

No end in sight: moving towards a social justice framework for mental health in continuous conflict settings

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The occupied Palestinian territory (oPt) exemplifies a situation of continuous, protracted violence and conflict. This paper explores the application of the concept of posttraumatic stress disorder to this situation of ongoing violence. It argues that using an individualised perspective ‘through a trauma lens,’ may not be the most appropriate approach to Palestinian distress, but that a model based on the concept of ‘social suffering’ may be a more holistic fit, exploring how individual and collective human suffering is associated with life conditions shaped by powerful social forces. Furthermore, the author asserts that an human rights informed, social justice framework is both a comprehensive and appropriate framework to address the mental health needs of populations affected by continuous conflict. She further contends that social justice is a core principle of public health, and that to truly incorporate social justice into their work, mental health practitioners must expand their traditional roles to include elements of activism and advocacy.

Keywords: human rights, occupied Palestinian territory (oPt), posttraumatic stress disorder (PTSD), social justice, trauma model

Introduction

The majority of the world’s violent conflicts tend to be located in the global south, with the global north playing contradictory roles of either arms dealer/aid provider and/or combatant/removed observer

(UNICEF, 1996). Traditional war contexts have shifted in the past half-century, from being international wars to internecine (civil) wars, where civilian populations bear the brunt of warring factions’ violent ambitions. Even international wars have now dissolved into intrastate violence, evident in the US invasions of Afghanistan and Iraq in 2001 and 2003, respectively. These wars and struggles can involve prolonged conflict situations that impact everyday lives, and physical and mental health, of entire societies.

This paper examines frameworks to address mental health in continuous conflict settings. It focuses on the experiences of Palestinians, living in the occupied Palestinian territory (oPt), under continuous, violent occupation for over 40 years. The paper critiques the use of the posttraumatic stress disorder (PTSD) model, within such a setting of prolonged conflict, and offers the ‘social suffering’ model as a more appropriate approach to describing and understanding causes of mental distress. The author argues for the adoption of a mental health framework rooted in a human rights and justice based approach. Such a framework draws attention to the wider determinants of mental health, including the political. The inclusion of the political dimension leads to a reconsideration of the role of mental health practitioners in situations of continuous conflict, and infuses advocacy into their work.

Mental health and human rights: the Palestinian experience

The ongoing Israeli occupation of the West Bank and the Gaza Strip epitomises a state of continuous social stress, within a prolonged conflict setting. It also highlights the need for the mental health field to move beyond a trauma paradigm and implement mental health models rooted within a human rights framework (Giacaman et al., 2010a; 2010b; Rabaia et al., 2010a; 2010b; Ziadni et al., 2011). While much action has been taken in response to conflicts and emergencies, the *'Palestinian case begs a re-conceptualization of complex emergencies in more than one respect'* (Mataria et al., 2009). It exposes the limits of the trauma paradigm that is frequently applied to mental health approaches in oPt, and places human rights violation at the root cause of the distress.

Contextualising Palestinian mental health

The Palestinian reality in the oPt is unique in the world. The establishment of the Israeli state in 1948 created a Palestinian refugee population that has grown, over the years, to 4.6 million refugees. In 1967, Israel occupied the West Bank and the Gaza Strip, effectively fragmenting the land and creating an environment of continuous violence against Palestinians through massive human rights violations. The 1993 Oslo Accords ostensibly purported to grant Palestinians self-rule by implementing a façade Palestinian government, the Palestinian National Authority (PNA). However, the PNA holds no real power against the Israeli occupation (and has, in fact, been charged with further oppression of the Palestinian population by Human Rights Watch (HRW) (Human Rights Watch, 2011). Israel furthered the fragmentation, collective punishment and impoverishment of the oPt in 2006 by

means of a devastating siege on Gaza, which nearly hermetically sealed Gaza's borders, and thereby imprisoning its population (Giacaman et al., 2009).

