Pain and Resilience in the Palestinian Struggle to Survive

An interview with Dr Samah Jabr

Dr Jabr is a Palestinian Jerusalemite psychiatrist, psychotherapist and writer, and former Head of the Mental Health Unit in the Ministry of Health in Palestine. She recently toured Australia with the support of the Shifa* project to promote her book, *Radiance in Pain and Resilience: The global reverberation of Palestinian historical trauma*. Dr Jabr has practiced in East Jerusalem and the West Bank, taught in the faculties of several Palestinian universities and written columns about the psychological consequences of the Israeli occupation in Palestine. Her areas of interest are the rights of prisoners, the problem of stigma, psychoanalysis, childhood trauma and the integration of mental health with public health. She spoke to NEHAD KENANINE about her perspective on the shortcomings of Western mental health models when applied to the ongoing, collective trauma of Palestinian people. She offered a profound and empathetic look into the unique psychological landscape of Palestine, highlighting the importance of such indigenous concepts as Sumud (steadfastness) and the healing power of community.

THE INTERCONNECTION OF TRAUMA AND THE POLITICAL REALITY

NK: **How do Western-centric models of trauma, such as Posttraumatic Stress Disorder (PTSD) fall short in addressing the continuous, collective trauma experienced by Palestinians?**

SJ: I think the exported PTSD concept assumes two things that do not apply to the Palestinian reality: that the traumatic experience is concise with a clear beginning and end; and that there is an aftermath of safety. Neither applies to Palestine.

In our reality, trauma is political. It is anticipated, it is accumulative, it is administrated intentionally, with the objective to impose helplessness and make people lose their agency, their will and political aspirations. This is why the conventional trauma therapies do not help us. They do not acknowledge the intentionality of trauma. They shy away from a political response to the traumatic situation. They assume safety when we do not have safety. We operate in an environment that is very problematic.

This is just one example of Western psychology and mental health failing to understand our experience, and it pushes us to generate knowledge and wisdom and make observations from our unique reality. In Palestine, while it is complicated, we try to be honest and fair to people's experiences by describing things as they are. We see also that the political intertwines with the personal and produces psychological symptoms.

If we listen carefully to the people who come to see us in the clinics, behind every symptom, there is political pressure. It can be as simple as a woman asking that I increase the antipsychotic medication of her husband. When I ask and I argue with her that he has been stable on two milligrams for so long and ask her: "Why is it necessary now?" She says: "My husband used to go to the men's coffee shop in the refugee camp so we had less tension at home. Now that the coffee shop is destroyed, he stays at home and the tension increases. So we need more antipsychotic for him."

I am expected to respond with medication to address a political reality. I think anyone working in Palestine understands this dilemma. I think we need not pathologise people and not provide medical responses to the painful reality that is intended to break the will of the people.

Dr Samah Jabr image courtesy of STARTTS

Gaza, Mohammed Ibrahim Unsplash

How do you effectively communicate a complex reality to a wider audience that is not familiar with it? Especially when dealing with both, the medical and humanitarian aspects of the situation. For example, how can you help people understand the daily political impacts on an individual's life?

Political oppression is often overlooked in Western psychology and psychiatry, which typically focus on the biopsychosocial model without considering how oppressive power structures and political realities intentionally harm people. This oversight may be due to a Western educational system that developed in environments of relative peace and stability.

This issue is not only confined to the West. Countries in the Global South are often more aware of oppression, poverty and war, but marginalised groups in the West also face racism and discrimination. The experiences of mainstream Western populations are not necessarily universal. Mental health knowledge that understands political injustice is relevant everywhere.

Living under political oppression often manifests as physical symptoms. In Palestine, for example, many people who lack the freedom to express themselves openly may somatise their distress, presenting with such physical complaints as headaches, dizziness or stomach aches. Instead of simply treating these symptoms, it is crucial to help people understand the meaning behind their physical distress. By creating a safe space for people to put words to their feelings, we can help them connect their somatic symptoms to the political realities they face. This approach acknowledges that their bodies are telling a story that the oppressive power structures prevent them from speaking aloud.

You have noted that "the clinical description of PTSD captures the experience of a soldier who goes back home, while in Palestine, the loop is reality. Can you elaborate on the concept of "chronic traumatic stress" and how it manifests itself?

Let me first say that the chronic traumatic stress does not capture the experience of Palestinians completely. Because if you are in Australia and you are coping with an abusive husband, that is chronic traumatic stress.

