

When psychological first aid is not enough: personal reflections on psychosocial interventions in Duma, a village in north West Bank

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This personal reflection describes the experience of a Swiss/Belgian psychologist who has been working as a mental health programme coordinator in Palestine for Médecins du Monde France for 2.5 years. His reflection (which does not necessarily reflect the view of Médecins du Monde France) touches on the importance of rethinking psychosocial interventions for individuals and communities facing continuous critical events. The author also reflects on his background, his motivation and challenges, as well the impact of the current situation on Médecins du Monde, in terms of both international and national staff.

Keywords: critical incidents, Palestine, psychological first aid, settlers' violence

Introduction

In June 2014, after 4 years in Mali, West Africa, I started work for Médecins du Monde (MdM), first as a mental health adviser in Nablus and then as a mental health coordinator in Jerusalem for the West Bank and Gaza. Over the last 12 years I have been working for various international organisations, such as Médecins Sans Frontières (MSF) and the International Committee of Red Cross (ICRC) at headquarters and in the field providing psychosocial support to humanitarian staff and working on mental health and psychosocial projects in emergency settings. I have to say that Palestine is a very different and unique context from what I have known before this time. I had primarily been

working with people facing a single, or a series of, traumatic events over a limited period of time. However, in 2014, I arrived in a context in which communities are continuously, directly and indirectly, exposed to high levels of acute and chronic stress due to protracted occupation and related political violence, exposure to threats to personal safety including settlers and Israeli forces violence, displacement, arrests and detention, home raids and periodic outbreaks of shelling and bombardment. Whereas before I worked in one country, here I arrived in one land with two peoples, two worlds separated by an insurmountable wall that prevents any human or social connections. One of the most important lessons I am learning during my time here is to be humble and to work with patience.

Palestinians living in West Bank: some background and context

The humanitarian vulnerability situation in the occupied Palestinian territory (oPt) is characterised by protracted occupation (now approaching its 50th year) with systematic denial of Palestinian rights, and unrelenting conflict punctuated by frequent outbreaks of violence, blockages and restrictions. The recent escalation of violence, which spread from east Jerusalem to the wider oPt, has been characterised by violent clashes between Palestinian civilians and Israeli forces. In the West Bank, continuing settlement expansion, settler's violence,

household demolition and the lack of an endpoint for the occupation are major sources of frustration and conflict. Furthermore, Gaza has been devastated by three *official* wars in the past 6 years, and the population is surviving in an area of only 362 square kilometres, making it one of the most densely populated territories on the planet.

Duma

Duma (also spelled Douma) is a village in the Nablus Governorate in the northern West Bank, with a population of about 2,220 inhabitants. On 31 July 2015, suspected Israeli settlers firebombed two Palestinian homes there. Graffiti was left on the houses reading, in Hebrew, *‘Revenge’* and *‘Long life to the Messiah’*. This terrible incident killed 18-month-old Ali Saad Dawabsheh and critically injured his parents and 4-year-old brother. The boy, Ali, died in the attack, his father (32), died later of second-degree burns over most of his body, followed by the death of his wife from her injuries about 5 weeks later, leaving the surviving 4-year boy an orphan.

On the 20 March 2016, 234 days after this first incident, around 1:30 am people set fire to the house of a member of the broader family, known as the only eye witness of the first incident. No one was physically injured, but this event reactivated the psychological wounds and trauma of the recent past: *‘I am scared, and my parents are scared for me, which makes me feel bad. I have stomach pain and headaches, I get angry easily with my family. I have thoughts in my head about Riham and Sa’ed dying in the flames. . . . When my aunt told me that I will be a father, I did not even feel happy, and did not find any joy, despite the fact I was anticipating this moment so much. . . .’* said one member of the family (Zimmermann, 2015).

Recently, on 20 July 2016, unknown people firebombed the house of a member of this same family. No one was physically injured, but the whole village is once again in shock.

