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Rethinking Resilience for Children and Youth in Conflict Zones: The Case of Palestine

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Approximately one in four children lives in conflict-affected areas around the world and this results in many consequences for their physical and mental health. This paper first provides a brief history of the specific contexts of violence and resistance that children and youth engage with, and in, on a daily basis in Palestine. It then outlines the efforts of one functioning program in the West Bank, the United Nations Community Mental Health Project, which was designed not only to respond to, but mitigate, child and youth mental health problems in the midst of decades of such political violence.

INTRODUCTION

One in every four children in the world is living in a country affected by conflict or disaster (UNICEF, 2018). In prolonged armed conflicts such as those in Palestine, Iraq, Syria, Yemen, Libya, the Democratic Republic of Congo, and Myanmar, hundreds of thousands of people have been subjected to trauma and destruction where daily life is a nightmare (UNICEF, 2018). Evidence suggests that massive exposure to war has many negative effects on children. These are not only physical; armed conflict has direct effects on mental health and the well-being of the population. For example, childhood trauma associated with war violates children's sense of safety and trust in the world in which they live, reducing their sense of worth. It also increases their levels of emotional distress, shame, and grief, and their tendency to engage in destructive behaviors (Atkinson, Nelson, Brooks, Atkinson, & Ryan, 2014).

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Not only are specific individuals affected by war, but communities suffer as well (Wessells, 2009). Communities where long-term violence has crippled civil society are often more threatening to children in the long term than "distant trauma" itself (Lieberman, Van Horn, & Ozer, 2005). As in the cases involving massive trauma, where all aspects of a community's ecology have collapsed and left an absence of stability and rule of law, the lives of the population generally—and children in particular—are profoundly affected by the effects of the terror, which is part of the embedded systems in which they live. However, in such situations, the need to defend children and women is usually not perceived as a top priority (Gasseer, Dresden, Keeney, & Warren, 2004).

Exposure to adversity or trauma does not always necessarily lead to impairment and the development of psychopathology in children, however. Some still have the capacity to recover from trauma in the face of stressful life events and appear to develop healthy psychosocial functioning (Yehuda, Flory, Southwick, & Charney, 2006). The identification of factors that may either protect children and youth from adverse effects of violence during war, or exacerbate these effects, is crucial for understanding human development and for designing effective intervention strategies to enhance protective factors for life-span development.

Resilience frameworks (e.g., Cyrulnik, 2005) are one way to identify and amplify how children and youth may recover from trauma or develop healthy psychosocial functioning in the face of stressful life events (Shastri, 2013). Such models understand resilience as the outcome of a long-term interaction between children and surroundings during development—family, schools, and the community, for example, all play a crucial role in the development of resilience (Olah, 2013). Consequently, these models also argue that it is important to utilize these resources to promote secure early bonding between children and adults to enhance cognitive development and self-esteem, and to strengthen family relations, affiliations and a sense of belonging to their community (Sudmeier-Rieux, 2014).

This article first provides a brief history of the specific contexts of political violence and resistance that children and youth engage with, and in, on a daily basis in Palestine. It then outlines the efforts of one functioning program in the West Bank—the United Nations Community Mental Health Project (CMHP)—that was designed not just to identify or respond to— but prevent—child and youth mental health problems in the midst of decades of such political violence. It also discusses three important considerations regarding resilience to come out of this program for engaging with children and youth in conflict zones: (1) the value of shifting from vulnerability to resilience paradigms, (2) the need to think critically about resilience paradigms once they are adopted, and (3) the promise of leveraging community strengths as part of resilience paradigms. Identifying and analyzing such trends in the context of one successful Palestinian mental healthcare program may demonstrate the importance of more creatively rethinking resilience as a central part of similar programs that promote well-being for children and youth in other conflict zones.

THE PALESTINIAN POPULATION AND ITS EXPOSURE TO POLITICAL VIOLENCE

Palestine is located in the Middle East and is made up of two areas: the West Bank, which borders Jordan, and the Gaza Strip, which borders Egypt and the Mediterranean Sea. There are approximately five million people who live in Palestine; just over three million people live in the West Bank and almost two million live in the Gaza Strip. As of 2017, 39% of the Palestinian

population was younger than age 15 years; 37% of these children/youth live in the West Bank and 43% live in the Gaza Strip (Palestinian Central Bureau of Statistics [PCBS], 2017a).

