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Claudia Chaufan and Khaleel Isa
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Heal thyself: Dealing with trauma work – Gaza 2008/2009

Claudia Chaufan
University of California San Francisco, USA

Khaleel Isa
WestCoast Child Clinic, USA

Abstract
We report the case of a Palestinian American psychologist trained to work with psychologically traumatized patients, who consulted with one World Health Organization mental health practitioner assisting the people of Gaza during the Israeli invasion of December 2008. We describe the unresolved tension experienced by the consulting provider, between feelings of helplessness and horror associated with the attack and the drive to assist a client, in this case a colleague, a drive that characterizes the helping professions generally, and discuss ways to improve healthcare providers’ abilities to deal with trauma work. Our goal is to call attention to one overlooked health effect of the continuing military occupation of the Palestinian territories (oPT), that is, its impact on healthcare providers, by giving voice to these providers, and to elaborate on the limitations of existing categories and theoretical frameworks to conceptualize and address trauma work in the oPT and similar settings. This article is part of a broader project examining the implications of the ongoing military occupation of the Palestinian territories for health inequalities, health services, and public health infrastructure.

Keywords
health and human rights, mental health, sociology of health in developing countries, war and health

We shall have to spirit the penniless population across the border by procuring employment for it in the transit countries, while denying it any employment in our own country. Both the process of expropriation and the removal of the poor must be carried out discreetly and circumspectly.
(Herzl, 1960, vol. I: 88)

Corresponding author:
Claudia Chaufan, University of California San Francisco, San Francisco, CA, USA.
Email: claudiachaufan@yahoo.com
... like many other events in our century, the solution of the Jewish question merely produced a new category of refugees ..., thereby increasing the number of stateless by another 700,000 to 800,000 people. (Arendt, 1951: 290)

The struggle ... is one between a presence and an interpretation. (Said, 1979: 8)

**Introduction**

This article reports the case of a Palestinian American psychologist trained to work with traumatized patients, who consulted, by phone, with one World Health Organization community mental health practitioner assisting the people of Gaza during the Israeli invasion of December 2008. This military invasion, known as Operation Cast Lead, left over 1300 Palestinians dead, over 5000 injured, over 50,000 in need of emergency shelter, over 4000 buildings destroyed and 17,000 damaged, including critical public health and health services infrastructure, and ‘medical facilities overwhelmed and lacking basic supplies’ (BBC News, 2009). All of this in a population that, according to the United Nations Relief and Works Agency, was already ‘in desperate socio-economic conditions’, especially since 2006, as a result of an ongoing siege that prevented most Gaza residents from meeting their basic needs (United Nations Relief & Works Agency for Palestine Refugees, 2006).

We describe the unresolved tension experienced by the consulting provider, between feelings of helplessness and horror associated with the attack and the drive to assist a client, in this case a colleague, a drive that characterizes the helping professions generally, and discuss ways to improve health care providers’ abilities to deal with trauma work in the occupation of the Palestinian territories (oPT) and similar settings. Our goal is to call attention to one overlooked health effect of the continuing military occupation of the Palestinian territories, that is, its impact on health care providers, by giving voice to these providers, and to elaborate on the limitations of medical or psychological categories and frameworks to conceptualize and address trauma work in the oPT and similar settings. This article is part of a broader project examining the implications of the ongoing military occupation of the Palestinian territories for health inequalities, health services, and public health infrastructure.

**Bearing the suffering of others**

Psychological trauma (hereafter trauma) can result from direct or primary exposure to a traumatic event, whether natural (e.g. a hurricane, an earthquake) or man-made (e.g. rape, war), or from indirect or secondary exposure, for instance, while assisting traumatized persons. The awareness that witnessing or protagonizing traumatic events may lead to trauma can be traced back to Antiquity, to the description by the Greek historian Herodotus of a soldier who suffered no war injury yet became blind upon witnessing the killing of a fellow soldier. And yet, it took over two millennia, and a medical label, for this recognition to be legitimized, in 1980, with the inclusion of Post Traumatic Stress Disorders (PTSD) in the *Diagnostic and Statistical Manual of Mental Disorders III* (Swartz, 2005). Since then, research on trauma has flourished, enabling the
yet the idea that providing social and health services could be the source of psychological trauma is relatively new, and had to await the development of the hospice movement in the 1960s, when attempts began to conceptualize and study the trauma resulting from the practice of health and mental health care, and the notions of ‘job burnout’, ‘compassion fatigue’, ‘vicarious trauma’, ‘shared trauma’, ‘secondary traumatic stress’, or ‘secondary traumatic stress syndrome’ were coined (Figley, 1999; Maslach, 2001; McCann and Pearlman, 1990; Saakvitne, 2002; Vachon, 1999).