In Palestine, the best terminology that captures our

experience is historical colonial trauma. Now, chronic traumatic stress is one element of colonial historical trauma because chronic traumatic stress is again about the individual. Colonial historical trauma is about the community, it is about belonging, it is about relationships between people, not only about what happens to you as an individual, it is about what happens to the social fabric of your community. It is about identity, culture; it is about erasure, erasure of the past. It is about the negative representations that are created for the collective self of a population, the group.

Chronic traumatic stress is the anticipation, the accumulation and the elements of the trauma and the fact is there is no relief, there is no pause.

Those are common elements with the Palestinian experience. But what is missing is the cross-generational aspect. What chronic traumatic stress does not capture is that our experience is colonial, cross-generational. It targets the community, the collective identity. It damages the social fabric, and it is not poverty, it is man-made, it is deliberate and intentional.

Within colonial trauma, we find specific experiences that affect people. Within the general description of colonial historical trauma, you will find the trauma of torture that can generate a set of symptoms that are different, the trauma of starvation, the trauma of home demolition, and the trauma of displacement.

People are exposed to different experiences that generate different symptoms and different distress within the framework of colonial historical trauma. The trauma of starvation changes our relationship to food, to other human beings who would compete with you for the food.

It is a big attack on the social structure, on the fabric of society. With the trauma of torture, the community might respond with empathy to you when you are tortured – it is different from other types of trauma. We need to be mindful of all the different details.

The most common trauma in Palestine, affecting everybody and now a part of daily experiences, is humiliation that takes place in every encounter. At checkpoints with soldiers, Palestinians are belittled. They are made to feel they have no will and no agency. They are objectified.

I give this example because when people come to see us for certain symptoms, I ask about what is happening to them, what is happening in their life. I avoid the language of personal dysfunction. Instead of "What's wrong with you?" we ask "What is happening in your life?"

Then when I am told the story and how it generates the symptoms that person is experiencing, I need to tackle that particular story. Humiliation has a different impact to displacement so the interventions should be suitable for the individual experiences people present with.

How do you determine the most suitable interventions for a patient when their specific set of challenges is something you have not encountered before, either personally or through your prior professional experience? This unique combination of hurdles must add a layer of difficulty to your work.

I will share an observation that has preoccupied me. A colleague from Gaza was telling me about the difficulties of maternity, childbirth and pregnancy – then during a truce, she got pregnant.

In the beginning she was happy with the pregnancy, but when the truce ended and the situation became violent again, she started contemplating abortion because of all the data surfacing about the anomalies of babies born during war, miscarriages, and the lack of maternity care, all of these issues. She said that her husband and family discouraged her. They were upset with her when she mentioned it. She told me that she kept the pregnancy, but she said: "I psychologically aborted my baby." Then she miscarried. She was telling me about this experience.

When I write something in my file, I try to be authentic. I try to do justice to the authentic expressions of people. This woman who had this experience of traumatised motherhood during war, she talked about circumstances that made her not want her baby. She psychologically did miscarry her baby, and the baby died. She could not carry it because of malnutrition and other challenges. So that constitutes trauma, a very specific trauma.

I think we are doing a lot of injustice to people when

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we just say PTSD. If this person is coming to an NGO where I want to admit her, I need to give her an International Classification of Disease Code ICD 11 code. Usually, the code does not capture the experience of psychologically miscarrying her baby because of the political violence surrounding her. It does not talk about traumatised motherhood. I find it important to use this vocabulary even when it is not acknowledged by the bibles of psychiatric diagnoses.

RESILIENCE, DIGNITY, AND COMMUNITY

You have emphasised that professional mental health provision is just one part of the solution. What role do grassroots, community-led initiatives play in promoting mental wellness and resilience in a context of ongoing, chronic exposure to traumatic events?

I may say something controversial here, but I just want to be honest to our experience in Palestine. In times of difficulties, highly trusted people, trusted messengers are more important than professional experts in Palestine. If people trust the teacher, the Imam, the midwife, the youth activist, the youth volunteer, community leader, those people play a much more important role in times of crises than highly experienced mental health professionals like me.

As mental health professionals, we do not need to compete with them or criticise them at all. We need to collaborate with them, train them and support them, to enable them to provide low-intensity interventions, to respond to people's needs and to know when to refer them to us.

Also, I learnt that we need to create the conditions so that ordinary people, with a similar experience, can help each other. This is usually done organically. A woman, the mother of a martyr, told me that for her, the help from other mothers with a similar situation was more helpful than Cognitive Behaviour Therapy.

We need to listen and respond adequately to people so that they have a chance to feel they belong again, connected. They are treated by the community and feel they can help and receive help from others. In classical individual therapy, they feel they are in a position to receive, but not to give. They lose their agency. And agency is very important in the treatment of these people.

