

## Psychiatry and the Palestinian Population

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**Abstract:** Some key issues pertaining to Palestinian psychiatry are described. Bearing in mind the geographical location and history of the Palestinian population, the development of psychiatry needs to be seen in the context of the Arab world, on the one hand, and of Israel, on the other. In the Middle Ages, Arab culture and medicine were more developed than in Europe. Aspects of general and forensic psychiatry on the West Bank and Gaza are outlined. Issues pertaining to the death penalty, suicide and suicide bombers are also discussed. The biblically-described relationship between the Arab and Jewish peoples has its resonance today with regard to cohabitation and conflict.

From remote times, close historical links have existed between Israel and the Arabs (1). A specific Palestinian national identity has now emerged seeking statehood (2-4). The territories of Gaza and the West Bank have since 1967 been subject to Israeli military rule but are now undergoing, albeit turbulently, a process of autonomy. Palestinian sources estimated the population in 1992 in the West Bank to have been approaching 1.5 million and that of the Gaza Strip as just under 800,000 (5), with an increase of about 45% anticipated over the next decade (6). Just under one-fifth or about one million Israeli Arabs also live within the borders of the State of Israel, with a birth rate double that of the Jewish population (7). Significant numbers of Palestinians also live in surrounding Arab countries, especially Jordan, where they may even be in a majority (7). The majority of Palestinian and Israeli Arabs are Muslim, though about 6% are Christian (8).

Aspects of the general and forensic psychiatric care of Palestinians have not been widely reported in the international medical press. The purpose of this article is to seek to describe some key issues in Palestinian psychiatry in a manner intended to avoid political bias (though perhaps in reality such a phenomenon is not entirely possible). The personal perspectives of both authors, one a Palestinian Arab and the other a British Jew, is the hope that the Israeli and Palestinian peoples may coexist in dignity and harmony, even if not in friendship.

### Psychiatry in the Middle East

Psychiatry and health care in the Palestinian conurbations needs to be seen in a context comparable to that in Israel, on the one hand, and other Middle Eastern countries, on the other.

The Arab countries may have been among the first in the world to establish mental hospitals at a time when European civilization dealt with the mentally ill by condemnation and punishment (9, 10). Mental hospitals were built in Baghdad in the year 705, then in Cairo in 800, and in Damascus in 1270. In the Arab world, political and religious forces have always been intimately intertwined and Islam is a crucial factor in all aspects of life (11, 12). However, in most Middle Eastern Arab countries until relatively recently, mental illness was thought to be due to possession by demons, failure to follow ritual, or fate — Inshallah (13-15). On the other hand, the secular nature of Western psychiatry means it is subject to the challenge of avoiding any religious or spiritual perspective or any framework for the meaningfulness of life (16). When Sigmund Freud, of Jewish heritage and the founder of psychoanalysis, penetrated the realms of the unconscious mind, he did not relate such psychological processes to God; he saw the human belief as a universal obsessional neurosis (17).

Psychiatry in contemporary Arab societies is well established, though Egypt is the only Arab country with its own postgraduate degree in psychiatry (9). The Arab Federation of Psychiatrists publishes a reg-

ular psychiatric journal twice a year from its base in Jordan. British and French influences on Arab psychiatry emanate from the colonial period and are interwoven with Islamic tradition. Traditional and religious healers still play a major role in primary psychiatric care (18-20). Most Arab countries, however, practice psychiatry in the context of legislation enacted during the colonial period or have none at all, and a draft Pan-Arab Mental Health Act is currently under consideration (21). Notwithstanding the legal vacuum, criteria for involuntary hospitalization in Arab countries are based on the presence of mental illness and the likelihood of the patient being a danger to himself or others and/or inability to provide basic needs for himself (22), these being similar to many Western legislations. Indeed, in England and Wales psychiatric detention can be based even more widely on the interests of the health of the patient (23). The extended structure of families in Arab societies is however associated with a high level of tolerance to assimilating family members with psychiatric illness in the community (9), though the severely mentally ill have tended to be isolated by society and subject to physical restraint (15). The family's control over whether a mentally ill member can be admitted or discharged may be very considerable (24). All of the Arab countries are generally undergoing significant social change towards modernization, albeit with the retention of traditional values (15), leading to conflicts on the role of women in society and increases in the population in the level of drug and alcohol abuse (9, 11, 25).

Psychiatry in Israel is rooted in the Western tradition, but as an essentially new immigrant society, mental health is conditioned by extensive transcultural factors (26-28). Traditional folk healers together with conventional psychiatry also play a role in Israel, but mostly in relation to Jewish patients from Arab countries (28-30).