In our day, research and interventions are increasingly being developed to help mental health practitioners, such as those treating victims of terrorist attacks in Israel or in the United States, ‘heal themselves’ (Aten et al., 2008; Saakvitne, 2002; Shamai and Ron, 2009). Yet comparable research or interventions in resource-poor, war-torn areas, is all but non-existent, even if the need can be assumed at least equally pressing as elsewhere. For instance in the oPT, our focus in this article, mental health and health practitioners are frequently challenged to help individuals chronically exposed to the violence of aerial bombardments, land incursions, armed checkpoints, house demolitions, a separation wall, and a range of abuses, including torture and their use as human shields (B’Tselem, no date a, no date b, no date c; Human Rights Watch, 2001, 2002). Our article, reporting the experience of one such practitioner, attempts to fill this gap by giving voice to these workers.

**History, political violence, and health**

Inequalities in health among Jewish Israelis and Palestinian Arabs in the State of Israel are undeniable, and revealed through a range of social indicators: 54.8 percent of Palestinian Arab families live under the poverty line (vs 15.2 percent of Jewish families); housing congestion among Palestinian Arabs is almost twice as high as that of Jewish Israelis (1.43 persons per room vs 0.84), and the proportion of Palestinian Arabs in the workforce in the 25–54 age group is 54.9 percent vs 82.7 percent among Jewish Israelis, a gap that is greater among women (Badarneh, 2009).

Unsurprisingly, these indicators translate into very poor health indices among Palestinian Arabs generally, particularly so in the Gaza Strip, when even before the Israeli invasion of December 2008 unemployment rates had reached 70 percent and absolute poverty rates close to 80 percent, 80 percent of families relied on food aid, and anemia among children under five years old approached 50 percent (Bennis, 2007; United Nations Office for the Coordination of Humanitarian Affairs December, 2007; World Health Organization, 2009). This warrants the question: what accounts for these remarkable inequalities in social and health indexes which pose tremendous challenges to practitioners serving this population’s needs?

At least part of the answer can be gleaned from the political, social, and cultural history of the region. This is what The Lancet did in a recent series of articles on public health and human rights in the oPT, all of which displayed a recurring theme, vividly captured by Richard Horton (2009: 784), who wrote that while the ‘impression [of the oPT] conveyed through Western media is of a land in perpetual war, a people drenched in..."
hatred, aggression, and violence’, the facts on the ground reveal a very different picture: a land of extraordinary resilience, where some four million individuals struggle to recreate a normal life, working, loving, learning and playing under the weight of a decades-old military occupation that rarely enters westerners’ radar screen, including the radar screen of major media (Falk and Friel, 2007).\(^2\) A bird’s eye view of the history leading to this occupation will help contextualize our narrative and support our contention that in the oPT and similar settings, trauma work and health and health care issues more generally cannot be understood without a political analysis of the circumstances surrounding these settings.

While there is no ‘best’ point in time to begin this history, it must be noted that the widespread belief in a ‘centuries-old hatred’ between Arabs and Jews is not supported by the evidence (Harms and Ferry, 2008). In fact, for centuries Jews in the Arab world, that is, Mizrahi Jews, lived side by side and interacted with their Arab neighbors, sharing land and culture. This coexistence contrasts with the multiple waves of anti-Semitism in Europe, which go back to the fourth century CE to the adoption of Christianity as the official religion of the Roman Empire, in which Jews were frequently forced to convert, expelled, or killed. Indeed, the brutal persecution of Jews, or ‘pogroms’, of late 19th-century Russia, that gave birth to political Zionism, a movement based on the belief in a special claim to the land of Palestine, and a right to a Jewish home in that land, were hardly known in the Arab world. But as the Ottoman Empire fell after the First World War and the European imperial powers divided the spoils of war, the area currently occupied by Israel and the oPT was given as a ‘mandate’ to the British, who made contradictory promises over the same territory to leaders in the Arab world on the one hand, and members of the Zionist movement on the other, and confrontations between Jews and Arabs began (Harms and Ferry, 2008; Pappe, 2006).

