Children Living Under a Multi-traumatic Environment: The Palestinian Case

Roney W. Srour, MA
Palestinian Counseling Center, Jerusalem.

Abstract: This paper will focus on some of the most traumatic factors faced by the average Palestinian child during times of war. Unlike most research, which limits the Palestinian child’s experience in war to military-related traumatic events, in this paper I will attempt to illustrate the Palestinian child’s internal and external experiences, using empirical studies, my own clinical experience and an analytic understanding of historical and present events, in addition to a case study. This includes the different sources of stress and trauma that face Palestinian children and which ultimately create a multi-traumatic environment. I will also compare the situation of Palestinian children during the first and the second Intifadas. The analyses will include concepts such as trauma, witnessing, trans-generation, familial and social stress factors, and sense of loss of control. This paper could help clinicians as well as researchers to develop a more comprehensive conceptual model of understanding the emotional lives of Palestinian children.

Introduction

Four years since the second Intifada started on September 28, 2000, 3,785 Palestinians have been killed as a result of war circumstances, approximately 2.5 people a day (proportionally, this would be equal to about 12 people in New York each day); about 23% of them (827) were children under the age of 18. Another 27,925 Palestinians have been injured, 3,409 of them of elementary and secondary school age (Miftah, October 12, 2004). In addition, about 500 children have been arrested during this period for Intifada-related activities.

Our assumption that psychological symptoms give an indication of children’s suffering received support even before the first Intifada. Punamaki (1) found that levels of aggression, nervousness and withdrawal are higher in Palestinian children due to the amount of trauma they are exposed to. Those found to be traumatized continued to show a stronger fear of darkness, ghosts and violence than did their non-traumatized peers. During the first Intifada and its daily high stress factors, mothers reported that children suffered more from sleep disturbances (nightmares and insomnia), depression and psychosomatic symptoms (headaches and stomach aches) (2).

Thabit and Vostanis (3) assessed PTSD and other emotional and behavioral problems in Palestinian children (aged 7-12) from Gaza from individual, parent and teacher reports, during the first Intifada and one year later. They found that the children who reported moderate to severe PTSD reactions during follow up had decreased from 40.6% to 10%. These findings may show that a significant proportion of psychological symptoms in children may disappear when the source of stress is eliminated and their environment becomes safer. Still, a substantial number of children still suffer from a range of emotional and behavioral problems.

Most of this research limits Palestinian children’s emotional suffering to direct military violence. In this paper, I attempt try to widen our perception of war.

Accumulating Stressors

Upon reviewing the limited literature, which directly refers to Palestinian children in war zones, I categorized the risk and resilience factors facing these children into three categories: individual, familial and social. The social factor will not be discussed in this paper for lack of space.

Individual

Comparing children whose houses were bombed and/or demolished during the second Intifada to other children living in the same city in Gaza who...
did not experience this tragedy directly, Thabet et al. (4) found that children directly exposed to the trauma developed more severe PTSD, while those who had been indirectly exposed to house demolitions developed more anxiety and mild/moderate PTSD. They give two interpretations for this finding: One is that those directly exposed develop emotions and a physical reaction to the bombing, while others only worry about what may happen. The second interpretation is that the PTSD in those directly exposed masked their anxiety.

Here, I would like to emphasize another important concept: “losing control.” At each stage meaning is organized around central developmental tasks. For the toddler, it is predictability and control made possible through the constraining guidance of the caregiver (5). Most children living in a normal, loving and sensitive environment develop a secure working model (representation) of the world that he/she is protected by his parents (and later by other social systems) in addition to other beliefs, attitudes and expectations about how the world works, which can alarm him when there is impending danger. These beliefs create the representation of the self as safe and strong in addition to a sense of being in control over one’s own environment.

When a child hears that these beliefs may not be reliable because others very near and similar to him/her have been harmed (their houses demolished), rendered helpless (they could not protect their houses) and unsafe (nobody helped them), this representation of the world becomes suspect. The child may feel exposed to danger but still does not know what it means to be harmed.

