

LESSONS FROM PSYCHIATRY IN THE ARAB WORLD

A Lebanese Trainee Psychiatrist's Qualitative Views on the Provision of Mental Healthcare Services for Palestinian Refugees in Lebanon and an Interview with a Consultant Psychiatrist on the Effects of the Arab Spring on the Mental Health of Libyans

Ahmed Hankir¹ & Asad Sadiq²

¹National Institute of Health Research Academic Clinical Fellow Psychiatry, Manchester University, Manchester, England, UK

²Fairfield General Hospital, Bury, England, UK

SUMMARY

In this manuscript, a Lebanese trainee psychiatrist qualitatively analyses and discusses the provision of mental healthcare services for Palestinian refugees in Lebanon. There are more than 250,000 Palestinian people sporadically dispersed in the refugee camps in Sidon, Beirut and other major cities in the Levant. Displacement, conflict, trauma, unemployment and poverty are but some of the myriad factors that influence Palestinian refugee mental health. This article traces the historical, political and socioeconomic determinants of health for Palestinians exiled in Lebanon and describes the pivotal role that the non-Governmental Organisation Medical Aid for Palestinians is playing in helping to alleviate the psychiatric distress of Palestinian sufferers of mental illness. The latter half of the manuscript contains an interview with a consultant psychiatrist about his experiences volunteering in the war-torn lands of Libya post Arab Spring. He expounds on how he feels mental healthcare services in Libya are woefully inadequate and broaches on his perception of how the resilience and the 'family-centric' model of the Libyan people has conferred a certain degree of protection towards developing severe psychiatric illness.

Key words: *refugee - mental health – Lebanon - Libya*

* * * * *

BACKGROUND

Palestinian Refugees in Lebanon

During the 1948 Nakba, approximately 100,000 Palestinians were forced to exile from their homes fled into adjoining Lebanon. This exodus of Palestinian refugees came mainly from the north of Palestine: the city of Galilee and the coastal cities of Jaffa, Haifa and Acre. Although there was historical familiarity based on social and economic links between the people of northern Palestine and southern Lebanon, and although they also spoke the same language, enjoyed the taste of the same delectable cuisine, listened to the same music and swam in the same Mediterranean sea, there remained the seemingly insurmountable barrier separating the former and the latter: namely the refugee status of the Palestinians. As refugees the Palestinians had a specific identity and specified areas of residence: the squalid and derelict refugee camps which remain conducive of contagion and psychopathology to this day. This 'specific identity' facilitated, in a way, the social exclusion of the Palestinian people from the Lebanese society and had a deleterious effect on them in terms of integration and acceptance. The psychological and psychiatric effects of social exclusion are well documented in the literature (Hankir 2013) and the negative impact that the marginalisation was having on the people of Palestine, particularly the second generation Palestinian population who were more prone to

developing psychosis (Tahira 2012), was both visible and palpable.

Limited assimilation of Palestinians did, however, occur with some 40,000 receiving citizenship between 1948 and 1978. However, the majority of Palestinians who were either unable or unwilling to obtain Lebanese citizenship lived in 17 refugee camps (sporadically dispersed in the hinterland and coastal cities) and numerous unofficial settlements around the country as a 'floating class' people, longing to return to their homeland and susceptible to scapegoating and other negative social phenomena.

Operation Peace for Galilee and Massacres of Sabra and Shatila

In 1982, Israel invaded Lebanon as part of 'Operation Peace for Galilee'. The Israeli operation killed approximately 17,000 Lebanese civilians, and Israeli forces advanced all the way to the country's once renowned opulent capital, the 'Paris of the Middle East' itself namely Beirut. What then ensued was the darkest era for Palestinians living in the Lebanon. Yasser Arafat and the PLO fighters were forced to leave the country, and their evacuation was followed by a bloody massacre at the Palestinian refugee camps of Sabra and Shatila in Beirut. The atrocities were meted out by the Lebanese Christian militia and allegedly under the auspices of the Israeli military. For 40 hours between the 16th and the

18th of September 1982 the militia raped, pillaged, killed, and injured over 1,000 unarmed Palestinian and Lebanese civilians in the camps (3). Memories of those dark days have not faded and have had a profound effect on the mental health of all those who were involved by precipitating psychopathology in the form of depressive illness and post-traumatic stress disorder (Bastin 2013). Every year, the People of Palestine in Lebanon commemorate the massacres out of respect for their beloved departed.

