Psychological support for Palestinian children and adults: an analysis of data from people referred to the Médecins Sans Frontières programme for behavioural and emotional disorders in the occupied Palestinian territory

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Since the beginning of Al Aqsa Intifada, Palestinian children and adults living in the occupied Palestinian territory have been exposed to stressful events on a daily basis. As a result, some individuals develop severe and chronic reactive psychological syndromes. The nongovernmental organisation Médecins Sans Frontières (MSF) provides medical and psychological support to them, using psychodynamic psychotherapy adapted to the Palestinian culture and to the low intensity conflict context. This article presents data from 1773 children and adults who received treatment by psychotherapists between November 2000 and January 2006, in the Gaza strip and the West Bank. Nearly half of the patients were children between 4 and 14 years. The three main diagnoses were a) anxiety disorder other than posttraumatic stress disorder (PTSD) or acute stress, b) mood disorder, and c) PTSD. The psychotherapy included a median of six sessions over a period of around 11 weeks. At the evaluation at the end of therapy almost 80% of all patients had improved. These observations suggest that brief psychodynamic psychotherapy could have positive effects on the psychological wellbeing of Palestinians, even in difficult circumstances (war context) and within an Arab culture. The authors argue that this type of individual psychological support can be a useful complement to a psychosocial approach at the community level.

Keywords: individual psychological support, occupied Palestinian territory, outcome of treatment, psychodynamic psychotherapy

Introduction

Conflict generated by the Al Aqsa Intifada, which began in September 2000 and continues to date, exposes the Palestinian population to *violence and helplessness*. The population suffers from stress imposed by armed and/or military violence together with continuous restriction of movement through checkpoints, closures and curfews. *Traumatogenic events* such as shootings or bombings, destruction of houses or fields, physical violence and deaths of relatives, also occur on a daily basis (Abdeen, Qasrawi, Nabil & Shaheen, 2008; Qato, 2004; Rytter, Kjaeldgaard, Bronnum-Hansen & Helweg-Larsen, 2006; Salignon, Ismael & Sgorbati, 2003).

Within this context, individuals' reactions are extremely variable. Stress is a normal effect on adults and children subject to daily violence, but may also trigger deeper psychological suffering. Some individuals develop severe and chronic reactive psychological syndromes, including various forms of depressive states, acute or posttraumatic stress disorder (PTSD), complex PTSD, anxiety and behavioural problems (Abdeen et al., 2008; Abu Hein, Qouta, Thabet & El Sarraj, 1993; Baker & Shalhoub-Kevorkian, 1999; Khamis, 1998; Thabet, Abed & Vostanis, 2002; Thabet, Tawahina, El Sarraj & Vostanis, 2008; Zakrison, Shahen, Mortaja & Hamel, 2004).

Since November 2000, Médecins Sans Frontières (MSF) has provided medical and psychological care to those affected by the violence and lacking medical support (Salignon et al., 2003). Complementary to a more psychosocial approach at community level, the psychotherapeutic work that is offered through the MSF programme is based on Winnicott's therapeutic consultations model (Winnicott, 1971). This work encourages individuals (children and adults) and families to externalise their emotions and fears, to elaborate their traumas, and to cope with their stress in a manner respectful of their own cultural representations. This is similar to some therapy used for the consequences of trauma on displaced communities at Avicene Hospital, Bobigny (Rezzoug, Baubet, Broder, Taieb & Moro, 2008; Sturm, Baubet & Moro, 2007) or in other MSF fields (Hustache, Moro, Roptin, Souza, Gansou, Mbemba, Roederer, Grais, Gaboulaud & Baubet, 2009). The psychodynamic approach of trauma (Garland, 1998) was adapted by experts in trans-cultural psychiatry to the Palestinian culture (Baubet & Moro, 2003; Rezzoug et al., 2008). Depending on the initial evaluation and the context, therapy was proposed with one patient (individual), a caregiver and child (dyad), or several members of a family (family). Through work on trauma and life history narratives, our objective was to help patients to rebuild meaning, coherence, and self-continuity, to

Box 1. A brief description of the therapy sessions

Therapy mainly took place in patient's homes due to travelling restrictions for Palestinians in the cities, as well as the fear of leaving their homes. The psychologist or psychiatrist, with an interpreter from the community, explained that the objective of the therapy focused on the consequences of trauma. Explanations were given in a vernacular familiar to Palestinians. During consultations, the MSF driver stayed outside the house, making the presence of the team as visible as possible, in order to guarantee security. For some patients in Hebron or Jenin, the therapeutic sessions were done in a specific consultation room.