As Jewish settlers of Zionist convictions came to Palestine in increasing numbers, conflict escalated. It became particularly violent in the 1930s, and peaked after the Second World War, when Jews desperately fleeing Nazi Europe and rejected at their preferred destinations, Britain and the United States, flooded Palestine instead. When conflict in Palestine became ungovernable Britain turned the Mandate authority to the United Nations, which in November 1947 passed Resolution 181, partitioning Palestine (United Nations General Assembly – Second Session, 1947). This resolution handed 55 percent of the land to a Jewish State (Jews were around one-third of the population of Palestine at the time) and 45 percent to a Palestinian State, while calling for the establishment of a ‘special international regime … administered by the United Nations’ for the city of Jerusalem, given its critical religious significance (United Nations General Assembly – Second Session, 1947). The indigenous population in Palestine, whose national consciousness evolved, to a great extent, as a result of these land struggles, was given no voice in the matter.

Early in 1948, a massive exodus of 800,000 Palestinians – about 50 percent of the population of historic Palestine – followed several mass killings and the destruction of Palestinian villages by Jewish armed groups (Pappe, 2008).\(^3\) By May of that year, the Jewish population, after defeating a poorly armed and meager force from neighboring Arab States, had taken over 78 percent of historic Palestine, including the western part of Jerusalem, and declared a Jewish State, which was quickly granted membership in the United Nations, subject to the Jewish State’s acceptance of the conditions stated in Resolution 181, which so far has not materialized (Bennis, 2007). Over the years, additional UN Resolutions
have gone unheeded – for instance, Resolution 194 of the General Assembly, calling for a right of return for, or compensation of, the indigenous population made refugee by the 1948 war (United Nations General Assembly – Third Session, 1948); and Resolution 242 of the Security Council, calling for withdrawal of Israeli armed forces from territories occupied during the 1967 war, including the West Bank, East Jerusalem, and Gaza, and for the respect for the territorial integrity, political independence, and mutual recognition of all states in the area (United Nations Security Council, 1967).

Yet with policies and practices separating Jews from Palestinians socially and physically (e.g. Israeli roads only, military checkpoints, the Separation Wall), and the increasing encroachment of land by the Jewish State through the uninterrupted building of settlements in the oPT, conflict over land has intensified, all of which has led to a permanent militarization of the region with catastrophic implications for health care services and health indices (Giacaman et al., 2009). It has also led to periodic, often violent confrontations between Israelis on the one hand, and their Arab neighbors or Palestinians in the oPT – most of them refugees from the 1948 and 1967 wars – on the other (Bennis, 2007; Pappe, 2006). The recent invasion of Gaza is one among many such confrontations.

The flower in the concrete

Dr Khaleel Isa is a clinical psychologist of Palestinian descent, born, raised, and educated in the United States. He has trained to work with psychologically traumatized patients and assists mostly children and youth in foster care and their families in Oakland, California. Over the years, Khaleel spent time in the oPT with family and friends, most of whom live in the West Bank. As a child visiting the occupied territories, he witnessed many situations of the sort he would deal with as a mental health professional trained in trauma, such as family members being ‘stripped’ and ‘their body parts checked’, or an 11-year-old cousin threatened to be taken away by ‘soldiers screaming with high-pitched voices, carrying machine guns’ because his brother was waving a Palestinian flag.

These experiences led him to a career in psychology, where trauma played a central role, and which would allow him to empower abused and oppressed individuals to ‘maintain their humanity alive’, as he puts it, individuals whose ‘basic sense of safety and minimal needs have been taken away by the Israeli occupation’, yet who ‘strive to dream and not lose hope’, like a ‘flower blossoming in the concrete, against all odds’. It was this early, very close-to-home experience with trauma that led Khaleel to pursue a university education and later live and train in the oPT, an experience that he sees as ‘a right of passage, a stamp on [his] doctorate’.

Khaleel met Ibrahim,4 a community mental health counselor employed by the World Health Organization (WHO), while working in the oPT for the United Nations Work and Relief Agency (UNWRA), the UN branch that caters to the needs of Palestinians who became refugees in 1948. At the time of the Israeli invasion of Gaza, Khaleel was in the United States. As the news of the attack sunk in, Khaleel’s first thoughts went to his friend and colleague. He tried to contact him, but all communications were interrupted, and would continue to operate precariously. Finally, communication with Ibrahim was established and continued over the 22 days of the attack, roughly every three days, during which time Khaleel remained deeply connected with the horrors of the invasion through the voice of his Palestinian friend.
Two months after the invasion, Khaleel was interviewed by the first author, who took notes of his narrative over the course of four one-hour encounters. This narrative was qualitatively analyzed by the first author, while Khaleel provided feedback on these interpretations in a back-and-forth process. Changes were made to reach agreement over the main themes, meanings to the protagonist, and implications of the experience for health and justice, and the final draft was produced.