Throughout the years of Israel's occupation, the Gaza Strip has fared much worse than the West Bank. In 2006, Israel closed Gaza's borders and imposed an economic siege on the Palestinians of Gaza, in a punitive response to the Palestinians' (democratic) election of the Hamas political party to government. The continued economic siege on Gaza culminated in a three week attack, between December 2008 and January 2009, resulting in massive Palestinian civilian death, homelessness, destruction of infrastructure and high levels of insecurity (Abu-Rmeileh et al., 2011). Today, to speak of *'the occupied Palestinian territory'* denotes a sort of false unity, political and/or geographical, between the two pieces of land, as though they share mirrored realities, whereas in truth their daily experiences of life under occupation differ greatly. However, despite these differences, the loss of their homeland Palestine, and living a life defined by and saturated with the Israeli occupation, in its multitudinous manifestations, creates a fundamental commonality for Palestinians of the Gaza Strip and the West Bank. This commonality comprises a shared *"Palestinian experience"*.

The Palestinian experience has remained consistently stressful for the past 45 years, varying in degrees of stress with every political evolution and upheaval the population endures. On the ground, Israel oppressively controls Palestinian life through physical restrictions on movement (closed borders, the Separation Barrier, military checkpoints), disruption of daily life (curfews, raids, illegal detentions, separation of family), economic hardship (land theft, destruction of land, house

demolitions), and the threat and use of violence against civilians (Giacaman et al., 2009). These restrictions are human rights violations, and comprise the main determinants of mental health outcomes in the oPt (Giacaman et al., 2007). Indeed, Israel's imposed blockade on Palestinian movement *'affects all three psychosocial domains of human security by disrupting a sense of home and safety, family relationships and community cohesion, and preventing a positive outlook for the future'* (Batniji et al., 2009). Each infringement of Palestinian rights is far-reaching, and affects numerous aspects of daily life.

The Israeli occupation also has strong negative repercussions on intra-familial relationships and their protective factors. It upsets the role of parents as protectors, leaving children feeling vulnerable and parents feeling impotent (Arafat and Boothby, 2003; Joudeh, 2008). Furthermore, a 2010 study found a *'significant'*, positive correlation between exposure to political violence and intimate-partner violence in the oPt (Clark et al., 2010).

No understanding of mental health in the oPt would be complete without reference to *al Nakbah*, perhaps the greatest of all violations perpetrated on Palestinian society. *Al Nakbah* (literally, *'the disaster'*) is the experience of profound social disruption; dispossession from, and the destruction of, the state of Palestine in 1948, as a result of Israel's creation. The collective memory of *al Nakbah* is a continuous presence in the collective consciousness of all generations of Palestinians, throughout the many upheavals. According to Batniji et al. (2009), *'[t]his history of being repeatedly uprooted creates feelings of insecurity and instability, which are reinforced by the continuing occupation'*. The distress created by *al Nakbah* is the ultimate embodiment of continuous social stress, a collective distress that *transcends temporality*,

spanning generations of Palestinians, with no end in sight.

Mental health interventions in the oPt

Despite the politico-historical, socio-economic causes of continuous distress for Palestinians, many researchers and practitioners maintain a trauma-centred model when approaching mental distress in the oPt. Epidemiological studies on trauma within the Palestinian population abound, perhaps contributing to the continued focus on traumatic stress interventions in the oPt (Abdeen et al., 2008; Canetti et al., 2010; Espie et al., 2009; Thabet and Panos, 2011). Numerous programmes and interventions, varying in methodology, focus on alleviating traumatic stress within Palestinian populations. Qouta et al. (2012), conducted a cluster, randomised control trial among school children in Gaza, in which the intervention group received teaching on recovery techniques (TRT) sessions, which was aimed at reducing posttraumatic stress symptoms (PTSS). (The TRT methodology employs emotional recognition exercises and various imagery techniques to strengthen young people's coping skills in the aftermath of war or disaster.) The intervention revealed *'modest'* effectiveness for the TRT approach, producing mixed results along gender lines, and dependant on baseline data for PTSS. In the West Bank and Gaza Strip, Médecins Sans Frontières (MSF) runs mental health programmes whose prime focus of care is diagnosing and treating traumatic stress in Palestinians. The programme offers psychotherapy sessions to its participants, ranging in age from one year upwards (Espie et al., 2009; Gaboulaud et al., 2010; Médecins Sans Frontières, 2012). Staples Abdel Atti & Gordon (2011) describes a pilot study intervention in Gaza, conducted by researchers

