should be co-developed with Palestinian clinicians, contextualized to local values, and delivered in local language, strengthening epistemic justice and supporting knowledge exchange. Likewise, all research involving Palestinian communities should similarly adopt collaborative, bottom-up methodologies, consulting participants at every stage—from design to interpretation—and prioritizing their perspectives over external assumptions.

Kleinman's notion of *category fallacy* illustrates the risk of applying Western diagnostic categories without interrogating local meanings. In Palestine, this can pathologize normative reactions to oppression—anger, humiliation, moral injury, and collective grief, as well as collective coping (e.g. *sumud*), and spiritual/political meaning making—by forcing them into individual, symptom-based frameworks (Kleinman, 1977).

Recent work on cultural humility, geopsychiatry, and alternative definitions of trauma further emphasizes that trauma cannot be conceptualized only as a past event. It is an ongoing, cumulative condition shaped by structural violence, collective grief and historical and cultural history (El-Khoury et al., 2024; Hamadeh et al., 2025). Following these conceptual frameworks, the authors of this article have worked closely and collaboratively on building training materials that were culturally grounded and specific to the unique realities of psychological trauma in Gaza.

Supporting Palestinian practitioners who are both therapists and citizens

Palestinian clinicians face dual roles as caregivers and as citizens operating under the same violence, precarity, and grief as their patients. Their psychological well-being is deeply entangled with the communities they serve. Practical decolonization therefore, requires attention to the moral, emotional, and collective burdens carried by local providers. Supporting these practitioners requires ethically informed and reflexive supervision designed specifically for contexts of collective trauma, peer support spaces that acknowledge political realities, and trauma-informed practices that recognize both vicarious and direct exposure to violence. Support structures must include policies that protect rest, boundaries, and time away from case loads, as well as acknowledgment of shared suffering—not a demand for neutrality or emotional detachment. Trainings should provide strategies for resilience, stress management, and professional solidarity. In the field, authors have embedded reflexive, context-informed supervision sessions for Palestinians mental health practitioners, reflecting both vicarious trauma and ethical decision-making. Concrete measures like funded supervision time, transport allowances, rest rotations, and advocacy support for local providers are ways to show what ethical responsibility looks like in practice.

Ethical humanitarianism: reflexivity, positionality and accountability

Every clinical encounter in Palestine is shaped by what Derivois calls the *geohistory of the encounter*: colonial histories, power disparities, and competing meanings of suffering (Derivois, 2017). Ethical practice requires clinicians—especially foreigners—to continuously examine their positionality, institutional role, and the political implications of their work. International mobile MHPSS staff must situate themselves as collaborators rather than sole experts to avoid overriding local knowledge. Humanitarians must reflect on the ethos of their interventions and on the centrality of their positioning as service implementers.

This includes questioning whose narratives are legitimized in clinical settings, recognizing the epistemic privilege of Western models and intentionally disrupting it, recalibrating who is heard and listened to, so Palestinian voices are not overshadowed, and ensuring accountability mechanisms that responds to community needs and expectations, not merely donor agendas. Ethical humanitarianism also requests acknowledging when care risks becoming 'palliative' for structural violence. MHPSS cannot heal what is structurally inflicted. Reflexivity,

therefore, includes recognizing limits and avoiding the tendency to normalize ongoing injustice through psychological language. While adhering to principles of neutrality in their operations, international organisations can—and arguably must—offer mental health services informed by a politically conscious understanding of the conditions that produce psychological harm.

International actors must maintain reflexivity around positional safety. The asymmetry between international mobility and Palestinian immobility shapes every working relationship. This calls for humility, equal decision-making, and an ethic of co-resistance - partnership directed toward shared goals of justice and safety. One of the aims of these MHPSS programs is to deconstruct previous humanitarian models rooted in a savior mentality and to foster an ethical model rooted in solidarity and collaboration. As such, knowledge exchange should be bidirectional, with international actors also learning from local strategies and healing practices, promoting mutual care and an ethical commitment to reciprocity.

This involves humility in acknowledging what one does not understand, collaborative interpretation of symptoms, stories, and needs, and challenging the institutional expectation to be the expert. Valuing Palestinian explanatory models and idioms of distress and co-creating culturally and contextually adapted programs are key in building these relationships. These practices are not optional—they are foundational for ethical care in politically saturated settings. Throughout their collaboration, authors have consistently worked collaboratively in discussing the ways mental health issues take form, in trying to understand local meaning-making and healing practices. Program implementation was consistently done collaboratively and there was a conscious reflexivity on the part of the international mobile staff for relational awareness.

A transformative justice and ethical reorientation of humanitarian mental health work require moving beyond sole service delivery models toward approaches grounded in dignity, accountability, and local leadership. Transformative justice frameworks—though challenging to implement within traditional humanitarian structures—offer direction: shifting from service delivery to genuine collaborative partnership, from capacity building to capacity exchange, and from temporary psychosocial interventions to long-term, rights-based systems of care embedded in local institutions.