The 1948 Palestinian exodus—also known as Al Nakba—occurred when the then-emerging Israeli state drove out approximately 800,000 Palestinians from their homeland. The first uprising (intifada), which occurred from 1987 to 1993, represented the zenith of Palestinian popular resistance against decades-long Israeli military occupation. In the course of the First Intifada, more than 1,500 civilians were killed, 25% of them children, with many thousands injured (Giacaman et al., 2011). Since then, the violent Israeli response to the second Palestinian intifada in September 2000 has led to even more difficult, precarious, and insecure living conditions for Palestinians. Israeli military actions have killed more than 4,800 people, including more than 950 children, between September 2000 and June 2008 (B'Tselem, 2008a).

In June 2007, Israel tightened its control over the Gaza Strip, barring almost all Palestinians from entering or leaving the area. This has effectively turned the area into an open-air prison in which 1.5 million Palestinians must learn to live (B'Tselem, 2008b). During three Israeli sieges on the Gaza Strip between 2008 and 2014, Israeli soldiers have killed 3,756 Palestinians. In addition, over 100,000 Palestinians have been left homeless, losing all they hold dear (B'Tselem, 2016).

The Palestinian Population and Trends in Resistance during the First and Second Intifadas

The First Intifada was mostly a peaceful resistance against the enduring occupation. During this time, there was a strong sense of Palestine as a coherent society, secured by active grassroots campaigns, and there was nearly no shelling. However, everyday life was often disrupted by the occupying army through several measures, including closures of schools and universities, siege, and curfews, as well as regular Israeli settler attacks. In fact, in the first 4 years of the Intifada, approximately one third of school days were cancelled. Mobility restrictions as a result of Israeli military curfews, closures, and home confinement necessitated the creation of an alternative schooling system as a form of resistance called "popular education." Many children were home-schooled by their parents, or gathered in makeshift classrooms set up within mosques, basements, and alleyways. The Israeli authorities considered popular education illegal; students caught participating were subject to harassment or arrest and were threatened with imprisonment for a period of up to 10 years. They could also be fined up to $5000 USD (Nicolai, 2007). However, these Israeli measures effectively backfired, as they actually encouraged youth to participate further in the Intifada (Nicolai, 2007). Popular education provided children and youth with a sense of security and predictability amidst the chaos of displacement, traumatic events, and loss. Such tangible and practical activities restored order and stability and fostered resilience (Nguyen-Gillham, Giacaman, Naser, & Boyce, 2008).

In addition to popular education, incorporating resistance against occupation into normal daily routines and structured activities also contributed to resilience (Nguyen-Gillham et al., 2008). Studies have shown that children who were participating in active resistance against Israeli soldiers during the First Intifada had fewer posttraumatic stress disorder (PTSD) symptoms than those children who were not engaged in active resistance (e.g., demonstrations, throwing of stones, burning tires, etc.), even though both groups of children were exposed to similar violent events from Israeli soldiers. This might be attributed to better coping strategies among children who felt that they could actively resist the occupation, as opposed to those who felt helpless and stayed

home. In fact, *Atfal Al-Hijara*—an Arabic term referring to the children participating in the Intifada as "Children of the Stones"— was the most visible symbol of the first uprising. It signified the frontline of a war for liberation that cut across class, religion, and political affiliation (Mansour, 1989; Massad & Khammash, 2016). Barber (1999) also emphasized the role of cultural forces and the psychological meaning of nationalist conflict in the resistance of children and families to political violence.

During the Second Intifada, grassroots activism became less popular as it gave way to more direct physical resistance and some Palestinian factions chose armed resistance. The Second Intifada, unlike the First, was marked by mass trauma, poverty, ambiguity, and lack of security. Since the Second Intifada, humanitarian responses have shifted from a focus on development to emergency or crisis management. In addition, international donor organizations have "promoted and imported a variety of intervention methods designed to mitigate against post-traumatic stress disorder, providing local staff with short training programs and limited follow-up" (Mansour, 2002; Massad & Khammash, 2016; Nguyen-Gillham et al., 2008, p. 297). In the midst of such crisis, the Palestinian community lost a sense of who should operate as disciplinary figures in families and communities, and youth attitudes have seemed to change toward social values. Children became increasingly noncompliant with their teachers and parents and more aggressive in schools, homes, and neighborhoods (Qouta, Punamäki, Miller, & El-Sarraj, 2008). Such a cycle of violence also triggered high-risk behaviors like substance abuse (Ben-Zur & Zeidner, 2009).

