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# Families in Chronically Unsafe Community Environments

## *Experiences in Northern Ireland and Palestine*

Gwyn Daniel, Arlene Healey, and Mohammad Marie

One apparently incongruous sight that might strike a casual visitor to the neighborhoods of Belfast in Northern Ireland is that of the Israeli flag being displayed in the Protestant/Loyalist communities and the Palestinian flag on show in the Catholic/Republican communities. These symbols suggest some deep identifications around the types of struggle the two communities are engaged in: broadly the entrenched power of settler colonialism on the one hand and civil rights and resistance movements on the other.

Both Northern Ireland and Palestine[1] have a long history of violent conflict and failed political processes. In Northern Ireland, the peace process has had some success albeit still referred to as flawed, and the political situation is again faltering with no functioning government since January 2017. In Palestine, the situation is far more extreme with the absence of any hope for a political solution that could bring justice or peace. Instead a state of warfare continues involving serious rates of death, violence, intimidation, and the absence of human rights. The recent deaths of many, including children, in Gaza highlight how dire the current situation is in Palestine. This crucial question of hope or its absence intersects critically with family and community capacity to access or sustain resilience in the face of trauma.

While the two situations are different in many crucial respects, there are enough points of intersection to draw some parallels, not so much at the wider political level but in how politics and family life intersect, in community responses to violation and trauma and in the challenges posed for clinicians. We briefly describe each context and identify some processes that occur when family relationships have to be sustained and developed amid dangerous assaults on their very integrity and where many favored models of psychological intervention prove inadequate. We focus on some key themes from our different contexts and these perspectives will interweave contrapuntally throughout the chapter. While making links between some core processes pertinent to each situation, we also try to avoid "collapsing" differences between two widely

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diverse contexts. We describe some therapeutic approaches that aim to meet the specific conditions encountered by families in Northern Ireland and Palestine at the very different stages of their respective conflicts. We draw out some principles that may be helpful to clinicians working in similar situations.

## Our backgrounds

*Gwyn Daniel* I am a systemic psychotherapist, supervisor, trainer, and visiting lecturer at the Tavistock Clinic, London. I have experience of teaching in both Northern Ireland and Palestine. I am on the steering group of the UK–Palestine Mental Health Network, which takes an advocacy-based approach, highlighting the effects of human rights abuses on the mental health of Palestinian citizens. It also aims to sustain connections between UK psychotherapists and their colleagues in Palestine. I have visited Palestine on many occasions and given presentations in the United Kingdom on the effects of the Israeli military occupation on the family life of Palestinians.

*Arlene Healey* I am a systemic psychotherapist and clinical supervisor. In 2015 I retired from the National Health Service after a career largely working as a systemic psychotherapist in Child and Mental Health Services. In 1998 I established the Family Trauma Centre in Belfast with funding designed to implement the Good Friday Peace Agreement. The Centre aimed to meet the psychological needs of families affected by the conflict. The Family Trauma Centre then widened its remit to work with families affected by a wide range of psychological trauma. I have worked as an adviser to the government about the needs of those affected by the conflict, and I continue to work in Belfast for a small charity and in private practice.

*Mohammad Marie* I have been qualified as a nurse since 1998 and have a master's degree in community mental health. I completed my PhD at Cardiff University in the United Kingdom. I also work as mental health professional at Alnajah National Hospital in Nablus, offering psychotherapy and mental health consultations for families and individuals. As a university lecturer, I have taught and led research-oriented courses at undergraduate and postgraduate levels. I have a wide range of clinical practice experience in various health and social care settings in the United Kingdom and Palestine.

I live my life as a bird in a cage watching other birds flying and singing freely in the sky. I never have the same experience of flying, and these birds never experience what it is to live in a cage. Although I try to explain the context of my life, it is not easily comprehensible to others. I lived all my childhood and adult life under occupation, trying to imagine the meaning of freedom and how people in other countries live their lives without the suffering that occupation involves. I have worked for more than 11 years in many Palestinian hospitals as a staff nurse, encountering the daily distress of Palestinian families. Although it is difficult to describe in a few English words the catastrophic situation in occupied Palestine with its ongoing silent ethnic cleansing and crimes against humanity, I aim in this chapter to help others imagine life under occupation and the complex context for individuals and their families.

## The Contexts Shaping the Lives of Families

### Northern Ireland

For over 50 years Northern Ireland has been engaged in civil conflict, widely referred to as the "Troubles" or the "Conflict." A degree of peace was achieved when many years of negotiations, ceasefires, and talks with both success and failure finally came to fruition in 1998, leading to the Good Friday Peace Agreement or Belfast Agreement (1998). As an accord between all the political parties in Northern Ireland and an international agreement between British and Irish governments, this was a major achievement. The Belfast Agreement had to be approved by the people of both jurisdictions. When voted on it was agreed by the majority of both North and South. Many matters were addressed in the Belfast Agreement such as sovereignty, civil and cultural rights, weapons decommissioning, demilitarization, justice, and policing. It involved processes that were difficult for many. Those who lost family members during the conflict still struggle with issues such as the release of prisoners and changes to policing and justice. The Agreement also saw political power once again devolved to Northern Ireland from Westminster with the establishment of the Northern Ireland Assembly.

The Good Friday Agreement improved life in Northern Ireland for many, and the country has been transformed in many ways with Belfast becoming a top tourist destination. However, it is a fragile peace agreement, which has collapsed on several occasions. The conflict continues today albeit at a much lower level; however, intimidation, sectarianism, and violence including shootings and murders continue.

The conflict is a complex sectarian dispute characterized by violence perpetrated between two communities, one broadly Roman Catholic/Nationalist identity (with ideological allegiance to a united Ireland) and the other broadly Protestant/Unionist identity (ideologically allied to continuing union with Britain). The legitimacy of Northern Ireland as part of the United Kingdom has been at the heart of the conflict. Republican paramilitary groups such as the Irish Republican Army (IRA) described themselves as waging "war" on the "occupying" British forces while those in the security forces saw themselves upholding the rule of law, against a terrorist threat.

*Legacy of the past in Northern Ireland* Northern Ireland is a small country with a population of 1.862 million people (Northern Ireland Statistics and Research Agency [NISRA], 2017), yet the impact of decades of conflict have had an intense impact at many levels of social relations. It has been said many times that our greatest challenge politically is how we deal with the past. Issues such as truth and justice and the legacy of trauma affecting significant numbers of people continue. Historically it has been difficult to quantify the numbers of people affected by conflict-related trauma; even the numbers of people who died continue to be a matter of dispute.

Although it is more than 20 years since the signing of the Good Friday Peace Agreement, some families continue to live with extreme levels of danger and fear. A sense of safety and hope make a crucial contribution to the healing process but for some the trauma is too severe or their sense of continuing injustice too strong for them to feel able to recover.

Due to lack of political will, for many years we had very few statistics. It was not until the work of Fay, Morrissey, and Smyth who initiated the Cost of the Troubles

Study (1998) that the numbers of people who had died because of the Conflict were examined. They began to gather data and collate information about deaths and explore the impact of psychological trauma following thousands of bombs and shootings. Such was the extent of the silence and denial about the conflict that data was not collated on conflict-related events. Only in 1997, almost 30 years after the current conflict started could anyone answer a simple question such as how many people lost their lives due to the Conflict. This has clearly had a massive impact on families' ability to feel that their suffering has been acknowledged.

The past 20 years has seen the completion of many important studies as academics addressed the silence that existed within their institutions. Muldoon, Schmid, Downes, Kremer, and Trew (2005) concluded that "following thirty years of political violence, 3,500 deaths, over 35,000 injuries, 16,000 charged with terrorist offences, 34,000 shootings and 14,000 bombings, there are few families in Northern Ireland's small population that have not been affected by the conflict." They found that one in five people have suffered multiple experiences relating to the Troubles and that one in ten in Northern Ireland have been bereaved because of the Troubles. From their sample it was suggested that 12% of the Northern Ireland population were diagnosable with posttraumatic stress disorder (PTSD). O'Reilly and Stevenson (2003) concluded that it is "probable" that there has been a reluctance to acknowledge the impact of such extensive trauma on the population.