In contrast, the child who has been directly exposed to a traumatic event has had the opportunity to test his ability and gain strength on his own. In this case he may have been able to face the danger and surpass it peacefully by internalizing it so he is less afraid/anxious. The alternative is that the event was much greater than his ability to comprehend it and his psyche could not attribute any meaning to the overwhelming experience taking place (6), so he starts to believe that “the reality is really dangerous and I have the proof that I cannot control anything not even my emotions or body.” This way the body keeps the score (7).

Another type of losing control and breaking the “safe” assumption is by “trauma through witnessing” (8) where parents, friends or strangers face extreme events or daily difficulties like enduring insults at checkpoints. Herman (9, p. 2) stated, “Witnesses as well as victims are subject to the dialectic of trauma.” In an attempt to answer the question: What is stressful about being a witness of violence, Oliver (10, p. 3) comments, “... a suffering that would find in its own discomfort a comparison to what the victim has suffered... We suffer, so to speak, the impossibility of suffering the other’s suffering.” Weingarten (11) identified four types of trauma through witnessing: the most relevant one to our Palestinian case, for example, house demolitions in Gaza, is the fourth, where the child experiences the most evident distress, when he/she is aware of the meaning of what he/she is witnessing but feels helpless.

In addition to the question: “What may shake this safe representation of the world?” I would like to ask, “Does the average Palestinian child have a fair chance to develop such a safe representation? Can this continuous stressful environment serve as a resilience factor instead of a risk factor?”

This representation of a safe world has been dubbed by Janoff-Bulman (12), “the good world assumption.” According to Janoff-Bulman, the more positive this assumption is in a person’s cognition, the more difficult the surprise and the symptoms are after a traumatic event, though flexible and realistic beliefs toward the world are more protective. In contrast, Foa and Rigges (13) claim that negative beliefs toward the world make the person more vulnerable to PTSD because the trauma corroborates his/her beliefs. In reference to the Palestinian case, let us pose the question: Is this highly stressful environment in which Palestinian children live more likely to create a negative assumption of the world and make the child more vulnerable, or will it create a flexible assumption and bring about more strength and resilience?

The answer requires much more empirical and theoretical work in the Palestinian context. It is my impression that the long-term multi-stress factors an average Palestinian child lives under serve more as a risk factor by not allowing him/her to build a positive world outlook.
Coping strategies during the first Intifada

Studies have found that some of the effective psychological coping strategies children used during the first Intifada are: active fighting and problem reconstruction (helping prisoners, dreaming of suing the killers). Punamaki and Puhakka (14) found that personal exposure to stressful events increased behavioral coping, active fighting and problem reconstruction and decreased emotional models of coping. Active fighting and behavioral coping were effective only during the Intifada but not before the Intifada. That means that active fighting and behavioral coping strategies were not only an unwanted result of the confrontations but also had a protective effect.

Qouta, Punamaki, and El-Sarraj (15) found that the more active the children were during the Intifada, the more their self-esteem increased after it. It seems that active fighting is not only a physical way of decreasing temporary stress; it is also a way of empowering and maintaining high self-esteem by giving the illusion of being strong and in control. In certain circumstances (usually not extreme violence) the child preferred to risk his physical wellbeing by participating in the confrontation to the benefit of his self-esteem and sense of control and contribution.

After the end of the first six-year Intifada, Palestinian children attained a more secure environment. However, they had already learned that violence is valuable behavior and continued to use it systematically as teenagers and adults. Even after the actual threat decreased they continued to react to the environment as threatening. The difference was that after the Intifada the violence was not only used against soldiers but also against other Palestinians. For example, during the period between the two Intifadas there was more violence between Christians and Muslims and between nuclear and extended families than during the first Intifada.

Recently, another factor has enforced the value of violence in Palestinian society, which is the myth of “suicide bombers” as national heroes, who will bring an end to the occupation and the national and the personal suffering, through national revenge. This violent attitude becomes a generalization, especially since an emotionally-free adult, collective environment has never existed, which dictates what violence is acceptable (against soldiers) and what is not.