Each session usually took one hour. In the beginning, the therapist assessed the symptoms and the context in which they occurred, and tried to identify the family members (adults and children) who needed specific help. In the event that a woman needed help, for cultural reasons, a female co-therapist was offered. Work with children was facilitated because children were usually in the house anyway. This was due to the awareness of the children's fear of going to school, as well as the difficulties of playing outside due to the war. Because of the difficulties encountered reaching patients, the time between two sessions could be long, usually one week, but sometimes longer.

relieve psychic suffering, and to limit the development of further complications (Salignon et al., 2003; Rezzoug et al., 2008), while also addressing interpersonal, family, social and cultural issues.

Expatriate therapists sent to the MSF programs were selected for their cultural competence including awareness of the various ways in which culture impacts on psychosocial development, psychopathology and therapeutic transactions. Most therapists had already done clinical work using a psychodynamic approach, often with victims of extreme violence in the context of humanitarian interventions.

Although very little data exist on the effectiveness of therapy in such contexts, a recent publication on the use of this type of psychotherapy in conflict settings is encouraging (Hustache et al., 2009). The project developed a systematic prospective data collection system that enables us to describe the suffering and the psychological status of the population targeted by the MSF programme, and to document the outcome of treatment.

Methods

We included all patients supported by psychotherapists between November 2000 and January 2006, in different places of the occupied Palestinian territory affected by the Israeli–Palestinian conflicts: Gaza Strip and the West Bank (Hebron, Jenin and Nablus). Patients were referred to MSF through a local mental health and counselling network, or by beneficiaries talking about the programme to friends or neighbours. Through home visits, the MSF team identified affected people and proposed appropriate treatment. All individuals were eligible for programme inclusion. For the data collection, each patient was informed and ethical approval was obtained from local authorities.

After obtaining informed verbal consent, the psychologist or the psychiatrist administered a standardised questionnaire. This questionnaire covered sociodemographic characteristics (age, gender and place of residence), major traumatogenic life events, main complaint and diagnosis. For diagnosis we used modified DSM-IV categories (American Psychiatric Association, 1994). The use of categories and criteria have been strongly criticised in trans-cultural and post conflict contexts because their validity is questioned. It is difficult to distinguish what is pathological, and what is not, in post conflict settings with repeated trauma, death of relatives, organised violence and destruction of social bonds, even when using validated screening tools (Bolton & Betancourt, 2004; Summerfield, 1999). To modify categories and criteria, and to make them suitable to both Palestinian culture and a conflict context, we organised a focus group with professionals (teachers, medical doctors, nurses, community leaders, psychiatrists) in the beginning of the programme in order to determine the cultural specificity in the presenting complaints for diagnosis (Kitzinger, 1995). In our categories, PTSD includes complex PTSD, mood disorder includes major depressive disorder and dysthymia (with milder symptoms than depression). Anxiety disorder encompasses generalised anxiety disorder, panic disorder, agoraphobia, social and specific phobia. Data used to describe the therapy included: type (individual, family or caregiver/child), number of sessions, date of the first and last session, main place of follow-up (home or consultation room), psychotropic medication prescribed and main reason for ending therapy.