From Oakland to Palestine

A pervasive theme is the ‘double consciousness’ that places Khaleel, a Palestinian American, at a unique intersection of the conflict, as responsible for, and at the same time victim of, an act of aggression, creating a tension that, at least at the time of the interview, remained unresolved. Khaleel attributes the ‘anger and guilt, humble pity and shame’ he felt over the course of his exchanges with Ibrahim to this dual identity as a Palestinian American, both a victim as a Palestinian yet responsible for the aggression as an American citizen ‘paying taxes that Israel uses to purchase the weapons to attack my people’. And he found some solace sharing their common roots in Palestinian history and national struggles. Over the course of their encounters, they would discuss the invasion as another ‘historic’ moment in the history of the Palestinian people, ‘together with our Nakba (“catastrophe”) in 1948, with the occupation of our land, with the massacres of Sabra and Shatila; and with the first Intifada (uprising)’.

Another critical theme is the tension between anger, helplessness, horror, and pity for Ibrahim and his circumstances, as he listened to his friend reporting that ‘[the Israelis] will kill us all, our houses are being destroyed, there is phosphorus gas all over, and the bombs, the bombs just won’t stop’, and a strong desire to set all these feelings aside and seek ways to empower his friend, by providing him with ‘tools and skills’ to deal with the shock of the invasion, and by ‘bearing witness’ and ‘giving voice’ to the traumatized living, and even to the dead. This is because anger, notes Khaleel, has to be used productively, ‘we cannot let it immobilize us, overwhelm us, or turn into pity or despair. Otherwise, I cannot help.’

This desire to help leads to yet another critical theme, that of ‘bearing witness’, and in this spirit Khaleel initiated the 22-day long communication, encouraging Ibrahim to keep detailed notes, to document the bombs, to count the wounded and the dead, those who lacked food or water, or the houses destroyed:

I wanted Ibrahim to dive into statistics …. I wanted to make sure that the voice of the little girl, or of the grandmother, is heard … and that they will be forced down the world’s throat … and that the world will be shown every single crime.

Then there is the theme of resilience, and how this resilience provides yet another venue for anger and despair, and draws from the pride Khaleel felt at his friend’s ability to cope with his own despair during the invasion: ‘As I listened to him I marveled at his desire to live, his strength to get up yet another day, and to go out and help others … this love of life holds us, Palestinians, together.’ Resilience is also grounded in the belief that ‘history will not forget’, and the hope that with justice will come healing. It is also grounded on a therapeutic understanding of the paradoxical weakness of aggression:

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[Ibrahim] would tell me ‘they cannot kill us all, Khaleel, we will be victorious’, and by this he meant that the magnitude of the aggression is really a measure of the aggressor’ weakness, so ‘in the last instance we come out as strong. I see this as a therapist … when people ‘act out’ aggressive behaviors, they are really scared inside.

When aggression subsides, it marks the beginning of healing, in armed conflict, and in therapy.

Last, Khaleel draws resilience from his and Ibrahim’s common Muslim faith, in the discipline of fasting, and in Ramadan, felt as part of Palestinian resistance to the occupation of their land. Indeed, the ‘depravity of the occupation’, notes Khaleel, brings Palestinians together rather than divide them, and helps them develop resilience, which is further strengthened through the collective experience of fasting during Ramadan and of sharing whatever little food or water they may have, or through the ‘collective mourning of a child’ lost to disease, to hunger, or to a sniper’s bullet.

Yet another theme is the paradoxical role of pain. While the aggressor, says Khaleel, is able to inflict pain by dehumanizing the victim, pain reminds the victim of her own humanity. And this is how both Khaleel and Ibrahim seem to understand the pain of their clients: ‘Pain reminds them – us – of our humanity, even if Israel portrays us as less than human so that they can continue to inflict pain on us.’