Another limitation to behavioral coping strategies is gender differences. As a traditional society, girls participated less often in demonstrations and confrontations with soldiers (16) which kept their stress at levels low enough they could be handled emotionally and less behaviorally (17). But when girls needed behavioral coping strategies, they were allowed to utilize them to a lesser extent, so they introjected instead.

Comparison between first and second Intifadas

There are significant differences in children's lives during the second Intifada in comparison with the first uprising. In contrast to the first Intifada, the second Intifada has very few street fights and confrontations with Israeli soldiers. This present Intifada is more like real war, conducted by intelligence forces, airplanes, bombs, assassinations and Special Forces, against which children are defenseless, given their simple tools and confrontation-coping strategies. In the present Intifada, children face frequent, unexpected and uncontrolled events: bombardment, curfews, checkpoints, insults, death and walls separating them from familiar areas like their schools, without being able to protest as a means of empowerment, commonplace in the first Intifada. For example, there are about 180 checkpoints throughout the West Bank, many of which are “moving checkpoints,” which makes it difficult to adapt.

On any given day in a Palestinian child’s life, he/she could wake up to curfew or to an Israeli army raid on his/her home or town. Children oftentimes must cross checkpoints to reach their schools where they are subjected to insults and long waits, transportation may not be allowed to reach the child's neighborhood. If children were able to pass, their school could be closed or classes cancelled because other students or teachers could not make it due to closures. There have been cases when children were not allowed to pass checkpoints because they did not have a copy of their birth certificate in hand.

The absence of a regular, stable and safe routine in their lives makes children tense, vigilant and oftentimes irritable, leaving little room or energy for learning and development.
Psychological outcomes
It seems that this high stress level caused by loss of control and lack of predictability is overwhelming to the average Palestinian child even if he/she has not faced extreme military violence directly. Added is the stress of not having opportunities to participate in actual confrontations during the second Intifada, which results in an increasing number of children who suffer psychological symptoms related to war, fear and rage-related stress.

Throughout my clinical work with Palestinian children in the West Bank during the second Intifada, I have seen two main types of symptoms related to political violence in Palestinian children: First are the symptoms related to “losing control,” such as enuresis, controlling parents through obstinacy, mutism, separation anxiety and not going to school for fear of losing mother after seeing or knowing that she was in danger. The second group is about “transferring emotions,” especially fear and rage: when a child cannot articulate his accumulated fear and anxiety caused by secondary or preliminary trauma, he may reenact this fear by direct or indirect aggression to show others “how it feels to be frightened.” This is usually displayed by conduct behaviors or agitated depression in boys, and increased withdrawal in girls. These gender differences make girls less visible and less accessible to receive help.

Familial
Early research on civilians in war zones suggested that the mother’s sound mental health was the main protector of children’s mental health (18, 19). More recent research shows that a well-functioning family and stable emotional relationships with one parent at least (20) can enhance children’s wellbeing in a stressful environment. Garbarino (21) observed that children’s strong positive attachment to their families and the ability of the parents to protect the children’s sense of stability, permanence and competence help the children to cope better with traumatic events.

Punamaki et al. (17) empirically showed that traumatic events experienced by Palestinian children during the first Intifada were mostly related to political activity, which was associated with increased adjustment problems. Good parenting lessened adjustment problems for children who were politically active. In addition, a good perception of parents by the child protected his/her intellectual, cognitive and creative resources from being negatively affected by the traumatic event. Here, allow me to highlight a few obstacles facing the Palestinian family, which hinder its ability to be an affectionate, stable and emotionally protective source for the child.

Trans-generational trauma
Palestinian society went through massive displacement in the war of 1948. Those who were exiled during that war lived in tents for years and then slowly established their new life without accepting the new reality, in addition to economic hardship and a strong longing for their lands, houses and relatives whom they were prevented from seeing. Today, these people are grandparents who retell their stories and relay their emotions to their children and grandchildren. These emotions include longing, anger, defeat and, most of all, fear of being uprooted again.

