Harrold, D. and Altawil, M. (2012). The Child, the Family and the Community: Overcoming Trauma in Gaza. *The International Journal of Evacuee and War Child Studies*, 1(9), pp.65-69.

The Child, the Family and the Community: Overcoming Trauma in Gaza

By

David Philip Harrold [1] and Mohamed Ali Altawil[2]

Palestine Trauma Centre(UK), www.ptcuk.org

October 2011

1 David Harrold: He is a Special Needs Learning Support tutor at the University of Hertfordshire and has done mental health drama work with children, and with adults who have learning difficulties. He is joint Chairman of Palestine Trauma Centre (UK) with Dr. Mohamed Altawil. David is working on drama projects for children.(diddeus@aol.com)

2 Mohamed Altawil, PhD: He works as a Research Fellow at the School of Psychology, University of Hertfordshire. He is the co-ordinator of the Intervention Research project, which is about adapting/developing a Family Therapy Approach to the treatment of traumatized children and their families after the war in Gaza. Also, he works a free lancer as clinical psychologist and he is still acting as a volunteer director for PTC-Gaza and PTC(UK). (ptc.2006@yahoo.com)

***

A nine year old boy runs beside his father. They run from gunfire. The boy's father drops to the ground. The boy runs on for a bit then stops, turns and sees his father lying there, still. Soldiers approach from the end of the street. The boy has a rush of fear and continues to run.

This happened during Operation Cast Lead, the Israeli invasion of Gaza from December 2008 – 9. Since then, the boy has become the senior male figure in his family. He has a beautiful smile and a faraway look in his eyes. He is calm, but how do we interpret his experience in 2009 and its remaining effect on him? Earlier, there had been signs of Post Traumatic Stress Disorder – nightmares, withdrawal from social communication, difficulties in sustaining concentration – but thanks to support from the broad family network, his symptoms are less pronounced. This support is crucial and is the basis for additional intervention from mental health workers in the area who visit the family and offer therapeutic guidance. The boy has experienced a double trauma: first witnessing the killing of his father and secondly the dreadful and undeserved feeling of shame that he ran away when he feels he should have stayed to help. Should the boy be invited to talk about all this or encouraged to avoid looking at it? During 2010 – 2011, therapy work concentrated on building resilience inside the child, providing positive, uplifting, normal childhood experiences. A Family Therapy Project integrated positive forces in the family, then friends and other community resources to help him function productively on a day-to-day level. Many organisations in Gaza provide play therapy, artistic projects and community activities to bring children together to reinforce their youthful capacity for psychological regeneration. One day, perhaps, the boy will talk about his traumatic experience in 2009. For now, support mechanisms for recreating normality are the priority. So, this generation of young people in Gaza will have experienced not only the horror of Operation Cast Lead, but also the community-based initiatives that have set in motion a recovery process.

A study of the effects of chronic war trauma among Palestinian children by Dr Mohamed Altawil in 2006 found that 41% had symptoms of Post Traumatic Stress Disorder. After Operation Cast Lead this increased to 98%. Incursions from Israel continue to occur in Gaza. This means that children experience repeated or

chronic trauma. Research suggests that these children will have lower rates of recovery because of the on-going fear that goes with living in a state of constant danger. In looking at long-lasting impacts, the experience of a single traumatic event is not the only factor. The ways in which the brain processes and, indeed, continues to process this event has to be studied as well. A certain amount of healing can occur, if the environment allows. The battle in Gaza at present is for circumstances to be created and sustained in which the child has the confidence to begin a process of psychological healing.

