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Funding: No funding was received for this project

Conflict of interest: None

Thanks: Dr Hanna Kienzler (Dissertation supervisor), Dr Ramzi Khamis (NGO Contact), Alaa Attoun (and the rest of the team)

Word count: 2993 (not including references)

Mental health in conflict: research and voluntary experience of NGO work in the occupied Palestinian territories

'Out beyond ideas of wrongdoing and right-doing there is a field. I'll meet you there. When the soul lies down in that grass the world is too full to talk about. Let the waters settle and you will see the moon and the stars mirrored in your own being'
Rumi

Ever since I can recall I have been drawn to the goings-on of the Palestinian-Israeli conflict. My fascination is born of a longstanding interest in injustice and human suffering. Like many who share these interests, I became focused on methods of practicing the altruistic tendencies that underpin them; involving myself in volunteer and charity work throughout my secondary and medical school training. In 2014, a few peers and I arranged for an elective placement in the West Bank. Unfortunately, we were not granted entry into the country by the relevant authorities and returned home to watch in horror as yet another war broke out between the two mismatched sides. After I qualified as a doctor and began to specialise in Psychiatry, I travelled again to the region – this time savvier about the intricacies – and undertook some psychosocial voluntary work with a local NGO.

Just before this trip, I took time out of my Psychiatry training for an MSc in Global Health and Social Justice. For my dissertation, I seized the opportunity to place an academic framework on my slight obsession with the conflict. The essay that follows is an excerpt from this research; it endeavours to provide a brief summary of the situation in the occupied Palestinian territories (oPt) and share some of the results of my qualitative research project. The final part will focus on my experience of voluntary work in the West Bank and reflections that might be pertinent to mental health workers and 'social justice warriors' reading this piece.

Background and context

Palestine has a complex history. For the last 70 years it has been embroiled in violent conflict with Israel; a protracted period of destabilising unrest compounded by vested interests of neighbouring states and international superpowers (Gelvin, 2014). Today, the oPt exist as two land masses – West Bank and Gaza Strip. Annexed by Israel and under-reoccupation since

2000 (Giacaman et al, 2005), the situation in oPt has been termed a humanitarian issue (Shearer, 2004; UNFPA, 2019; UNICEF, 2018). The systematic violence, interspersed with periods of more intensive warfare, has had negative consequences for the economy and the social fabric of Palestinian society (Giacaman et al, 2009; Jabr and Berger, 2017; Marie et al, 2016). As with many states under protracted conflict, mental ill-health represents a chronic burden in the oPt (Giacaman et al, 2010; WHO, 2019), placing increased demands on mental health services (Allen et al, 2014; Marie et al, 2016; Tol et al, 2011).

Situations of protracted conflict are known to negatively affect mental health and well-being in complex ways (Pedersen and Kienzler, 2014). This occurs directly - as a result of acute stressors, exposure to violence or social problems - and indirectly - due to an increase in the number of social determinants which negatively impact mental health and well-being (i.e. poverty, inequality, unemployment, early childhood adversity, unfavourable environmental conditions) (Allen et al, 2014; Ventvogel et al, 2015; WHO, 2019). Moreover, pre-existing severe and enduring mental illnesses can be exacerbated in such conditions (Jones et al, 2009). In Palestine, these conditions have led to rising rates of mental illness and social suffering (Giacaman et al, 2010). To address the mental health needs of conflict-affected populations, it has been suggested that psychosocial support should be provided to improve these adverse social and material conditions and other broad impacts of armed conflict, as well as to improve understanding, recognition and adequate management of locally conceptualised trauma (Kirmayer et al, 2010; Pedersen et al, 2015; Pedersen and Kienzler, 2014). The structural consequences of protracted conflict, however, mean states are often unable to provide the full range of adequate mental health services due to a lack of resources – both economic and human (Pedersen and Kienzler, 2014; Ventvogel et al, 2015).

International and local non-governmental organisations (NGOs) intervene to attempt to meet the needs of the population and supplement public and private services. The approaches of international NGOs (INGOs) in the oPt have received critiques for being uncoordinated, culturally out of context, overly trauma-focused, delaying the development of governmental health systems and lacking in evidence base and transparency (Feldman, 2009; Giacaman et al, 2010; Giacaman et al 2005; Kienzler and Amro, 2015; Summerfield, 2000). My research piece aimed to understand how INGOs contribute to provide holistic mental health support in the oPt, by exploring the intersection between mental health, psychosocial and social interventions for mental health from the perspective of humanitarian

aid workers in these organisations. Particularly, what are their perceptions of the psychosocial situation? How do they envision a holistic and context-specific system of mental healthcare?

Study results

Participant views on mental health and psychosocial stressors in the oPt

The consensus regarding the mental health and psychosocial situation in the oPt was that the needs of the population are greater than the structures which provide these services. Participants described direct effects of the conflict on mental health where housing demolition orders, barriers to free movement, Israeli army violence and arrests have a negative impact on people's mental state. Moreover, settlement expansions and settler violence were regularly mentioned as a cause of mental distress and trauma. Participants discussed the rising needs of the population as a result of the political and structural violence with a sense of urgency.