Physical and mental suffering of both Jews and Arabs as a result of war and violence in the Middle East is acknowledged as a serious problem for both the armed forces and civilians (31-37). In the context of the national aspirations of the Palestinian population, a significant impact on their health during Israeli military occupation has been recorded (38-40). According to El-Sarraj (38), the Intifada, or Palestinian uprising, which began in 1987, was a socially

therapeutic process, replacing depression and hopelessness by pride and optimism. Statistics prior to and subsequent to the Intifada are unavailable, however, to test this supposition. A recent report from the Gaza Community Mental Health Program (41) regarded Gazans as having been significantly traumatized as a result of the Israeli occupation. On the other hand, Israeli casualties resulting from Arab and Palestinian acts of violence have been a persistent phenomenon throughout the history of the State of Israel. The tragedy of injury and death through violence has affected both communities extensively.

### General Psychiatry and the Palestinians

Studies on psychiatric morbidity in Israeli Arabs have not been undertaken, as far as the current authors are aware, although the Israel Ministry of Health does have an epidemiology unit (42). Indeed, the unavailability of such studies led to a transcultural review of Israeli psychiatry (27), being unable to offer any comment on them. According to Stendel (7), however, the development of medical services and rising standards of living in Israeli Arab communities have raised average life expectancy to 74 years, this being higher than that in all other Arab countries.

Mental health legislation in Israel draws upon Ottoman Turkish, British and Jewish influences (43). Since the Six Day War in 1967, the West Bank and Gaza have been subject to Israeli military law, but the mental health law has not applied, so that there has effectively been no legislative framework in which mental health has been practised. Parameters of general health in the West Bank and Gaza differ according to whether reported by Israeli figures (44, 45), or by Palestinian (38, 46), the former being more positive and the latter more negative in their assessment.

Accounts of psychiatric epidemiology in Palestinians are scarce (38). Studies of the effects on Palestinians of the circumstances of their lives in Israel and the territories still partly occupied by Israel but increasingly under autonomous rule tend to focus on general rather than overt psychological factors (2, 47). However, aspects of unemployment, lack of full self-determination and refugee status have all had an adverse bearing on the state of mind of Palestinians.

In May 1994, the Palestine Council of Health,

formed in July 1992, began its implementation of an Israeli/Palestinian agreement on health care in the West Bank and Gaza (48). In regard to psychiatry its objectives included the reduction of alcohol and drug abuse, reduction in the level of disability associated with mental illness, decrease in the mortality and disability associated with interpersonal and self-directed violent behavior and the revitalization of the psychiatric hospitals on the West Bank and Gaza, as well as of the community psychiatric health clinics in various cities.

### **West Bank**

On the West Bank there is one psychiatric hospital in Bethlehem which has 320 beds, of which 178 are for males and 142 are for females. Community psychiatric clinics are also provided in Jenin, Tulkarm, Nablus, Qalqilia, Ramallah, Hebron and Jericho. Under the British Mandate and subsequently until the Six Day War, both the East and West Banks of the Jordan River were part of Jordan (previously Transjordan), with the psychiatric services for both provided by Bethlehem Psychiatric Hospital (49). After 1967, Jordan developed its own separate services (49, 50). For many years until his death in 1993, the Medical Director at Bethlehem Psychiatric Hospital was Dr. Mohammed Kamal, who had undertaken part of his training in Britain at the Institute of Psychiatry in London and was also a Fellow of the Royal College of Psychiatrists. The current Medical Director, Dr. Mustafa Mujahed, and the second author of this article (IM) have also received psychiatric training in London at the Institute of Psychiatry and are committed to medically-led multidisciplinary team work. The hospital is recognized for teaching by the Jordanian and Arab Board of Psychiatry. Current staffing includes nine psychiatrists, of whom three are trainees, 12 social workers, three clinical psychologists, 71 nurses, two EEG technicians and other administrative staff. Although there are no separate sub-specialties as such, the hospital provides general adult psychiatry, old age psychiatry, child psychiatry, organic psychiatry, learning disability, drug abuse and forensic psychiatry. Treatment in the community is both enhanced and disadvantaged by the structure of Palestinian Arab society. The extended family system allows for the

chronically mentally ill to be cared for at home. However, there is no provision for any other community services outside of the family. Hence, in some instances, a patient may have to remain at home even where this may not be psychologically conducive to his or her health. There are also particular difficulties facing the mentally ill woman as the stigma of such an illness would significantly impair her role as mother. It is possible that delays in women obtaining necessary treatment are occasioned by the reluctance of family members to encourage women to seek help.

