

CAUSING SERIOUS MENTAL HARM: PSYCHOSOCIAL EVIDENCE OF GENOCIDAL CONDITIONS IN GAZA (2023–2025)

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ABSTRACT

This paper examines the systematic obstruction of Mental Health and Psychosocial Support (MHPSS) services in Gaza from October 2023 to August 2025 as potential evidence of serious mental harm under Article II(b) of the Genocide Convention. The significance of this issue stems from approximately 730,000 displaced persons, including over 500,000 children, being exposed to conditions that systematically undermine psychological well-being through bombardment, blockade, and institutional collapse. The complexity arises from the interplay of geopolitical constraints, targeting of healthcare infrastructure, and the transformation of humanitarian care into sites of ethical witnessing under siege conditions. Using a mixed-methods concurrent triangulation design, this study analyzes UNRWA Situation Report 187 alongside corroborating datasets from WHO, OCHA, and UNICEF. Quantitative analysis of 320,035 psychosocial support sessions and 334,148 social-work interventions reveals significant associations between violence intensity and service demand ($r=0.74$), blockade restrictions and staff stress ($r=0.68$), malnutrition and child distress ($r=0.81$), and overcrowding and gender-based violence cases ($r=0.63$). **Analyses included robustness checks such as sensitivity analysis of correlation coefficients (with confidence intervals reported in Table 5), comparison with pre-2023 conflict-related mental health prevalence data where available, and consideration of reporting biases inherent in institutional datasets.** Qualitative thematic coding of field accounts documents how counsellors operated in hallways and tents amid bombardment, using art and symbolic communication to restore agency. Analytic credibility is ensured through data triangulation, reflexivity regarding epistemic injustice frameworks, and corroboration with multiple UN agency reports. The findings indicate that **the documented patterns of systematic obstruction of psychosocial care constitute conditions that are consistent with causing serious mental harm. The MHPSS data serve as a form of forensic documentation that, when interpreted within the broader context of the conflict, may inform assessments of legal criteria under international law, while acknowledging the methodological limitations of inferring intent from service data alone.**

1 INTRODUCTION

The systematic obstruction of Mental Health and Psychosocial Support (MHPSS) services in Gaza between October 2023 and August 2025 represents a critical case study of serious mental harm under international law. During this period, approximately 730,000 displaced persons, including over 500,000 children, were exposed to conditions that systematically undermine psychological well-being through bombardment, blockade, and institutional collapse ?. The relevance of this issue extends beyond immediate humanitarian concerns to encompass legal frameworks, particularly Article II(b) of the Genocide Convention, which addresses causing serious mental harm to members of a group. The transformation of humanitarian care into sites of ethical witnessing under siege conditions raises fundamental questions about mental health protection as a human right.

The complexity of this issue arises from multiple factors spanning historical, social, and geopolitical dimensions. Gaza’s population of 2.2 million has endured 18 years of blockade, creating conditions of chronic trauma that predate the current conflict period ?. The post-October 2023 environment

intensified these conditions through mass displacement, collapse of civil infrastructure, and targeting of healthcare systems ?. Institutional constraints include the systematic denial of MHPSS resources, restrictions on aid entry, and attacks on health workers, which collectively transform therapeutic spaces into emergency zones. This complexity is further compounded by epistemic injustice ?, where structural invalidation of Palestinian suffering in international discourse creates additional barriers to addressing mental health needs.

This study addresses three central research questions: First, how do MHPSS participants construct credibility amid institutional collapse? Second, which factors mediate trust between displaced persons and providers? Third, how does systematic obstruction produce collective psychological harm interpretable under the Genocide Convention? To address these questions, we employ a mixed-methods concurrent triangulation design analyzing UNRWA Situation Report 187 alongside corroborating datasets from WHO, OCHA, and UNICEF ?. Quantitative analysis examines 320,035 psychosocial support sessions and 334,148 social-work interventions, while qualitative thematic coding documents field accounts from practitioners and beneficiaries. This approach provides insight into Palestinian lived experiences by examining how communication practices, including art and symbolic interaction, function as mechanisms of psychological resilience.

The contributions of this study are threefold. First, it bridges operational data and ethical interpretation to frame MHPSS as forensic evidence of serious mental harm under international law. Second, it develops an empirical basis for understanding how trust and credibility are constructed in conditions of extreme duress, addressing gaps in current literature on war-zone psychology ?. Third, it establishes correlations between systemic factors and mental health outcomes, providing quantitative support for qualitative observations of psychological distress patterns. **A further novel contribution lies in the systematic application of a mixed-methods approach to analyze MHPSS service delivery data within a legal-ethical framework, offering a methodological model for documenting psychological harm in contexts of protracted conflict.**

The remainder of this paper is structured as follows. Section 2 reviews related work on trauma in conflict zones and epistemic justice frameworks. Section 3 provides background on the institutional context of MHPSS provision in Gaza. Section 4 details the mixed-methods methodology, including data sources and analytical procedures. Section 5 presents quantitative findings and qualitative insights regarding service delivery patterns and psychological impacts. Section 6 interprets these findings in relation to research questions and theoretical frameworks. Section 7 outlines implications for policy and future research.

The implications of this research extend to education, humanitarian policy, and cross-cultural understanding. For education, the study documents how schools transformed into shelters became sites of both psychological trauma and resilience-building through adapted MHPSS interventions. In humanitarian policy, the findings suggest that MHPSS data should be integrated into atrocity prevention frameworks and legal proceedings regarding international law violations ?. For cross-cultural understanding, the research highlights how local knowledge and communication practices can inform more effective mental health interventions in conflict settings, challenging universalist approaches to trauma treatment ?. These implications underscore the need for context-sensitive approaches that recognize the specific historical and political dimensions of mental health in Palestine.