The State of Play of the Provision of Healthcare Services for Palestinian Refugees in Lebanon: Medical Aid for Palestinians (MAP)

"The provision of Palestinian healthcare is a 'moral issue'"

Salvatore Lombardo, Director of the United Nations Relief and Works Agency (UNRWA) in Lebanon

Medical Aid for Palestinians is a British charity that was founded by Dr Swee Ang FRCS (consultant orthopaedic surgeon at London and the Barts and forever affectionately known as 'the Angel of Beirut') and her colleagues in the wake of the 1982 massacre of Palestinian civilians at the Sabra and Shatila refugee camps in Lebanon. Dr Ang was specialising in orthopaedic surgery at the time and was deeply concerned about harrowing reports that would trickle in of a burgeoning number of non-combatant deaths during the 1982 Lebanon war. In her autobiography, 'From Beirut to Jerusalem' Dr Swee describes packing her bags one day and resolutely responding to an international appeal for a trauma surgeon to assist the casualties of the onslaught that was inexorably unfolding in the Fertile Crescent. Unbeknown to her at the time, she would later be bestowed the highest award of valour for services rendered to the people of Palestine, the Star of Palestine, from the former PLO leader himself Yasser Arafet (5). Dr Swee, in many ways, is a hero and still occupies a very special place in the hearts and minds of the Arab people for had it not been for her intervention, many more innocent souls would have perished.

Medical Aid for Palestinians is, in a way Dr. Swee's legacy, and works for the health and dignity of Palestinians living under occupation and as refugees. Working in partnership with local health providers and hospitals, MAP addresses a wide range of health issues and challenges faced by the Palestinian people including the many psychosocial problems that prevail (6)...

A recent report commissioned and compiled by MAP entitled, 'Terminal Decline? Palestinian Refugee Health in Lebanon' revealed that Palestinian healthcare in Lebanon is severely underfunded and chronically unfit for the needs of the refugee population. Of particular concern are the overburdened and under-resourced United Nations clinics, an acute shortage of Palestinians training to become doctors and an inadequate tertiary healthcare system that places unbearable stress upon patients.

The report highlights how in Lebanon there are currently between 260,000-280,000 Palestinian refugees living within a host population of roughly 3.9 million. In addition, there are also some 35,000 non-ID Palestinians who are registered with the Lebanese authorities but not the UN, and some 3,000 Palestinians who are undocumented and therefore not officially recognised in any capacity. An estimated 65% of the Palestinian refugees in Lebanon live in 12 refugee camps scattered throughout the country. Many others live in 20 unofficial camps and settlements.

MAP's briefing report also brings to the fore the two major social determinants on health (particularly mental health) namely unemployment and poverty and the effects they are having on Palestinian refugees in Lebanon...

Unemployment Amongst Palestinian Refugees in Lebanon

"Only two things matter in life, love and work..."
Sigmund Freud

Unemployment, running at roughly 56% for Palestinians and at 17% for Lebanese, is the abiding manifestation of the refugee status quo. Palestinians are quick to highlight their exclusion from the Lebanese labour market (3). In an interview with a Lebanese doctor, he informed me that there are people who do not consult him based on his accent alone. Although he is of Lebanese ethnicity, his father once worked in former Palestine and acquired the Palestinian accent. This rubbed off onto his son, the future surgeon, and consequently had an influence on his patient population. Such are the depths of the divide amongst the two peoples.

Poverty Amongst Palestinian Refugees in Lebanon

Two thirds of Palestinian refugees are poor. This equates to an estimated 160,000 individuals. Salvatore Lombardo, the Director of UNRWA in Lebanon, stated: "more than 60% of the refugee population live below the poverty line of \$6 a day, and within this there are pockets (of people who) live on less than \$2 a day". On a recent visit to the camps, the Department for International Development (DFID) officials stated that "the situation for Palestinian refugees in Lebanon is amongst the worst of any refugees, perhaps even worse in some instances than the situation in Gaza" (3).

UNRWA, was established in late 1949 and became operational on 1 May 1950. Today, the agency provides education, healthcare, social services, camp improvement and emergency aid to an estimated 4.7 million Palestinian refugees living in the Gaza Strip, the West Bank, Jordan, Lebanon and Syria (3).