### **Gaza**

Until 1979, Gaza referred its psychiatric patients requiring admission to hospital to Bethlehem Psychiatric Hospital (38). In 1979, a 20-bed unit was opened, expanded to 32 beds in 1984, based in El Naser Psychiatric Hospital in Gaza. There is also a Community Mental Health Program based in Gaza (51) and an outpatient clinic in Khan Younis. This is staffed by one psychiatrist who is the Director, Dr. Eyad El-Sarraj, three other physicians, six psychologists, three social workers, three nurses, three EEG technicians and administrative staff. One of the main objectives of the Palestinian National Authority Mental Health Department is the training of staff of all disciplines in mental health. Collaboration with psychiatrists and health professionals from various other countries has also been developing. A post-graduate multidisciplinary course in Community Mental Health is to be undertaken in Gaza in liaison with the Norwegian government, and including lecturers from Norway, Britain, United States, Australia, Holland, Tunisia and Israel.

### **Forensic Psychiatry and the Palestinians**

According to El-Sarraj (38), after the Six Day War and during the Israeli occupation, levels of antisocial behavior and aggression, including homicide, increased within the Palestinian population. In addition drug abuse, especially cocaine, spread among younger Palestinians. Similar increases in criminality and drug abuse have occurred more recently within the Israeli Arab communities (7), though aspects of social change are not identical for the Pales-

tinians in the territories and those Arabs living within Israel. The concept of family honor remains prominent for Muslims, with episodes of young women being murdered by their fathers or brothers for having brought "shame" on the family continuing to occur (7).

The psychiatric hospitals in Bethlehem and Gaza are generally unable to take offender patients who may require a significant degree of security on account of their being dangerous to society (52). Indeed, the provision of high and medium secure facilities for the dangerous mentally disordered offender is also a current issue in Israel (53). In practice Israeli prisons have provided psychiatric care for the most dangerous offender, whether or not mentally disordered and whether Palestinian or Jewish. The rate of incarceration in Israeli prisons was recorded as being higher than in any country in Western Europe except Northern Ireland, though lower than in the United States (54). A Palestinian charter for patients' rights for standards of physical and psychological health care has also now been announced (55). The protection of human rights in both Israel and Palestinian autonomous areas has, however, been the subject of ongoing concern (56, 57). Dr. El-Sarraj, quoted several times in this article, has himself been imprisoned by both Israel and by the Palestinian authority in connection with political activity (56). Neither author of this article, though, would want to simplify the complex circumstances prevailing either for Israelis or Palestinians historically or at present. Indeed, religious and ideological conflict and turbulence pervade Israel and the Arab world with the development of Islamic fundamentalism (58) and of Jewish extremism which formed the background to the assassination of Israeli Prime Minister Yitzhak Rabin, in 1995.

### **Criminal Responsibility**

Common strands of philosophy in Jewish, Christian and Muslim thought exist with regard to the issue of criminal responsibility by a person who has committed a criminal offence (53). The Islamic formula for responsibility is based on the notion that Allah may withdraw the gift of sanity from a person who is thereby cleared of guilt for his crimes (12, 59). The Prophet Mohammed is said to have regarded the

young boy, the sleeping person, the mentally handicapped and the insane as free of guilt for acts they may commit. Islamic Sharia law, however, has a wider definition for criminal acts than in the West. Behavior such as suicide, fornication and alcoholism are all regarded as criminal in Islamic religious courts (60).

### **Death Penalty**

All the Arab countries retain the death penalty (61) with a prevailing sentiment that it is essential for the maintenance of law and order and is an integral part of Islamic law (62). The Islamic states are among the most determined nations to retain the death penalty (63). Exemption from the death penalty for the mentally ill is also endorsed by Islamic law (11, 12, 31). Punishment for serious crimes in some Arab countries is often carried out in public, including beheading for murder, amputation of hands for theft and public lashing for blasphemy (11). Doctors refusing to be involved in carrying out such sentences have allegedly themselves been executed in Iraq (64). The Arab and indeed non-Arab Muslim states are engaged in a struggle between Islamic fundamentalism and modernity, and some Muslim scholars have attempted to devise Islamic legislation which is consistent with internationally agreed principles of human rights (65). The exemption of the mentally ill from criminal responsibility and from the death penalty clearly requires a high level of diagnostic accuracy by trained psychiatrists. Even in the United States, studies have indicated the presence of mentally disordered prisoners on Death Row (61, 66). It is not unlikely, therefore, that around the world where the death penalty has been retained some undergoing execution may have been suffering from mental disorder which may well have had a bearing on the offence they committed. The incompatibility of medical ethics being preserved by doctors' participation in executions has been outlined by the World Medical Associations (67). In Israel there has been no death penalty since 1954 (61, 68), except in the case of crimes of genocide for which the Nazi war criminal, Adolph Eichmann, was hanged in 1962 (69). Under Israeli military law, the death penalty can be carried out but has invariably been commuted (61). The first death sentence by a Palestinian court