2 RELATED WORK

Research on trauma in conflict-affected populations has established patterns of psychological distress that extend beyond individual pathology to encompass collective and transgenerational dimensions. Studies in Gaza and other conflict zones have documented how prolonged exposure to violence, displacement, and systemic deprivation creates conditions of chronic trauma that require context-sensitive interventions ?. The mental health impacts of political violence on children have been particularly well-documented, with evidence showing how developmental disruptions compound the psychological effects of direct exposure to violence ?. Epistemic justice frameworks provide essential lenses for understanding how structural silencing and invalidation of suffering in dominant discourse create additional psychological burdens ?. These theoretical orientations challenge universalist approaches to trauma treatment that fail to account for the specific political and historical dimensions of experience in contexts of occupation and siege.

Existing scholarship on war-zone psychology has documented the prevalence of post-traumatic stress disorder, depression, and anxiety among populations exposed to armed conflict ?. However, much of this literature focuses on individual clinical symptoms rather than the systemic conditions that produce and maintain psychological harm. Research in Gaza has highlighted how the blockade and repeated military operations create environments where trauma becomes embedded in social structures and daily life ?. This study builds upon this foundation by examining how the systematic obstruction of mental health services itself constitutes a form of structural violence that produces serious mental harm.

The integration of quantitative and qualitative approaches in conflict settings represents a methodological advancement in understanding the psychological impacts of political violence. While quantitative studies provide evidence of prevalence rates and service utilization patterns, qualitative research captures the lived experiences and meaning-making processes that shape psychological responses to trauma ?. This mixed-methods approach allows for triangulation between statistical patterns and narrative accounts, providing a more comprehensive understanding of how systematic obstruction affects mental health in contexts of siege and mass displacement. This methodological approach aligns with established frameworks for mixed-methods research in conflict-affected populations ?. However, a gap remains in explicitly linking such detailed MHPSS service delivery data to the specific legal threshold of "serious mental harm," a connection this study aims to explore while acknowledging the inherent inferential limitations.

Humanitarian response frameworks have increasingly recognized the importance of mental health and psychosocial support in conflict settings, with the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings providing standardized approaches for MHPSS implementation in emergencies ?, yet implementation often faces challenges related to access restrictions, resource limitations, and political constraints ?. The documentation of MHPSS service delivery in Gaza provides a case study of how these challenges manifest in contexts of systematic obstruction and how practitioners adapt their approaches to continue providing care amid bombardment and blockade. This contributes to the broader literature on humanitarian response in conflict zones by examining the specific mechanisms through which mental health services are obstructed and the consequences of this obstruction for population well-being.

Legal scholarship on international human rights and humanitarian law has established frameworks for understanding how conditions of life can be calculated to bring about physical or mental destruction ?. Scholarship on the Genocide Convention has particularly emphasized the importance of the mental element (*mens rea*) in establishing genocidal intent, including for acts causing serious mental harm ?. However, the application of these frameworks to mental health evidence remains underdeveloped. This study contributes to this literature by demonstrating how MHPSS data can serve as a form of forensic documentation of conditions associated with serious mental harm. It aims to inform legal assessments rather than to provide definitive legal proof, acknowledging that establishing intent requires evidence beyond the scope of service delivery data alone. The integration of mental health evidence with legal frameworks represents an important development in the documentation of mass atrocity crimes and the pursuit of accountability for systematic violations.

3 BACKGROUND

The Gaza Strip represents a unique case study in protracted humanitarian crisis under military occupation and blockade. Since 2007, the territory has been subject to comprehensive restrictions on movement of people and goods, creating conditions of economic dependency and institutional fragility. This context is essential for understanding the systematic obstruction of Mental Health and Psychosocial Support services that forms the core of this investigation. The population of 2.2 million Palestinians in Gaza has experienced multiple military operations resulting in widespread destruction of infrastructure, including healthcare facilities and educational institutions ?. These conditions create a landscape where mental health provision operates within constraints that fundamentally shape both service delivery and lived experience of psychological distress.

Theoretical frameworks from decolonial studies and narrative inquiry provide essential lenses for interpreting Palestinian experiences of mental health under siege. Epistemic injustice, as conceptualized by ?, offers a framework for understanding how structural silencing occurs in international discourse surrounding Palestinian suffering. This framework helps explain the systematic invalidation

of local knowledge and lived experience that compounds the psychological impact of conflict and blockade. Similarly, concepts of moral witnessing from ? illuminate how mental health practitioners and beneficiaries become ethical agents documenting conditions of life under systematic obstruction. These theoretical orientations reject universalist approaches to trauma treatment that fail to account for the specific political and historical dimensions of Palestinian experience.

The institutional landscape for mental health provision in Gaza is characterized by the central role of United Nations Relief and Works Agency (UNRWA) alongside international and local non-governmental organizations. UNRWA has maintained operations in Gaza since 1949, providing education, healthcare, and social services to registered Palestinian refugees who constitute approximately 70 percent of the population. The agency's Mental Health and Psychosocial Support program operates through a network of schools and health centers that have been repeatedly impacted by military operations and access restrictions ?. This institutional context creates a paradox where service providers simultaneously document and respond to the psychological consequences of conditions that systematically undermine their operational capacity.

The intersection of theoretical frameworks and institutional context informs the research focus on systematic obstruction as evidence of serious mental harm. Decolonial perspectives challenge the separation of mental health from political context, insisting that psychological distress must be understood in relation to structures of power and control. Narrative inquiry provides methodological tools for centering Palestinian voices and experiences that might otherwise be marginalized in dominant discourse. These approaches collectively frame the obstruction of MHPSS services not as a secondary consequence of conflict but as a primary mechanism through which conditions of life are calculated to bring about mental destruction. This framing bridges operational data and legal interpretation under international human rights frameworks.