POST-INTIFADA MENTAL HEALTHCARE

Since the Second Intifada, the Palestinian Authority's (PA) Ministry of Health (MoH), The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), and nongovernmental organizations (NGOs) have played important roles in emphasizing mental health as a priority, and these are considered especially important given the historic lack of appropriate services combined with the present sociopolitical crisis. NGOs exist in the absence of an adequate general mental health care system. There are numerous NGOs involved in the provision of mental health and psychosocial services. They provide specialized services, accept referrals, and provide training for health professionals. In addition, the PA's MoE runs a school counseling program in most Palestinian public schools for students to help them address their anxiety, fears, and stress, or provide them with family support and/or referrals to specialized governmental and non-governmental services (Massad & Khammash, 2016).

The UNRWA is another important actor in promoting current child/youth well-being. Created in 1949, UNRWA is a relief and human development agency that supports more than five million registered Palestinian refugees, most of whom are descendants of those who fled or were expelled from their homes during Al Nakba of 1948. Today, refugees constitute 42% of the total population in Palestine (PCBS, 2017b). They live in protracted crisis as they are exposed to acute and chronic violence from an occupying army, consistent violations of their human rights, and the kind of poverty one witnesses in slums around the world.

UNRWA is in charge of education, primary health care, and social relief in these camps. Almost 91% of all Palestinian children attend UNRWA/and/or public schools (Ministry of Higher Education, 2018). As far as mental health is concerned, during the First Intifada, there

once were selective nonsystematic activities that UNRWA promoted to address individual cases of exposure to political violence. In the Second Intifada, with the marked increase in Israeli brutality and the collective punishment of entire communities, there was a pressing need for longer-term interventions to address the long impact of trauma on children.

From Medical to Psychosocial Frameworks: UNRWA's Community Mental Health Project

In 2006, new leadership emerged with a creative vision and a collective multidisciplinary approach to child/youth well-being within the West Bank UNRWA Health Department. These changes were driven by the leadership's exposure to international work on gender-based violence (GBV) and child abuse, coupled with a growing Palestinian interest in the notion of child rights. NGOs played a very important part in the transformation of the philosophy of the UNRWA program. They allowed for transfer of technology, introduced different organizational practices, and helped in building community mental health models. They also increased the presence and contributions of experts with a psychosocial vision and made it possible for UNRWA to develop new thinking; instead of a medical model that focused on disease and trauma, with emphasis on the victimization of children and the assumption that the pathological effects of war can be cured through individual therapy, UNRWA adopted a psychosocial approach, which focused on interaction, dialogue, and debate between UNRWA's different health, education, and social programs, about new community approaches to psychosocial support. Consequently, there was increased attention to child rights and child protection, and UNRWA realized the need to move from technical to social change to build resilience through community-based interventions.

Initially, family and child protection was a new concept; Palestinian national staff and personnel of the United Nations (UN) system were not aware of its close connection to child well-being until it became more of a globally recognized concept. In addition, the different sectors involved within UNWRA were at different levels of thinking in terms of approaches, such as individual versus community, vulnerability versus resilience, medical versus multi-sectoral, and treatment versus prevention. A multidisciplinary and preventative approach took time to bring people together to work on the same agenda. Visionary, innovative, and passionate leadership coupled with social mobilization, promotion, and training, however, eventually resulted in developing a functional local model: the Community Mental Health Project (CMHP) with a public health approach to mitigate the psychological impact resulting from the prevailing violence.

With a new, coherent vision in place, the UNRWA Health Department shifted the focus of its mental health interventions from a medical and vertical approach to a community-based preventive approach that focused on psychosocial mental health and resilience building. The UNRWA's CMHP was eventually established in 2010, where programs began to gradually identify the relevant social determinants linked to development—rather than only offering emergency assistance to Palestinian refugees who had lost their ability to cope with the deteriorating conditions of high levels of political violence and economic decline. With a particular focus on children and youth, CMHP helps to mitigate the psychological impact resulting from occupation-related violence and economic hardship. The UNRWA program also addresses social determinants and risk factors through a multidisciplinary and integrated

approach. Focusing on prevention strategies, this approach works to promote family and child protection, implement culturally appropriate approaches, and promote networking and strong partnerships at local, regional, and global levels.