However, it is an on-going struggle. The experience of grief for these children has historical as well as contemporary meaning. Palestinians are the largest single group of refugees in the world. Hundreds of thousands have been displaced over at least three generations. Since 1948, Palestinians have suffered from repeated episodes of war and conflict which have occurred approximately every seven to ten years. So they live with the sense that another outbreak of violence is inevitable. The stifling effect of unrelieved occupation contributes to a feeling of despair. Many well-educated young people long to travel and explore the world and cannot do so because of the siege. Their anger is justifiable and needs some outlet. The majority of Gaza's children were born as refugees. The number of Palestinian refugees has increased from one million in 1950 to more than seven million in 2007 (UNWRA,2007). In addition, during the last sixty years families have had to cope with traumatic events like house demolition, kidnapping and imprisonment; humiliation and delay at checkpoints; violence in the family because of frustration derived from unemployment; witnessing or experiencing extreme violence (e.g. shootings), bombings and now a siege that has lasted for six years. This collective historical suffering is part of the culture in which the children are raised. Grief is normal. Dr Altawil's 2006 study looking at trauma exposure for children during the second Intifada (from 2001) revealed that 99% had experienced humiliation from occupying forces; 97% were used to hearing explosions or bombs; 85% witnessed martyrs' funerals; 84% witnessed shelling by tanks, artillery or military planes; 79% had friends, neighbours or relatives that had been killed; 66% had had their homes occupied by Israeli soldiers and 65% had directly witnessed someone being killed. And this was before the slaughter and destruction during Operation Cast Lead. The cumulative effect of these multiple traumas challenges resilience to depressive disorders. Any "solution" has to be political, not psychological. All the mental health workers can do is empower victims of PTSD to cope with their symptoms.

One way of looking at these symptoms is in terms of the individual's way of attaching themselves to (a) the traumatic event (b) supporting agencies, like parents, therapists, neighbours, friends (c) places which give identity, like home, school, spiritual community, land and nationality (d) the way the traumatised person relates to him or herself in terms of having agency. The way in which all these interact can affect the neural processing of trauma. Symptoms of PTSD develop in different ways and on different levels in children who have experienced the same event. Dr Altawil (2006) found that often boys would have more direct experience of violence than girls, but be less affected by it. What the balance is regarding gender differences, cultural practices (girls have less freedom of movement) and group dynamics is a matter for speculation. It is possible that boys had powerful psychological mechanisms like ideological commitment, national pride or a stone-throwing release of energy to enable them to cope with the experience.

Attachment to parents and family members is a crucial factor in the way a child responds to a traumatic event in war or conflict. Parents' anticipation of the traumatic event, their reaction while it happens and the way they deal with it afterwards can increase or reduce the PTSD levels in children to a significant degree. This is why a Family Therapy approach – a holistic understanding – can alleviate PTSD symptoms. For example, one woman witnessed most of her adult children being killed during Operation Cast Lead. After the trauma of that shocking experience, she was left with grandchildren to support. The small children, too young to understand the significance of what had happened, would play with toys and run out into the street. At home, the grandmother would tell of her traumatic event to anyone who was there to listen. She would go over the emotional devastation again and again. Very understandably. When the children came up to her, they

experienced someone distraught and, in their view, rejecting. It was not the child, but the grandmother who needed the psychological intervention. The clinical work needed in this case was very sophisticated and that is just where the mental health services in Gaza require most support.

Attachment to the event itself is more complex that one might imagine. Studies to do with proximity to the traumatic event produced interesting results. Guilt and grief reactions to, say, a sniper shooting near the border, tended to be higher amongst children who were further away from the event than in those who were more directly exposed to it. A distance away from the event leaves the observer helpless and this increases anxiety. The ones closer to the event are reacting physically and have no time for anxiety. The people at a distance are passive and therefore internalise more. The ones close to it release pressure dealing with the event in front of them. A study in 1993 found that this therapeutic release of anger applied to the children throwing stones during the first Intifada. Taking some form of revenge can be part of a healing process. The trouble, of course, is that this is dangerous. For more introverted types, PTSD symptoms may be delayed. Someone who looks unaffected now may develop somatic or behaviour problems years later because of the traumatic event. All of this requires the child to be seen as a whole, for their personality traits to be noted and understood. Dr. Altawil has noted the importance of positive personality traits in children for reducing symptoms of PTSD. The interaction between individual personality traits and networks of psycho-social support is important to understand before effective support for these children can begin.