The level of psychological distress presented at first contact was measured by the therapist, based on the Global Assessment of

Functioning (GAF) scale for adults, or the Children's Global Assessment Scale for children. The clinician takes into account the number and intensity of signs and symptoms, and consecutive alterations in functioning in terms of carrying out daily activities (Endicott, Spitzer, Fleiss & Cohen, 1976; Jones, Thornicroft, Coiey & Dunn, 1995). This scale is usually scored from 0 to 100 (100 being the highest level of functioning in a large range of activities, without any symptoms). Due to the need for simplification in our study, three levels of severity were defined: mild (score from 61 to 100) corresponding to mild symptoms or few difficulties functioning in social, work or school spheres; moderate (score from 31 to 60) corresponding to moderate or serious impairment in social, work or school functioning; and severe (score below 30), corresponding to a disability of functioning in all spheres (for example, someone remaining in bed, without any professional or social activity), with possible severe auto- or hetero-aggression.

Using the same criteria, and compared to the initial level, the therapist rated patient improvement at the last session. Four categories were defined: improved, unchanged, aggravated (according to the evolution of symptoms), or unable to assess. Patients who received only one session of therapy were excluded from the outcome analysis. For caregiver/child therapy or family therapy, data were collected for each patient focused by therapist.

Monthly supervision sessions between therapists in the field and an expert psychiatrist, who was not involved in the therapy, were organised. During those sessions, material from clinical cases were compared and analysed and the diagnosis or evaluation of patients were discussed to ensure the quality of data.

Data were entered with a data entry software (Epidata, Odense, Denmark) and analyses were conducted using a statistics software (StataV 8.2, Stata Corporation, College Station, Texas). To analyse the influence of age on diagnosis and outcome of therapy, only individuals aged more than 3 years were included. Three different age groups were examined: 4 to 14 years were defined as children, 15 to 19 years as adolescents and > 20 years as adults. We used descriptive statistics to present the characteristics of the programme population. To analyse differences between groups, we used the chi^2-test, a statistics test used for comparison of categorical variables. For quantitative variables, number of sessions and length of therapy, median and inter quartile were calculated. For the comparison we used another statistics test, the Kruskal–Wallis, non parametric test used for comparison of numeric or ordinal variables.

Results

Data concerning 1773 patients referred to the MSF programme between November 2000 and January 2006 were obtained. This cohort included 656 (37%) followed in the Gaza Strip and 1117 (63 %) in the West Bank. The mean age of patients was 20 years, ranging from 0 to 78 years. Half of the beneficiaries were children less than 15 years of age (900/1773). More than half of the patients were referred to the programme by the MSF team visiting the families and around 20% came to the centre on their own after hearing about the programme.

Table 1 describes the baseline characteristics of patients for the Gaza Strip and the West Bank. There was no difference in the age distribution between the two regions. The overall sex ratio for both regions was similar. At both sites, children (4 to 14 years) were predominantly male, while adults were

Table 1. Sex ratio and age of the 1773 patients, MSF medico psychological programme, Palestine, November 2000–January 2006

	Gaza Strip n = 656		West Bank n = 1117		Total N = 1773	
Sex ratio (M/F)	1.1	(350/306)	1.06	(577/540)	1.09	(927/846)
Age groups (years)						
0 to 3	18	(2.7)	33	(2.9)	51	(2.8)
4 to 14	323	(49.2)	526	(47.1)	849	(47.9)
15 to 19	58	(8.9)	119	(10.6)	177	(10.0)
≥ 20 years	257	(39.2)	439	(39.3)	696	(39.3)

Table 2. Major life events and consequences of the conflict declared by the patients themselves, or caregivers for the different age groups, MSF medico psychological programme, Palestine, November 2000–January 2006

	Children (4–14 years) n = 816*		Adolescent (15–19 years) n = 173*		Adults (≥20 years) n = 676*		Total N = 1665	
	n	(%)	n	(%)	n	(%)	n	(%)
Property lost or destroyed	192	(23.5)	31	(17.9)	195	(28.9)	418	(25.1)
Witness murder or physical abuse	172	(21.1)	35	(20.2)	120	(17.8)	327	(19.6)
Close family member killed	105	(12.9)	25	(14.4)	170	(25.1)	300	(18.0)
Received threats	121	(14.8)	41	(23.4)	120	(17.8)	280	(16.8)
Physical injury	103	(12.6)	59	(34.1)	115	(17.0)	277	(16.6)
Incarceration	39	(4.8)	24	(13.9)	88	(13.0)	151	(9.1)
Break up of the nuclear family	18	(2.2)	7	(4.0)	34	(5.0)	59	(3.5)
Close family member died from illness	10	(1.2)	2	(1.2)	13	(1.9)	25	(1.5)
Being forced to flee	10	(1.2)	1	(0.6)	14	(2.1)	25	(1.5)
Sexual and/or gender based violence	2	(0.2)	0		2	(0.3)	4	(0.2)

Each patient can declared one or several events. The total of the column is not the same as the number of patients by age categories.