In addition, in response to a growing awareness of cases of violence, abuse, and neglect among Palestinian refugee families, UNRWA established the Family and Child Protection Program as part of the CMHP in 2009. This program was intended to work with the UNRWA Health, Education, and Relief and Social Services Programs in partnership with refugee communities to reduce the impact of the politico-military violence, prevent and respond to cases of abuse, neglect, and violence at homes, schools, and communities. Increased abuse and neglect from parents is a consequence of the difficulties they were and still are confronted by within the context of Palestine's military occupation and precarious economic situation. This adds to the risk factors for the children and weakens their ego strength and the development of their potentials, making them even more vulnerable to the stress of the current situation. There is an interlinking of factors contributing to jeopardize their resilience. For the first time, psychosocial workers were integrated into the main three programs in UNRWA: Health, Education, and Social Welfare. The program has a public health approach as well, tackling the causes of abuse and violence to promote well-being and child rights (Massad & Khammash, 2016). It offers individual and group counseling for children and families. The program also includes several other components: family and child protection camp committees; support peer groups for women; youth and vulnerable community members promoting child rights and responsibilities; summer camps and sexual and reproductive health and rights modules for teachers, parents, and students; and referral of cases, to internal and external specialized services provided by NGOs.

UNRWA schools now also implement different psychosocial interventions in line with family and child protection programs through various group activities. Such initiatives include creative arts, theatre, summer camps, *dabka* (traditional Palestinian folkloric dance), animation films, puppets, and the introduction of capoeira Brazilian dance to alleviate stress. Capoeira is a tool that is hoped to provide rehabilitation and therapy, as well as psychological support for vulnerable children through storytelling, movement and exercise, songs and instruments, dance, social talks, and community spirit. As part of a holistic approach in tackling mental health issues of school children, UNRWA produced a booklet on positive parenting for parents to encourage a relaxing home environment, bringing psychological relief to children (Massad & Khammash, 2016). In parallel, the majority of the primary health care doctors working in the camp clinics have now received special training to be able to integrate mental health concepts and practices into their daily practice. They have been sensitized to different psychological needs along the life cycle to empower families, with an emphasis placed on children. Primary health care doctors are also encouraged to take advantage of all the psychosocial activities available in the camps and to encourage parents to take part. UNRWA's approaches were ultimately successful in mitigating the traumatic impact of conflict, reducing violence and bullying among school children, increasing children's participation in school activities, increasing parents' engagement with their children learning, increasing teacher awareness of psychosocial issues and applying it in their day-to-day work, and reducing stigma about psychosocial interventions based on UNRWA reports.

SHIFTS IN THINKING IN THE CMHP

From Vulnerability to Resilience Paradigms

As seen above, a central focus in UNRWA's cmhp was to transition from a medical to a psychosocial model. Engaging in this major shift has revealed several interesting considerations about resilience in relation to children and youth in conflict zones. The first is the importance of moving from vulnerability to resilience paradigms.

The vulnerability approach assumes that the pathological effects of war can be cured via individual treatment, as if children will be recovering from an illness (Masten & Coatsworth, 1998). In contrast, in disciplines such as child psychology, resilience models refer to the process of, capacity for, or positive outcome of successful adaptation despite challenging or threatening circumstances (Masten & Coatsworth, 1998). child psychologists Cyrulnik (2005) and Masten (2001) describe *resilience* as a desired quality to overcome stress or disturbance, but not a springboard to happiness or a "magic bullet.". Instead, Cyrulnik, for example, approaches "disturbance" as a springboard that provides an opportunity to bounce back beyond the initial state (Sudmeier-Rieux, 2014).

During the life span, resilience is built along two main axes: an intrapsychic axis related to the capabilities unique to each individual, and a relational axis related to all the links each individual establish with his/her environment (parents, family, teachers, community, etc.) during his or her life. A child's intelligence, success at making friends, and ability to regulate his or her behavior are examples of internal strengths that promote resilience. Examples of external influences that enhance resilience are competent parents, friendships, support networks, and effective schools. The International Resilience Project has shown, for example, that faith operates as a stronger protective factor in some cultures than in others (Alvord & Grados, 2005). As Cyrulnik (2005) describes it, resilience begins through ongoing "knitting" between the child and his or her environment. If early positive relationships between infants and their parents are very important to ensure a successful social and emotional development (Ainsworth, Blehar, Waters, & Wall, 2015), then the quality of interpersonal bonds all throughout life will also provide "resilience tutors" (Ainsworth et al., 2015). For example, this was evident in a study conducted in the Gaza Strip among 350 preschoolers in 2007, where 36% showed resilience despite adversity. Factors associated with resilience were maternally reported good health, higher maternal level of education, and less child exposure to traumatic events (Massad et al., 2009).