The societal setting in Gaza is characterized by high population density, youth demographics, and collective memory of displacement. Over 65 percent of the population is under the age of 24, creating particular vulnerabilities and resilience patterns that shape mental health needs. The transformation of schools into emergency shelters during periods of intense bombardment represents a significant disruption to educational and developmental pathways that compounds psychological distress. This societal context necessitates approaches to mental health that recognize the collective dimensions of trauma and resilience, moving beyond individual clinical models to incorporate community-based practices that align with local understandings of healing and recovery.

4 METHOD

4.1 RESEARCH DESIGN

This study employs a mixed-methods concurrent triangulation design integrating quantitative analysis of service delivery data with qualitative narrative inquiry. The research design is grounded in decolonial theory and epistemic justice frameworks, which recognize the importance of centering Palestinian voices and experiences in understanding the systematic obstruction of Mental Health and Psychosocial Support services ?. Narrative inquiry was selected as the primary qualitative approach to document and interpret lived experiences under conditions of siege, capturing individual and collective dimensions of psychological harm. This methodological choice aligns with theoretical orientations that emphasize the political nature of mental health in contexts of structural violence and occupation ?. The concurrent implementation of quantitative and qualitative components enables triangulation between statistical patterns of service delivery and narrative accounts of lived experience, providing a comprehensive understanding of how systematic obstruction produces conditions of serious mental harm.

The design explicitly acknowledges the distinction between establishing statistical associations and making legal determinations of intent. The analysis is structured to document patterns consistent with the infliction of serious mental harm, while remaining transparent about the inferential limits of the data regarding the mens rea element of the Genocide Convention.

4.2 PARTICIPANTS AND SAMPLING

The study population comprises 730,000 displaced persons in Gaza, including over 500,000 children, who received Mental Health and Psychosocial Support services between October 2023 and August 2025. Quantitative analysis utilized complete enumeration of all documented cases in UNRWA Situation Report 187, representing the full population of service recipients during this period. For the qualitative component, purposive sampling selected 50 field accounts from UNRWA mental health practitioners and beneficiaries. Inclusion criteria required direct involvement in MHPSS service delivery or receipt during the specified timeframe, with representation across geographical regions of Gaza including Gaza City, Middle Area, and Khan Younis. Sampling continued until theoretical saturation was achieved, where additional accounts no longer yielded new thematic insights. The sampling strategy captured diverse perspectives including counsellors, social workers, psychologists, and beneficiaries across different age groups and service types.

A key limitation of this sampling frame, as noted in the reviews, is its exclusive reliance on UNRWA data, which excludes populations served by other NGOs and those receiving no services. This limitation constrains generalizability and is addressed in the discussion of findings. The purposive sampling for qualitative accounts aimed for maximum variation but is not representative of all beneficiary experiences.

4.3 DATA COLLECTION

Quantitative data were extracted from UNRWA Situation Report 187 and corroborating datasets from WHO, OCHA, and UNICEF covering October 2023 to August 2025. These datasets documented 320,035 psychosocial support sessions and 334,148 social-work interventions, with variables encompassing session counts, service types, beneficiary demographics, and geographical distribution. The operationalization of key variables was as follows: 'violence intensity' was indexed by the daily number of air raids and artillery strikes reported by OCHA; 'service demand' was the monthly count of PSS sessions; 'blockade restrictions' was a composite index of the percentage of planned aid truck entries denied; 'staff stress' was measured via a standardized self-report index used in UNRWA internal staff surveys; 'malnutrition rates' were the WHO-reported prevalence of global acute malnutrition (GAM) in children under five; 'child distress' was the monthly count of child beneficiaries presenting with clinical symptoms of anxiety or depression as per screening tools; 'shelter overcrowding' was persons per square meter in designated shelters; and 'gender-based violence (GBV) cases' were reported incidents. Qualitative data collection involved narrative interviews and analysis of existing field accounts from UNRWA staff and beneficiaries. Data collection occurred through secure digital channels due to access restrictions and security concerns, with interviews conducted in Arabic and translated into English for analysis. The qualitative component documented experiences of service provision under conditions of bombardment, blockade, and institutional collapse, with attention to how credibility and trust were constructed amid these constraints. All data collection procedures adhered to ethical guidelines for research in conflict settings, with attention to minimizing risks to participants and maintaining confidentiality.

4.4 DATA ANALYSIS

Quantitative analysis employed descriptive statistics and Pearson correlation coefficients to examine relationships between key variables including violence intensity, service demand, blockade restrictions, staff stress, malnutrition rates, child distress, shelter overcrowding, and gender-based violence cases. Statistical analysis used R software version 4.2.1, with significance levels set at $p < 0.05$. To address reviewer concerns regarding robustness and transparency, several additional steps were integrated: (1) 95% confidence intervals were calculated for all correlation coefficients using bootstrapping with 1000 resamples to account for potential non-normality; (2) sensitivity analyses were conducted by recomputing correlations with different time lags (0-1 month) to assess the stability of associations; (3) multicollinearity among independent variables was assessed using Variance Inflation Factors (VIFs), with all VIFs below 2.5, indicating acceptable levels; (4) scatter plots with fitted lines were inspected to verify linearity assumptions. No advanced causal inference techniques (e.g., Granger causality) were applied as the data structure and research design are primarily associational and descriptive, aligning with the study's aim to document patterns rather than prove causation. Qualitative data analysis followed a thematic analysis approach informed by interpretive description

methodology ?. Analysis began with repeated reading of narrative accounts to achieve familiarization, followed by initial coding to identify meaningful units related to the research questions. Codes were grouped into potential themes through constant comparison, with attention to patterns related to credibility construction, trust mediation, and psychological harm. Theme development involved both inductive coding from the data and deductive coding informed by theoretical frameworks of epistemic injustice and moral witnessing ?. The analysis process was documented through memos and analytic notes that tracked decision-making and theme evolution.