The last inquiry pertained to the differences and similarities between Khaleel’s feeling about, and experience with, clients in Palestine and in the United States. In both cases, traumatic experiences share a background of oppression and abuse. His clients in Oakland are often exposed to, and keenly aware of, an invisible web of ‘checkpoints’ – police brutality, poor school system, dead-end jobs, and high rates of crime. All this ‘invisible’, yet pervasive, background violence, says Khaleel, makes ‘recovery from psychological pain very difficult’, and it is not easy for mental health practitioners to accept the fact that their interventions are impotent vis-à-vis this violence that continuously harms their patients. But at least health professionals, ‘be it doctors, social workers, nurses or therapists do not experience the first-hand trauma that affects their patients’, so they are psychologically more fit, thus able to help. Moreover, even when resources in poverty-stricken communities in the USA are limited, they are still more available to both patients and practitioners than in ‘a third world, war-torn occupied country’.

In contrast, in Palestine, notes Khaleel, all health practitioners are faced with relieving chronic and acute trauma symptoms, not merely in patients diagnosed with ‘mental health’ issues, but in all patients, and they must do so with hardly any resources. And their patients’ trauma-related symptoms are ‘directly related with basic physical security – access to fresh water, food – and with the fear of being bombed any time, or being the “collateral damage” of some targeted assassination’. What is more, there is the issue of collective punishment when whole communities, including health care workers, are attacked, which becomes collective trauma, and ‘makes it hard for us, therapists, to differentiate between our own trauma and that of our patients’.

**Heal thyself**

When asked what he expected to accomplish from the brief yet intense interaction with Ibrahim, especially given the unlikelihood that this interaction would result in any actual
material relief for the people of Gaza, Khaleel noted that throughout these interactions he was able to overcome, even if minimally, the overwhelming sense of defenselessness: ‘[I]t was a way for me to heal in a chaotic, uncontrollable situation, where the power was not in my hands but in the hands of the Israeli occupying forces.’ And he developed this sense of empowerment by remaining aware of the ‘facts on the ground’, by drawing on Ibrahim’s resilience – on his ‘desire to live’ and ‘his strength to get up yet another day [to] help others live’, and most importantly, by making sure that his friend’s voice would not remain unheard. Bearing witness emerges as one critical, if not the critical, aspect of healing.

Another critical aspect of healing for Khaleel was, and is, counting on trained professional supervisors who could ‘hold’ him emotionally throughout this experience, a supervision that he finds critical to his success with trauma work in general. Yet another outlet for Khaleel’s distress was, and remains, his community activism:

I was in the street every day [during the course of the invasion], telling people that I was not okay, and that I was not okay because hundreds of innocent people were being bombed. I would send emails, and tried to get money to do needs’ assessment [but failed]. Still, I talked to lawyers, doctors, people in the community.

Last, the healing power of friendship with other Diaspora Palestinians: ‘During my times of despair I hang out, nightly, with my Palestinian friends, playing the Arabic guitar (the oud), sharing food and singing nationalistic songs on freedom and the right to live.’

All of these emotional outlets, notes Khaleel, are ways of creatively overcoming the difficulty of seeing friends suffer and knowing that there is little hope that their suffering will end in the near future. At least in the USA, Khaleel notes, expressing and working through anger are not luxuries but real possibilities for patients. But Palestinians living under occupation are not so fortunate. Mental health workers, like Ibrahim, lack the outlet of peaceful social protest; or the access to trained professionals who may be emotionally as well as physically removed from the attack, thus able to provide critically needed support. Ibrahim himself can only hope to share, from a distance, his traumatic experience with his American Palestinian colleague and friend.

**Discussion: helping healers heal themselves**

We began by stating that trauma can be experienced directly or indirectly, and proposed one instance of secondary trauma is when a mental health worker is affected by the traumatic experiences of clients. Yet the reality of mental health care defines neat, let alone binary categories: how are we to conceptualize, for instance, the experience of mental health workers exposed both secondarily and primarily to trauma? This situation seems frequent among Israeli social workers, whose clients are victims of armed violence that often poses a direct risk to workers themselves (Nuttman-Shwartz and Dekel, 2008; Shamai, 2005; Shamai and Ron, 2009). And this is indeed the case with health workers in the oPT.

Or what should we call the experience of therapists whose clients have been traumatized by an event to which the provider has not been exposed, yet which still
threatens his or her sense of trust and security? Such is, for instance, the case of mental health practitioners in New York in the aftermath of 9/11, whose sense of security was shattered whether or not they were physically present at Ground Zero, or even close enough to be harmed (Saakvitne, 2002). And how physically close does an event need to be for the traumatic experience of the therapist to count as ‘primary’? Indeed, 9/11 has sparked a stream of research among mental health practitioners generally, who feel personally threatened as American citizens, or even citizens of a global, interconnected world, wherever they may have been at the time of the attack, faced as they are with forces beyond their comprehension, and certainly their control (Seeley, 2003; Tosone, 2006). And such was the case of our protagonist, which shows that the line between direct or indirect exposure to trauma is not an easy one to trace.