When our center personnel was called urgently to the Jenin Refugee Camp for an emotional intervention after the invasion of Israeli forces in April 2002, the most predominant sentiment detected among young children was their fear of being sent back to live in tents, although these children were born 30 years after the 1948 war when their parents and grandparents lived in tents. Still, they have lived in fear of poverty and not belonging, which are symbolically associated with tents.

Almost half of Palestinian children living in the Occupied Palestinian Territories (OPT) live in families with refugee grandparents, but nearly all of the Palestinian children in the OPT come from families in which the parents lived through the 1967 war and have thus been living most of their lives under the occupation ever since. Living under occupation does not mean living only under military authority and the violence this entails, but also means living in a continuous state of uncertainty, which has lasted for more than 35 years. Conditions include being paid on a daily rather than monthly basis with no basic social rights, which render the main provider of the family incapable of making any long-term plans, no citizenship or free movement, no police (only soldiers), continuous arrests, massive male worker immigration to the Persian Gulf, etc.

This preoccupation with the state of instability in
which parents constantly live makes it difficult for them to provide their children with any real sense of stability. Growing up in a home with an adult suffering PTSD as a result of the Holocaust can make a child the subject of emotional abuse and vulnerability to PTSD (22). This vulnerability can be ascertained by biological factors of a low level of cortisol or by acquiring attitudes and representations of the world and the self that could predispose children to PTSD. According to Weingarten (11), “it is highly likely that political violence also creates extreme fear in caretakers, leading to frightened or frightening behavior resulting in inconsistent behavior with his or her children” (p. 50). In the Palestinian case this is applicable not only to a militarily-terrorized parent, but it can also apply to a situation where the father has a long-term (10-20 years) and humiliating job or is unemployed, which makes him less sensitive (23), thus projecting his fear and anger onto his children.

This parent or even older brother can also be traumatized from imprisonment. About 50 percent of Palestinian prisoners suffer PTSD (24). Other studies put this figure at about 60 percent (25). We should not forget here that the absence of clear civil, legal and mental health systems make these children more vulnerable to domestic abuse.

Case description

Ahmad was four years old when his mother first brought him to our center. He is the youngest of six brothers and sisters. His father used to work inside Israel, but last year he became unemployed as a result of the political situation. His mother has never worked outside the home and both parents only have an elementary education. The family used to live in Nablus, but when Ahmad was three, they experienced an extremely traumatic event.

One afternoon, while the family was at home, shooting broke out near his house between Israeli soldiers and Palestinian activists. The shooting was close, a number of windows broke and glass shattered everywhere. His 15-year-old brother, who was watching the gun battle from the window was taken as one of the activists and did not have time to hide before being shot in his face. Ahmad saw the entire bloody event. His brother received medical attention and was later put on medication. From the mother’s description, I deduced that this young man suffers from severe PTSD. The family decided to temporarily move from Nablus to Jerusalem and look for a safer place to live and where the father could work. The father did not find work, however, and the oldest married brother started working to support his parents and sometimes buy medicine for his brother.

Since the shooting, Ahmad stopped talking to anybody but his mother. His language did not develop properly from lack of practice and he did not go to kindergarten because the family did not have enough money.

I saw Ahmad on a weekly basis for psychotherapeutic sessions and charged one shekel per session. During the first few sessions Ahmad refused to come into the room without his mother. During these sessions I observed the relationship between child and mother. She was supportive and very sensitive to his needs even though he did not talk to her while I was there. During these sessions I started to join the mother and son’s play until Ahmad slowly began accepting me. Two months later, he agreed to enter the room without his mother.