Psychosocial impact: far beyond Duma

As a clinical psychologist working in emergency situations, I was taught to normalise legitimate, human reactions following an *‘abnormal’* or exceptional event. I was taught to say to affected people that those emotional, physical, behavioural, and sometimes spiritual reactions, to crisis decrease with time and social support for the majority of people. This is certainly true within contexts of unique critical incidents, such as a typhoon (I was in the Philippines during the last emergency), when individuals and communities can slowly recover and regain control over their lives. This is more challenging within the Palestinian context, where incidents happen continuously and where natural social support networks are already fragmented: what advice can you give to a parent from Duma how to respond when his child asks: *‘Dad, when will it be our turn? When they will come and burn us?’*

Case study: the last bottle of milk

Shurouq¹ is a 27 year old women living in Duma. She is the sister of Sa’ed, whose house was attacked and burned by settlers. She is a married housewife and a mother of two girls. She was with her brother’s family a couple of hours before the tragic event happened. When the MdM psychosocial team met Shurouq, she started the conversation by saying: *‘I am the last person who saw them. . . . They were at home with my family before it happened. When my sister in-law was preparing a bottle of milk for his son Ali (the baby who was burned to death), she asked me to take care of him. . . .’*

She continued the story by crying: *‘It was the first time the baby accepted me. . . . he was comfortable in my arms. . . . It was the last bottle of milk he drank. . . .’*

Indeed, when Ali finished his bottle of milk, his mother (Riham) asked Shurouq to accompany them home. As it was dark, she was not comfortable to return home alone. So they walked and talked together during the way back. Then, Shurouq returned to her own home and went to sleep.

Suddenly, she remembers being woken up by the screams of neighbours: *Your brother's house is burning... Your brother's house is burning...?*

Since the incident, Shurouq is suffering from sleeping difficulties, headaches and flashbacks,

I can't forget their smile, our talk... I have the feeling they have just left my house, I feel unsafe, the night brings fear and horror...?

The MdM psychosocial team visited Shurouq and her family several times providing psychological support. Last time the team saw her she said she was feeling better.

Those three critical events have had unprecedented psychological and psychosocial impacts, with no words to describe those impacts: not only on the direct victims of the burned houses, but on the whole village. This is the first time that firemen asked for psychological support from my Palestinian colleagues (I am working with a team of six, well trained Palestinian psychologists and social workers who are in direct contact with the communities), in a culture in which talking about emotions and feelings is still perceived as a weakness (especially for men). To be honest, to say that the work is extremely challenging is an understatement.

Main difficulties and challenges **Loss of meaning and psychological impact on the team**

As my team live within the heavy Palestinian context, their empathetic engagement with the people of Duma (and other villages at

risk) and from their reports of traumatic experiences, it is clear they sometimes feel sad, stressed and angry. My colleagues are meeting people already made fragile by previous critical situations and at risk of experiencing critical situations at any given moment. These human beings will continue to suffer psychologically unless the political situation changes. Consequently, we are putting bandages on wounds that don't have the time to heal, as incidents occur again and again... Therefore, it is often difficult to find meaning within our humanitarian actions:

What for Max? How can we help? Even if we could provide the best psychological intervention to these people today, they would be affected all over again tomorrow!

(This was said to me recently by one of my female colleagues, at the time of writing this reflection.)

It is worthwhile mentioning that the MdM France psychosocial teams are not only technically supervised, but they regularly take part in emotional supervision sessions (by an external Palestinian psychologist) in order to enable them to reflect within a confidential space (away from operations) about their practices and in order to take care of themselves. As a psychologist, I am regularly supervised by an experienced psychologist and I find that it is really needed. In addition to this, the whole MdM France staff in Palestine, national and international, has access to external culturally relevant psychosocial support when needed (without passing through any of the hierarchy).

I strongly believe in psychosocial interventions done by well trained and regularly supervised local professionals (psychologists and social workers). I still do think we can help and do something useful by actively listening to the needs of the affected people, by a human, humble and compassionate presence which implicitly says: *we recognise the impact of the context, we cannot change it right*

now, we have limits, but we care for you', and finally by referring them to appropriate mental health services when needed.