What is the meaning of Sumud (steadfastness) in the context of Palestinian mental health, and how does it act as a form of psychological resistance?

Every Palestinian understands "Sumud" but finds it difficult to give an accurate definition of what it is. Everyone has a different definition. It's not stoicism. Sumud is when someone wants to push you back… you hold on, you try to be grounded and anchor yourself. That is Sumud.

Because the attack is collective, we do it collectively. We do it as individuals, but we hold each other's hands to stay grounded. It is a reflexive reaction against uprooting, erasure and displacement. Its psychological component is similar to resilience, but larger than the individual aspects of psychological resilience. The action-oriented component is what we do in the face of displacement. This is also Sumud.

Sumud is about the collective story we write together, we tell together the story of our experience. It is about maintaining a structure that helps us to survive the routine of each day, strengthen connectedness and help each other. That is the structure. It is about solidarity and supporting the people who are most vulnerable, to help them survive in difficult times.

That is our collective concept of Sumud. It is a highly valued political notion. In the book, I explain it has a religious origin – it is one of the names of God. A Sumud was the person in the community on which everyone leans on when they are in times of fragility. Therefore they summoned their absolute protector. The action of Sumud is like seeking protection from each other in times of adversity.

The word is also prevalent in Arabic heritage and literature as well as in psychological literature. The word as a political notion has been common in Palestinian literature over the past century since the British mandate.

To give an image of Sumud: There is a musician from Edward Said Conservatory in Gaza, who has one or two surviving musical elements as musical tools. He takes the children and helps them chant national songs, using the humming of the drones as a background, which is a very disturbing noise as an element of music. Yet he creates songs.

There are some people like sisters, older sisters, taking little children and teaching them to memorise the Quran and emphasising the positive messages that help people survive in a difficult time. People organise themselves organically in a way to help each other. The friend I mentioned previously from Gaza, who was telling me about the horrors of maternity, said that people taught women midwifery. These are women who do not have any medical education. They are teaching capable women to study for free – to help people give birth in the tents because the hospitals cannot take

them – as well as first aid.

These are examples of Sumud. The community sustains itself on its own virtues, on those of the Palestinian people, wanting to help, wanting to support each other. There are many images and examples like that.

How can organisations operating in a settlement context, such as STARTTS, provide support that affirms the dignity and agency of refugees and trauma survivors, rather than reinforcing a sense of helplessness?
First, we need to ensure safety and basic needs are covered. Second, we need to help people find a new purpose in their life. One of the definitions of trauma is the disaster of helplessness... giving, helping people to find a purpose and to find new belongings and a new community is very important for the restoration of agency and dignity.

The experience of displacement... it detaches the person from his roots. It damages his identity, his role. We need to know: who was this person before the events that displaced them, what happened to them, what is happening with his identity, his sense of belonging? How does that change his view of himself, of the world where he lives, and how can we restore some of the loss?

As an example, a patient who was previously a senior doctor in his country, was helping others, was responsible for medical examinations, supervised the PhD studies of other colleagues and now he is jobless. When displaced, he has no role, does not do anything. Maybe he does not need psychotherapy – but he would get more benefit if you involve him in research, for example, and return some of his role and show respect to his capacities and his abilities. This would be more effective therapy than Cognitive CBT or Eye Movement Desensitisation and Reprocessing or anything else.

PRACTICAL AND PERSONAL EXPERIENCE

What are some of the most common manifestations of psychological stress you see in your patients, and how do you approach these in your clinical work?
Many of the people that come to us for clinical help suffer from situational trauma. The symptoms are physical, somatic feelings that arise in the body. This becomes more acute when trust is less, when they cannot speak their thoughts or they cannot put words on their emotions. The more we help them talk about the emotions and share thoughts, the somatic symptoms improve.

I do not receive people in Palestine who come to tell me, "I had a traumatic experience." They do not use this word because the meaning is so broad and so prevalent.

In our reality, trauma is political. It is anticipated, it is accumulative, it is administrated intentionally, with the objective to impose helplessness and make people lose their agency, their will and political aspirations.

They don't say, "I was exposed to a traumatic experience," but they talk about Qahr, a word that can be translated into 20 English words that mean experiencing a sense of being crushed from oppression – a sense of sheer helplessness.

Another common word expressed by people is Khuzlan, which means abandonment and betrayal. They use a lot of metaphors in therapy. I work with other people in Jordan and Egypt. I think that in Palestine they use a metaphor to expand the margin of safety, because if you express something in a metaphorical way, you can say, no: "No, I did not mean exactly that, you misunderstood me." They have a special way of speaking, which is implicit and uses a lot of metaphors.