Over the next three months, Ahmad used to play two games almost obsessively, which revolved around gaining control over two situations: The first game portrayed a situation where people are traveling by train when soldiers suddenly start shooting at them without them being able to protect themselves. After a few sessions, this game changed with the people being given some power to protect themselves by shooting back. The last stage was that the battle would end with the people winning. The second game was that a sick child goes to the doctor and Ahmad tries to help him recover, but also causes him pain by giving him an injection. This game did not evolve at all and never had a clear end.

Both these games were played without Ahmad saying a word. I accompanied the child’s game by words focusing on being sympathetic to the pain of the sick child and to the fear of the travelers.

One time Ahmad came late and was obviously angry. He entered the room for a few minutes and then started to play the shooting game. When the people started to shoot back, Ahmad took all the toy soldiers and started beating them and throwing them on the floor and the walls. When he finished his outburst, he looked at me and detected the fear in
my face before going to the window and staring outside. At first, I did not know whether I should react to his anger against the soldiers or his disappointment at my frightened expression? But I realized that this child wanted to teach me a lesson, to ask me, “Do you realize now how frightening it is to be shot at?” I also realized that he needed me to be strong and not helpless. He did not want me to be like his parents during the shooting incident in his house where they could not protect him or his brother. I said, “It is very frightening to be shot at, especially when you are alone, isn’t it?” He kept his back to me for a while and then invited me to play the doctor game with him.

I talked to Ahmad’s mother after the session and she told me they were late because soldiers at the checkpoint were shooting in the air. Ahmad was shaking and screaming. When I realized why Ahmad acted that way during the session, I smiled at him. He took his mother’s hand and told me in broken language, “see you later.” These were his first words to me.

During the following sessions, Ahmad realized that I understood his fear, so he felt safe enough to abandon the two games and widen his circle of creativity to drawing, music games and family. During these games, the language he used was not always clear. His mother said that although he began talking again to family members and later to others, Ahmad also became very stubborn and did not respond to discipline. She said he sometimes would put himself at risk by climbing high places or running into the street. Here, I believe Ahmad was trying to do two things simultaneously: to frighten his parents to test their strength and ability to protect him; and second, his obstinacy was used to gain other forms of control over his life because he still believes they are not reliable or strong enough.

I started meeting with the mother every few sessions to talk about Ahmad’s home life. She told me that she feels helpless in disciplining Ahmad and is very preoccupied with the family’s present financial situation, her child with PTSD, in addition to complaints from the school about her eight-year old daughter. Her husband was falling into a depression because he felt he was unable to be a good father or breadwinner. As result, she felt she was unable to talk about her own anxieties from the shooting incident or the difficulties and longing she experienced after leaving her house and family in Nablus.

During one session, Ahmad started to play a new game. Again, his play was obsessive. He brought a toy pot, made tea and gave both of us cups to drink; he played this game again and again throughout the entire session. After the session was over, his mother asked him if he had told me what happened the day before.

Apparently, his brother with PTSD had not taken his medication for some time. At the breakfast table, he had gone into a rage while the family was drinking tea. When Ahmad tried to play with him, he got angry and threw the hot tea from his hand. It landed on Ahmad, burning his leg.

I realized that Ahmad plays his obsessive games when he wants me to understand something very important to him. I decided to start working with both parents rather than the mother only, to encourage and teach them how to make Ahmad feel more secure. Police intervention was not an option because that would mean the same Israeli soldiers who frightened Ahmad would become the source of his protection.

Throughout this period, Ahmad started to test me and test the limitations of the setting. He started to finish the session before the time was up, or he would want to go out of the room to play and leave me on my own.

On one occasion, Ahmad came with his mother. He looked upset and did not want to come into the room. When I asked him what was wrong, he refused to answer. His mother told me he wanted candy since she would usually buy him some on the way. Because they were late this time, she promised him to buy him candy on the way home, but Ahmad would not have it. He refused to come in until he got some candy.