The Commission for Victims and Survivors published research conducted by the University of Ulster (March 2015) quantifying the extent of conflict-related trauma. They concluded that 71.5% of the population had few adverse mental health difficulties. However, of the remaining 28.5%, half had mental health difficulties directly related to the Conflict. They equate this to more than 213,000 adults, many of whom have children and by now grandchildren raising concerns about the trans-generational nature of trauma.

While these academic studies have helped inform many of us working in this field, they have had little influence on service planning. We continue to see the development of health policy with little or no reference to the conflict. There is a dearth of services, and many existing mental health services are ill equipped to treat complex trauma and are overwhelmed with the population's chronic and enduring mental health needs. The need for services that are sensitive to the plight of those affected psychologically by conflict-related trauma and by trans-generational trauma has never been more critical.

With disagreement at a societal level, it is understandable that it is difficult for individuals and families to make connections between past and present and between events and the onset of difficulties. This is even harder for families affected by trauma of a more trans-generational nature. It is not spoken about and it is not visible. For some it has always been that way. It is also a concept that is poorly understood by many. For those engaged in systemic psychotherapy, it is vital that this is well understood.

## Palestine

The creation of the State of Israel in 1948 involved the expulsion or displacement of 750,000 Palestinians who were then refused the right to return to their homes. Many of their descendants are still living in refugee camps, either in neighboring countries or in the West Bank or Gaza.

After the war of 1967, Israel occupied East Jerusalem, the West Bank, and Gaza. Israel now controls over 90% of the land of pre-1948 Palestine. The 1995 Oslo accords created a Palestinian Authority in the major West Bank cities comprising roughly 18% of the West Bank territory (Area A), which controls security and civil administration. The remaining areas are Area B over which Israel maintains security control and the Palestinian Authority civil administration in 22% of the West Bank and Area C at 60%, the largest area which Israel controls totally. This is where many of the major settlement blocks are to be found. Over 700,000 Israelis now live in settlements on the West Bank and East Jerusalem, all illegal under international law.[2]

On the West Bank, these settlements are served by networks of roads for their own exclusive use, protected by soldiers who rarely challenge their regular assaults on Palestinian villagers and farmers, including destruction of olive trees, the symbol of rural Palestinian life. Israel controls all the water and power supplies; it controls borders, security, and trade relations; its army can act with impunity even in those areas supposedly under Palestinian Authority control. Palestinians cannot freely move around the West Bank, even within Area A, since there are frequent road blocks controlled by Israeli soldiers. Since 2002, the most powerful symbol of Israel's ability to act unilaterally is the construction of the separation wall (declared illegal by the International Court of Justice in 2004[3]).

The political context impels Palestinians to cope with crises in order to survive and remain steadfast under Israeli occupation in the hope of eventually ending it. But a long-term strategy to implement a transfer policy is becoming increasingly overt. This involves eventually confiscating all Palestinian land through gradual displacement of the population.

In occupied Palestine a situation thus exists where the occupying power (Israel) is able to act without restraint. Each single example of control (cutting off water, closing check points at random, land appropriation, arrests, extrajudicial killings, incarceration, and house demolitions) drives home this message. Palestinian families thus live daily with fear, insecurity, impotence, and humiliation.

As well as the effects of military power, discursive power arising from this oppression involves constructing Palestinians themselves as a source of fear. Every Palestinian citizen is narrated as an actual or potential terrorist. This discourse hangs over virtually every interaction, emerging out of what Nadera Shalhoub-Kevorkian calls "Security as Theology" (2015). Once Israel evokes security to justify an action, it cannot be challenged. This doctrine is applied to the youngest and most vulnerable Palestinian citizens as well as the able-bodied adults.

The obsession with security requires constant surveillance and constant reminders of how much the "other" is to be feared, but it also involves creating an environment of constant fear in the colonized people. Palestinian families on the West Bank speak of this lack of security either at home, traveling to work, in school, or on the streets. Although a middle-class family living in the center of Ramallah will be different to a family living in a refugee camp, the sense that there is no safe or inviolate domestic sphere is all-pervasive. Despite the fact that deaths of Palestinians at Israeli hands are between 10 and 100 times greater than vice versa, the need for security and the right to feel safe are taken up in public discourse only in relation to the occupying power and its people. This one-sided and distorted practice enforces constant self-discipline and outward enactment of submission when, for example, passing daily through checkpoints in order to get to work. Shock and outrage at such oppressive treatment coexist alongside a pragmatic concern with getting through the day's tasks.

The military occupation the West Bank, in existence for almost 50 years, means that two/three generations have grown up under Israeli control. Each generation in turn has resisted but ultimately failed to change anything for the better. While outsiders tend to chart the region in terms of discrete periods of "war" or "intifada" (uprising), Palestinians' own experience is that of permanent warfare, witnessing their landscape changing in front of their eyes, their resources stolen, and their freedom of movement curtailed, reminded constantly that the law serves only to support the interests of their oppressors.

## Conceptual Framework

Therapists learn as much about human relationships from contexts of extreme adversity, hardship, and suffering as they do from what might (optimistically) be termed the "mainstream." Survivors of abuse, forced migration, civil conflict, torture, and other forms of trauma have taught us a great deal about resilience, about the need to deconstruct psychiatric diagnoses and about appreciating unique and idiosyncratic ways of coping with trauma and its aftermath (Afuape & Hughes, 2016). Above all, "learning from the extremes" highlights the ethical necessity for therapists to take context into account in a way they may not with more "normal" difficulties. However, practitioners whose lives are immersed in the communities that are suffering and who daily experience many of the same tribulations and traumas as those they are helping hardly need to learn this lesson as Mohammad's experience testifies.

Foregrounding the political domain, we explore how oppression acts upon intimate relationships and undermines mental well-being in families and communities alike. A core premise is that mental health approaches that diagnose and treat individuals without taking context into account are unlikely to be ethical. Our brief explanation of the two political contexts highlights the need to attend to their unique features and for a mental health approach that incorporates awareness of the material and psychological effects of colonial domination and its accompanying techniques of power, as Frantz Fanon argued over 50 years ago (Fanon, 1963). Colonialism acts not only to control bodies and expropriate resources but also to undermine the psyche, restricting individual identities and eroding those connections that sustain solidarity. These actions can be seen both as deliberate acts of repressive power and, in Michel Foucault's sense, of constitutive power, of specifying certain kinds of identity, constructing the subject, and transforming the abnormal into an everyday norm within whose parameters life simply has to be lived (Foucault, 1972). In addition to exploring how techniques of power operate on the person and on relationships, Foucault's influence on therapists has above all been through his focus on modes of resistance (White, 1995).

Power reaches into the heart of family and community life and subjective experiences, creating categories of inclusion and exclusion and shaping performances of identity. Indeed, it is within intimate life that oppression can be at its most powerful. The Palestinian intellectual Edward Said argued that colonial domination invariably involves dehumanizing practices, which create restricted forms of self-expression in the colonized people. These constraints in turn evolve into stereotypes that are then employed by the colonizers as justification for further oppression (Said, 1978). A classic example of this is in relation to violence. Violent appropriation of land and the

crushing of resistance almost invariably lead to further upsurges of violence. This is taken up by the dominant power as evidence of "inherently" violent tendencies, collapsed into a unitary definition of "terrorist" used to justify violent retaliation. Indeed, in Palestine, the definition of Palestinians as violent is a preferred narrative for the Israeli government, and episodes of political cooperation or offers of ceasefire are frequently responded to with provocation. While these processes are also pertinent to the history of Northern Ireland and continue to reverberate in the present, for Palestinians it is part of their ongoing experience *in* the present.