Practical tools & strategies for decolonizing MHPSS

To synthesize the principles discussed above, several strategies could be implemented:

1. **Co-Design Everything**: From assessments to training manuals, initiatives should be developed mutually with Palestinian professionals. Collaboration ensures interventions reflect lived realities rather than imposed assumptions, prejudices and understanding.
2. **Power-sharing**: Local teams should at least co-manage evaluations, program decisions, funding priorities, and training structures, if not lead them. Shared decision-making can also take the form of clearly defined Memorandum of Understanding (MoU) between INGOs and Ministry of Health on decision rights, data ownership and authorship. Indicative targets like ensuring that a specific proportion of the budget is locally managed or insisting on multi-year commitments can be other ways of fostering 'local leadership' at the operational level.
3. **Adapt Training**: Training must be contextualized, culturally grounded, and co-authored by Palestinian clinicians, integrating Western frameworks selectively and appropriately.
4. **Build Long-Term Partnerships**: Avoid short-term models, focus on programs that are sustainable, institutionally grounded, and that ensure local ownership, while strengthening Palestinian infrastructure over time. Evaluation indicators should also consider shifting from narrow clinical outcomes to include community sense of agency, social cohesion, staff well-being, trust and the strength of referral pathways.
5. **Ethical Supervision**: Provide trauma, context-informed and politically aware supervision for practitioners experiencing oppression, vicarious and direct trauma.
6. **International Humility**: Replace dominance with learning-oriented positioning, acknowledging that local knowledge is primary.
7. **Field-Informed Practice**: Before implementing any programs or developing any training materials, authors insist on meeting and discussing with local partners, mental health practitioners and patients, to better understand the needs but also the perspectives, the lived experienced and ensure content that is not only relevant but contextually and culturally rooted.

> Pre-designed, evidence-based psychological programs may be useful, yet ethically demand co-adaptation and co-implementation to foster meaning, sustainability and accountability for local partners and communities. Lastly, ethical strategic planning must acknowledge predictable barriers, donor conditionalities, bureaucratic limitations, and security constraints—it must abide by strong ethical guidelines and find practical ways to navigate the tension between contextual needs and organisational priorities.

Although these methodological insights are shaped by experiences in the Palestinian context, they hopefully also serve as a starting point for broader reflection, application and practical guidelines across global mental health settings.

Conclusion & future directions

This article argued that mental health care under a relentless occupation cannot be separated from justice, dignity and collective liberation. Distress in this context cannot be addressed as an individualized pathology but a rational, patterned response to structural violence, displacement and chronic precarity. Western diagnostic frameworks—when applied uncritically—risk pathologizing survival where the political determinants of suffering predominate. Decolonial, liberation-oriented, and human rights frameworks instead emphasize that individual psychological well-being is inseparable from safety, rights, and collective self-determination. While liberation psychology provides an essential starting point, it cannot be applied uncritically; it must be expanded and adapted to contemporary realities.

Experiences from other conflict-affected regions reinforce these insights. In Bosnia, effective post-war recovery arose when mental health rebuilding was implanted within broader social reconstruction efforts. Rwanda's community-based trauma initiatives demonstrated the importance of collective, relational healing embedded in local meaning-making, while humanitarian responses in Sudan and the DRC illustrated how externally driven systems can create dependency and marginalise local expertise. Across Indigenous settings globally, healing is deeply tied to identity, land, collective memory, and resistance, elements mirrored strongly in Palestinian concepts such as *sumud*.

These lessons underline the need for future models of MHPSS in Palestine that are locally led, sustainable, and justice-focused. This includes co-governance with Palestinian institutions, long-term system strengthening rather than short-term psychosocial projects, and evaluation methods grounded in dignity, agency, and social connection. Mental health recovery is impossible without addressing structural determinants: freedom of movement, safety, protection of civilians and health infrastructure, and an end to displacement, scarcity and collective struggle. Mental health upholds dignity and means to act like a guardian of human rights, as a foundation to psychological care.

As such, this paper suggests that policies must focus on key aspects: 1) international organisations committing to genuine power-sharing with Palestinian stakeholders; 2) funding supporting public mental health systems, workforce training, and community-based care, for long-term sustainability, and local ownership; 3) Palestinian mental health practitioners—who are both caregivers and affected civilians receive sustained support; and 4) MHPSS should be intentionally and consciously thought as part of broader systems of justice, advocacy, reconstruction, and liberation frameworks, and not isolated clinical services and interventions.

Ultimately, healing requires structural change rooted in solidarity, not only intervention. This work must be approached with humility, recognizing both our positionalities within unequal global power structures and our moral, shared responsibility to avoid reproducing them. There is a need to explicitly recognize that psychosocial recovery is inseparable from justice, and the safeguarding of civilian environments. Decolonizing mental health is not solely about practice; it is about who defines trauma, who produces knowledge, and whose visions for the future shape the path to collective recovery.

> *'So Dear World, we as Gazan people invite all scientists and researchers from every field to come to Gaza, the ideal place to learn everything new, to write new books, and to throw away what you currently have into the abyss. With open hearts, you are most welcome to change everything you think you know.'*
> *- Salsabeel Al-Khatib, Gazan mental health professional*

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