I realized that Ahmad was testing me and his mother at the same time. I decided to approach the situation passively, telling the boy that he was welcome to come in when he wanted. While I was waiting inside I heard the mother giving Ahmad money. “Here you have the money (giving him control). When we finish, you can go and buy the candy.”
Quickly, I went out and tried to correct the mother’s mistake and to convince him to come in. Ahmad refused and started to walk towards the door to go outside alone to buy candy. I brought him back, took the money from him (to return control from his hands to adults’ hands), and said, “I have the money. When we finish the session I will give it to you and you can go with your mother to buy your sweets. But you should never go alone. I’m inside and you can come in whenever you want.” I had taken control over a situation, which should have been the mother’s role. But her weakness forced me to intervene.

Ten minutes before the session was over Ahmad came in, took a few cars and started to play by himself. During the game, he looked at me and said, “Roney, I love you.” I told him I loved him too. He probably felt that I had protected him from a dangerous situation. After the session, I gave Ahmad the money back. During our next meeting with the parents, I made use of this session as a model for putting limitations on the child.

In later sessions with Ahmad, limitation testing was reduced and play concentrated on family games, which portrayed how weak the father is. The father had recently experienced manic depressive episodes after the older brother immigrated to the United States in search of a better job. I convinced the father to seek psychiatric help, but it was difficult for the family to find money for medication. This therapy ended after 15 months because the wall between Jerusalem and the rest of the West Bank was built, making it difficult for the family to travel to the sessions each week.

Discussion

I chose this case in order to illustrate how different stressors can accumulate in a single child’s life, forcing him/her to live under difficult environmental circumstances, mainly as a result of living in a war zone. I also wanted to illustrate how war circumstances are interpreted and emotionally reacted to by young children.

Ahmad suffered from multiple and easily detectable simultaneous traumas. He faced danger alone during the shooting at his house and at the checkpoint. He witnessed his brother being injured and his parents’ helplessness in addition to his house being invaded. He also had to deal with a disturbed and violent older brother at home, in addition to a father who was weak and depressed. This child faced poverty and unemployment over the last two years in addition to losing his original environment (house, grandparents, uncles) in order to move to Jerusalem. Ahmad is an example of a child who lost control over his surroundings and was traumatized. He tried to regain control by the pathological method of turning mute and stubborn and challenging his parents while even putting himself in danger.

Being subjected to shooting is a very visible war trauma; witnessing violence or living with a violent family member is less visible, but stress as a result of living in an insecure society in general is hardly seen as a war stressor. In this article, I attempted to clarify and highlight all of these different levels of trauma. Although much of what I describe needs further illustration and research, what is more important is highlighting these factors that are still invisible to most of us. As a result, I could not include them all in this paper. Nonetheless, they continue to affect Palestinian children and probably other children around the world who unfortunately live under similar circumstances.

Most Palestinian children in the OPT live under more than one war-related stressor at the same time. These different stressors can form different combinations. Ahmad’s case is not even the most extreme. Every child may react differently to these stressors and even use some of them as resilience factors. As clinicians, as well as researchers, we need to understand all of these factors, which may affect any given Palestinian child. Only such an understanding can help us intervene with children either preventively or therapeutically. Considering the Palestinian child as a victim of direct military violence may only result in the loss of a lot of emotional information about these children and could underestimate the stress that other children who have not experienced direct militant violence are experiencing.

One of the limitations of this paper is that a serious part of the material presented depends on my own daily and clinical impressions. As a clinician, I am more exposed to children who were not able to learn adaptive coping strategies and live under more traumatic stressors. But there is a neutralizing factor to this diversion from the selected material, which
could be described as numbness or adaptation of the society in general to the odd behavior of individuals. For example, a teenager who steals cars from time to time and often picks fights would be diagnosed with conduct disorder in any western country. But in Palestine this teenager usually does not receive any help because such behavior is common and largely acceptable. As one of my colleagues said, "Every Thursday, the day I work in the school (ages 6 to 12), I find one or two new cases of children who have never stopped bedwetting." It seems that, given the major stresses of their daily lives, the parents do not consider bedwetting an odd enough behavior in order to seek help.

References