from The Center for Mind–Body Medicine¹, assessing the effectiveness of mind-body techniques in reducing symptoms of PTSD, depression, and hopelessness.

These interventions and programmes are important, as well as crucial for those suffering from traumatic stress. However, they also miss the mark in addressing fundamental causes of traumatic events, and the wider need of the population to alleviate daily stressors. The frequent application of a trauma-centred model within Palestinian mental health practice leads to this paper's critique of the trauma framework, when used in prolonged conflict settings.

Fitting a square peg into a round hole: the ill fit of the PTSD model in settings of continuous conflict

Over recent decades, a trauma-centred approach to mental health (with PTSD in the spotlight), has become a popular approach to addressing the mental health needs of populations experiencing adverse circumstances and violence. At the same time, the concept of PTSD has been criticised for several reasons, including the difficulty of distinguishing it from other disorders, its lack of cohesiveness in clinical characteristics, its lack of biological correlates and its longitudinal diagnostic stability (North et al., 2009; Rosen, 2004). This paper does not address these criticisms, but rather focuses instead on the problems that arise from applying the PTSD concept to populations affected by continuous conflict and social stress. This section will highlight five points that limit the value of the PTSD concept in such settings: its central focus on an acute traumatic event; its individualistic approach; its medicalisation of mental distress; its universal application; and its temporality.

Acute traumatic events vs. the continuity of stress

A PTSD approach to mental health presupposes an individual's (sufficient) exposure to one or more acute traumatic events, which has led to the disorder (North, 2009). However, the nature of prolonged conflicts is one of continuous, cyclical stresses that arise from the ubiquity of the conflict in daily life, and its disruption of routine and stability (Giacaman et al., 2010b; Pérez-Sales and Beristain, 2008). Those living through prolonged conflicts are exposed to a continuous, daily form of stress that has been given neither sufficient weight, nor attention, in the development of mental health models. This is despite the fact that it may be more prevalent in these settings than acute traumatic stress (Miller & Rasmussen, 2010; Timko, Moos & Michelson, 1993).

Furthermore, a clear distinction between stress and trauma remains nebulous (Shalev, 1996; Summerfield, 2005). This lack of precision becomes especially problematic when examined in settings of continuous conflict, in which acute traumatic events and continued social stresses may blur together, be cumulative and/or cyclical. This meshing of experiences '*may [...] lead to difficulties in differentiating between the effects of recent and previous traumatogenic events*' (Gaboulaud et al., 2010), making the precise root of extreme distress difficult to distinguish.

The term '*continuous social stress*' better describes the continuous upheaval and oppression of a society during conflict, analysing the larger dimension of stress, rather than simply acute episodes. This analysis is not to deny the existence, or significance, of isolated stressful and/or traumatic events, but rather to highlight the need to employ an approach that recognises and addresses the issue that stress in

conflict settings is overwhelmingly continuous and social in nature (Giacaman et al., 2010a; Rabaia et al., 2010a). Additionally, the term '*continuous social stress*' draws heavily from, and supports the concept of, '*social suffering*', which interlinks health with social factors and human suffering with ill health (Giacaman et al., 2009; Kleinman, Das and Lock, 1997).