Lack of mental health structures and professionals

Regarding the latter, the second challenge that we are facing is the lack of specialised mental health services with well trained mental health professionals. There is no curriculum in psychiatry in Palestine and the first curriculum in clinical psychology has only just recently started in the University of West Bank (in Nablus). In addition to this, there is no real and solid legislation regulating mental health professionals. In such a context, even if we identify needs for referring a patient to specialised mental health services, there is a very limited suitable response available for communities (despite the development of a comprehensive national mental health strategy and efforts made by the government, the United Nations, and national and international nongovernmental organisations to upscale existing services). Moreover, people are reluctant to go and see specialists for stigma related reasons.

Stigma

As stated, another challenge we are facing is indeed the significant stigma attached to mental health issues. In terms of my own perceptions, even if there is currently less stigma attached to mental health issues as a direct consequence of critical incidents, there is still stigma attached to mental health in general. In other words, people can, in certain circumstances, talk more easily about difficult emotions following a demolition or a settlers' attack. However, it is still not easy for the majority of them to talk about depression or anxiety. Therefore, people remain reluctant to seek mental health services and/or talk to clinical psychologists or psychiatrists who are often not trained enough in psychotherapy and sometimes over-prescribe psychotropic drugs.

At this point, it is worthwhile mentioning that Palestinian communities (and most of the communities I have worked with) have not waited for specialists, psychologists, psychiatrists nor any other humanitarian actor to deal with the psychological and psychosocial consequences of potentially traumatic events. They do have resources, sometimes very limited ones, but they have learned to cope with adversity, and I have learned a lot from people facing adversity. As humanitarian actors, both international and local, we should be extremely careful when we shower communities with concepts such as posttraumatic stress disorder (PTSD), as misusing these sorts of terms or concepts in a blanket way can cause harm. When I say this, I am not saying communities are not suffering and/or experiencing acute stress and other significant social and psychosocial difficulties impacting their lives, nor am I denying the existence and the usefulness of the concept of PTSD, but there are certainly limits to the medicalisation of distress (decontextualised from the context) and there is value in focusing on adaptive coping and resilience during and after traumas (Stein, Seedat, Iversen, & Wessely, 2007). Striking a balance between a focus on heroism and resilience versus victimisation remains crucial for the MDM mission in Palestine, and particularly in the context of the Palestinian cause, we are fighting for resilience. If we need to be cautious and recognise the limits of the (over)use of western psychological concepts, such as PTSD, to understand and describe the psychological consequences of critical incidents, we need to be equally cautious when using the few existing tools and techniques that we do have to deal with those consequences.

The lack of existing tools: psychological first aid, is it a panacea?

The final challenge to discuss here is the lack of evidence based psychosocial approaches and tools within emergency settings. I had

extensive training after my Master's degree in emergency and disaster psychology in Switzerland, and then volunteering in my own country for many years in emergency crisis cells, intervening after violent car incidents, fires and avalanches. One of the main techniques my colleagues and I used was the Critical Incident Stress Debriefing (CISD). Debriefing is a specific technique designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing allows those involved with an incident to process the event and reflect on its impact. Ideally, debriefing can be conducted on or near the site of the event (Mitchell, 1986). I do not want to debate here again the unresolved controversy about the efficiency of CISD, which on the one hand has been one of the most widely implemented interventions after exposure to potentially traumatic events for years. On the other hand, however, systematic reviews have suggested that single session debriefing may be harmful (Van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002; Rose, Bisson, Churchill, & Wessely, 2002).