* Data missing for 33 children, 4 adolescents and 20 adults.

Table 3. Main diagnosis by age groups more than 3 years old, following the DSM-IV classification, MSF medico psychological programme, Palestine, November 2000–January 2006

	Children (4–14 years) n = 841*		Adolescent (15–19 years) n = 175**		Adults (≥ 20 years) n = 687***		Total N = 1703	
	n	(%)	n	(%)	n	(%)	n	(%)
Anxiety	181	(21.6)	38	(21.7)	118	(17.2)	337	(19.8)
Mood disorder	20	(2.4)	34	(19.4)	210	(30.6)	264	(15.5)
Posttraumatic stress disorder	185	(22.0)	26	(14.9)	50	(7.3)	261	(15.3)
Adjustment disorder	71	(8.5)	15	(8.6)	41	(6.0)	127	(7.5)
Acute stress disorder	54	(6.4)	15	(8.6)	47	(6.8)	116	(6.8)
Mother & child relation disorder	44	(5.2)	1	(0.6)	18	(2.6)	63	(3.7)
PTSD & mood disorder	12	(1.4)	2	(1.1)	42	(6.1)	56	(3.3)
Learning disorder	22	(2.6)	2	(1.1)	0		24	(1.4)
Other main diagnosis	59	(7.0)	8	(4.6)	47	(6.8)	114	(6.7)
No main diagnosis	193	(22.9)	34	(19.4)	114	(16.6)	341	(20.0)

* Data missing for 8 patients,
** Data missing for 2 patients,
*** Data missing for 9 patients.

predominantly female with a M/F sex ratio of 1.6 (521/328) and 0.7 (278/418), respectively. The major life events or consequences of the conflict declared by the patients are detailed in Table 2. One quarter of the patients reported lost or destroyed property. At the first consultation, the main patient or parent complaint was documented for 1474 patients. The two most important complaints were '*fear*' (20.5%: 302/1474) and '*sadness*' (16.4%: 242/1474). Another important complaint occurring for a quarter of the children was '*bedwetting*' (24.5%: 169/691). Table 3 describes the main diagnosis by age group for patients over 3 years as evaluated by the psychiatrist or psychotherapist. Anxiety disorder other than posttraumatic stress disorder (PTSD) or acute stress was diagnosed for approximately 20% of the patients. There was no statistically significant difference between the three age groups ($p = 0.08$). For mood disorder, the frequency ranged from 2.4% for children to 30.6% for adults. In contrast, for PTSD, the prevalence decreased with age from 22% for children to 7.3% for adults. Diagnosis following the DSM-IV criteria was not specified for 20% of patients despite the presence of psychological distress and the need for support.

Results for the main diagnosis analysed separately for the Gaza Strip and the West Bank showed the same tendency concerning mood disorder and PTSD by age group (increasing and decreasing for older age

Table 4. Length, number of psychotherapy sessions and percentage of patient improved by age group, sex, region and condition of patient at first contact, MSF medico psychological programme, Palestine, November 2000–January 2006