Decontextualising the individual

PTSD treatment focuses on the individual, assessing his/her level of trauma after a specific incident, or the accumulation of discrete incidents. Within the context of continuous conflict, this approach neither appreciates the intricate relationships between individuals and social networks, nor does it recognise the individual as part of a larger social fabric and ecology. A PTSD approach '*focus[es] attention on a 'problem' being with the individual, rather than a reflection of the overall social and political contextual environment*' (Prosser & Bawaneh, 2010). Excising the individual from his/her environment ignores the larger constellation of societal de-fragmentation affecting his/her health, as well as the positive impact social networks can provide (Antonovsky & Sagy, 2001; van der Kolk, McFarlane & van der Hart, 1996). Additionally, this focus on the individual, as separate from his/her surroundings, conflicts with the experiences of collectivist societies, in which events are also experienced in their relation to the larger social network (Prosser & Bawaneh, 2010).

Medicalisation of human rights violations

Within contexts of continuous conflict, the medical nature of trauma models, specifically that of PTSD, pathologises reactions to stress. As shown in recent literature

(listed below), trauma models run the risk of misidentifying the causes of stress reactions, and distracting attention away from human rights violations, injustice and other social issues that lie at the heart of continuous social stress. Such an approach may also lead to the negligence of local healing resources and obscure individuals' true voice, feelings and place in society (Abu-Rmeileh et al., 2011; Giacaman et al., 2010a; Moghimi, 2012; Rabaia et al., 2010a; Summerfield, 2004; 2005; Ziadni et al., 2011). Pathologising an individual's reaction to daily stress, such as uncertainty of the future, or the past, will not allay or stop his/her reactions to the stress that surrounds the individual. Indeed, a review of literature on daily stresses in conflict and post conflict settings found that daily stresses are greater causes of mental distress than acute, stressful events (Miller & Rasmussen, 2010). As such, redressing daily stressors, such as unemployment and barriers to movement, is a more appropriate '*therapy*' for individuals experiencing continuous social stress than biomedical, trauma-centred therapies.

Universalising diverse experiences with stress

These days, the PTSD diagnosis is applied to a host of diverse situations, calling into question its universality as a model. The bulking together of dissimilar events, under the category of '*trauma inducers*', challenges the basis and measurement of trauma (Rabaia et al., 2010b; Wessells & Monteiro, 2008). This issue raises questions such as; can events, such as surviving a car accident, be considered in the same category as surviving the Rwandan genocide? Furthermore, humans are subjective beings, therefore, the application of a standardised model that assumes trauma (a concept which, in and of itself, is foreign to some

cultures) overlooks the subtleties, intricacies and diversity of human response.

Temporality: where is the 'post' in continuous conflict?

Another important tenet of the PTSD model is its focus on a return to normalcy, *post* trauma. Inherent in *post* traumatic stress disorder is that the traumatic incident is separate and distinct, it has a beginning, and an end, that can be delineated. However, in areas of continuous conflict, individuals do not necessarily find respite from traumatic stress or events, as there is no benign environment in which to recuperate. In this sense, there is no *post* in traumatic stress disorders in environments of protracted conflict (Gattermann, 2011).

Implicit in this model, is this need for a benign environment in which to recover from the traumatic event, as well as an assumption of synonymy between a non-threatening environment and *'normalcy.'* However, *'normal'* is a relative term, and not always representative of positive environments. Therefore, how is normalcy to be established? Through consistency in experience? Or through a rights based, moral lens promoting experiences of equality and freedom? Is it ethical for mental health practitioners to work towards returning traumatised individuals to a state of *'normalcy,'* in which said normalcy is defined by daily human rights violations and the continuous threat of violence, without further attempts to address the broader social infringements? Is it ethical to employ a palliative approach to mental distress rooted in human rights violations, without working to rectify the violations themselves? This author believes mental health practitioners have a professional and ethical obligation to actively probe these questions, which will be addressed further, below.