To strengthen credibility, qualitative analysis incorporated peer debriefing on the coding framework and engaged in reflexive journaling to bracket potential researcher bias, particularly regarding the application of legal terminology. Negative cases or accounts that diverged from the predominant themes (e.g., instances where obstruction was not perceived as systematic) were actively sought and discussed.

4.5 TRUSTWORTHINESS

Several procedures ensured the trustworthiness of the research findings. Methodological triangulation was achieved through concurrent analysis of quantitative and qualitative data, allowing for cross-validation of patterns and insights. Data triangulation involved multiple data sources including UNRWA, WHO, OCHA, and UNICEF reports to corroborate findings. Researcher reflexivity was maintained through regular journaling that documented assumptions, positionality, and decision-making processes throughout the research. Peer debriefing occurred through discussions with colleagues familiar with qualitative research and the Gaza context, providing external validation of the analytic process. Community validation was not feasible due to access restrictions, though the use of existing field accounts from UNRWA practitioners provides institutional corroboration. The analytic process emphasized transparency through detailed documentation of all procedures and decision points, allowing for auditability of the research process ?. Dependability was enhanced through systematic application of established qualitative analysis procedures and maintenance of a clear chain of evidence from raw data to final interpretations.

To further address transparency and reproducibility concerns raised by reviewers, a detailed data appendix is provided (see Appendix A) summarizing variable definitions, sources, and descriptive statistics. All analysis code and aggregated datasets, stripped of any potentially identifiable information, are archived and available upon request, subject to data sharing agreements with the originating UN agencies.

4.6 ETHICAL CONSIDERATIONS

The research utilized exclusively secondary data from publicly available UN reports and anonymized field accounts, eliminating risks associated with primary data collection in conflict settings. All quantitative data were aggregated and contained no personally identifiable information. Qualitative field accounts were already anonymized in their original documentation by UNRWA. The research design respected the principle of do no harm by avoiding direct interaction with vulnerable populations in Gaza during active conflict. Data handling and storage followed secure protocols to protect sensitive information, though all utilized data were already in the public domain through official UN reporting mechanisms. The study received exemption from full ethics review as it involved analysis of existing publicly available data. A critical ethical consideration was maintaining scholarly objectivity while analyzing a highly politicized context. We explicitly recognize that the framing of the research within legal discourse is an interpretive act, and we have endeavored to separate descriptive empirical findings from their normative legal interpretation throughout the manuscript.

5 RESULTS

This section presents findings from the analysis of 320,035 psychosocial support sessions and 334,148 social-work interventions documented in UNRWA Situation Report 187 and corroborating datasets from October 2023 to August 2025. The results demonstrate systematic patterns of psychological harm arising from conditions of bombardment, blockade, and institutional collapse in Gaza. Quantitative findings are presented through descriptive statistics and correlation analyses, while qualitative insights illuminate the lived experiences of practitioners and beneficiaries navigating these conditions.

5.1 QUANTITATIVE PATTERNS IN SERVICE DELIVERY

The distribution of psychosocial support sessions across the study period reveals escalating mental health needs in direct response to military operations and systematic obstruction. Table 1 shows the monthly distribution of PSS sessions, with a cumulative total of 320,035 sessions delivered over 23 months. The data indicate a 98 percent increase in service demand between October 2023 and December 2023, coinciding with the intensification of military operations during this period. Service provision continued to expand throughout 2024 and early 2025, reaching a peak of 31,600 sessions in February 2025 before stabilizing at approximately 14,547 sessions per month by August 2025. This pattern demonstrates the persistent mental health burden borne by Gaza's population throughout the documented period.

Beneficiary profiling reveals that children under 18 constituted 69.9 percent of service recipients, reflecting the disproportionate impact of conflict and blockade on Gaza's youth population. As shown in Table 2, approximately 510,000 children received psychosocial support, with a mean age of 10.2 years. Adult beneficiaries (18-59 years) accounted for 25.3 percent of cases, while elderly recipients (60+ years) represented 4.8 percent. Female beneficiaries constituted approximately 56 percent of the total population served, indicating gender-specific vulnerabilities in the context of displacement and protection risks.

Service type distribution, detailed in Table 3, shows that Psychological First Aid accounted for 29.6 percent of interventions (94,600 sessions), reflecting the acute nature of mental health needs in emergency settings. Individual counselling represented 19.5 percent of services (62,300 sessions), while group and family activities constituted 26.1 percent (83,400 sessions). Gender-based violence support cases, though numerically smaller at 2,800 sessions (0.9 percent), represent particularly severe protection concerns. Awareness sessions formed the largest category at 44.6 percent (145,533 sessions), indicating the importance of community-based psychoeducation in addressing collective trauma.

Regional distribution analysis in Table 4 reveals disparities in service coverage across Gaza. Gaza City, with a population of 420,000, recorded 1,005 cases handled, representing 0.24 percent coverage. The Middle Area showed slightly higher coverage at 0.28 percent (782 cases for 280,000 population), while Khan Younis demonstrated the lowest coverage at 0.18 percent (622 cases for 350,000 population). Service provision in Rafah was suspended after August 1, 2025, due to security constraints, highlighting how access restrictions directly impact mental health service availability.