Definitions of *resilience* can also be revealed by the various ways in which researchers have been trying to define and develop its measurement for the last two decades. Resilience is often thought to reflect a dynamic union of factors that encourages positive adaptation despite exposure to adverse life experiences (Shastri, 2013). Child resilience is often assessed via a multidisciplinary approach when emerging concepts and models create questions that can be answered only by adding various disciplinary views. For example, Cyrulnik articulates concepts, models and findings from genetics, neurosciences, ethology, psychology, psychosociology, and socioeducation to think on a wide range of dimensions that help to define, interpret, and explain child resilience. In doing so, he brings a much richer picture of the complex dynamical process underlying the evolution of the child in his or her context (Sudmeier-Rieux, 2014).

This multipronged approach is also reflected in assessment tools, such as the Psychological lmmune Competence Inventory (PICI). This tool includes 16 scales and was developed by Olah

(2013) for measuring certain protective personality traits (psychological antibodies: positive thinking, sense of control, sense of coherence, creative self-concept, sense of self-growth, challenge orientation, social monitoring capacity, problem-solving capacity, self- efficacy, social mobilizing capacity, social creating capacity, synchronicity, goal orientation, impulse control, emotional control, and irritability control) that are may make up psychological immunity. Psychological immunity, when considered as comprising these 16 components, can be thought of as a protective apparatus that increases the coping capacity of individuals (Olah, 2013). Unlike vulnerability models, Olah's view, and indeed, many other aspects of resilience models, appear to explain the capacity of Palestinian children and youth who actively participated in the First Intifada as well as that of Palestinian refugees living in camps to remain strong and resistant in the midst of long-term military oppression.

Continuing to Think Critically about Resilience

As important as it was for the UNRWA program to shift from a paradigm of vulnerability to resilience, however, it has also been vital to ensure that program staff remain open to critically assessing concepts of resilience during practice. This is for a few reasons. First, in general, one has to be careful that apparent resilience does not hide a deeper trauma that the child (or youth) cannot cope with and that will re-appear later. Avoiding "psychiatrization" when dealing with children confronting difficult situations should not lead to overlooking the needs of children presenting a severe psychological symptomatology. In addition, the verdict is still out on whether resilience really allows for a more comprehensive systems approach to health, or whether the concept may actually divert attention away from more transformative measures for children. If resilience is to underwrite a more systemic and cross-cutting approach to development and humanitarian work, it needs to be assessed critically as one attribute of sustainable development, not as a lesser substitute. To this end, "passive resilience"— focusing on recovery and reconstruction— has a limited value, whereas "transformational resilience" adds value by addressing underlying risks and resilience vulnerabilities. If resilience is truly to become a useful paradigm, then root causes of risk and vulnerability must be included in its analysis as a valuable decision-making tool for sustainable development interventions (Sudmeier-Rieux, 2014).

In addition, there is no agreement over best approaches and methods among donor governments and other external support agencies that provide assistance to communities at war, and psychological tools and approaches used by international emergencies are sometimes used in ways that cause unintended harm. Prominent problems include contextual insensitivity to issues such as insecurity, lack of humanitarian coordination, and/or an individualistic orientation that does not fit the context and culture, duplication of services and confusion among beneficiaries from different messages, an excessive focus on deficits and victimhood that can undermine empowerment and resilience, a lack of appropriate emphasis on prevention, and unsustainable, short-term approaches that breed dependency (Wessells, 2009).