This is where community organisation can be most important. The release of tension for children most often occurs in organised events: in sport, recreational activities and festivals. The Gaza Strip has the highest population density in the world and everyone is directly or indirectly affected by the violence. There is often a sense of solidarity in the face of danger, similar to that of London residents during the blitz. Parents alone cannot cope with the range and frequency of traumatic events that affect not only their children, but themselves. War disrupts basic parental functions such as protecting children and enhancing trust in family security and human virtues. It threatens parent-child bonds. As mentioned above, successful parent-child attachment is vital for providing a protective shield to enable children to be resilient in dangerous conditions. However the constant stress has overwhelmed many parents. Conflict within families has created a need for outside intervention from social workers and psychologists. Some Palestinian parents have feared that the children who threw stones and fought the occupation were likely to challenge parental authority as well. Schools have similar worries. They cannot cope on their own with disruptive pupils when class sizes can be as many as 50 and one-to-one contact with students is rare.

There are not enough social workers and professional mental health workers to cope with all of this. However, simple therapeutic practices can be taught for parents to practice at home and teachers in class. Focusing methods – sometimes known as a Community Wellbeing approach – can be developed for use here. Some mention should be made in this context of the influence of the extended family. It can be positive as a reliable network of support and a burden if there are too many needy or dependent relatives. A community approach will enable chosen individuals within families and schools to take on some of the semi-professional therapy work. These key individuals do not need backgrounds in psychiatry, but the good practices they are taught can quickly spread throughout families and social groups.

All these programmes for resiliency, however, stand little chance of success if the economy of Gaza is destroyed. The appalling economic stagnation directly affects the psychological well-being of children and families. Lack of food, fuel, green areas or pure water and with regular power cuts, levels of everyday stress remain high. All therapeutic intervention has to take this important social basis into account.

Yet, in spite of all the fear and despair, hundreds of welfare projects are being developed. The most effective psycho-social programs in Gaza at present are the play or drama therapy groups which get children in large numbers to develop co-operation, trust, social skills, creativity, self-confidence and self-expression.

Harrold, D. and Altawil, M. (2012). The Child, the Family and the Community: Overcoming Trauma in Gaza. *The International Journal of Evacuee and War Child Studies*, 1(9), pp.65-69.

UNWRA leads the way here in spectacular group challenges and activities, often on the beautiful beach that everyone in Gaza can easily get to. All this fun activity will lower the intensity of trauma symptoms when any stimulus (and this could be a minor event) induces them to return. This particularly works when reaction to the traumatic event is reprocessed though painting or drama. Space allowed for self-expression is vital and animators in these sessions have to be trained in psychology as well as art and drama. Photography, film-making and dancing can be used in the same way.

Whatever its other benefits, all this organised play is bound to rebuild attachment to the community and give children a renewed sense of confidence in their environment. The mosque is still a very important agent in giving the community a sense of harmony and discipline and the call to prayer continues to be a comfort to many.

Politically, allegiance is difficult to instil in the young. They suspect all political groups of being corrupt in varying degrees and the movement called Gaza Youth Breaks Out offers a useful outlet for dissent. But the older children do have a strong sense of national identity. They paint the flag often. They understand what it means to be Palestinian as a result of the history of displacement and oppression. This awareness of History and its relation to the symptoms of trauma also takes away the stigma of "therapy" that is off-putting to people who, rightly, do not see themselves as being "sick". To focus exclusively on the behaviour of the child is a mistake. Relationships between parents and children are crucial, as already mentioned. The perceived and actual role of communities as reliable sources of protection and nurture cannot be underestimated. But if community leaders fail to protect or relieve Palestine of its history of suffering, then people offering violent solutions may become more influential. Mental health services in Gaza need a national policy and to be seen as effective.

However, government services are limited and lack efficient co-ordination. There is confusion over responsibilities of administration from the West Bank (Ramallah) and Gaza. This slows-up decision-making and the implementation of solutions. As a result, bottom-up initiatives have a better chance of rapidly co-ordinating local services for families and individual patients with PTSD. This, however, does result in a certain degree of chaos. Many different psycho-social organisations compete for funds in Gaza. Supervision of their work by funders from outside is limited because of the siege and this can prevent some much-needed help getting through. Above all, psychiatrists in Gaza need extra professional resources, especially in the cognitive behaviour therapies which are adapted to suit the age, circumstances and level of development of the children.

