

A visit to the Gaza Community Mental Health Programme: training in child mental health

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Programme: training in child mental health

The high prevalence of post-traumatic and other psychiatric disorders in children and adults who have experienced violence and war-related traumas are well documented by research (Thabet and Vostanis, 1997 in press). So far, there has been less systematic evaluation of treatment interventions or training programmes for staff working with traumatised individuals in zones of war and longstanding conflict. Training initiatives have recently been described in countries such as Rwanda (Brandon, 1998). This paper describes the work of a community mental health programme in the Gaza strip, particularly through a visit by the second author to work with the child mental health care staff.

The Gaza strip

This is an elongated area along the Mediterranean sea, between Israel and Egypt, covering 360 km². It is overcrowded, with a population of about 860,000 (approximately 2.300 inhabitants per km²), which is a risk factor for the development of child psychopathology. Refugees consist 63% of the total population, while 51% are under 15 years of age. The Gaza strip is divided in five districts: North Gaza, Gaza city, Mid-zone, Khan Younis and Rafah.

The Gaza Community Mental Health Programme (GCMHP)

The Programme was established in 1990 to meet the mental health needs of the population following longstanding external conflict in the region, as well as internal social upheaval and economic deprivation (current unemployment rate of 70%). It is being funded by a number of international organisations (e.g. Amnesty International, United Nations Fund for Human Rights,

Medecins Sans Frontieres), and charitable bodies in Europe and North America.

The GCMHP provides a general community mental health service and specialist provision for the more vulnerable societal groups, i.e. traumatised children, women who may have also suffered domestic violence, victims of human rights abuse, and drug addicts. In addition to clinical work, there are training activities for the staff (workshops, study days, seminars, courses) and ongoing research. In 1997, a two-year multidisciplinary Postgraduate Diploma course in Community Mental Health was developed.

Of the 70 staff of the GCMHP (including secretarial and other administrative staff), there are eleven clinicians working with children and their families (one psychiatrist, six psychologists, one general practitioner, one nurse and two social workers). About 1200 new clients are referred annually. About 45% are children (500 new cases), 72% are refugees, while the male:female ratio reflects the general population (55%:45%) and, despite cultural taboos, the engagement of female clients. The majority of families are self-referred (65%). The whole range of psychosocial and pharmacological treatment modalities are being provided, and there is liaison with local schools.

Objectives of the training visit

The GCMHP has close links with a number of University Departments in the UK and other western countries, with representatives on the Advisory Board. The aims of this visit were to review and plan future research and training collaboration, to discuss the direction of the child mental health service, and to organise intensive seminars for the staff:

Seminars with the multidisciplinary child mental health team

Like other training activities, the most convenient and probably least

effective educational approach is to pre-decide a number of topics and present an indiscriminate amount of facts. The opposite position is to be completely guided by the trainee group, thus risking the absence of focus and learning objectives. We opted for a middle solution, i.e. the first author agreed the framework with the staff prior the visit, but we remained flexible to the training methods throughout this period.

This was a cohesive and fairly experienced group of professionals who, despite working with children and families at the time, originated from the adult mental health service. Their primary requirement was to translate (not literally!) a child mental health structured approach to assessment and treatment to their own training, patient and service characteristics. As one member of staff put it: "we want your experience with children, not your knowledge". Cultural aspects were obviously essential, but not as prominent or inhibiting as one might expect. The framework was therefore to follow a traditional format on "interviewing and treating children and families with mental health problems", with continuous exchange of case material at the end of each section.

For example, the presentation of the frequently anxiety-provoking assessment of suicidal risk was followed by UK-based case vignettes (the similarities between Asian and other types of extended families were useful to the trainer). The staff were immediately invited to recall their own case material. This was the only way of constantly checking the overlap and differences between two distant clinical settings and their client groups. In the example of self-harm assessment, there was an immediate split within the training group on whether it was relevant to their clients. Some clearly interpreted behaviours as self-harming (a nine-year-old boy who sustained severe burns injuries by pouring gasoline following family arguments), others dismissed

them as accidental. Although the intent of certain behaviours is often difficult to interpret, on this occasion staff were encouraged to explore with the patient statements such as "I want to go to heaven", i.e. to distinguish as far as possible between religious beliefs and suicidal thoughts.

Khan Younis clinic

The outreach clinic serves a population of 250,000 living in towns, villages and refugee camps in the southern part, down to the border with Egypt. We attended the team meeting, attended joint appointments and discussed case management with the staff. The child caseload was broad, including somatising, emotional (particularly post-traumatic stress) and oppositional disorders, enuresis, learning disability and child protection issues.

A ten-year-old girl had developed PTSD (nightmares, recurrent thoughts, avoidance) and stammering after witnessing her sister being accidentally injured by a car. Her symptoms had almost resolved following brief play therapy and behavioural work with the parents. We also saw a 28-year-old female patient with a long history of recurrent depressive episodes. She had been blinded by tear gas ten years earlier, and was being treated with antidepressants and supportive psychotherapy. She described her sensory and emotional state as being "blind outside and blind inside".

We returned to Gaza city past Palestinian villages and Israeli settlements, with schoolchildren of both communities enjoying playtime at their respective schools. The buzzing noise from both playgrounds was the same as from any other playground in the world.

Jabalia clinic

The second outreach clinic covers North Gaza (population of 200,000), also a

mixture of towns, villages and refugee camps. It included an occupational therapy department for people with chronic mental illness. The staff described their main difficulty as engaging the local community because of the stigma attached to mental illness. Also, the extreme deprivation and the parallel involvement of United Nations clinics, raises patients' expectations from the staff to find employment, improve their limited residence or local standards of hygiene.

A case discussed concerned a five-year-old girl who had become mute two years earlier (her early language development had been normal). More recently, she had recovered some of her language capacity, i.e. she presented with elective mutism within the family environment. It transpired that she had initially suffered from a specific phobia of the dark, but her anxiety symptoms had increased, mediated by the family response (anxiety and overprotection from the parents and teasing by her siblings). She was responding well to behavioural management with the parents, which aimed at re-establishing a normal pattern in the girl's life.

The team meeting and supervision was followed by a home visit in the refugee camps. About 100,000 people live in an area of only nine km², with very poor living standards and very limited employment opportunities. We saw a family of eight children. The team had been involved for years, mainly with the father who had a long history of depression and social withdrawal. At different times they had seen five of the children because of bedwetting, aggressive behaviour and emotional problems. As we were talking to the parents, a 13-year-old girl watched anxiously. We invited her in and explored her worries. She said that she worried about her father being unwell and not having a job, and about her parents arguing. The father gave her a warm look and a gentle telling off "why she was saying all this". The parents then started

an argument about their poor finances.

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