		Sessions			Length (weeks)			Improved		
	N	Median	IQ	*P**	Median	IQ	*P**	n	(%)	*P***
Age (years)				0.003			0.2			0.09
4 to 14	766	6	[4–9]		10.8	[6–18]		629	(82)	
15 to 19	159	5	[3–8]		10.6	[5.4–18]		126	(79)	
≥ 20 years	589	6	[3–11]		11	[6–19]		456	(77.4)	
Sex				0.2			0.6			0.06
Female	712	6	[3–10]		10.8	[6–18.7]		584	(82)	
Male	802	6	[3–9]		11	[6–19]		627	(78.2)	
Region				0.1			0.03			0.7
Gaza Strip	543	6	[4–10]		10	[5.3–18]		437	(80.4)	
West Bank	971	6	[3–9]		11.6	[6.3–19]		774	(79.7)	
Condition of patient				0.0001			0.0001			0.5
Mild	320	4	[3–6]		7	[3.8–12.8]		249	(77.8)	
Moderate	723	6	[4–9]		11.3	[6.3–18.7]		583	(80.6)	
Severe	471	8	[5–13]		13.1	[8–22]		379	(80.5)	
Total ***	1514	6	[3–10]		11	[6–19]		1211	(80)	

* Kruskal–Wallis test.
** Chi-square test.
*** Patients with missing data, those who received only one session of therapy and children aged less than 4 years were excluded from the analysis.

groups). A higher frequency of acute stress disorder and mood disorder was seen in the Gaza Strip, with respectively 8.1% and 17.6% compared to 6.1% and 11.3 % in the West Bank. In contrast, PTSD was more frequent in the West Bank (17.7% vs 11.3%). The level of distress was documented for 1714 patients and qualified by the therapist as moderate for 46.5% (797/1714) and severe for 30.6 % (524/1714). The level was similar for the different age groups ($P = 0.08$). Regarding gender, male patients had more severe psychological distress compared to females ($P = 0.03$).

Half of the patients received individual therapy, more than one-third had family therapy and 10% had caregiver/child dyad therapy. The number of sessions ranged between 1 and 52. The median number of sessions was 6 [IQ: 3–10]. The median length of therapy was 11 weeks [IQ: 6–19]. Length and number of sessions of therapy by age group, sex, condition at first contact or region of follow-up (Gaza Strip or West Bank) are detailed in Table 4. The median number of sessions was higher for children and adults compared to adolescents even if the length of therapy was similar between the three age groups. In contrast, the length of therapy was significantly higher in the West Bank compared to the Gaza Strip, despite a similar number of sessions. The

number of sessions and length of therapy increased with the severity of the patient's symptoms.

The proportion of patients that improved by the last session by age group, sex, region and patient condition are presented in Table 4. The proportion of patients that improved tended to decrease with age. The proportion of female patients showing improvement was higher compared to male patients. Results were similar for the Gaza Strip and the West Bank and for the severity of patients' symptoms. Therapists reported that at the last session, 80 % (1211/1514) of the patients had improved with therapy.

Discussion

Characteristics of patients

The proportion of patients less than 15 years represented half of the patients followed by the programme. This number is consistent with the Palestinian population structure, following the Palestinian Central Bureau of Statistics and the last census (http://www.pcbs.gov.ps/). The proportion of the population aged 0 to 14 years was, respectively, 44.3% for the West Bank and 49.2% for Gaza strip. Within this young population, males between 4 and 14 years and those between 15 and 19 were over represented in our cohort. These population groups are known to be particularly exposed to violence and susceptible to trauma. Fombone (2005) also reported a higher prevalence of psychiatric disorders for male children in a recent epidemiological study. The major life events reported by patients underline the particularly harsh conditions of civilians in the occupied territories.

Diagnosis

The rate of PTSD is high, as this syndrome affected 20% of the patients. The other main syndromes observed were severe mood disorder and anxiety disorders. This is not surprising. In their epidemiological survey, De Jong, Komproe & Ommeren (2003) found high prevalence figures for the Palestinian general population. In our cohort, children were at higher risk of PTSD than adults. This is in accordance with the literature. Some authors report that when a traumatogenic event is experienced before 11 years of age, the risk of the occurrence of PTSD is three times higher than when the same event is experienced by an adolescent or an adult, thereby indicating a higher psycho traumatic fragility (Yule, 2001).

A higher proportion of acute stress syndrome could have been expected, given the particular nature of the programme, which was carried out during the conflict and at the very moment of the traumatising events. Various hypotheses could be put forward to explain these low figures. First, it was not possible to identify the patients sufficiently early, or it was not possible to care for all patients early, due to cultural factors (for example, in the case of mourning, the family stays at home). The diagnosis of acute stress syndrome and PTSD may have been occasionally confounded because of repeated traumatising events. This may also lead to difficulties in differentiating between the effects of recent and previous traumatogenic events (the first Intifada for example).