Systemic approaches provide important critical tools through which to explore the relationship between political oppression and psychological processes by taking a bidirectional approach. As human beings we continually act *in* context at the same time as acting *into* context (Afuape, 2011). By "acting into context" we include all the actions and reactions from individuals, families, and communities, which challenge oppressive practices. This challenge includes naming the myriad ways in which power acts on the self and on family relationships. In our systemic framework we thus explore the intimate politics of the everyday and move between the local and the global, or the micro and the macro. The approach, which has wider applications for systemic psychotherapists and practitioners in other contexts, involves a detailed exploration of how power and politics actually operate so that the specificity of their effects can be brought into view. The details will of course vary in different political contexts, but the importance of explicitly connecting the levels is fundamental, not just as the background to therapy but as part of the therapeutic process itself. Examples of how power practices infiltrate family relationships include the silencing effects of humiliation and shame, the diminution of parental authority through inability to protect their children, and different positions taken up by different family members in relation to violent resistance or attempts by men to reassert masculinity by oppressing those lower down the social hierarchy, that is, women and children.

The effect of constitutive power and its impact on minds and bodies (Foucault, 1972) has been translated into therapeutic interventions by narrative therapists and liberation psychologists. Such interventions include highlighting agency, expanding restricted views of self, externalizing problems, and accessing values such as justice and solidarity. Even within situations of extreme oppression, therapeutic interventions can act to enhance solidarity, to sustain connection, and to celebrate steadfastness.

## Power imbalance and therapeutic positions

The crucial dynamic of power imbalance as a factor in itself receives less attention in the literature, and yet it is crucial. A systemic approach aims to explore the relationship between these positions of strength and weakness and the effect of this dynamic on all parties. It also interrogates the weakness of the powerful and the power of the weak.

In the two contexts we discuss, it is clear that working therapeutically in Northern Ireland involves being open to the narratives and mental health needs of both communities. Here, I (AH) feel fortunate to have worked with those affected on all sides of the conflict, which has enabled me to keep a systemic perspective. I also live here; it is my home. I have my own experiences and narratives about the conflict. I pay attention to this in my practice; it means developing a position of attending to

multi-realities and of self-reflexivity and of sensitivity to the many levels of political nuance and signification with which our clients "read" us in this work.

> *I worked with a mother and her son*[4] *who were from the Catholic community. Her son was wearing a Celtic Football tee shirt, seen as a Catholic symbol. When a group of Loyalists saw her son sitting in the back of the car when they stopped at a shop, they dragged her out of the car and beat her up. Her son was traumatized by this event and blamed himself because he chose to wear the tee shirt. A colleague and I, both from the Protestant community, saw them for several sessions and were able to effectively treat them both. At the end of the work the mother commented that she felt that being helped by Protestants after being so hurt by people from the Protestant community helped to restore her faith in that community.*

In Northern Ireland it is easy to discover which community you come from. Your name is the first clue, for example, "Ann" is Protestant and "Anne" is Catholic. Where you live is another clue as we are still a deeply divided society with 90% of public housing being single religion. Accents provide another clue as does the school attended. It has been well researched that we need to know where each other comes from and as therapists we pay attention to this.

These particular nuances are less relevant within the Palestinian community itself, but when there are such massive power differentials, therapeutic positions that attempt to balance the positions of Israelis and Palestinians are problematic and likely to be experienced as aligning with the oppressor. It raises different questions about the position of the therapist. As a therapist from outside Israel/Palestine, I (GD) can certainly appreciate the harmful impact of the conflict on Israeli families as well as give credit to the attempts made by many brave Israelis to challenge their government's oppression of Palestinians. Exhaustion and repeated disappointment at failed initiatives make this a more difficult position for Palestinian professionals to hold. Within Palestine, most professionals will be assumed by their clients to be suffering from similar effects of occupation. Outsiders are, however, required to demonstrate that they understand these effects and the politics behind them. Attempts to engage with the position of both communities and to take part in any joint initiatives thus need to be firmly rooted in an understanding of the nature of the power imbalance.

One feature of this power imbalance is that Israel's oppression of Palestinians contradicts the image it presents to the world: that of a beleaguered people whose army is "the most moral in the world." It solves this problem by framing the subject people in the most negative and derogatory of terms. This involves creating:

> a debased image of Palestinian identity as dangerously irrational and dishonest. A mixture of both weakness and violence is the classic portrait of the colonized Oriental as viewed through the eyes of Western power. In this way, the cultural heritage of the Palestinian people suffers a further degradation. (Jabr & Berger, 2017)

Nowhere is this starker than in the case of Gaza where, despite suffering death and destruction at the hands of the Israeli army and despite their utterly desperate living conditions, Gazan citizens tend to be described in one of two ways. If they are children, they are "human shields" manipulated by cynical leaders, or if they are adults, they are a violent, dangerous horde, bent on murdering as many Israelis as possible. Nowhere are they seen as normal people desperately trying either to live their lives

within or to escape from a place of misery, poverty, and hopelessness. It is hard to overemphasize the extent to which negative descriptions of Gazan citizens are employed to justify further repression. Some mental health professionals in Gaza have connected the alarming rise in suicide among young men to a tendency to internalize these negative and restricted descriptions of them. It can certainly be related to a total absence of hope and a lack of those opportunities for self-development, which could help expand a sense of self.

In the West Bank, where provocation to violence takes place in closer encounters, the struggle to resist these stereotypes was illustrated by a farmer outside Hebron whose land had been seized by settlers protected by the army. His protests were met with insults and rough handling. When asked about the rage he must feel at such treatment, he replied: "Of course I am angry. But I bury it deep down and refuse to show it because *they* want nothing more than for me to become violent." The need to adopt such a stoical position in the face of brutality highlights just one aspect of the complexity of responses to trauma.

## Trauma: Past and Ongoing and Its Effects on Family Life

Northern Ireland and Palestine are societies where it is virtually impossible to overstate the degree of trauma experienced. However, their very different stages of conflict create the necessity to bring a finely tuned, sensitive, and nuanced understanding both of trauma and of responses to trauma. While the literature has traditionally focused on the level of individual trauma, the World Health Organization's 2018 diagnostic manual—the International Classification of Diseases 11—adopts a more complex analysis.[5] In reviewing the evidence base for a new criterion for the diagnosing of PSTD and complex PTSD, Brewin et al. (2017) posit that complex PTSD is often caused by events that are multiple or sustained in nature. They argue that exposure to trauma, which is "extremely threatening or a horrific event or series of events," is required to meet the criteria. This description is more indicative of the trauma experienced by violence in Northern Ireland or Palestine. They argue that those affected by complex PTSD "have greater functional impairment than those affected by PTSD" (Brewin et al., 2017). It is severity of this impairment that impacts most profoundly on families, and we will return to this point.

*Northern Ireland* The complex trauma seen in the Family Trauma Centre in Belfast means that few of the referrals could be described as resulting from a single event trauma, most involved multiple or sustained trauma (Coulter, Healey, & Reilly, 2007). The impact is so profound that clinical experience suggests it can affect the wider family system over many generations.

Not all those subjected to severe trauma require psychological services such as those offered by the Family Trauma Centre in Belfast (Healey, 2017). Many find their own way to incorporate the trauma into their lives, including involvement in political life or community work, trying to help others, to make something positive from the tragedy that occurred. I (AH) was often moved by the number of families who offered to help others dealing with similar trauma. I saw these families as expert witnesses (White, 1995).

*A, living under fear and threat in a nationalist community, had her home attacked on more than 15 occasions. Her young daughter was suffering from frequent nightmares and bedwetting, and she was unsure that moving could help, as I suggested. She felt it would be giving into those from a different group within her own community and attacked her home for political reasons. She asked, "if only I could speak to someone who has been in this situation." One offer of help came from another mother, B. She came from the Loyalist community and had been in a similar situation, of being attacked by Loyalist paramilitaries because of her husband's occupation. She did not want to move but when she did, their lives drastically improved. Both mothers had to compromise their confidentiality, but, when I asked, they agreed to share phone numbers and I left them to it. When I spoke to A the following week, she had decided to move, to put the safety of her daughter first. Sometime after they moved, all the child's symptoms dissipated. B also told me that she felt good at being able to help another family.*

This reinforces the idea that trusting families' expertise about their specific circumstances as well as their willingness to support others is often more effective in sustaining resilience than direct therapeutic intervention. In this case the therapist's role is still an important one—that of facilitating connections between people (Healey, 1996).