Use of metaphors is not unique to Palestinians, but I see it within the Palestinian population. I see that people who have trust issues and who have lost of a sense of safety, they use it more often.

In your role as the head of the Mental Health Unit, what were the biggest challenges you faced in developing and implementing mental health strategies for the Palestinian population, especially given the current circumstances?

Gaza, Little girl, War image - hosnysalah

My biggest challenge was to attract financial resources. The personnel working in this field is very small and my response to that was to equip other people in the community to provide appropriate mental health and psychosocial responses. A problem with the decision makers within the health system in Palestine is that it continues to prioritise physical injuries over psychological injuries, because the physical injuries are more visible.

I have been helping people to visualise the psychological injury in Palestine resulting from this reality. It is not limited to the suffering of individuals. It manifests itself in other ways such as road rage, fratricide, femicide, killing women ... in mistrust in the community. Sometimes people lose their temper over a parking spot. Not every person who suffers comes to a clinic with depression, sleeping problems or somatic, medically unexplained symptoms, but it can be expressed in a different way. We still need to address that and educate people, to promote mental health and make it accessible to them.

One-third of the Palestinian community is at school, so we developed an effective school mental health program to train teachers and counsellors. We encouraged schools to monitor absenteeism of children, for example, because those who suffer more than others drop out from school. We give special care to those who drop out and help minor detainees to be reintegrated in school once they are released from prison.

In terms of policy planning, I tried to prioritise the most disadvantaged and marginalised members of our community, for example, the Bedouin community in the West Bank, and the people living in area C (Israel is divided into four physiographic regions) where Israeli settlement expansion creates more pressure on the lives of farmers and villagers in the West Bank. In this area we noticed much higher school drop-out rates.

How do you personally cope with the vicarious trauma you experience while working with individuals and communities who have endured so much suffering?

I do not hoard pain. I hold pain. I hold the pain of people, but I express it. I express it in writing, in generating lessons from that pain, from reflecting on it. I think that my work as a teacher, a supervisor, a writer, in addition to a clinician who holds pain and other activities that I do, help me to make sense of that pain. It does not stay with me. I try to make something useful with it. My profession liberates me from the feeling of helplessness, and I try to help people be liberated from their helplessness and do something about it. I have a deep sense of gratitude that I have a profession that can help other people in difficult times.

I have a strong and deep spiritual feeling that matches with my ethical responsibilities in medicine and in mental health. For example, one of the responsibilities of a mental health professional working under oppression, according to liberation psychology, is witnessing. In Islamic ethics, witnessing is an obligation. There is a verse that tells us clearly: do not conceal testimony.

I feel that there is this match between my spiritual conviction and the professional role that I hold, and this is empowering for me. This is an important resource. I am surrounded by very good friends, and a caring family. I delegate a lot the things that I do not need to do myself. I recruit the help of others.

I have a deep relationship to the land. I have a garden; I plant my organic food. This helps me deal with the trauma of starvation that I did not experience myself, but I witness. Also with the massive loss of human beings, the massive killings, so to see the seasons come and go, the cycle of life, the seeds turning into blooms, and to see those seeds bring the promise of a new generation, I think this has sustained me in difficult moments.

Can you express what publishing the book means to you?

As a psychiatrist in Palestine, I do not have the luxury of time, so these essays were often born from moments of reflection while driving home from my clinic. They are my immediate reactions to both my professional observations and the political realities of my home.

I wrote these pieces as a way to process and channel my own pain. It is not about hoarding my pain, but rather holding it and turning it into something useful. This is what I hoped to convey with the book's title. I used the word "radiance" to explore its dual meaning. In medicine, pain can radiate from one part of the body to another. Similarly, the suffering in Gaza and Palestine has a global reverberation; the pain is felt far beyond our borders. But "radiance" also refers to a glow, like sunshine. This symbolises the possibility of turning something negative into something positive.

The "resilience" in the title refers to the strength and Sumud of our community. This resilience can be a source of inspiration for people everywhere. I hope my book passes on important lessons from this troubled place to my colleagues in medicine and mental health, as well as to anyone who cares about human rights. It is my contribution to human knowledge, a testament to what we can learn from a place of struggle.

**The Shifa Project is a collaborative initiative born out of a partnership between NGO and mental health practitioners to provide support and resource to Muslim communities affected by the conflict in Palestine. They provide psycho-spiritual support circles, events and resources. It received the 2025 NSW Humanitarian Award recipient (Best Project).*