Looking beyond trauma for Palestinian mental health

Beyond its questionable applicability in settings of prolonged conflict, a trauma focused approach in the oPt is no longer in concert with the ongoing, diverse developments in the field of mental health, which has grown well beyond the trauma model. Researchers, in acknowledging the roles of resilience, positive coping strategies and supportive environments in the mental well-being of Palestinians, have implemented interventions and studies focused on these factors (Constandinides et al., 2011; Veronese et al., 2012). Internationally, researchers and practitioners have developed guidelines that serve as international standards for effective and responsible responses to mental health needs in emergency settings, and these guidelines' core principles are firmly entrenched within a human rights framework (Inter-Agency Standing Committee (IASC), 2007; Sphere project, 2011). To identify research and action priorities for the mental health field over the coming decade, the MH-SET project² assembled a team, in 2011, of global researchers and practitioners who worked together to address this need. Their endeavour resulted in the generation of, and consensus on, 10 priority research questions; none of which explicitly prioritise PTSD (Tol et al., 2011). The field of mental health is wide and its approaches, methodologies and priorities are diverse. However, in the case of the oPt, there appears to be a persistent use of the trauma model, which is incongruent with the root causes of distress in the oPt, and the existing diversity of mental health models.

Many researchers have also criticised the use of the trauma model in addressing mental health in the oPt, because of the de-politicisation of Palestinian mental distress (Afna, 2012; Batniji, 2012; Gattermann,

2011; Prosser and Bawaneh, 2010; Rabaia et al., 2010a). Rather than addressing the root causes of the Palestinians' distress, such as the aforementioned human rights violations, trauma-centred interventions medicalise social ills. The persistent use of biomedical language, such as *'disorder'*, abnormalises human reaction to a destructive environment, and is inadequate to describe the situation in Palestine (Mann, 1997; Moghimi, 2012; Rabaia et al., 2010a). The resultant isolation and abnormalisation of Palestinian reactions to continuous social stress distances mental health practitioners from addressing the root causes of said stress. As such, mental health programmes begin to resemble *band-aid* (superficial) solutions (Wessells & Monteiro, 2008). Such an approach also does not account for the triumph of resilience within distressed populations. For some Palestinians, seemingly small achievements, such as continued attendance of school in the face of checkpoints and occupation violence, are acts of resilience and resistance (Rabaia et al., 2010b).

In contrast to a trauma-centred model, the *'social suffering'* model emerges as a holistic and appropriate lens through which to understand Palestinians' mental health needs, within the context of the continuous Israeli occupation. In fact, this model is gaining ground in the oPt. It is used and supported by progressive researchers in the area who believe it to be *'part of an overall approach that places the demand for rights and justice at the centre of public health'* and measures Palestinian quality of life as *'a dynamic concept that integrates the multiple determinants (economic, social, political, and cultural) of health and wellbeing of a society'* (Mataria et al., 2009). Once the indelibility of the Israeli occupation on Palestinian life is acknowledged, the situation forces a

reconceptualisation of the biomedical health paradigm within the context of continuous social stress. In cases of chronic conflict, health must be situated within a politico-historical context that addresses issues of justice and human rights.

Moving forward in partnership: reinstating social justice within mental health models

In settings of continuous conflict, mental distress is inextricably intertwined with social, economic and political environments. While trauma centred paradigms are undeniably important models within the field of mental health, their role should be minimised in contexts of ongoing conflict, as they fail to examine and address the human rights violations that overwhelmingly influence mental health outcomes. Rather, a larger role should be given to models that contextualise mental health within these human rights violations, and work to redress them. Practitioners and researchers, whose ultimate goal is the mental de-stressing of populations in conflict, must employ an approach that is faithful to, and reflective of, the core principles of a social justice based, public health approach. Such an approach holds the tenets of implementation of social justice, prevention and advocacy at its core, as set forth within a human rights framework.