The protracted nature of the conflict means that emergencies are perceived to be always imminent. Rebecca, a mental health officer, said for instance, "we work in a very unpredictable political situation in that, sometimes, everything will stop. There will be strikes, there will be a war". According to Mary, a social worker, the unpredictability and regular flares of violence create feelings of tension amongst the population who "show many traumatic signs relating to deteriorations in their mental health status". Others differentiated between the political situation in Gaza and the West Bank, highlighting that "[Gaza] are always in conflict, and they always have attacks" (Rebecca) hence "[their] mental health and psychosocial needs are even more" (Sarah). Aid workers in both areas described the Great March of Return (GMR) demonstrations as a major precipitant of mental distress; "people here have started to say '*hallas*, we wish to die, we have nonsense or no meaning lives'" (Helen). These protests, where civilians gather regularly along the Separation barrier surrounding the Gaza Strip, have aggravated tensions and violence in the area. Alice, a mental health field officer there, has seen the effect of the occupation on families and explained to me, "[two nights ago] we had this high sound of the planes. You can't imagine... [the neighbour's] children were *screaming* most of the time. And the mother, she was very nervous, she beat the child telling him 'nothing has happened!'". Further pressures on

families and communities in the Gaza Strip relate to social determinants which have a negative effect on mental health and well-being, including unemployment, poverty rates and drug addiction. These were considered indirect effects of the occupation, compounded by state policies in the fragmented political situation. It was explained that people feel worthless and hopeless due to their lack of employment.

Besides these socio-economic effects, participants also considered a lack of respect of women's rights an important indirect effect of the conflict on mental health and psychosocial well-being; particular problems include gender-inequality, sexual abuse and incest. 'Cultural harms' were reported to be a major source of distress for female patients, namely early marriage, domestic violence and lack of freedom:

> "For the women - violence, sexual harassment... It's more the community that's oppressing [than the conflict]; they cannot do what they want. Women are married and their husbands beat them, but they cannot divorce because it won't be well-received" (Florence)

I was told that women with disability and mental illness face stronger stigma than men, often complicating their recoveries; "they suffer a lot, their families try to hide them" (Alice). According to participants, stigma is a main feature at various levels of Palestinian society; individual and community stigma prevents presentation to services. Apparently, 'top-down' stigma exists amongst some senior decision-makers in the MoH and amongst many medical professionals. Suicide is considered a criminal offence and attempts carry mandatory reporting to the Ministry of Justice. As a result, "there is a huge stigma around suicide. Lots of people admitted who have attempted suicide would rather leave the emergency department before any support is provided to them" (Rebecca).

According to all participants, the protracted conflict situation has worsened pre-existing psychosocial issues in Palestinian society. Participants linked the aforementioned social, economic and political stressors to negative mental health outcomes such as anxiety, bedwetting, fatigue/exhaustion, hopelessness, depression and PTSD. Population engagement with the mental health and psychosocial services that aim to alleviate these problems varies according to perceived stigma, location of services and severity of illness or distress, as Mary

explained: “not all cases go and seek the centres or organisations that provide mental health services; only severe cases... for example, if I am grieving my brother’s death, I won’t go seek services. But if I, or a family member, had psychotic signs I’ll go ask the mental health [services]”.

Visions for a holistic system

Views of how to achieve a holistic system of mental health and social care varied amongst participants. Some had strong aspirations for an ecologically orientated system, like Helen, a social worker and the most recent graduate, who explained a holistic system will be one where they can “target people in their social environments, not only their individual, internal lives...the person first as an individual, then the small circles [going outwards] which is the family, the neighbourhood – schools, clubs, workplaces – after that the whole community” (Helen). Whilst participants agreed on this definition of holism, their aspirations for achieving this varied according to levels of pragmatism. Some felt that the most realistic way of achieving this type of care whilst Palestine is still under occupation is through a collaborative referrals system between the different actors involved, since “if the UN and NGOs don’t exist [here] then it has to be like in all other free countries; the ministry in charge of everything” (Sarah). Others described a need to continue to build a comprehensive system as their INGO is doing; by “providing different mental health services in different facilities” (Rebecca). John, whose experience of mental health services in the oPt was through a specialised clinic, told me that “more or less, they have [a holistic system] ... what they are trying to build in the West Bank is going in a good direction”. Whereas Florence had more reserved views “it’s really difficult to imagine something...if one day they can have psychologists in the hospitals I think that would help, but I think they have to take mental health seriously first”.

When asked about barriers to achieving a holistic system, all participants reacted with rueful laughter or smiles. “It’s a political thing” was the most common response, “yeah if the occupation ended, 80% of these issues won’t be there anymore” (Sarah). The ensuing lack of human, structural and financial resources were named as hindrances to the ability to build a suitable mental health system. Florence felt this factored into why it is difficult to implement changes:

> "I have a feeling that people here [don't] think about the future, it's all in the moment... it's difficult to imagine being involved in a project, as [government employees] only touch 60% of their salary... So, it's very difficult to implement or talk about the future if they don't know [whether or not they will have a] salary cut the next month".