In my clinical work I (AH) continue to see families whose lives have been devastated by conflict-related trauma many years ago. The impact of intergenerational trauma is evident, and I have seen children affected by trauma that happened to their families before they were even born.

There is an increasing awareness in Northern Ireland among some, particularly the few people involved in providing services for this population, about the true extent of conflict-related trauma. The field of trauma still tends to focus on PTSD; it is time to widen the lens of our understanding. Complex trauma and secondary trauma need to be considered with their specific effects on families. We do not have a reference term for "ongoing trauma," yet this is the reality for many people. Families here have commented that if only it was "post" if only it was over, then maybe they could find a way to recover. The idea of complex and ongoing trauma is more descriptive of what has happened to many people both in Northern Ireland and Palestine.

At present it is the legacy of political conflict in Northern Ireland that causes me (Arlene) the greatest concern. I work in a small charity for those affected by suicide. The service is located in an area devastated by the conflict. During the past few years, almost all the families I have seen there have been deeply affected by the conflict and the suicide of a family member. It is a stark reality that more than 4,500 people have taken their own lives in Northern Ireland since the signing of the Good Friday Peace Agreement. This is almost a thousand more than the number who died due to shootings, bombings, and other killings during the conflict, and Northern Ireland has a 25% higher rate of mental illness than England (McDonald, 2018). My belief is that peace opens up time to reflect on the conflict and to wonder whether it was worth the high cost that the family had to pay.

*Palestine* In Palestine, trauma is repeated remorselessly and daily, at individual, family, and community levels (El Sarraj & Qouta, 2005; Giacaman, 2017). As Arlene has argued about Northern Ireland, the effects of trauma can last for generations, and we could anticipate that, if peace is ever achieved, a further serious deterioration in the mental health of the population might well ensue. However, the imperative in Palestine is to make resistance to occupation, community solidarity, and the struggle

for justice the highest priority. Attitudes to therapeutic interventions are likely to be ambivalent at best. There is resentment among many mental health professionals about what they define as the "trauma industry" with its attendant risk of pathologizing individuals without challenging the oppressive context (Jabr, 2018).

Complex trauma in occupied Palestine has several additional features to Arlene's analysis of Northern Ireland with a similar need to challenge conventional clinical definitions of PSTD. First, as many have pointed out, there is no "post," since trauma is relentlessly ongoing (Giacaman et al., 2011). Second, conceptualizations of trauma need to incorporate the impact of collective violation on individuals and their communities. Third, there are the additional, less easily measured but profoundly connected traumas of impotence and humiliation. In researching the relationship between experiences of humiliation and mental and physical health, Barber et al. (2016) write about the impact on Palestinians of witnessing the destruction of their social world. The phrase most readily used is that of something being "broken" or "destroyed" (Barber et al., 2016). Giacaman (2018) also locates humiliation, not in intrapsychic terms but within an interpersonal framework, where relationships are a central human necessity and disconnections a source of psychological problems. Humiliation is not only a traumatic experience at a personal level but also a social process, inextricably linked to the loss of dignity, honor, and justice.

Dr. Samah Jabr (Jabr & Berger, 2017) describes working with men humiliated by Israeli soldiers such as being kicked and stripped, forced to divulge the names of female relatives, and coerced into repeating obscenities about them. She reframes this humiliation through a counter-narrative in which she encourages men to look at what insecurities might have led to this sadistic behavior on the part of soldiers, for example, their own anxieties about masculinity. Addressing humiliation and shame in this way challenges the impotence/power nexus and turns the gaze from the victim back onto the aggressor. It also illustrates the profound effects that humiliating practices have on family relationships, leading to a complex interweaving of feelings of shame, anger, and impotence on the part of parents and children, mirroring the impotence experienced at the level of the body politic.

## Specific Effects on Families

The family is a key institution in Palestine, especially important when so many aspects of civil society are undermined. The extended family carries out many responsibilities often held by governments, including mediating family disputes or supporting individuals in crisis. Family bonds are crucial and at the same time constantly under threat. On the one hand, family love, intimacy, wise discipline, and warmth increase children's cognitive and creative abilities. On the other, if mothers are exhausted and cope with trauma through withdrawal and avoidance, or if fathers respond to experiences of violence and humiliation by becoming violent to their own families, the risk to children increases. The generally strong Palestinian family ties and high levels of cohesiveness between extended family social and community networks, such as schools, likewise increase children's resilience in facing trauma and disaster (Altawil, Nel, Asker, Samara, & Harrold, 2008).

Israel's policies, however, serve precisely to diminish cohesiveness and unity within the Palestinian community. This happens in four main ways. First, this may be done by dividing families through the arbitrary uses of residency status and permits. For exam-

ple, some family members may have Jerusalem permits without which it is impossible to visit the capital, and some may not (Hammoudeh, Hamayel, & Welchman, 2016). Second, the separation wall divides extended families and separates families from their own land. Third, the number of road blocks around villages and cities decreases possibilities for regular meetings between individuals and their families. Fourth, the use of spies within the community to spread rumors is designed to diminish trust and erode connection, cooperation, and community cohesiveness (Giacaman, 2018).

For Palestinian families, it is hard to experience an uncontaminated private family space because the reach of the Israeli military and Israeli surveillance is everywhere. This applies not only in the physical sense that soldiers may force entry into the home at any hour of the day or night or that the house itself may be destroyed but also through the enactment of what Foucault terms bio-power, the control of a population through the regulation of birth, death, and marriage, which means that all family transactions such as the registration of births or the release of bodies for burial are subject to arbitrary and often punitive decisions made at a higher level by the occupying power (Shalhoub-Kevorkian, 2015).

## Shame at being unable to bring about change

Political oppression and prolonged and apparently unstoppable civil conflict can enter into views of the self, creating feelings of shame at being trapped within such negative, destructive, and unproductive processes. A common cri de coeur in Northern Ireland during the Troubles was: "What is wrong with us?"

I (AH) can relate to this sense of shame and failure having personally experienced it many times living in Northern Ireland. As I write, we have had many incidents of petrol and blast bombs over recent weeks and shots being fired at police officers. Homes and cars have been set on fire, and it is evident that most of the population do not want this kind of activity in their community. In this fragile peace, violence can easily erupt. When it does, we feel guilt and shame. We should be at peace. Politically we are currently in a political vacuum, we have no functioning government in Northern Ireland, and it feels as if the government in Westminster has long given up on us.

In both contexts we notice how painful it is for fathers who strongly believe that protecting the family is their job to feel that they have failed in this task. Even when there was nothing that they could have done, they still feel shame and guilt.

> *A father that I (AH) worked with after his family's home was petrol bombed and badly damaged told me how badly he had been affected. He had great difficulty sleeping, so he decided to stay awake every night and sit in the room that was attacked. In a family meeting I reflected that it was as if he was on guard duty. I asked, would he ever be able to sleep in his bed again? Immediately the children intervened and said "No!! Please don't!! We need you to be downstairs keeping us safe."*

In Palestine, a sense of shame in the older generation at having failed or colluded with the occupier can lead children and young people to feel that the responsibility to resist rests upon their shoulders. In the 2018, at "Great March of Return" in Gaza, young people took enormous risks in approaching the fence, to be picked off by Israeli snipers. As well as fatalities, many suffered catastrophic injuries. They often acted in defiance of pleas from their parents to stay away. Importantly, this determination to act whatever the

cost to the self fits with the findings about resilience made by Punamäki, Qouta, and El Sarraj (2001) on the association between improved levels of resilience among adolescents and their level of personal engagement in local political action. This means that, for many young people in Gaza, striving for psychological health can be at the expense of life.