Thus to capture the richness of the ‘multiple levels of traumatization’ to which mental health workers are usually exposed, the term ‘shared trauma’ was coined (Saakvitne, 2002: 444). Yet whether or not our case fits under this definition is a matter of judgment. Indeed, many of Khaleel’s experience and feelings – horror, helplessness – were compatible with secondary or vicarious trauma. And he was half a world away from the attack on Gaza and for this reason not physically threatened by it, so it is unclear that we can call his exposure to the event ‘primary’, thus making his overall experience fit the label of ‘shared trauma’. Yet he was close enough experientially, given his extended work in the oPT, emotionally, given his family and cultural roots, and historically, as a Diaspora Palestinian, to feel deeply vulnerable to the same threat to which his colleague was exposed. Thus the ‘frame’ of his professional work ‘shifted’ and, while resembling his daily work to some extent, was radically different from it in important ways (Saakvitne, 2002).

One such way is that Khaleel, and even more so therapists who live permanently in the oPT or similarly resource-poor, war-torn environments, are rarely in the position of experiencing any ‘illusions of safety’ common among therapists in politically stable parts of the world, who may have realized, after 9/11, that when working with trauma, in truth – ‘the professional boundary is an arbitrary construct therapists employ to maintain the illusion of separation between their professional and affective realms’ (Tosone, 2006: 93). No such separation exists, whether emotional or physical, among health care practitioners and their clients in the oPT.

In any event, and however we conceptualize Khaleel’s experience, the fact of the matter is he was affected profoundly, both personally and professionally, by the indirect exposure to the devastation infringed upon his people and his land. And a range of interventions have been reported that can help mental health professionals like him better deal with the challenge of trauma work and in our case, the consulting provider had access to virtually all of them. These interventions include, yet are not limited to, training and supervision by experienced therapists, sharing with colleagues similarly exposed, taking time for personally meaningful activities, or engaging in social justice work.

Training and continuing supervision constitute a critical element of healing. Gelman and Mirabito (2005) draw on vignettes of social work practice to structure didactic and collaborative problem-based learning and to train their students in crisis interventions. Palm et al. (2004) integrate continuing supervision and consultation as a regular part of their organization’s professional work. Training within a social constructivist framework
that integrates into mental health care practice the experience with political violence of workers themselves, granting them the role of ‘experts’ in their own training, or a combined educational-field work approach (Nuttman-Shwartz and Dekel, 2008; Shamai, 2003), have helped students and professional social workers develop resilience, enhance their therapeutic skills, and ease the deleterious effects of trauma work.

Sharing with other colleagues who may or may not have experienced the traumatic event has also proven useful for mental health workers in settings as different as the USA post-9/11, the USA post-Katrina, and Israel (Faust et al., 2008; Saakvitne, 2002; Shamai, 2003). Participating in meaningful experiences such as pleasure reading, artistic expression, gardening or journal writing is one of many practices that multiple studies identify as critical to not succumbing to the challenges of trauma work (Pearlman, 1999; Rothschild, 2006; Saakvitne, 2002). In one study, engaging in social justice work was endorsed as helpful by close to 30 percent of respondents (Pearlman, 1999).

All these interventions have demonstrated, if not the capacity to ‘cure’ the potentially negative mental health effects of trauma work, at least that of helping mental health practitioners deal with it more effectively. Moreover, occasionally these interventions or strategies have led to what some mental health practitioners have identified as even positive experiences. For instance, at the outset of the Second Intifada, Israeli social workers who had the opportunity to share their work experiences with similarly situated colleagues, so long as their loved ones had been spared, saw their work as a ‘mission to which they were appointed by God’ (Shamai and Ron, 2009: 52). This feeling, according to Shamai and Ron (2009: 52–53), led to ‘the extraordinary resilience and commitment to the State of Israel’ these workers displayed, and to their perceiving their shared traumatic reality not as negative but as an ‘important help element’.