Numerous scholars, seeking ethical principles for public health, have hailed social justice as one of the field's core principles (Baylis Kenny & Sherwin, 2008; Beauchamp, 1976; Krieger and Birn, 1998; Mackie, 2010). Indeed, Krieger & Birn assert, with lucid succinctness, that *'social justice is the foundation of public health'*, while Beauchamp challenges that *'public health should be a way of doing justice'* (Krieger &

Birn, 1998; Beauchamp, 1976). Social justice is a philosophy that holds communal equality, fairness and security at its core (Baylis, 2008; Beauchamp, 1976; Vera & Speight, 2003). An approach that squarely places the quest for social justice at the heart of public health challenges, and requires researchers and practitioners to confront and engage human rights violations that may contribute to populations' ill health. Indeed, the IASC's humanitarian guidelines charge that *'promoting human rights goes hand-in-hand with promoting mental health'* (IASC, 2007). However, the promotion of human rights is not solely a reactive effort, but a proactive one. It is a framework that shapes and influences all actions taken in the pursuit of mental health promotion. As such, it entails two key tenets: protection and prevention, both of which are largely absent from trauma paradigms. Protection of health and populations is the crux of the mission of public health practitioners (Beauchamp, 1976; IASC, 2007; Mann, 1997; Sphere Project, 2011). In its proactive form, protection may mean prevention.

Prevention is a key element to a holistic and just approach to mental health and it pushes the roles of practitioners beyond the scope of their traditional boundaries. Prevention is consistent with the ethics of public health as the field *'generally values most highly (or at least is supposed to) primary prevention, that is, preventing the adverse health event in the first place'* (Mann, 1997). In situations where injustices and infractions prevail, prevention, at its most fundamental level, requires a restructuring of the structurally oppressive forces that create mental distress (Beauchamp, 1976; Gostin & Powers, 2006; Mackie, 2010). Such an endeavour demands an engagement in the political realm, for as Hart & Lo Forte assert in their assessment of the role of the international community

in child protection in the oPt, *'the protection of Palestinian children cannot be achieved without political action'* (Hart & Lo Forte, 2010). Such an engagement in the political realm entails a departure from mental health practitioners' traditional roles, moving them to connect the socio-political realities shaping communities' experiences to their own work. Additionally, by engaging in the political realm and pursuing accountability and rectification of human rights infractions and injustices by oppressive powers, mental health practitioners may be placed in the difficult position of challenging their own institution's unwillingness to confront human rights abuses (Hart & Lo Forte, 2010; Mann, 1997). As Mackie (2010) observed, *'what is so striking about this approach is the view that public health activity should not be focused on the intervention being undertaken, but on being just'*. Such a stance indeed takes courage and some personal professional risk. However, in doing so, practitioners shift towards a position of impartiality, which *'entails the consistent application of legal standards in an organisation's statements about and dealing with all parties in a conflict'* (Hart & Lo Forte, 2010). This position stands up for the rights of, and demands justice for, oppressed, marginalised or otherwise vulnerable populations, and may also help to increase trust between outside aid organisations and the populations they serve.

A social justice based, mental health model requires horizontal partnership³ between practitioners from the global north and global south. While such a model should be a partnership between the two poles, weight and respect should be given to the priorities vocalised by those who have experienced continuous social stress within these contexts, and can therefore add personal insight to the professional knowledge of mental health needs in these settings (Pérez-Sales

and Beristain, 2008; Tol et al., 2011). The previously mentioned MH-SET project is exemplary in its horizontal global partnership. While practitioners often strive to build meaningful global partnerships, it should be noted that too often funding requirements, deadlines and political interests fetter these partnerships [for a striking assessment of the effect of political influence on shaping (limiting) humanitarian programs, see Hart & Lo Forte, 2010].