From 2008 to 2009, health services accounted for \$212 million of UNRWA's annual budget of \$1.1

billion. By contrast, the UK spent \$199 billion on healthcare servicing a population of some 60 million in 2010, none of whom live under occupation or under the same refugee status as exists in Lebanon. A very rough comparison highlights the challenge facing UNRWA: every year the UK spends £1,800 per person on healthcare; Palestinian refugees receive the equivalent of £26 per person.²⁷ This equates to around 70 times more healthcare spending per person in the UK, despite the warning by the UNRWA Director in Lebanon that “the (Palestinian) population is incredibly poor and relies extremely on the services delivered by UNRWA” (3).

MAP's Psychosocial Health Programme

Psychosocial support is an integral part of MAP's work. According to MAP's website the programme, ‘helps individuals and communities to heal psychological wounds and rebuild social structures.’

After suffering from years of conflict, human rights violations, displacement, military occupation and blockade, MAP's work helps to support Palestinians in their determination to be active survivors rather than passive victims. MAP's aim is to help people to rebuild meaning, coherence and self-continuity; to relieve stress, and to limit the development of further complications, while also addressing interpersonal, family, social and cultural issues (5).

MAP is committed to psychosocial support because:

- Children and adults living under occupation and as refugees are exposed to a variety of stressful situations including imprisonment, beating, house demolitions, constant social and economic pressure and witnessing death or injury;
- Stress is a normal effect on adults and children who are subject to such situations, but may also trigger deeper psychological suffering;
- Widespread poverty is effecting people's lives, including health, nutrition and education, creating an environment of chronic instability and insecurity (5).

What MAP is doing:

- Supporting counselling sessions for mothers and their children, not only offering a safe place to discuss issues but also to learn about psychosocial health
- Offering counselling and psychosocial services and providing women who are subject to gender based violence a place where they can speak freely and seek refuge away from the danger
- Using innovative methods such as interactive theatre to raise awareness about the impact of domestic violence, gender based violence and child protection
- Empowering young people to deal with the issues they face on a daily basis, growing up in a violent and disadvantaged environment (5).

Any attempt to heal psychological wounds and alleviate psychiatric suffering in the Palestinian refugee

population in the Lebanon will require a concerted effort by healthcare providers, politicians and the general public. The political party Future Movement have sponsored social activities to promote solidarity between the people of Lebanon and the people of Palestine. As enumerated above, sectarian divide remains deep. If, however, we want the prevalence of psychopathology to reduce, we must channel our energies and time on reconciliation and social inclusion as well as allocating adequate resources to mental healthcare services.

Interview with Dr Asad Sadiq BSc (hons) MBChB MRCP (UK) MRCPsych MBA (LBS) lead consultant psychiatrist in Fairfield General Hospital in Bury Northwest of England

AH: *Thank you for accepting my invitation to interview you regarding your experiences in war-torn Libya, but there is so much more to Libya than it being ascribed the pejorative description war-worn is there not Dr. Sadiq?*

AS: *Indeed, Libya is a very cultured land that once boasted a spectacular opulence, with a very rich heritage. The land that is now called Libya was home to great civilisations and dynasties such as the Roman Empire and it also facilitated the Islamic Golden Age which had profound effects on the modern world as we know it in terms of scientific discovery and influencing the Enlightenment period in the Occident.*

AH: *What inspired you to travel to Libya?*

AS: *The opportunity to travel to Libya arose out of an acquaintance with a colleague who is from Libya who was working in Misrati which is the third largest city in Libya for one year during the conflict. It really is quite astonishing how, in a city that has a population of half a million people, there was not a single psychiatrist. During the war my colleague was the only psychiatrist in Misrata. After the ousting of Colonel Gaddafi my colleague was operating a clinic in Misrata that offered very rudimentary psychiatric services which was largely self-funded and from resources from the UK. His family is actually from the UK and we arranged for him to give a talk in Fairfield General Hospital upon his return about his experiences. After the talk, which was incredibly inspirational considering that he hadn't been remunerated and he was doing it on a purely voluntary basis, it inspired me and a colleague, a fellow consultant psychiatrist, to go to Libya and join him. Initially it was quite difficult to get there as this was during the period of the National Transition Council and we had numerous trips to the embassy in London which was quite exciting as everything was in a state of flux.*

AH: *Did you have any programme or plan prior to arriving in Libya?*

AS: *Once we obtained the visa, we didn't have much of a plan really. We were informed that we would help out in the clinics. We delivered a few talks in some of the hospitals. We went with very low expectations, booking a flight with Turkish Airlines, the only airline that had international flights to Misrata which was via Istanbul. It was a huge shock when we arrived as I had never seen a post-*

conflict city in my life. Misrata had been utterly ravaged by war. Even at the airport there was no clearly-defined terminal building. There were ruined planes and debris seemingly ubiquitous, buildings laden with shrapnel and gun shot holes. Literally every building was littered with bullet holes in the city centre. It was a bit of a shock to behold as I had never seen anything like it before.