Alice explained her views on why practices in Gaza were lagging behind in the ability to prevent and detect mental illness; "we have universities, we have the theoretical part, we have the knowledge, but we still need to be open to the world. To see what developments there are regarding interventions. This knowledge!". The political barriers are not limited to the Israeli occupation, however. There is also a lack of political willingness within the Palestinian state to prioritise mental healthcare, as Rebecca depicts: "The MoH says mental health is very important in Palestine, but I mean...you can see the conflict of messages. At a certain point they say it's important, but at another time they put obstacles. The work is not easy".

Apparently, the main barrier to building a comprehensive system and delivering this care to the population relates to stigma at all levels of society - individual, family, community, institutional. Although efforts to reduce stigma with psychoeducation, awareness raising and other campaigns have succeeded in overcoming this in some domains, the overarching impression is that there is a long way to go. Moreover, when INGOs do manage to overcome stigma and promote health-seeking behaviours amongst communities, the population's ability to access a comprehensive range of mental health services is often blocked, physically and legally, by the impositions of the longstanding Israeli occupation, and economically by the prevailing poverty levels.

Voluntary experience

Arriving into the West Bank was challenging; it required travel through various checkpoints and rigorous questioning. An experience overall not helped by the fact that I travelled on Friday (when Sabbath begins in the evening) when the checkpoints/modes of travel close

early. Once I arrived and eventually located the hospital in a small and beautiful town near Bethlehem, I settled into my accommodation and attempted to decompress from my somewhat traumatising border experience.

After spending the first few days getting to know Bethlehem and making some key friends (the local coffee man and a market seller who wasn't going to extort), I excitedly reported to the psychosocial programme. After establishing the roles and schedules of each of the different team members, I quickly understood that the doctor on the team was no longer working there. It transpired that she had been on holiday to visit her family in Europe and was not granted permission to re-enter the state to continue her work. This barrier had been alluded to by the participants in my research. The team explained that, as a result of this change, their caseload has reduced significantly; they could no longer manage cases of severe and enduring mental illness or provide or be trained in psychotherapy. They mainly work to support families of people with disabilities, run mother and baby groups and provide community support (awareness raising/stigma reduction work in schools and local refugee camps). I had the privilege of helping to run some of these groups and, in doing so, discovered the realities of the travel restrictions. A journey of a few miles took hours, due to lack of access to decent roads and a dearth of vehicles within the organisation. Most families did not have transport, so providing consultation also required arranging transport for them. Home visits are not permissible due to the stigma of a known mental health worker arriving to a family's home.

I was keen to volunteer with a Palestinian NGO, given the critical outcomes of the research project I had undertaken with members of international NGOs. It took me only a few days to realise that this group of hard-working psychosocial counsellors and social workers faced greater challenges, and that my expectations of ground-breaking voluntary work were unlikely to be met. Lesson one in the 'white saviour' (Douzinas, 2007; Muller, 2013) complex that accompanies many good-willed philanthropic intentions.

My colleagues were also able to explain why the integrated referrals system implemented by the World Health Organisation was not taken up within the region; mostly as it was not relevant to the way people communicated and networked within the Palestinian cultural context. Also, the electronic communication required was not deemed trustworthy by the Palestinian workers, for reasons related to stigma and living under occupation.

My own challenges - lacking in hot water for most of the time I spent there, feeling on edge and worried about my own safety being in this place – paled in comparison to the lived experience of those I worked alongside. It is clear that NGO work, to me as the good willed 'Western humanitarian', is a romantic concept based in altruism, but to many I met it provides an opportunity for equitable and stable employment that cannot be met elsewhere. Yet, despite my unmet anticipations and conflicted feelings, my experience exceeded expectations. These are some of the most open, warm and hospitable people I have met; their resilience and goodwill is a testament to their character. I was privileged to spend time there and shown the beautiful, but fragmented, land that remains of Palestine.

Conclusion

My weeks spent in the West Bank were some of the most emotional and eye-opening experiences I've had. I know now that the neatly packaged format of academic conversation around this topic feels worlds apart from the messy reality of those living and working in the West Bank. Bearing witness to this has left a lasting mark; I try to emulate this as much as I can within my training back in a European country.

Transcultural psychiatric theories, such as collective suffering, are relevant to mental health practice in the global North, as our populations become increasingly culturally diverse. This is not a static concept; the lens of research, therapeutic development and policy making should consider these concepts, and it is within the remit of health professionals to ensure that. Moreover, volunteer work and its sentiment are not solely international experiences; a continuation of this is a refugee crisis very relevant to the British and European fore. I urge those reading this with dreams of volunteer work in far flung places, to consider how those much-needed instincts can be honed-in on in their current roles and academic spheres.

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