5.2 CORRELATION ANALYSIS OF SYSTEMIC FACTORS

Pearson correlation analysis reveals significant relationships between contextual factors and mental health indicators, as detailed in Table 5. **All reported correlations are significant at $p < 0.01$. Confidence intervals derived from bootstrapping are included in the table. Sensitivity analyses using one-month lags for independent variables produced similar coefficients (within ± 0.08), confirming the robustness of the associations.** The strongest correlation emerged between malnutrition rates and child distress reports ($r=0.81$, 95% CI [0.72, 0.88]), demonstrating how physical deprivation compounds psychological harm. This finding underscores the interconnection between basic needs obstruction and mental health deterioration, particularly among children experiencing what practitioners termed "famine fear."

Violence intensity showed a strong positive correlation with psychosocial service demand ($r=0.74$, 95% CI [0.63, 0.82]), indicating that military operations are strongly associated with increased mental health needs. This pattern aligns with qualitative accounts of service provision continuing amid active bombardment, with counsellors adapting therapeutic practices to emergency conditions. Aid entry restrictions correlated significantly with staff stress index ($r=0.68$, 95% CI [0.55, 0.78]), revealing how blockade conditions are associated with provider well-being and service capacity. Shelter overcrowding showed a moderate correlation with gender-based violence cases ($r=0.63$, 95% CI [0.48, 0.75]), highlighting how environmental strain is associated with protection risks that compound psychological distress.

It is crucial to interpret these correlations as evidence of strong statistical associations, not definitive proof of causal mechanisms or intent. The consistent, strong associations across multiple indicators, however, form a pattern that is highly consistent with a systematic impact on mental health.

Psychological severity classification, presented in Table 6, reveals that 39.1 percent of sampled cases (3,910 out of 10,000) exhibited mild stress, while 42.8 percent (4,280 cases) demonstrated moderate anxiety. Severe trauma accounted for 18.1 percent of cases (1,810 individuals), with these beneficiaries requiring longer session durations (mean 55 minutes) compared to mild stress cases (mean 25 minutes). This distribution indicates substantial mental health burden across severity levels, with nearly one-fifth of beneficiaries experiencing symptoms requiring intensive intervention.

5.3 QUALITATIVE INSIGHTS AND LIVED EXPERIENCES

Qualitative analysis of field accounts reveals how mental health provision transformed under conditions of systematic obstruction. Practitioners documented operating in hallways and tents amid bombardment, adapting therapeutic spaces to emergency conditions. One counsellor from Gaza City noted: "Every drawing now has airplanes. The children make them big so they can erase them." This observation illustrates how art therapy became a mechanism for processing traumatic experiences of aerial bombardment, with symbolic communication enabling children to exert agency amid circumstances beyond their control.

The transformation of therapeutic relationships emerged as a key theme, with practitioners noting how shared vulnerability reshaped traditional provider-beneficiary dynamics. An assistant counsellor from Khan Younis reported: "We ran sessions in hallways; bombs shake the walls, but we keep talking about dreams." This account demonstrates how continuity of service amid danger became a form of psychological resistance, with therapeutic dialogue persisting despite environmental threats to safety and confidentiality.

The interconnection between physical and psychological harm manifested in practitioner observations of "famine fear" among child beneficiaries. A UNRWA health supervisor noted: "When food does not arrive, children cry all day; we call it famine fear." This phenomenon reflects how malnutrition and food insecurity produce distinct psychological symptoms that compound trauma related to violence and displacement. The systematic obstruction of basic needs thus directly contributes to mental health deterioration through multiple pathways.

Social workers documented disruptions to attachment relationships under conditions of mass displacement and loss. One practitioner observed: "Parents say they cannot hug their children anymore — too afraid to lose them." This account reveals how protective caregiving practices become constrained by parental trauma and fear, creating intergenerational impacts that extend beyond direct exposure to violence. The collective dimensions of trauma thus encompass not only individual psychological symptoms but also disruptions to fundamental relational bonds that support child development and family resilience.

5.4 INTEGRATION OF QUANTITATIVE AND QUALITATIVE FINDINGS

The convergence of quantitative patterns and qualitative narratives provides robust evidence of how systematic obstruction produces conditions of serious mental harm. The correlation between violence intensity and service demand ($r=0.74$) aligns with practitioner accounts of adapting therapeutic practices to active bombardment conditions. Similarly, the relationship between malnutrition and child distress ($r=0.81$) corresponds to observations of "famine fear" manifesting in therapeutic settings. This triangulation strengthens the interpretation of MHPSS data as forensic evidence of conditions calculated to produce mental destruction.

The disproportionate impact on children, evidenced by their 69.9 percent representation in beneficiary populations, reflects both quantitative service patterns and qualitative accounts of developmental disruption. Practitioners' documentation of children's drawings dominated by military imagery illustrates how trauma becomes embedded in developmental processes, with symbolic communication revealing psychological impacts that may not be captured through standardized assessment tools alone. This integration of numerical and narrative evidence provides a comprehensive understanding of how systematic obstruction affects the most vulnerable population segments.

Regional disparities in service coverage, particularly the suspension of services in Rafah, demonstrate how access restrictions directly constrain mental health provision. Qualitative accounts of operating in hallways and tents amid bombardment reveal the adaptive strategies practitioners employ to maintain service continuity despite these constraints. The transformation of therapeutic spaces from clinical

settings to emergency zones represents both a response to systematic obstruction and a form of resistance against conditions designed to undermine psychological well-being.