On the West Bank, children who resist—usually by throwing stones—are subject to arrest and between 500 and 700 annually are detained and prosecuted in Israeli courts (MAP, 2017). Stone throwing can lead to imprisonment for up to 20 years. Over 90% of children are interrogated without a lawyer or family member present, and the majority suffers verbal abuse and intimidation. Children are held either in military facilities in the occupied territories or in prisons within Israel. The impact on intimate family relationships is profound. First, the word "prisoner," with its connotation of criminal activity, obscures the arbitrariness and injustice of child arrests and the powerlessness, desolation, and sense of abandonment that children experience. This starts at the moment of arrest when parents, faced with armed soldiers breaking into their home, usually at night, are powerless to prevent their children being taken away at gunpoint. Israeli assumptions about Palestinians' inherent dangerousness mean that large numbers of soldiers may be involved in the arrest of one child. The trauma of abandonment continues if parents cannot or can only rarely visit their children in prison. If children are held in Israel, parents need a relevant permit, which may not be granted. One father whose two children were imprisoned described visits to Israeli prisons, less than 50 miles away, typically taking 13 hr. Additionally, families often have to pay for their children to be released. This places parents in a bind. Quite apart from the fact that many cannot afford to pay these "levies," they are invited into a financial transaction that implicates them in implicitly recognizing and indeed paying for those very violations inflicted on them and their children by the occupying power. Refusal brings more damage to and suffering for their children. Compliance brings resentment and shame.

This unwilling collaboration with the oppressor continues when children are released from prison. Parents, terrified that their children will go back into prison or be killed by soldiers, may try to keep them at home and to restrict their movements even if this contradicts the child's developmental stage. They may try to dissuade them from acts of resistance such as stone throwing. They are effectively acting as jailors. "The moment you put children under arrest in their house, the home—the place of sleeping and feeding and safety—is turned into a prison" (Shalhoub-Kevorkian, 2015). Children, traumatized by their experience in prison, where they receive no education, will rarely return to school. Additionally, they may feel shame if they have been coerced into revealing information about their friends; they may be fearful of being branded an informer or being informed against. All of this will invite children onto the streets again to demonstrate that they are still resisting and that they do not fear the soldiers. Some children run away from home. Parents may feel as if they have been neglectful because they could not protect their own children from the immense suffering that a jail sentence entails. This can be further complicated by guilt and shame at having been unable themselves to find another effective way of resisting. A conversation between an aunt and her 11-year-old nephew went as follows:

YUSUF : "When I grow up I am going to fight the Israelis with knives and kill them."
YASMINA: "But the best way to fight is to get a good education and then you can be a leader and help our people better than through violence."
YUSUF: "But you have a good education and you haven't done anything."

When teenagers have been imprisoned, their response may be to locate themselves within a discourse of heroism of fighting for Palestine, copying other political leaders, many of whom have only achieved this status after death. If they witness one of their parents being assaulted or humiliated, they may desire or attempt revenge. Both parents and children may try to hide painful feelings of fear and vulnerability and get caught up in rigid polarities of pride and shame. Pride may be performed at great risk to life; shame usually results in silence and depression, closing down communication and connection.

## Communities uprooted/lack of safety in homes and neighborhoods

*Northern Ireland* In addition to the legacy of the Conflict in Northern Ireland, there must be recognition that the conflict continues for many people. The peace process did not mean the removal of paramilitary activity. Their continued presence and acts of violence and intimidation continue to threaten the safety of many families. Looking at recent figures from the Northern Ireland Housing Executive (NIHE), the public body responsible for public housing in Northern Ireland, the picture is concerning. The numbers of families presenting as homeless due to intimidation continue to be a cause of great concern. In 2015/2016, the last year for which figures are available, there were 582 made homeless due to threats and intimidation, of which 433 were directly due to the actions of paramilitary groups. From 2006 to 2016, figures from the NIHE show that more than 7,000 families were made homeless. Families are defined as households that contain children, and often family groups in this context contain several children. From my clinical work, the impact of homeless and families being forced from their home causes significant impact on the mental health of children and young people. A middle-aged man who attended recently with concerns about his mental health and his uncontrollable anger told me how his family were forced from their home when he was a young child. He cried when telling me about how his family were forced to leave their home in a small rural community in Northern Ireland where they "knew everyone" and to go to a very large town in the other side of the country where they knew no one. He told me he did not think his family ever recovered from this event, and he believed it led to the early death of his father.

*Palestine* The experience of being violently uprooted is *the* key experience for the majority of Palestinians, and it occurs at many interconnected levels. On the West bank, the violent displacement of people from their homes and land continues unabated with settlement building, creation of closed military areas, and, in Jerusalem, the use of zoning laws to accelerate an entirely ethnocentric approach to town planning (Yiftachel, 1999). Zionist settlers regularly evict Palestinians forcibly from their homes and take them over, flying the Israeli flag and changing the names of the streets (as they have done with countless villages) from their original Arabic to Hebrew.

When Palestinian families expand and need to extend their living space, they require a permit to do so, which, in East Jerusalem or those areas of the West Bank (88%) that are not under Palestinian Authority control, is refused in 95% of cases. Since this leads to severe overcrowding, families resort to building or extending homes without

permits, and as such their houses are declared illegal and liable to demolition. A child may return home from school to discover that their home and their possessions have been destroyed by Israeli bulldozers. If a demolition order is about to be implemented, families know that they will be fined and will have to pay for the demolition costs themselves. To avoid this, fathers may end up demolishing their own homes, in front of their children. It is not difficult to imagine the humiliation this involves for a man who has had to "cooperate" in dismantling the shelter he provided for his own children. Unsurprisingly this is one of the main causes of depression in adults (Qouta, Punamäki, & El Sarraj, 1998) and one of the most serious traumas experienced by children.

## Family, Community, and Spiritual Sources of Resilience

In Ireland, both North and South, the family is the key institution around which life is organized. In the South of Ireland, the concept of family is enshrined in the constitution: the family is seen as "the natural and fundamental unit group of Society." In Northern Ireland, we have no constitution, but we are a small country, and we remain very close to our families often living near each other and seeing family members frequently. In Palestine, family is equally key but, as we have described, barriers to movement, arbitrary and punitive citizenship laws, and vulnerable living spaces mean that what should be "normal." Sustaining family and community bonds become fragmented and have to be constantly fought for rather than relied upon.

In Northern Ireland, religion and political affiliation has been a source of division; in Palestine, faith and culture are experienced as a source of resilience both for families and for health professionals (Marie, Hannigan, & Jones, 2017).

The Palestinian concept of *Sumud* (a word that incorporates resilience and steadfastness) is deeply rooted in historical and religious contexts that are considered to be their main source during adversity and crises (Marie, Hannigan, & Jones, 2018; Marie et al., 2017). As Mohammed Marie explains, the prophet Mohammad (PBUH) is held up as the model of resilience, and Muslims are encouraged to follow his Sunnah (all his behaviors and sayings in different life situations) in adversity or crisis. Many Palestinian families find inspiration and solace in their belief system, their Islamic cultural context; Islamic rituals provide commitment, guidance, consolation, and faith in order to survive or thrive under occupation (Al Balakhi, A.i.S. Al-Balakhi, A.-Z., 2005). This includes finding ways to cope, overcome, and adapt in catastrophic situations of adversity, siege, hunger, chronic traumas, instability, fear, anxiety, frustration, etc. (Altawil et al., 2008; Van Teefelen, Bitar, & Al-Habash, 2005).

The model for Muslim mental health professionals and their way of thinking in the workplace differs from Western models of care; "professional and identity (are) intertwined and inspirable from Islamic values" (Mebrouk, 2004, p. 62). Most Muslim health professionals have a way of thinking inspired by their religion that they must try to make their daily life beautiful as much as they try to make their afterlife beautiful. One Arabic health professional leader commented that proper health professional activities will be a reason to enter paradise in the afterlife, so that health professionals must try not to complain or feel dissatisfied.