Based on the '*social suffering*' model, and support from other literature on continuous conflict, the social justice model would emphasise the impact of socio-economic, politico-historical happenings (both past and present) on the population's mental health. By pinpointing social problems as the cause of distress, it would necessitate a mental health response which includes a response to the social problems themselves. As such, the model may include partnerships outside the circle of public health practitioners to include community leaders, physicians, lawyers, traditional healers, politicians, academics, economists and religious leaders, for example. Such inclusion would work towards ensuring an ecological, holistic approach to mental health needs in conflict settings. The model would focus on mental health and distress within the larger collectivist society, and as such, directly related to human rights violations and injustices. This proposed model and partnership may seem extremely ambitious, however, this author believes it is worth working towards.

Though numerous scholars have urged the inclusion of, or return to, a social justice outlook on public health, a scarcity of tools exists for the direct implementation of social justice within the global public health field. Vera and Speight (2003) call for the incorporation of social justice within the field of

psychology, and propose strengthening institutional supports for social justice, its inclusion in psychology curriculum, and the translation of research into public outreach and policy reform. These recommendations are useful and can be implemented in the broader field of mental health. In the case of the oPt, international practitioners may work towards foreign policy change within their home governments, or lobby for a policy of impartiality within their organisation. As an individual, one might write an editorial commentary, as shedding light on injustice is one step closer to defeating it. Those who have great staunchness may participate in the Boycott, Divestment and Sanctions movement⁴. This author has participated in, and supported many of, these recommended actions in her solidarity with the Palestinian people and a quest for justice. In the development of a social justice model for mental health, the creation of a culturally-adaptable set of guidelines, based on best practice, for the implementation of social justice in mental health programs is a worthy endeavour.

While the vocal defence of Palestinian human rights is becoming increasingly integrated into Western mainstream parlance, it remains strongly overpowered by the pro-Israel lobby. However, if one accepts the assertion that mental distress in conflict settings is overwhelmingly caused by violation and injustice, then does it not follow accordingly to address those root causes? Those in the mental health and humanitarian fields can be reminded of the dramatic example put forth by Eglantyne Jebb (founder of Save the Children) during World War I, who directly challenged Britain's participation in the Allied Powers' blockade against defeated European countries. Jebb understood that the blockade was the direct

cause of the starvation and suffering of German and Austrian children and, unable in good conscience to be a silent bystander in the children's suffering, challenged the political status quo. Her actions went beyond alleviation of suffering to address the roots of that suffering (Hart & Lo Forte, 2010). This author adds her voice to the call made by other researchers for mental health models to incorporate prevention, human rights and justice in their approach to mental health in continuous conflict settings (Batniji et al., 2009; Giacaman et al., 2010a; Hart & Lo Forte, 2010; Ziadni et al., 2011). In the case of the oPt, this would mean directly opposing violations of Palestinian rights and working to redress these infractions. Researchers from the oPt reaffirm this need for activism in the field of health, as, 'the *political domain [is] an ultimate determinant of the physical, psychological, social and environmental determinants, all affecting physical and mental health status*' (Giacaman et al., 2007).

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human interactions. The Center works both domestically in the United States, and internationally.

² The MH-SET Project (the Mental Health and Psychosocial Support in Humanitarian Settings Research Priority Setting Project) was formed to create a *consensus-based research agenda aimed at supporting the prevention and treatment of mental disorders and the protection and promotion of psychosocial well-being in humanitarian settings*² (Tol et al., 2011). Its steering committee is globally diverse with a significant percentage of members from low income countries.

³ A partnership characterised by equal power and influence of each member, in which no singular organisation, individual or group wields greater strength than any other in decision making and/or implementation.

⁴ The Boycott Divestment and Sanctions movement is a global campaign that calls for boycott, divestment, and sanctions against Israel, as a method to compel Israel to respect Palestinian rights in accordance with international law. The campaign began in 2005 in response to a call by Palestinian civil society for an organised global citizen action against Israel's disregard for Palestinian rights and international law. For further information, please see www.bdsmovement.net.

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¹ The Center for Mind-Body Medicine focuses on strengthening individuals' ability for self-care and health outcomes, using a combination of scientifically validated approaches, tradition and