since autonomy has been passed following the conviction for murder of one Palestinian police officer of another (74), but it has not been carried out.

In the event of autonomy progressing to independence, were the Palestinians to decide against the death penalty, it would be the only Arab state to have done so.

### **Suicide and the Suicide Bomber**

Suicide is contrary to Islamic law (12, 60), and its frequency is low (19, 71, 72) including in the Palestinian population (38). Differentiation needs to be made between suicide and self-injury and the practice of psychiatrists and the police in some Muslim countries to collude to avoid bringing those who have attempted suicide before the courts (11, 13, 73). In Jordan, where suicide rates are also low, there are high homicide rates (74). The phenomenon of homicide followed by suicide is also well-known (75-78).

Simultaneous homicide and suicide has occurred in a military context, for example in the Second World War by Japanese kamikaze pilots who sacrificed their lives in the name of national honor (79). Suicide bombing incidents have been a component of the Middle East conflict over the last decade or more and are very rare elsewhere (80). Deliberate self-injury or suicide is not the usual intention by those engaged in political activities designed to inflict major injury on an enemy outside of the Middle East. Espoused politically by the more fundamentalist wings of Islam, there is, however, no Islamic religious consensus that such acts are permitted (81, 82). Clearly the prohibition in Islamic law against suicide is in such instances being overridden by another factor, namely that of martyrdom for which there are historical precedents in the acts of the assassins in the eleventh and twelfth centuries (80, 83-85), the objectives of which were the attainment of Islamic unity.

There is therefore no need at all to seek to apply any psychiatric analysis to the suicidal bomber in the Middle East as the phenomenon can be accounted for in political terms. However, although that may be true in a general sense, it may not fully explain the specificity of which individuals are selected for and agree to carry out such acts.

There may be some characteristics which outline

the Palestinian suicide bomber, though these are based on journalistic rather than professional psychiatric enquiry (86). In the period of about two years from April 1994 until March 1996 there were 13 suicide bomb attacks in Israel which killed 131 people. The perpetrator would be described either as terrorist or as martyr, according to the political stance of the observer. He would be a young man aged 19 to 25 years from a devout Muslim family. He would be unmarried and the middle child of a large family and, hence, not usually the main wage earner on whom the family would be dependent financially. Many would have lived in refugee camps, especially in Gaza, and may have had a father or brother killed in the Intifada. They may themselves have been subject to physical punishment. The journalist felt that the common elements were a sense of hopelessness, being too poor to study and unable to find work, coming from a family of refugees, with a strong sense of Palestinian identity. Recruits by Hamas or Islamic Jihad would have been told that through martyrdom they would find riches in heaven.

If this portrait is accurate, then the suicide bomber would seem likely to be someone who is not formally mentally ill, but experiencing an existential depression, with a need to express his anger both externally and internally in a manner designed to cause maximum harm to his enemy, at the same time as seeking to rectify his severely damaged self-esteem and alienation. The phenomenon itself is a simultaneous manifestation of Freud's theories of the life instinct, Eros, and the death instinct, Thanatos (87, 88), activated in momentary explosive catharsis.

### **Future Developments**

The Arab and Jewish peoples have from an historical and biblical perspective a common heritage (Genesis xvi, 89). Conflict existed between two of Abraham's sons, Isaac and Ishmael, and the conflict between their descendants is no different today. Nonetheless, some attempts at Israeli/Palestinian cooperation in health care have been reported (90), while psychiatric interest in conflict resolution is also developing (41, 91). While the improvement in psychiatric care of Palestinians does not depend only on resolution of the military conflict, it is clear that it is a precondition for constructive efforts to prove fruitful. For this

to occur, Abraham's descendants must learn to coexist with one another even if there can never be mutual love. The fateful embrace of the two peoples must transform itself through mutual understanding into mutual forgiveness in order to fulfil the human potential of both (92).

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