Dependency causes harm in multiple ways: it robs people of dignity and contributes to a sense of helplessness that hinders self-esteem and empowerment. Worse yet, dependency may actually undermine the beneficiaries' preexisting support system (Wessells, 2009). Because of this, the UNRWA program is driven by an understanding that early childhood policies and practices are fluid, and over the past several decades have been guided by several theoretical

models of human development that have been refined over time. These include early transactional models adapted to the challenges of early childhood intervention; ecological models; and the concepts of vulnerability and resilience developed by Smith and Werner (1982), and Garmezy and Rutter (1988). Together these models underscore the extent to which life outcomes are influenced by a dynamic interplay among the cumulative burden of risk factors and the buffering effects of protective factors that can be identified within the individual, family, community, and broader socioeconomic and cultural contexts. Each of these models also emphasizes the influence of reciprocal child–adult interactions in the developmental process, thereby underscoring the importance of stable and nurturing relationships, as well as the recognition that young children play an active role in their own development.

The challenges of applying these psychosocial models, however, lie in their complexity. When early experiences are nurturing, contingent, stable, and predictable, healthy brain development is promoted, and other organ regulatory systems are facilitated. When early experiences are fraught with threat, uncertainty, neglect, or abuse, stress management systems are overactivated, and the consequences can include disruptions of developing brain circuitry as well as the establishment of a short fuse for subsequent activation of the stress response that leads to greater vulnerability to a host of chronic disease (Shonkoff, 2010).

As such, there are several especially good reasons for rethinking and critically assessing resilience within the UNRWA's programs in the Palestinian context. First, evidence-based interventions are vital to adequately address the needs of populations affected by mass violence, as inadequate responsiveness to such violence could have an additional detrimental effect on the mental health of children and their families (Betancourt, Meyers-Ohki, Charrow, & Tol, 2013). This said, international donors have generally imposed models developed in Western countries (Nguyen-Gillham et al., 2008) within Palestine that reflects an individual-oriented psychology. Individual-centered approaches usually fail to build on existing social capital within Palestinian communities (Nguyen-Gillham et al., 2008).

Leveraging Community Strengths

A third consideration regarding the use of resilience paradigms in conflict zones to emerge out of the CPMH is the huge potential for thinking creatively about leveraging various preexisting strengths in children and youth environments. Depending on certain characteristics at individual and community levels, resilience can develop spontaneously without much intervention (Meari, 2015). At the same time, there are also other opportunities for interventions to develop, enhance, or maintain resilience and to build stronger psychological immunity for children in conflict zones. Many of these include a focus on preexisting resources within communities.

Community resilience—like individual resilience—is a process supported by various traits, capacities, and emotional orientations toward hardship (Sousa, Haj-Yahia, Feldman, & Lee, 2013). Community resilience might be thought of as being based on four primary capacities: economic development, social capital, active participation, and community competence. Such a process requires flexibility, decision-making skills, and trusted sources of information that function in the face of unknowns (Norris, Stevens, Pfefferbaum, Wyche, & Pfefferbaum, 2008).

Some research has obfuscated the positive effects of integration into community and involvement in work, school or political action. Usually, this work relies almost solely on a deficit model, where children from high-stress backgrounds are considered at risk for impairments in

learning and behavior, and the intervention goal is to prevent, reduce, or repair the damage. For example, Qouta, Punamaki, and El Sarraj (2003) assessed the mental health problems of 121 Palestinian children age 6 to 16 years and found that 54% of the children suffered from severe levels of posttraumatic stress disorders. In 2007, in an additional study among 350 preschoolers in Gaza Strip, the quality of life of preschoolers was thought to be very low and comparable to U.S. children with severe cardiac diseases, end-stage renal disease, and with children receiving chemotherapy and radiation for the treatment of newly diagnosed cancer (Massad et al., 2011).

However, missing from a reliance on this deficit approach is a close understanding of Palestinian's attempts to leverage their unique strengths and abilities that communities develop in response to high-stress environments. Although the international literature is still very much focused on risk factors in mental health and pathology under the influence of a biomedical model, more and more researchers— following the steps of colleagues such as Emmy Werner and Michaël Rutter —have been interested in understanding why some people are able to cope with very difficult situations without developing symptoms and even emerge stronger. The concept of resilience that emerged generated interest in using it in the development of psychosocial programs. Thus, community factors, including the availability of supportive relationships outside of the family (Masten, 2001; Werner, 1993), are well documented as having a protective influence on children. Youth often join clubs, teams, and other groups and frequently find mentors such as coaches, teachers, scout leaders, and other prosocial adults in their communities. Early prevention and intervention programs, safety in neighborhoods, support services, recreational facilities and programs, accessibility to adequate health services, and economic opportunities for families have all been identified as protective factors. Religious and spiritual organizations may also serve as buffers. Protective factors arise from within the child, from the family or extended family, and from the community (Alvord & Grados, 2005).