AH: How did you pass the time when you first arrived?

AS: For the first few days we held a clinic. We don't actually speak Arabic so we had a doctor who would interpret for us, who by the way had no formal training in psychiatry, and neither did the other doctors who were also helping out. Counter-intuitively we didn't see much PTSD which was rather interesting we thought. With a mortality rate that was well into the thousands, we were expecting to see high rates of PTSD. This was the city which at the start of the war, rose up against the tyranny of Gaddafi's regime so we were really expecting to see a lot of PTSD but we didn't in fact see a single case. We actually saw the usual disorders, such as eating disorders, psychosis, depression which were not acutely war-related. The number of cases that were war related was actually relatively few. If you look at PTSD it tends to occur in a context of when you remove the people from that situation, refugees for example.

AH: What were the main problems in Libya in your opinion?

AS: The main problems there were really a lack of structure and infrastructure so we had stand alone clinics, there were no community services. The nearest inpatient units were in Tripoli which was 200 miles away and in Benghazi which is hundreds of miles away. So there were no inpatient facilities so you had to manage your patients in outpatient clinics which posed a real challenge in terms of follow up appointments. You know you are not going to be there in 3-4 weeks. So there were scenarios when someone was ill and you would ask yourself, 'do we start them on medication?' knowing full well that they might be taking that medication for long periods of time unsupervised and mindful that even if they went to Tripoli that the psychiatric care over there is very poor quality. There are no doctors who are actually trained in psychiatry to the best of my knowledge in Tripoli. It remains a specialty that is neglected. For instance, there were fifth year medical students who never heard of the term psychiatry before, even newly qualified doctors.

AH: What were the psychiatric hospitals like?

AS: When we did go to hospitals that had psychiatric healthcare services we discovered that they had been performing electroconvulsive therapy without anaesthesia up until 12-18 months prior to our arrival there. I don't actually have the exact figures of the prevalence of mental illness in Libya but a majority of patients who did present to our services did have psychopathology. The inpatient units in Benghazi were truly dreadful. They were actually reminiscent of descriptions and images of UK asylums from a century ago, that is how dilapidated they are. ECT was very common in the psychiatric unit in Benghazi that anyone who presented there with a psychiatric disorder was more likely than not to receive this form of treatment at some point. I feel that this illustrates that the provision of psychiatric healthcare was not evidence based.

The units were not well funded at all. There were up to 60 patients in a single room with patients tightly cramped together, they literally didn't have enough space to put

their feet over the bed. They were clad in uniforms much like inmates incarcerated in a penitentiary. It was quite a spectacle to behold.

AH: Where did you go in Libya?

AS: We lectured in hospitals in Khoms, Benghazi and Tripoli. There were residents working in these hospitals who had aspirations to pursue a career in psychiatry but they would have to go abroad as there was no structured career trajectory in psychiatry in Libya. What was of particular notice was that the history taking and communication skills were generally of quite a poor standard.

AH: How many patients would a doctor see on a typical clinic?

AS: They would see 50-60 patients in a day and this isn't conducive to a good psychiatric history. What was remarkable in patients who have psychiatric illness in Libya were the protective factors in terms of the support that they would receive from their families. The big question we were asking ourselves there was does the Western model of psychiatry fit in Libya? That is the big question and I'm not sure if it does to be honest with you. The Libyans have obviously dealt with mental illness for a long period of time. In some ways, when they have attempted to imitate Western medicine, their practices have been woefully inadequate. I'm not sure if the Western construct is best for the Libyan society. I feel that they need to develop their own model of psychiatry as opposed to it being imported from the West. We did meet the Minister of Health during our sojourn in Libya. We spoke to her at length about the provision of psychiatric healthcare in the West, in terms of community support and pharmacotherapy, and whether it would be 'compatible' in Libya. We feel that there may be a clash in paradigms. In the West there is a focus on the individual, whereas in Libya the fabric of the society tends to be 'tribalism'. For example I don't think psychology services would be effective in Libya. I feel that religion plays a huge role in convalescence in Libya, such as faith healers and the shekhs and they shouldn't be neglected. If you start to impose the Western model you neglect the systems that they have in place already. So I'm not convinced that the Western model would fit there and believe that a fusion is required.