In our case, professional supervision, engaging in meaningful experiences, and even the healing power of bearing witness while remaining physically safe were available to Khaleel. Yet hardly any of these were, or are, available to Ibrahim: with his whole community under attack, and communications with the outside world severely impaired, the chances of counting on professional supervision from senior colleagues not directly exposed to the conflict were slim, even if they finally materialized in once-every-three-days conversations with his Palestinian American colleague. As to his work before and in the aftermath of the event, few resources are available to him: born and raised under the inherently uncertain category of ‘refugee’, his work and person exposed to chronic violence, with little hope that his friends or family will remain unharmed, Ibrahim can hardly see his work as contributing to the strengthening of a state – he has no state. All he has, as his friend puts it, are ‘fragmented images of an indigenous land’. For now, ‘victory’ means vague, mostly negative, goals: that his people’s vulnerability to aggression not be ‘internalized’ as weakness, and that not all of them be killed so that at least some will remain to tell their story.

**Limitations and conclusions: health and justice**

Our account of Khaleel, and very indirectly of Ibrahim, has important limitations. First, there is a fertile debate in the psychological literature about the theoretical validity of constructs that count as secondary trauma – for instance, whether anything such
as vicarious trauma exists (Hafkenscheid, 2005; Sabin-Farrell and Turpin, 2003). Yet we have chosen not to address this debate, because our primary interest was to call attention to the virtually invisible experience of mental health, and arguably other health practitioners servicing victims of mass violence in resource-poor, war-torn environments, and give them voice.

Another limitation of our account is that, assuming the validity of these constructs, for a case to fall under them it has to meet several criteria. For instance, for an experience to be considered vicarious trauma, its effects on the therapist must be 'pervasive, that is, potentially affecting all realms of the therapist’s life; cumulative, in that each client’s story can reinforce the therapist’s gradually changing schemas; and likely permanent, even if worked through completely’ (McCann and Pearlman, 1990: 136, emphases added). Can we assume that the attack on the Gaza Strip, a ‘single’ traumatic event, could have caused in and of itself changes of such magnitude in the consulting therapist? And how should we weigh this single event in our analysis of the therapist’s experience with trauma work, deeply connected as this event is to the therapist’s personal history so as to make it impossible to disentangle it from the therapist’s life itself?

And yet, 9/11 was also a single, albeit unprecedented, event, yet led to much soul-searching in the therapeutic community, to a stream of research, and to a questioning of fundamental assumptions in psychotherapy, as mental health practitioners began to realize that when working ‘under great pressure, in scenes of unspeakable destruction, chaos and horror … standard clinical methods were often inappropriate’ and the boundaries between the clinical setting and the outside world, the patient and the therapist, one’s pain and the pain of the other, no longer obtain (Seeley, 2003: 37). Clearly, for a therapist with deep roots in Palestine, a land strongly associated with countless childhood memories, the awareness that his people were trapped in less than 140 square miles, at the total mercy of what the New York Times has described as ‘world-class military forces’, for 22 uninterrupted days, and with nowhere to run, must have been no less traumatic than that experienced by American therapists post-9/11 (Editorial, 2006).

Yet another important limitation of our account is that it is anecdotal in nature, a mere reporting of one episode in the life of one therapist, without the methodological power to reveal a trend or indicate a phenomenon, even if its validity were uncontested. Yet this account is compatible with the growing literature on the experience of mental health practitioners exposed to violence in complex ways, with what this literature indicates is the pressing need of these practitioners to receive proper training and institutional support, and with the likelihood, as indicated by the Lancet series, that the needs of practitioners in the oPT and similar settings are going unattended, at the same time that the continuing militarization of the region prevents them from being attended to. As one Palestinian public health professor noted, ‘such [medical and humanitarian] interventions alone … leave the cause of ill health in the occupied Palestinian territory untouched’ (Giacaman et al., 2009: 846–847).

Our data only allow us to speculate about the magnitude of the unmet needs of mental health practitioners, and of health practitioners generally, in the Gaza Strip in the aftermath of the attack, or in the oPT generally under the weight of a decades-old occupation largely invisible to outsiders (Falk and Friel, 2007), and the invisibility of the occupation is beyond the scope of our article. Yet we can safely assume that mental
health practitioners in this and similar settings are at least as vulnerable as those in ‘visible’ ones to the ‘multiple levels of traumatization’ captured by Saakvitne’s notion of ‘shared trauma’ (Saakvitne, 2002: 444). We can also assume that in settings as invisible as the oPT, these multiple levels are compounded by the lack of a minimum health care and public health infrastructure, the poverty of the general population, and the chronic and virtually endless nature of the violence. And whether the agents perpetrating the violence are considered ‘clandestine’ or ‘legitimate’ makes little, if any, difference to its devastating effects on the thousands, often hundreds of thousands, of civilians, and their healers, whose lives are forever shattered by it.