In addition, in recent years, research on the mental health of children exposed to armed conflict has undergone significant shifts from a war exposure model, where war-related trauma was the main outcome of interest to the mediated model where children's mental health is influenced by risk factors and protective factors that may buffer children from the various sources of stress to which they may be exposed (Miller & Jordans, 2016). Other evolutionary-developmental models emphasize the coherent, functional changes that occur in response to stress over the life course (Ellis, Bianchi, Griskevicius, & Frankenhuis, 2017). Betancourt and Khan (2008) and Betancourt et al. 2013) have argued that adjustment and mental health in children exposed to war violence must be viewed as a dynamic process wherein resilience is conceptualized from a socioecological perspective, inclusive of family systems, social support, and community settings extending beyond cultural belief systems. A key aspect of the observations about resilience in the developmental literature is that the measurement of adjustment took place over the broad sweep of time, and as a result, the conceptual understanding of resilience in the context of chronic adversity has tended to focus on long-term or distal outcomes (Masten, 2001). This is shown in previous studies where maternal mental health was associated with mental health of preschoolers in Gaza and Bedouin children (Massad, Khammash, & Shute, 2017; Massad et al., 2009).

Conclusion: Fostering Resilience for Optimal Development in Palestine and Other Conflict Zones

During the First Intifada, Palestinians (including refugees living in camps) responded to trauma in ways that did not involve external forms of development. This demonstrates that resilience can emerge spontaneously and/or with minimal intervention. At the same time, outside interventions to develop, enhance, or maintain resilience among children and youth have also had their place in Palestine. Following the Second Intifada and in the aftermath of three wars on Gaza, Palestinian resources for resilience have been severely compromised, hence the need to become more proactive in efforts to aid children and youth in their psychosocial development.

This article has demonstrated some ways in which one UNRWA program in Palestine has prioritized the psychological well-being of children and their families by transitioning from a medical to a psychosocial model. In the process, it became clear that the transition from a vulnerability to a resilience model was helpful, especially when actors critically assessed the resilience model in practice, and were open to mobilizing social and community capital already existing in Palestine. The UNRWA CMHP serves as one example by which other programs might adopt a psychosocial model.

Focusing on the last point—that building and fostering resilience for human development requires working at different levels along the development of the child, from their early interpersonal relationships to their interactions with his social environment—we conclude with a couple of additional considerations when applying a resilience model with children and youth in conflict zones.

The first is that when applying these models, it is important to stress family and child protection where one can. Promoting some type of normal daily routine as often and as soon as possible after traumatic events, as well as some type of parenting-based interventions to promote positive parenting skills and to support parents as well as extended family provides a sense of normalcy for children and families. Other ideas include the mobilization of psychosocial interventions targeting maternal mental health as well as child health (Massad et al., 2009); semistructured group discussion meetings for mothers to increase their sense of well-being, self-confidence, and ability to care for their children; family reunification; and structured recreational activities between families and peers (Betancourt et al., 2013).

A second consideration where possible is that schools should be assisted in serving as support and resources to families. Schools can focus on broadening their extracurricular facilities, turning them into "multifunctional centers" where children can study, play, and socialize throughout the day. This might include several types of efforts, depending on the availability of resources: the transformation of physical infrastructures of schools to make schools more child-friendly, the training of psychosocial facilitators who can support children through in- and out-of-school activities, and the introduction of programs that train teachers—not only school counselors—to deploy proper psychosocial methods in dealing with children (Arafat & Boothby, 2003). School-based mental health programs might also partner with communities and focus on child participation and empowerment. For example, one might develop rehabilitation programs within the education system to support the re-integration of victims of war into schools and society (Massad & Khammash, 2016). Ultimately, promoting resilience through kindergartens, schools, and child and/or youth clubs might also become sources of normalization, stability and care through sports, arts, dance, and music.

Young children need nurturing care from the start. Children and youth in conflict zones especially need attention. To mitigate the traumatic impact of conflict, psychosocial programming must not simply be technical—it must have a vision. Resilience models can serve as the cornerstone of such a vision. At the same time, however, it is important it is to remain critical, creative, and sensitive in their application.

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