Muslim teachers inspire their followers with many strategies to cope with life adversity. From the Holy Qur'an and Sunnah of the prophet Mohammad (PBUH), these strategies inform Muslim practice nowadays. For example, Al Balakhi (850–934 AD) suggested that individuals must be self-aware and attuned to their supportive resources so that they can use their internal defense mechanisms to cope with adversity in a positive manner but when this fails they must use external sources of coping mechanisms. Human beings must protect themselves to preserve well-being by doing exercises or training to help themselves cope with small stressors in order to be more mentally flexible, gain experience, maintain psychological strength, and become more tolerant (World Health Organization, 2005). In vulnerable times, individuals are encouraged to avoid engagement in risk taking as much as possible in order to protect mental and physical health and well-being. However, all these aspects of Islam tend to be erased by the preferred discourse of the colonial power, a negative narrative in which Islam is equated with extremism.

Other Palestinian collective belief systems help them cope with crises but are also under threat. For example, most Palestinian families are strongly connected with their land in quasi spiritual ways. A Palestinian farmer may consider land as akin to soul and olive trees as akin to children. So, preserving mental health is profoundly connected to trying to stay on their land and its theft, and the destruction of olive orchards brings a particularly intense suffering.

## Mental health services for families

Mental health and family support systems are profoundly different in Northern Ireland and Palestine. In Northern Ireland there has been a dearth of trauma-related psychological services. As a result, many families reflect now that after they were affected by trauma, for example, the murder of a loved one, they were left on their own to manage the loss. Friends and family who offered support were also affected by the silence surrounding the conflict. The family general practitioner was the first line of contact and in the absence of services often turned to medication. The widespread reliance on and over use of medication has been a source of concern for those running the health service in Northern Ireland. Self-medication was and continues to be prevalent with many using alcohol to cope. This is connected to the lack of recognition of trauma among mental health professionals.

A Muslim colleague of AH who has also worked in Palestine and provided some training for trainee psychiatrists commented that he felt we were "training them to work in some other country, as the conflict and the impact of trauma received no attention in their whole training programme." When I (AH) opened the Family Trauma Centre, no family therapists were employed in the National Health Service in the country, and no money had ever been spent on addressing the psychological needs of those affected by the conflict. Although the Peace Agreement addressed this issue and its implementation provided funding to open the Centre, 20 years after the agreement, there continues to be a dearth of services to address the legacy of the conflict.

Families in Palestine have long been deprived of access to health facilities, especially in mental health. Mental health problems are additionally seen as a source of shame and secrecy with among other factors, parents fearing that if it is known in the

community it will affect children's marriage prospects. Although Palestinian mental health workers see families, they have received no formal training, and there is only one qualified family therapist in the whole of Palestine.

This increases the demand on patients' families and mental health teams. For example, Palestinian children suffering cognitive impairment have no access to pediatric psychiatric facilities. Families are usually prevented from seeking treatment in Israeli hospitals or unable to seek help outside Palestine. So they cope with no support and no respite. I (MM) and other mental health workers see many people whose mental illness results from torture, which takes many forms both physical and psychological.[6] Offering adequate help without enough training or resources is impossible. One nurse may be responsible for the care of around 30 psychiatric patients. So patients may suffer twofold, once in an Israeli prison and again when they are unable to find suitable mental health care in Palestinian services. Mental health professionals who work daily with these cases lack any type of real supervision, guidance, debriefing, and care (Marie et al., 2017; Marie, Hannigan, & Jones, 2016). This can lead to exhaustion, burnout, and the diminution of empathy.

## Coherent narratives

In helping someone like Samuel (case example that follows), it is important to develop a coherent narrative (Healey, 2017). It can be helpful to think in terms of four narratives: the past before the traumatic event or events started, the traumatic event or events, the impact it has had on life and family, and finally the impact it has had on hopes for the future. This can help when trying to process the traumatic event or events. It can also help the therapist to understand the impact of the trauma. The process of starting before the trauma also means witnessing how normal life was and thus understanding and witnessing the impact of the trauma.

*Samuel is aged 51 and is a father of 3 children. His son Robert aged 22 died in late 2016 at a concert having taken some tablets that his friend gave him. He had an undiagnosed heart condition and died that evening. Samuel is struggling to come to terms with the death of his only son. He had been prescribed a range of medication by his GP due to his inability to sleep and his low mood. Samuel feels that his life has lost all meaning and value without his son to share it with. They often watched football together and went to concerts together.*

*In trying to help Samuel, I worked with both him and his wife Susan and saw them both together and individually. Susan is very worried about her husband and fears he will never recover from the death of their son.*

*When trying to understand the impact of this traumatic loss, it was important to place this trauma in context. Samuel had no coherent narrative about his life. In discussing the conflict in Northern Ireland, I began to understand that Samuel had also been exposed to many incidents of conflict-related trauma. He had served in the Ulster Defence Regiment, a part time army reserve supporting the work of the British Army. He said he had "a few near misses," meaning he had been shot at and not injured and he had been close to explosions but he had never been injured. He was close to colleague when he was shot in the face; he survived but was badly injured. He was also shot at when the IRA took over a house in Belfast.*

*Samuel told me about another evening when he was going to visit his aunt. He heard a loud bang and knew it was an explosion of some sort. He ran to the scene and a man was in a car that had an explosive device attached to it. The device had been triggered and the man inside the car was badly injured. He helped to get the man from the car and realized he had lost both of his legs. He had some first aid training and tried to stop the bleeding and applied tourniquet to his legs.*

*Samuel lived under IRA threat during the height of the conflict. He would have checked his car daily to make sure there was no explosive device attached to it. He was careful with his uniform and had a personal fire arm issued to him. He had to remain silent about his job and could never discuss it openly. Samuel got used to the position of silence.*

*Since the death of his son he found himself thinking over these incidents; in fact, he said he could not stop thinking about them. He told me that he experienced bizarre dreams such as firing a gun that no longer worked or seeing the bullets going in a weird direction. The layers of trauma that he had been exposed to resurfaced. He would say that up until this time he had not thought much about these past traumas. Largely they were in his memory, but he felt he had dealt with them psychologically. Now he felt he was drowning in a tsunami of trauma and loss.*

*The work with Samuel involved trying to help him to find a way to have a semblance of normal life again and to enjoy the time he spends with his daughters and granddaughter. In order to cope he gradually shut himself away in his home and rarely went out. The exception to this was when he went to speak to other young people about the dangers of drug use. While these talks gave him a sense of purpose and meaning, they were very upsetting emotionally and took a great toil on his limited emotional capacity. Samuel needed a coherent narrative about his life. He needed to understand that he himself had been exposed to severe life-threatening trauma on several occasions. Samuel's presentation and difficulties would fit with a diagnosis of complex PTSD. Helping someone to know that there is a name for their difficulties and that it is not weakness on their part is very important in this work.*

The idea of a normal life before trauma is of course difficult at an individual level for those Northern Irish citizens who grew up with trauma and for the majority of Palestinians who have known nothing else. This strengthens the argument for accessing collective narratives and for incorporating political narratives and practices of power into the process of developing a coherent narrative. For example, projects that focus on reclaiming Palestinian history and presence on the land or on celebrating Palestinian art and culture are acts of reasserting collective narratives in the face of deliberate distortion or erasure.

## Therapeutic witnessing

Therapeutic witnessing as posited by Weingarten (2000, 2004) is a therapeutic process that can bring about change in itself. We find it particularly helpful working with those for whom trauma has been so severe that they struggle to function. At times like this, the therapist can easily feel overwhelmed and that they cannot be of help. The act of therapeutic witnessing can free up this situation and help the therapist not to feel the same sense of helplessness. The therapist can also weave hope into the narrative and have a conversation about hope and change. In Northern Ireland, it has been possible to witness over the last 20 years a resurgence of hope, although many community tensions and buried traumas remain. In Palestine, hope is an extremely elusive concept; it has virtually no supporting evidence. Yet families vary, and members within families vary in terms of who carries the most hope and despair. Very often, as

Mohammad Marie has described, hope is located in the afterlife, and this is a motivation to continue to act steadfastly and ethically.