In our sample the proportion of anxiety disorders among children was high, and the proportion of mood disorder was low. This is understandable, as the majority of epidemiological studies report between 5 to 10% anxiety disorders among children, while mood disorder is rare in children under 12 years (Fombone, 2005).

Therapy

Using therapeutic consultations, mainly at the patient's residence and often involving

the family, more than three-quarters of patients had improved at the end of therapy. The importance of this adapted therapy, based on the psychodynamic approach and respecting the Palestinians' cultural characteristics, was possible and efficient. Based on our results, the therapy seems more efficient for children compared to adults, and more efficient for females than males. Therapy ended on mutual agreement for almost 80% of patients, further highlighting the positive relationship between patients and therapists. This type of therapy has already been used with success for trauma related psychological disorders in different contexts, and/or for migrant populations (Hustache et al., 2009; Rezzoug et al., 2008). Our findings reinforce the notion that, as a complement to the psychosocial approach, individual psychotherapy adapted to the cultural context could be developed and evaluated.

More public health programmes should approach the assessment and support of the individuals' and families' mental health, and not only focus on medical strategies, to help community recovery (Toole, 2002). Those programmes that address the consequences of violence on an individual and community level should have two objectives: at individual level, the programme must support and facilitate the process of the traumatised individual to reconnect to his/her environment, community and culture. At the community level, the programme needs to create an environment that facilitates the reintegration of individuals, or rather groups of traumatised individuals (De Jong & Prosser, 2003).

Limitations

These findings in this paper should be interpreted with caution. There are several limitations that need to be considered when evaluating our data.

Firstly, our data represent only the population referred to the MSF programme. The characteristics of our population seem to be consistent with those of the Palestinian population, but patients were not purposefully selected in a representative manner.

Secondly, it is a major limitation that the therapists themselves rated patient improvement. This can be a source of bias. Self ratings by caregivers/family members, and ratings by independent professionals would have been more appropriate. However, the data were gathered during an ongoing intervention with difficult conditions in the field, and in such circumstances it is often not feasible to use more sophisticated methods to evaluate therapy.

Thirdly, another limitation is the absence of a control or comparison group. We do not know whether the observed reduction in symptoms can be attributed to the therapeutic intervention alone. It is possible that other factors (such as natural or spontaneous recovery, or changes in context, could have played a role.

In short, our data do not enable us to draw hard conclusions on the effectiveness of the treatment. Our intention was to document the results of an intervention in difficult circumstances and to share this with other practitioners and the scientific community.

Conclusion

This paper gives some insight in the degree and type of suffering of a part of the Palestinian population exposed to traumatic experiences, living in harsh conditions in the occupied territory and targeted by a treatment programme of the MSF. Our findings suggest that in spite of the difficult circumstances, short term psychodynamic psychotherapy resulted in the improvement

of symptoms in more than three quarters of the patients. This is consistent with a recent analysis of a review of empirical psychopathology and treatment literature (Schottenbauer, Glass, Arnkoff & Gray, 2008).

Given the main objective of the project was to relieve mental suffering, the question is whether there will be any long term benefits of the intervention for this population. For individuals undergoing repeated traumatogenic events, short term psychodynamic interventions may help alleviate suffering related to a particular event, but the stress may resume when another event occurs. Short term therapy may also have benefits in the long term, providing patients with tools to process and deal with subsequent traumatogenic events, or the knowledge to seek mental health support earlier. These issues remain to be studied and are a clear direction for future research. Clinical evaluations of patients who were able to follow early short term psychotherapy could be conducted to examine their status in the future as it was done in the Congo Brazzaville (Hustache et al., 2009).

We believe that a psychodynamic approach is a valuable therapeutic intervention in areas affected by collective violence. We hope that this paper can stimulate efforts to do more research on the effectiveness of psychotherapeutic approaches in such settings.

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