Therefore, the World Health Organization (WHO) Department of Mental Health and Substance Abuse has issued a statement that it does not recommend psychological debriefing (WHO, 2003)². In fact, most organisations such as Médecins du Monde in Palestine are not using it anymore and have replaced it with Psychological First Aid (PFA), as recommended by Inter-Agency Standing Committee *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007). PFA is defined by the World Health Organization (WHO) as 'a humane, supportive response to a fellow human being who is suffering and who may need support' (van Ommeren, Snider & Schafer, 2011). It includes interventions such as: listening, comforting, helping people connect with others, and providing information and practical support to address basic needs. According to existing literature and experience,

this implies that PFA is not only provided by mental health professionals, but could eventually be delivered by lay people with appropriate training and supervision (which is unfortunately often missing in humanitarian settings). Nowadays, perhaps because of its apparent simplicity, PFA has become very popular and somehow 'fashionable' within the humanitarian aid world. As a result, for many stakeholders, including institutional donors, PFA after emergencies is perceived as a must and sometimes even a 'magical wand' to be used to heal any psychological wound after any critical incident (man made or natural disaster). While PFA is an important element in preliminary care of disaster victims, there is a real need for more research and further scientific evidence on its effectiveness (Dieltjens, Moonens, Van Praet, De Buck, & Vandekerckhove, 2014). I also strongly believe in the 'do not harm' principles of PFA in emergencies, that each humanitarian worker should adhere to this principle. I also fully recognise the importance of human support for people facing adversity, given in a non intrusive and respectful way in order to avoid re-traumatisation of the victims.

What I wonder, however, is why these techniques are often presented in manuals as simple and practical, ready to use by anyone without any background in psychology or social work? Meeting a person who lost the words to explain the horror they have survived, implementing good active and empathetic listening and dealing with their difficult emotions requires significant experience and expertise that simply cannot be taught in a couple of hours or even weeks. I am also wondering if there is a danger of impoverishing the existing concept of 'first aid' reducing it to mere technical skills by creating this relatively new concept of PFA, which reminds us in a redundant manner of the necessity of **human** skills in emergencies? Finally I wonder if the growing popularity of PFA is not to the detriment of other crisis intervention models or to the

development of new innovative approaches more adapted to the needs and challenges we are facing in the field? I am not really sure that 'PFA is enough' to support people experiencing complex or multiple critical incidents, as in Duma. Maybe it is not even meant to be applied to such situations. However, as we hardly have any tools or interventions for people who are living in violent situations for years with no hope it will change in the near future, we have to tinker the best we can. Regarding the latter, and to partially address this issue, MdM France employs well trained social workers and psychologists who provide PFA (not to everyone facing a critical incident in order to avoid psychologising legitimate human reactions), but only to those most affected. They always come back to see people who received PFA to continue giving support and for a deeper follow-up, as we don't believe in the efficiency of large scale 'one shot sessions' which are still often provided after emergencies in the world, and finally they are referred to appropriate services when needed. We are now considering using *low intensity*³ psychological interventions, a new area of mental health and psychosocial work at the WHO.

Final thoughts

As humanitarian workers working in the mental health and psychosocial field, we need to take the time to reflect and analyse our practices, even in emergency, as we are not providing lifesaving activities and to contribute to the development of innovative approaches for supporting people who are facing complex and multiple trauma. In the meantime, we always have to remain humble and recognise the limits of our actual psychosocial interventions. We might not have all of the answers of all the questions raised in this paper today. However, acknowledging this growing tendency to universalism and standardisation of theoretical and practical psychosocial knowledge, while taking account the human being in

its culture with its own needs and resources, is certainly guiding our way.

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psychological treatments by specialists. As a result, aspects about the intervention are changed to make them feasible in communities that do not have many specialists. Such modifications can thus create more accessible mental health care that reaches a larger number of people (WHO, 2014). Web: <http://www.rcpsych.ac.uk/pdf/WHO-%20Volunteering%20and%20Internships-%20Brochure.pdf>

¹ MdM France obtained the consent of Shurouq (fictitious name) to publish this case study.

² Source: <http://www.who.int/mental.health/mhgap/evidence/other.disorders/q5/en/>.

³ The term 'low intensity' indicates a less intense level of specialist human resource use. It means that the intervention has been modified to use less resources when compared to conventional

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