AH: Can doctors affect change in the current medical landscape in Libya?

AS: I think that we can affect change, but there is the potential of us causing a lot of harm there if we are not careful. One of the really positive aspects there was the resilience and the warmth of the people, the lack of globalisation, and because of that as I mentioned before they had a tribal society. If you erode these values, you will take away something that is really quite precious and unique. If they allow globalisation to creep in, part of which is psychiatry as we know it in the West that will not come without negative consequences I feel. So I emphasize that we shouldn't impose a system but rather we should allow it to evolve naturally as what happened in the West because the Western model fits the Western psyche and the Western form of living and the government and so on. I'm just not sure if it would work in a tribal society.

AH: Can you give us an example?

AS: For example the Mental Health Act law. The patient has rights here in the UK which are dependent upon the state deciding what is best for a person, whereas the family

has little or no say in the matter. So over here if a patient is very ill and the family has a certain view, that is largely irrelevant in the legal sense. I just have to act in what I feel is in the patient's best interests because he is an adult who has capacity. There is nothing that I can do. If you impose that in Libya, I just don't think it would work because the family is an integral part of that person, the person isn't an individual but rather a member of the family/ tribe. People don't perceive themselves as individuals over there but rather they see themselves as part of a bigger whole.

AH: What was the most striking feature of Libya?

AS: The culture of hospitality in Libya is really one of the amazing phenomena that I witnessed there and it was such that it rendered an indelible effect on me. For example, we were invited to this gentleman's house who lost a brother in the war so not only did he have his own children to look after but his brother's children to look after too. He was there serving us tea and never once did he intimate that he had to excuse himself or ask us to leave even though he had two families he had to care for. In the end we had to come up with an excuse to leave, he wouldn't allow us to leave on the pretext that he had to return to his family. It really was quite extraordinary. The selflessness, the hospitality. Returning to England it took a while to adjust to the culture and sensibilities and it really put things in perspective. In a tribal society, the warmth and fraternity between two individuals, it is ineffable and difficult to quantify. It goes beyond wanting for your neighbour what you want for yourself. It felt at times like a reckless hospitality to the detriment of yourself even, it was astonishing. We would say to them, that they had something very special that conferred, to an extent, a certain resistance to psychopathology. We hope that they don't lose this and that they do whatever they can to protect it and preserve it.

AH: What is your take home message to readers and medical students?

AS: My take home message to my fellow learners, is that at the end of the day we may view psychiatry as a science, I personally feel that the provision of mental healthcare is

about alleviating psychological and psychiatric distress. In my reckoning, it is fundamentally about people and their relationships with other people which is based on building trust and respect. That costs time and energy to sustain but it is well worth it, for yourselves, for your personal lives and ultimately for your patients and for the society at large. The people of Libya may not have much resources in the monetary sense, but they have each other and I feel that we in the West can learn form much from them.

AH: Thank you once again for accepting my invitation to interview you Dr. Sadiq.

Acknowledgements: None.

Conflict of interest: None to declare.

References

1. Hankir A, Zaman R: Jung's Archetype, 'The Wounded Healer', mental illness in the medical profession and the role of the health humanities in psychiatry. *BMJ Case Reports* Published Online July, 2013
2. Tahira A, Agius M: Epigenetics and migration – considerations based on the incidence of psychosis in South Asians in Luton, England. *Psychiatr Danub* 2012; (24 Suppl 1):S194-6.
3. http://www.map-uk.org/media/11474/943_map_lebanon_report_e-version.pdf
4. Bastin P, Bastard M, Rossel L, Melgar P, Jones A, Antierens A: Description and predictive factors of individual outcomes in a refugee camp based mental health intervention (Beirut, Lebanon). *PLoS One* 2013; 8:e54107. doi: 10.1371/journal.pone.0054107. Epub 2013 Jan 17.
5. <http://www.map-uk.org/what-we-do/how-we-work/psychosocial-health.aspx>

Correspondence:

Ahmed Hankir
National Institute of Health Research Academic Clinical Fellow Psychiatry
Manchester University,
Manchester, England, UK
E-mail: ahmedzakaria@doctors.org.uk