The persistence of service provision throughout the documented period, despite escalating violence and access restrictions, underscores the commitment of mental health practitioners to maintaining care amid genocidal conditions. This continuity itself constitutes a form of ethical witnessing that documents the systematic nature of obstruction while providing essential support to affected populations. The integration of quantitative service data with qualitative practitioner accounts thus reveals how MHPSS functions simultaneously as clinical intervention, forensic documentation, and psychological resistance.

5.5 PATTERNS OF SYSTEMATIC OBSTRUCTION AND MENTAL HARM

The escalation of service demand from 6,450 sessions in October 2023 to 31,600 sessions in February 2025 represents a nearly fivefold increase that directly correlates with the intensification of military operations and systematic obstruction of humanitarian aid. This pattern demonstrates how the destruction of infrastructure and targeting of healthcare facilities created conditions where mental health needs multiplied exponentially. The 98 percent increase in service demand between October and December 2023 coincides with the period of most intense bombardment and mass displacement, revealing how psychological harm was systematically produced through military means.

The distribution of service types reveals critical insights into the nature of psychological distress under siege. The predominance of Psychological First Aid (29.6 percent) indicates the acute nature of trauma experienced by Gaza's population, where immediate crisis intervention was required to address the psychological impacts of bombardment, displacement, and loss. The relatively low percentage of Gender-Based Violence support cases (0.9 percent) likely reflects significant underreporting due to cultural stigma and the collapse of protection mechanisms, rather than actual prevalence. The high proportion of awareness sessions (44.6 percent) demonstrates how community-based approaches became essential for addressing collective trauma when individual therapy was constrained by security concerns and resource limitations.

The correlation analysis reveals systematic patterns of harm that extend beyond individual psychological symptoms to encompass structural violence. The strong correlation between malnutrition rates and child distress ($r=0.81$) demonstrates how the deliberate obstruction of food and humanitarian aid produced distinct psychological symptoms that compound trauma related to direct violence. This finding supports the interpretation that systematic deprivation was calculated to produce mental destruction, particularly among children who constitute the majority of Gaza's population. The correlation between shelter overcrowding and gender-based violence cases ($r=0.63$) reveals how environmental conditions created by displacement and the destruction of housing directly contributed to protection risks that compound psychological harm.

The psychological severity classification reveals that 18.1 percent of beneficiaries experienced severe trauma requiring intensive intervention, representing approximately 132,000 individuals across the study population. This substantial burden of severe psychological harm demonstrates the systematic nature of mental destruction wrought by conditions of siege and bombardment. The longer session durations required for severe trauma cases (mean 55 minutes) highlight the resource-intensive nature of addressing these psychological impacts, particularly under conditions where access to mental health professionals was systematically obstructed.

The regional disparities in service coverage, with Khan Younis showing the lowest coverage at 0.18 percent, reveal how access restrictions and security concerns created geographical inequalities in mental health provision. The complete suspension of services in Rafah after August 1, 2025, demonstrates how systematic obstruction directly prevented the delivery of essential psychological support to populations in need. These patterns of unequal access constitute additional evidence of how conditions were calculated to produce mental harm through the denial of care to specific population groups.

The qualitative accounts of practitioners operating in hallways and tents amid bombardment reveal how mental health provision was systematically obstructed while simultaneously being transformed into acts of psychological resistance. The persistence of therapeutic dialogue despite environmental threats to safety and confidentiality represents a form of moral witnessing that documents the

systematic nature of the obstruction. The transformation of art therapy into a mechanism for processing traumatic experiences of aerial bombardment demonstrates how symbolic communication became essential for maintaining psychological agency amid circumstances designed to produce mental destruction.

The integration of quantitative and qualitative evidence reveals a comprehensive picture of how systematic obstruction produced conditions of serious mental harm that meet the criteria for genocide under international law. The patterns of service delivery, correlation analysis, and practitioner accounts collectively demonstrate that psychological harm was not merely a byproduct of conflict but a calculated outcome of conditions imposed on Gaza's population. This evidence establishes MHPSS data as forensic documentation of systematic mental harm that warrants investigation under international legal frameworks.

6 DISCUSSION

This study addressed three research questions concerning credibility construction, trust mediation, and systematic obstruction of Mental Health and Psychosocial Support services in Gaza. The findings indicate that credibility arises through shared vulnerability and continuity of service under fire rather than institutional authority. Trust is mediated by familiarity through schools transformed into shelters, cultural idioms of faith, and collective rituals of mourning. Systematic obstruction through denial of MHPSS resources, targeting of health workers, and famine conditions creates circumstances that meet criteria for serious mental harm under international legal frameworks. These insights emerge from the triangulation of quantitative patterns in service delivery with qualitative narratives of lived experience.

The correlation between violence intensity and service demand ($r=0.74$) demonstrates how mental health needs escalate in direct response to military operations. This pattern aligns with existing scholarship on trauma in conflict zones, yet extends understanding by documenting how service provision continues amid active bombardment. The transformation of therapeutic spaces from clinical settings to hallways and tents represents an adaptive response to institutional collapse that merits consideration in humanitarian policy. Similarly, the correlation between malnutrition rates and child distress reports ($r=0.81$) underscores the interconnection between physical deprivation and psychological harm, supporting legal interpretations that frame systematic obstruction of basic needs as contributing to mental destruction. **However, it is methodologically imperative to note that these are associations documented in a specific context; inferring the legal "intent" to destroy from this data requires additional evidence beyond the scope of this study.**

The epistemic injustice framework provides a lens for understanding how structural silencing compounds psychological harm. The systematic invalidation of Palestinian suffering in international discourse creates additional barriers to mental health provision that extend beyond material constraints. This study documents how MHPSS practitioners and beneficiaries become moral witnesses through their continued engagement in therapeutic practices amid conditions designed to undermine psychological well-being. The use of art and symbolic communication represents not merely clinical interventions but acts of epistemic resistance that assert the validity of Palestinian experiences against structural silencing.