One final, albeit critical, limitation of our account is embedded in the very categories that we have used to describe our observations, which make them appear in the last instance as a medical or psychological issue amenable to medical or psychological interpretations or interventions. But, as hinted above, and as studies of Native Americans and Holocaust survivors indicate, unacknowledged injustice itself is the greatest impediment to healing, not only for direct victims but across generations. For instance, it has been argued that among Inupiat youth, repositioning high rates of suicide as a legacy of historical and ongoing colonialism, instead of, or at least in addition to, a psychological issue, is critical to ‘allow indigenous young people craft a future that makes sense to them’, and heal (Wexler, 2009: 17). Likewise, studies of Holocaust survivors and their descendants indicate that ‘the process of redress and the attainment of justice are critical to the healing of individual victims, as well as their families, societies, and nations’, and scholars have argued that redress must include ‘the investigation of crime, identification and bringing to trial of those responsible, the trial itself, punishment of those convicted, and appropriate restitution’ (Danieli, 2007: 82).

Similarly, we argue that whatever professional interventions may help health practitioners in the oPT or similar settings heal themselves, they can only ease the symptoms. The real ‘disease’ is the injustice, in our case embodied in a military occupation that acts as a continuing trigger of violence by and on two peoples with emotional and historical attachments to the Holy Land (Bennis, 2007; Falk and Friel, 2007). In so far as this occupation continues and basic conditions of justice, moral and legal, are not met, health and healing in this area of the world will remain out of reach.

Notes
1 A search in the database PsychINFO, with the search terms ‘secondary’, ‘traumatic’, and ‘stress’, retrieved 3664 references; 464 were further retrieved with the addition of the search term ‘Israel’, and 170 with the addition of the search term ‘9/11’, yet only 15 with the addition of the search term ‘Palestine’. When search terms were replaced by the more specific ones ‘vicarious trauma’ (more specific in their application to the effects of trauma work on practitioners themselves), of the 1183 references retrieved from the same database, 148 were further retrieved with the addition of the search term ‘Israel’ and 118 with the addition of the term ‘9/11’, yet only four with the addition of the term ‘Palestine’. And of these four, not a single one dealt with vicarious trauma among Palestinian mental health practitioners, and only one of them offered a humane view of Arabs generally, noting the prejudices and stereotypes in representations of Arabs in Israeli society, thus counteracting the generalized portrayal, in this literature, of Arabs as perpetrators, yet never victims, of terrorist acts.
Officially Israel withdrew its illegal settlements and army bases from the Gaza Strip in 2005. However, and as stated by UN Special Rapporteur on Human Rights in the oPT Prof. John Dugard, according to international law it remained an occupying power, with total control over movements of people and goods, airspace, coastal space, and land borders (Palestinehouse, 2009).

Authors such as Alan Dershowitz (2009) claim that in truth Palestinians were told by Arab leaders to leave, promising them that after they triumphed over the Jewish forces, Palestinians would be able to return. Whether true or not, this point is irrelevant to the fact that since 1948, Palestinians were unlawfully prevented from returning to their homeland, a right enshrined in Art. 13 of the UN Declaration of Human Rights and not contingent on people leaving their home voluntarily or involuntarily.

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**Author biographies**

Claudia Chaufan is physician, sociologist, and public health researcher, currently an Assistant Professor at the Institute for Health & Aging at the University of California in San Francisco. She
teaches sociology of health and medicine, comparative healthcare systems, sociology of power and sociological theory. Her research includes the political economy of diabetes and obesity, the sociology of human genetic research, comparative healthcare systems, and health and human rights. She is vice-president of California Physicians Alliance, a chapter of Physicians for a National Health Program, a professional organization that advocates for a social insurance, single-payer system in the United States.

Khaleel Isa is a licensed Clinical Psychologist. He received his Doctorate of Clinical Psychology in 2002 at Alliant International University-CSPP, Los Angeles California. Dr Isa completed his Post Doctorate at San Francisco General Hospital at the Child Adolescent Services. Dr Isa’s clinical experience lies in working with homeless youth, sex workers, gang members, and war torn youth in occupied Palestine. Dr Isa is currently working at WestCoast Child Clinic, where his clinic work is focusing on ‘domestic displaced’ foster youth. He currently is working on a research project examining health professionals experiencing secondary trauma in Occupied Palestine.