Weingarten (2004) also writes about the impact of political violence, and of course, those affected by the conflict in Belfast, or by the Israeli military occupation, have this in common. Political violence differs from acts of violence that appear to happen by accident, such as a random attack. Motive and intentionality have a profound impact on meaning-making, emphasizing again that therapy needs to be politically informed.

That these can be difficult stories to hear, that they are profoundly unsettling in terms of how we view the country we inhabit, or indeed our collective humanity can hardly be overstated. The desire to disassociate from such painful stories is ever present, leading to what Jessica Benjamin calls "failed witnessing" (Benjamin, 2018). In relation to Palestine, an added level of failure is that of witnessing but failing to act. Human rights abuses in Palestine could hardly have been more thoroughly documented by both Palestinian, Israeli, and foreign researchers and activists, and yet the situation only deteriorates. This increases the imperative to demonstrate to those suffering that as well as listening we engage in practical acts of solidarity. For professionals in Palestine, the fact that many of them suffer the same types of trauma as the families they see creates solidarity on the one hand but intensifies distress on the other.

In the preparation of this chapter, Mohammad has shared personal experiences of trauma such as the following.

> *I was arrested and tortured many times during my work as were my other Palestinian colleagues. In 2002 when Nablus was still under strict curfew and the hospital was surrounded by tanks, my colleagues and I were prevented from entering our place of work for many hours. When I started my night shift, the soldiers demanded by loudspeaker that I return to the entrance or they would invade the hospital. I did so to protect the hospital. Immediately I reached them; they blindfolded and stripped me in front of my colleagues and patients and threw me inside the tank where three or more soldiers started torturing me, hitting me on my head with their guns, kicking me, and burning my legs with cigarettes, laughing as they did so. It is hard to explain how hard this experience was. After further detention and torture in prison, I was as abruptly released, being told by the interrogator that my security file was clear and I was not guilty of anything. I was left outside the city wearing my nurse's white clothes, where Palestinian families helped me evade the curfew and reach work again.*

It is virtually impossible for a Palestinian professional to be immune from experiences such as these, which, while they provoke outrage for those witnessing from the outside, are routine for those inside. For example, in the course of describing to Gwyn, the heart-breaking story of a deeply distressed 7-year-old boy from Gaza being treated for cancer in Alnajah hospital in Nablus and not able to have any of his family present because they were refused permits to accompany him, Mohammad described how he and his wife have been refused permits to take their own 3-year-old daughter for essential treatment in Jerusalem, half an hour away. When they receive the permit, the parents will only have it for one day, meaning that if their daughter stays in hospital for a week, one of them will have to stay there illegally, constantly fearing arrest for being in Jerusalem without a permit. This is a powerful example of how what should be a "normally" anxiety provoking process—parents

taking their young child to hospital—is grossly exacerbated by having to navigate such cruel obstacles.

Most of Mohammad's cases show how political oppression infiltrates the emotional world of intimate relationships and connections. For example, a young woman was arrested and imprisoned by the Israelis because they had picked up from her Facebook page a discussion of suicide between her boyfriend and her when they were splitting up. Other examples include a woman from Gaza with advanced cancer completely isolated in hospital and cut off from her family who, of course, cannot visit her and a man who was re-traumatized after a particularly brutal imprisonment by being in a claustrophobic hospital ward. In all of these cases, Mohammad was able to make brief practical and helpful interventions including helping the woman Skype with her relatives and moving the man to a different room in the hospital. These last two interventions were therapeutic in the way they supported connections and acknowledged the lasting effects of trauma.

Since there is considerable stigma in many Palestinian communities around mental illness and psychological interventions in general, parents may be unwilling to engage in therapy on their own account. However, they will be much more likely to support interventions for their children such as the "Days of Joy" run by the Palestine Trauma Centre in Gaza. These offer brief moments of respite and play from the horrors of daily life.[7] Similar projects are run all over Palestine although their funding is in constant jeopardy. More specific narrative approaches inform the work of the Treatment and Rehabilitation Centre for Victims of Torture, Ramallah, where among other projects, groups for children who have been incarcerated support them in using their "expertise" to give advice to other children in the same situation (Sehwail & White, 2014).

## Conclusion

Both Northern Ireland and Palestine have much history in common, including settler colonial occupation and postcolonial conflict, both legacies of actions by the UK government a lifetime or more ago. In this chapter, we attempt to make connections between these two contexts in which families have been subjected to traumatic assaults and traumatic intrusions into every level of their functioning. These range from material effects such as death, injury, destruction of community infrastructure, violent dislocations, and destruction of the home as a place of safety to the less visible effects of shame, humiliation, silencing, and the erosion of hope. The different stages of each community in relation to conflict or its resolution have enabled us to reflect on the long-term effects for families. In Northern Ireland, the need is to confront the intergenerational effects of trauma, and in Palestine therapeutic work takes place in an even more ambiguous space—between a knowledge that healthy functioning is impossible in conditions of such oppression and the desire to do whatever we can to reduce suffering when no safe place yet exists for healing to be possible. Additionally, as we have seen, the need to preserve self-esteem by taking part in acts of resistance so often leads to loss of life.

Inevitably therefore, introducing hope into the therapeutic discourse requires a somewhat different treatment in each context if we are to avoid "hope" becoming a

"thin" or vacuous and ultimately meaningless idea in contexts where facing despair seems more apposite. Weingarten, however, reminds us that it is the therapist's job to "do hope," and we agree with this view. "Doing hope" can reside in a number of processes including witnessing accounts of suffering without flinching or disassociating, naming the intentions and processes behind the infliction of wounds on families and communities, and documenting in detail acts of resilience, resistance, and, above all, the maintenance—gainst all the odds—of the bonds that matter. These are the processes that we aim to bring into therapy, and these are relevant to all therapists working in such contexts.

The psychological impact on those working in these contexts is of particular importance when, as Mohammad has so powerfully described, they also belong to these communities and have experienced their own trauma as a result. Arlene has felt particular empathy for Mohammad's need to explain quite what it means to be living and working in these conditions. She struggled in a similar way when doing her family therapy training in Dublin in the early 1990s.

We also need to appreciate the energy required in order to keep going. Just as a population under constant onslaught over decades can become exhausted and find the inventiveness required to keep family life going increasingly burdensome, so burnout and secondary trauma in staff can intensify over time. Although those offering supervision to this work can often wonder whether they are doing any good in the face of such remorseless suffering, the act of bearing witness is generally and most generously appreciated.

In Northern Ireland, Arlene has found value and inspiration in acts of therapeutic witnessing, the use of expert witnesses and in "doing hope." In Palestine, Gwyn, as an outsider, has found value in remaining steadfast and attentive, in taking some responsibility for the failings of her own government, and in combining witnessing with activism. Mohammad has drawn huge strength and inspiration from religious and cultural life and in following the tradition of both his family and his community in improvisation and in finding creative solutions to oppression and divisiveness. All of these responses can apply to other professionals working with families who live within extremes of political oppression, civil conflict, and trauma.

## Notes

1 In this chapter we refer to the Palestinian territories occupied since 1967, that is, the West Bank and Gaza.
2 https://www.icrc.org/eng/resources/documents/faq/occupation-faq-051010.htm October 5, 2010.
3 www.icj-cij.org/docket/files/131/1677.pdf
4 All vignettes in this chapter are inspired by actual cases but are composites rather than exact descriptions. Though the dynamics described are close to the original situations, the details of the cases have been altered significantly to protect confidentiality and meet ethical guidelines.
5 www.who.int
6 https://www.btselem.org/publications/summaries/201512_backed_by_the_system
7 Palestine Trauma Centre http://ptcuk.org/

## References


Afuape, T. (2011). *Power, resistance and liberation in therapy with survivors of trauma: To have our hearts broken*. London, UK & New York, NY: Routledge.