Researcher positionality shapes the interpretation of Palestinian testimony and institutional discourse in several ways. The reliance on UN agency reports positions the analysis within institutional frameworks that document human rights violations, while the inclusion of field accounts centers Palestinian voices that might otherwise be marginalized. The decision to frame findings in relation to international legal standards reflects a commitment to accountability mechanisms that recognize the political dimensions of mental health in contexts of occupation and siege. This positionality acknowledges the power dynamics inherent in research on Palestinian experiences while striving to maintain analytical rigor through methodological triangulation and reflexivity. **We explicitly acknowledge that the choice to examine the data through the lens of the Genocide Convention is an interpretive framework that guides the research questions and discussion, not a foregone conclusion dictated by the data.**

The findings have implications for documentation practices in conflict settings. The correlation patterns between service delivery indicators and contextual factors suggest that MHPSS data can

serve as forensic evidence of conditions calculated to produce mental harm. This expands the scope of documentation beyond traditional human rights monitoring to include mental health metrics as indicators of systematic violation. The integration of quantitative service data with qualitative narratives provides a model for future documentation efforts that seek to capture both the scale and lived experience of psychological harm in contexts of mass atrocity.

Educational implications emerge from the documentation of how schools transformed into shelters became sites of both trauma and resilience. The disruption of educational pathways compounds psychological distress while creating opportunities for adapted MHPSS interventions that recognize the collective dimensions of healing. This suggests a need for educational frameworks that integrate mental health support as a core component of emergency response in conflict settings, particularly given the youth demographics of Gaza's population where over 65 percent are under age 24 ?. The use of art and symbolic communication in educational spaces under siege represents a form of psychological resistance that merits further study.

Policy implications extend to humanitarian response and legal accountability. The correlation between blockade restrictions and staff stress ($r=0.68$) indicates that access limitations directly impact the capacity to provide mental health services, supporting calls for unimpeded humanitarian access as a matter of psychological well-being. The finding that systematic obstruction creates conditions meeting legal criteria for serious mental harm suggests that MHPSS data should inform atrocity prevention frameworks and international legal proceedings ?. This represents a shift in how mental health evidence is utilized in human rights documentation and legal accountability mechanisms. **A critical policy recommendation arising from the methodological constraints noted in this study is the need for more systematic, standardized, and publicly accessible data collection on MHPSS service delivery and mental health outcomes across all providers in conflict zones to enable more comprehensive analyses.**

Limitations and Alternative Explanations: Several important limitations, highlighted by the reviewers, must be considered. First, the exclusive reliance on UNRWA data introduces potential selection bias, as populations served by other NGOs or receiving no services are excluded. This may over-represent certain demographics or under-represent the full scale of need. Second, while strong correlations are documented, the observational design cannot definitively establish causation or disentangle the effects of confounding variables not included in the analysis (e.g., pre-existing trauma levels, cultural factors in help-seeking). Third, the use of institutional data carries inherent risks of reporting biases, both in terms of under-reporting due to access constraints and potential inflation of service numbers for advocacy or funding purposes. We attempted to mitigate this through data triangulation. Fourth, the term "famine fear," while evocative and grounded in practitioner observation, is not a clinically validated construct; its use here is descriptive rather than diagnostic. Fifth, the lack of a comparative baseline from before October 2023 or from other contemporary conflict zones (e.g., Ukraine, Yemen, Syria) makes it difficult to contextualize the absolute severity of the mental health burden documented here, though the internal patterns and rates of increase remain stark. Finally, the inferential leap from documenting patterns of harm to asserting they meet the specific legal threshold for genocide is the most significant limitation. The data presented are consistent with conditions that could cause serious mental harm, but attributing these conditions to a specific genocidal intent requires evidence of a conscious plan or policy, which is beyond the scope of this service delivery analysis. The study's contribution is to present MHPSS data as a crucial form of evidence that must be integrated with political, military, and legal analyses to form a complete picture.

The transformation of humanitarian care into sites of ethical witnessing has implications for how international organizations conceptualize their role in contexts of systematic violation. The continued provision of MHPSS services amid bombardment and blockade represents not only a clinical response but a form of moral testimony that documents conditions of life under siege. This expands understanding of humanitarian action beyond material assistance to include practices of witnessing that challenge epistemic injustice through the systematic documentation of lived experience ?. The integration of this documentation into international scholarship and policy represents a form of epistemic justice that recognizes the validity of Palestinian knowledge and experience.

The limitations of this study include reliance on secondary data and the constraints of research in active conflict settings. The use of existing field accounts, while necessary for ethical reasons, means that the analysis is limited to documentation already produced through institutional channels. The correlation patterns, while statistically significant, represent associations rather than causal relationships, and

their interpretation must acknowledge the complex interplay of factors in conflict environments. Future research could build on these findings through longitudinal studies that track mental health outcomes over time and comparative analysis with other contexts of systematic violation.

The societal context of Gaza, characterized by collective memory of displacement and high population density, shapes how mental health needs manifest and are addressed. The finding that overcrowding correlates with gender-based violence cases ($r=0.63$) demonstrates how environmental conditions create protection risks that compound psychological harm. This underscores the need for integrated approaches that address both mental health and protection concerns in humanitarian response. The collective dimensions of trauma and resilience documented in this study challenge individual-focused clinical models and suggest the importance of community-based approaches that align with local understandings of healing.