The Gaza Community Mental Health Programme is the most well-known institution for providing expert specialist intervention. Yet, even here, the director is keenly aware of the limits of therapy. He has pointed out that unless there is a significant increase in employment opportunities in Gaza, the general sense of despair and futility will grow. Unemployment rates are now at 45%. Young people have to have belief that they will be able to earn a living and not be condemned en masse to a potentially dangerous idleness. Once again, the political situation is paramount in affecting psychological conditions in Gaza.

One important difference between Gaza and the West Bank is that in Gaza there is a greater sense of autonomy. This is an important psychological difference, giving the inhabitants a greater sense of national identity. The dangers in Gaza from this isolation are that Hamas government forces can act with great severity and any political opposition does not have room to develop. The same situation applies in the West Bank, but there it is Fatah which is the controlling force. There are also one or two small but significant Salafist groups who are likely to tempt young men into the use of violence which, as we have seen, can even target aid workers from abroad. In a way, community work must keep itself energetic and renewed so that it can combat these temptations. Another incidental danger is drug addiction. Tramadol, used in some

psychological treatment, is coming through the tunnels illegally and some people are becoming addicted to it.

The Palestine Trauma Centre in Gaza City offers regular home visits to vulnerable families and implements a variety of projects funded by external agencies to work with large groups of children. It also has a link with a UK support group which offers training in Focusing Therapy and E.M.D.R. These and other mind/body methods increase the repertoire of skills for therapists and families who use the Centre. PTC(UK) aims to provide training courses for the mental health workers in PTC(Gaza). An Art Therapist from the UK visited in 2010 and two other therapists delivered the first stage of another training programme in 2011.

More international links like this are needed. Most of the children who suffer severe symptoms of PTSD do not get enough continuous treatment. Funded projects lasting a few months are not sufficient. It is estimated at 10,000 specialists are needed to cope with the number of severe PTSD cases. Gaza alone, obviously, cannot provide this. Playgrounds are also needed. Building restrictions because of the siege have made it extremely expensive for projects to even begin. It is possible that individual playground items can be brought in on the humanitarian convoys. There is also a great opportunity for international links between theatre groups. Drama therapy and poetry writing could be developed much more and once again, this is only limited by the restrictions put on international groups when they try to enter, either through Israel or at the Rafah Crossing in Egypt.

So the boy who lost his father in 2009 in such dreadful circumstances faces a very uncertain future. One option he might follow is to educate himself as well as he is allowed. Education is taken very seriously in Gaza. It is seen as another form of resistance to occupation. It is a healthy rejection of the abnormality that continuous bombings and shootings can impose on a population. These attacks and the punitive sanctions from Israel are intended to demoralise the population. Education promotes morale. One boy proudly told Dr. Altawil: "My father and uncles told me to study hard and keep strong no matter what is happening around me." But the schools need more resources: books, computers, even paper. Any educational links are to be welcomed and children's art work has revealed their belief that one of the crimes of the siege is that it denies young people the opportunities to continue education outside Gaza.

It used to be widely believed that children are naturally resilient and will readily adapt to changing circumstances. We now know that they can have emotional scars from traumatic experiences which may last the rest of their lives. How they deal with these traumas – or, as the jargon expresses it, "process" them over time - is the subject of Dr Altawil's research inside Gaza itself. This research must continue. The moderating factors which reduce levels of Post Traumatic Stress Disorder need to be more clearly understood. In this work there is some hope that the psycho-social enhancement of personal resilience on a family and community level will serve the wellbeing of the next generation of children in conflict zones wherever they may be.

This account is based on the PhD research done by Dr. Mohamed Altawil in 2008 at the University of Hertfordshire, England and in Gaza.

The thesis is called: "*The Effect of Chronic Traumatic Experience on Palestinian Children in the Gaza Strip*." It covers the period known as the second Intifada (2001-2007). Palestine Trauma Centre(UK) is the support group in England. Its website is www.ptcuk.or and a website for the Centre in Gaza is www.ptcgaza.com .