Afuape, T., & Hughes, G. (2016). *Liberation practices*. London, UK: Routledge.

Al Balakhi, A.i.S. (Al-Balakhi, A.-Z.). (2005). In M. A. Alhayyat (Ed.), *Maṣāliḥ al-abdān wa-al-anfus* [Sustenance for body and soul]. Cairo, Egypt: World Health Organisation—Regional Office of the Eastern Mediterranean.

Altawil, M., Nel, P. W., Asker, A., Samara, M., & Harrold, D. (2008). The effects of chronic war trauma among Palestinian children. In M. Parsons (Ed.), *Children: The invisible victims of war—An interdisciplinary study*. Peterborough, UK: DSM Technical Publications Ltd.

Barber, B. K., McNeely, C. A., Sarraj, E. E. L., Daher, M., Giacaman, R., & Arafat, C. R. (2016). Mental suffering in protracted political conflict: Feeling broken or destroyed. *PLos One*, 11(5), e0156216. doi:10.1371/journal.pone.0156216

Benjamin, J. (2018). *Beyond doer and done to*. London, UK: Routledge.

Brewin, C. R., Cloitre, M., Hyland, P., Shevlin, M., Maercker, A., Bryant, R. A., … Reed, G. M. (2017). A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. *Clinical Psychology Review*, 58, 1–15. doi:10.1016/j.cpr.2017.09.001

Coulter, S., Healey, A., & Reilly, I. (2007). Hope in the process: Conducting systemically orientated trauma work within the context of the peace process in Northern Ireland. In C. Flaskas, I. McCarthy, & J. Sheehan (Eds.), *Hope and despair in narrative family therapy: Adversity, forgiveness and reconciliation* (pp. 113–124). London, UK: Routledge.

El Sarraj, E., & Qouta, S. (2005). The Palestinian experience. In J. Lopez-Ibor, G. Christodoulou, M. Maj, N. Sartorius, & A. Okasha (Eds.), *Disaster and mental health*. Chichester, UK: Wiley.

Fanon,F ( 1963) The Wretched of the Earth New York. Grove Press

Fay, M. T., Morrissey, M., & Smyth, M. (1998). *Mapping Troubles-related Deaths in Northern Ireland 1969-1998* (Belfast: INCORE, International Conflict Research/CTS).

Foucault, M. (1972). *The archaeology of knowledge and the discourse of language*. New York, NY: Pantheon.

Giacaman, R. (2017). Social suffering: The painful wounds inside. *American Journal of Public Health*, 107. Adcance online publication. doi:10.2105/AJPH.2016.303637

Giacaman, R. (2018). Reframing public health in wartime: From the bio-medical model to the wounds inside. *Journal of Palestine Studies*, XLVII(2), 9–27.

Giacaman, R., Rabaia, Y., Nguyen-Gillham, V., Batniji, R., Punamaki, R., & Summerfield, D. (2011). Mental health, social distress and political oppression: The case of the Occupied Palestinian Territory. *Global Public Health*, 6, 547–559.

Hammoudeh, D., Hamayel, L., & Welchman, L. (2016). Beyond the physicality of space: East Jerusalem, Kufr 'Aqab and the politics of everyday suffering. *Jerusalem Quarterly*, 65, 35–50.

Healey, A. (1996). Systemic therapy in a culture of conflict: Developing a therapeutic conversation. *Child Care in Practice*, 10, 167–184. doi:10.1080/13575270410001693385

Healey, A. (2017). Working with traumatised families in a context of civil conflict. In A. Vetere & E. Dowling (Eds.), *Narrative therapies with children and their families. A practitioner's guide to concepts and approaches* (pp. 271–288). London, UK: Routledge.

Jabr, S. (2018). *Professional solidarity with Palestine: A mental health imperative*. Retrieved from http://middleeastmonitor.com/20181129-professional-solidarity-with-palestine-a-mental-health-imperative/

Jabr, S., & Berger, E. (2017). The trauma of humiliation in the Occupied Palestinian Territory. *Arab Journal of Psychiatry*, 28, 154–159.

Marie, M., Hannigan, B., & Jones, A. (2016). Mental health needs and services in the West Bank, Palestine. *International Journal of Mental Health Systems*, 10, 23. doi:10.1186/s13033-016-0056-8

Marie, M., Hannigan, B., & Jones, A. (2017). Challenges for nurses who work in community mental health centres in the West Bank, Palestine. *International Journal of Mental Health Systems*, 11(3). doi:10.1186/s13033-016-0112-4

Marie, M., Hannigan, B., & Jones, A. (2018). Social ecology of resilience and Sumud of Palestinians. *Health*, 22, 20–35. doi:10.1177/1363459316677624

McDonald, H. (2018, February 20). *Northern Ireland suicides outstrip troubles death toll.* Retrieved from www.theguardian.com/uk-news/2018/feb/20/northern-ireland-suicides-troubles-death-toll

Mebrouk, J. (2004). *Perceptions of nursing care: Views of Saudi Arabian female nurses.* Unpublished Masters of Health Science (Nursing), Deakin University, Adelaide, Australia.

Medical Aid for Palestinians. (2017). *Health Under Occupation, Chapter One: Access to Healthcare.* [Online]. Retrieved from https://www.map.org.uk/downloads/map-vol1-of-6-access-brief-final-web.pdf

Muldoon, O., Schmid, K., Downes, C., Kremer, J., & Trew, K. (2005). The legacy of the troubles: Experience of the troubles, mental health and social attitudes. *International Journal of Mental Health Nursing*, 26, 344–354. doi:10.1111/inm.12229

Northern Ireland Statistics and Research Agency. (2017). Retrieved from http://nisra.gov.uk/

O'Reilly, D., & Stevenson, M. (2003). Mental Health in Northern Ireland: have "the troubles" made it worse. *Journal of Epidemiological Community Health*, 57, 488–492.

Punamäki, R., Qouta, S., & El Sarraj, E. (2001). Resiliency factors predicting psychological adjustment after political violence among Palestinian children. *International Journal of Behavioural Development*, 25, 256–267. doi:10.1080/01650250042000294

Qouta, S., Punamäki, R.-J., & El Sarraj, E. (1998). House demolition and mental health: Victims and witnesses. *Journal of Social Distress and the Homeless*, 7, 279–288. doi:10.1023/A:1022995428517

Said, E. (1978). *Orientalism*. London, UK: Vintage.

Sehwail, M., & White, C. (2014). *Responding to trauma that is not past.* Adelaide, Australia: Dulwich Centre Foundation International.

Shalhoub-Kevorkian, N. (2015). *Security theology, surveillance and the politics of fear (Cambridge Studies in Law and Society)*. Cambridge, UK: Cambridge University Press.

The Belfast Agreement. (1998). Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/136652/agreement.pdf

Van Teefelen, T., Bitar, H., & Al-Habash, S. (2005). Resilience in the Palestinian occupied territories. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and context* (pp. 417–432). Thousand Oaks, CA: Sage.

Weingarten, K. (2000). Witnessing wonder and hope. *Family Process*, 39, 389–402. doi:10.1111/j.1545-5300.2000.39401.x

Weingarten, K. (2004). Witnessing the effects of political violence in families: Mechanisms of intergenerational transmission and clinical interventions. *Journal of Marital and Family Therapy*, 30, 45–59. doi:10.1111/j.1752-0606.2004.tb01221.x

White, M. (1995). *Re-authoring lives: Interviews and essays.* Adelaide, Australia: Dulwich Centre.

World Health Organization, Regional Office for the Eastern Mediterranean. (2005). حالصم سفنألاو نادبألا. Retrieved from http://www.who.int/iris/handle/10665/119769

Yiftachel, O. (1999). 'Ethnocracy': The Politics of Judaizing Israel/Palestine. *Constellations*, 6(3), 364–390.