The continuation of MHPSS services amid systematic obstruction represents a form of psychological resistance that merits consideration in scholarship on resilience in conflict settings. The adaptation of therapeutic practices to conditions of bombardment and displacement demonstrates how mental health support can function as a mechanism for preserving agency and dignity amid circumstances designed to produce mental destruction. This expands understanding of resilience beyond individual coping strategies to include collective practices of care that sustain psychological well-being through shared vulnerability and mutual support.

The interpretation of these findings through frameworks of epistemic justice and moral witnessing situates the study within scholarship that recognizes the political dimensions of knowledge production in contexts of structural violence. The systematic documentation of how mental health provision continues amid conditions designed to undermine it represents a challenge to narratives that would render Palestinian suffering invisible or incomprehensible. This contributes to scholarly efforts to center marginalized voices and experiences in understanding the impacts of conflict and siege on psychological well-being.

The relationship between quantitative patterns and qualitative insights demonstrates how mixed-methods approaches can capture both the scale and lived experience of psychological harm in conflict settings. The convergence between statistical correlations and narrative accounts provides robust evidence of how systematic obstruction produces conditions of mental destruction that meet legal criteria for serious harm. This methodological approach offers a model for future research that seeks to document the psychological impacts of conflict while maintaining academic rigor and ethical responsibility.

7 CONCLUSIONS AND FUTURE WORK

This study documented the systematic obstruction of Mental Health and Psychosocial Support services in Gaza between October 2023 and August 2025 as **providing evidence of conditions associated with** serious mental harm under international law. The analysis of 320,035 psychosocial support sessions and 334,148 social-work interventions revealed **strong associations** between military violence and service demand, blockade restrictions and staff stress, malnutrition and child distress, and overcrowding and gender-based violence cases. These quantitative patterns, triangulated with qualitative narratives from field accounts, demonstrate how systematic obstruction creates conditions **that are consistent with the infliction of** mental destruction. The findings **present** MHPSS data as forensic evidence of conditions **that are consistent with the criteria for** serious mental harm under Article II(b) of the Genocide Convention, **while recognizing that establishing the requisite intent (mens rea) requires integration of this evidence with other political and legal analyses.**

The qualitative approach centered Palestinian voices and experiences through narrative inquiry and thematic analysis, contributing to ethical documentation practices that challenge epistemic injustice in conflict settings. This methodology preserves accounts of how mental health provision continued amid bombardment and institutional collapse, transforming therapeutic spaces into sites of moral witnessing. The documentation of how counsellors operated in hallways and tents, using art and symbolic communication to restore agency, provides a model for future research that recognizes the political dimensions of mental health in contexts of structural violence and occupation.

Future research directions include longitudinal studies tracking mental health outcomes across generations in Gaza, comparative analysis with other contexts of systematic violation (**e.g., utilizing similar**

MHPSS metrics from conflicts in Syria, Myanmar, or Ukraine to establish relative benchmarks), and the development of culturally-grounded assessment tools that align with local understandings of trauma and resilience. Cross-cultural understanding would benefit from examining how communication practices in MHPSS sessions function as mechanisms of psychological resistance across different conflict settings. Conflict medicine requires further investigation into integrated approaches that address both physical and mental health needs under conditions of siege and systematic obstruction. Humanitarian response frameworks should incorporate MHPSS data as early warning indicators in atrocity prevention mechanisms and legal accountability processes. **Methodologically, future work should aim to collect primary data where ethically feasible, incorporate more robust causal inference techniques when possible, and actively seek to include data from all service providers in a conflict zone to mitigate selection bias.**

The integration of quantitative service delivery patterns with qualitative lived experiences provides a comprehensive understanding of how systematic obstruction produces collective psychological harm. This approach bridges operational data and ethical interpretation, offering a model for future documentation efforts in conflict settings. The study contributes to scholarship that recognizes mental health evidence as essential for understanding the impacts of structural violence and for advancing accountability under international law, while maintaining a clear distinction between empirical documentation and legal judgment.

Table A1: Variable Definitions and Sources

Variable	Definition & Measurement	Primary Source
Psychosocial Support (PSS) Sessions	Monthly count of all individual, group, and awareness sessions conducted by UNRWA mental health staff.	UNRWA Situation Reports
Social-Work Interventions	Monthly count of case management, referral, and follow-up activities by UNRWA social workers.	UNRWA Situation Reports
Violence Intensity	Daily average number of air raids, artillery strikes, and ground clashes reported. Aggregated to monthly index.	OCHA Flash Updates
Blockade Restrictions Index	Composite monthly index (0-100) based on: % of planned food/aid truck entries denied, # of days with complete closure of crossings.	OCHA, UNRWA Access Coordination
Staff Stress Index	Monthly aggregate score from UNRWA staff well-being survey (5-item scale on burnout, safety concerns, workload; = 0.82).	UNRWA Internal Surveys
Malnutrition Rate (GAM)	Monthly prevalence of Global Acute Malnutrition (weight-for-height z-score < -2 or presence of edema) in children under 5, based on screening at health centers.	WHO Health Cluster Reports
Child Distress Cases	Monthly count of child beneficiaries (<18) presenting with symptoms of anxiety/depression per screening (using a locally adapted version of the Child PTSD Symptom Scale).	UNRWA MHPSS Activity Reports
Shelter Overcrowding	Average number of persons per square meter in UNRWA and public shelters, monthly.	UNRWA Shelter Reports
GBV Reported Cases	Monthly count of reported incidents of gender-based violence (including sexual violence, physical assault, psychological abuse) where survivors sought services.	UNRWA Protection Cluster Reports

Data Availability and Code: Aggregated, anonymized datasets and the R code used for statistical analysis and figure generation are available in a persistent repository [URL blinded for review]. Access to the raw, non-aggregated UNRWA data is subject to the data sharing policies of the United Nations.

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