

ADAPTING MENTAL HEALTH INTERVENTIONS FOR DISPLACED POPULATIONS IN CONFLICT ZONES: LESSONS FROM GAZA

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CONTEXT & OBJECTIVES

- Background on Gaza – August/September 2024
 - ~340 days
 - 41,000+ martyred, 93,000+ injured
 - Virtually full infrastructure collapse (healthcare, educational, utilities)
- Learning Objectives
 - Understand challenges of psychiatric care in war
 - Analyze coping differences between teams
 - Evaluate what works in extreme mental health crises

TIMELINE OF EVENTS SINCE MISSION

- Nov 2024 evidence emerging of large scale amputations among civilians, convoy hijacking and looting become the trend
- Dec 2024 Dr Hussan Abu Safiya was detained after siege of Kamal Aswan Hospital
- Jan 2025 "Ceasefire" goes into effect
- Mar 2025 "Ceasefire" collapse and humanitarian aid block begins, famine eventually sets in
- May 2025 Gaza Humanitarian Foundation (GHF) launched, subsequently shut down amidst disastrous operational failures and civilian harm while trying to receive aid
- July 2025 (and continuous) separation of Gaza in sections, forced displacement into small areas
- Aug 2025 Nasser Hospital journalists targeted and killed with precision
- Oct 2025 current "ceasefire" began
- Early 2026 (and continuous) blockade of humanitarian aid
- Apr 2026 rodent infestation begins

THE MISSION

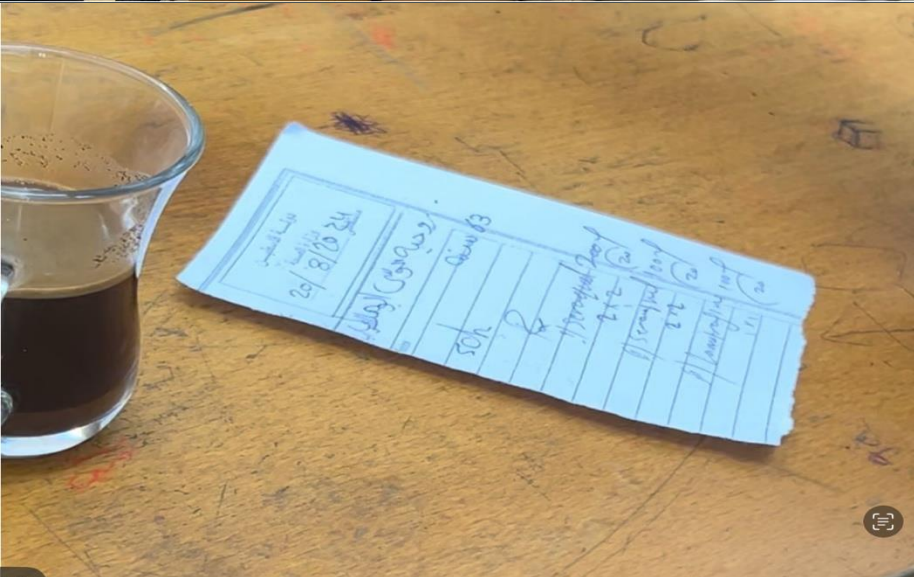
- Who: first two psychiatrists to enter Gaza (with Dr. Wa'el Almomani) with an EMT (PAMA)
- Where: Nasser Hospital Complex, Khan Younis, Gaza
- What: general population outpatient clinic





CLINIC CONDITIONS & CHALLENGES

- Single overcrowded room, no privacy
- Constant airstrikes, bombed out facilities
- No stable infrastructure (eMR, Rx)
- High demand for services
- High volume of patients

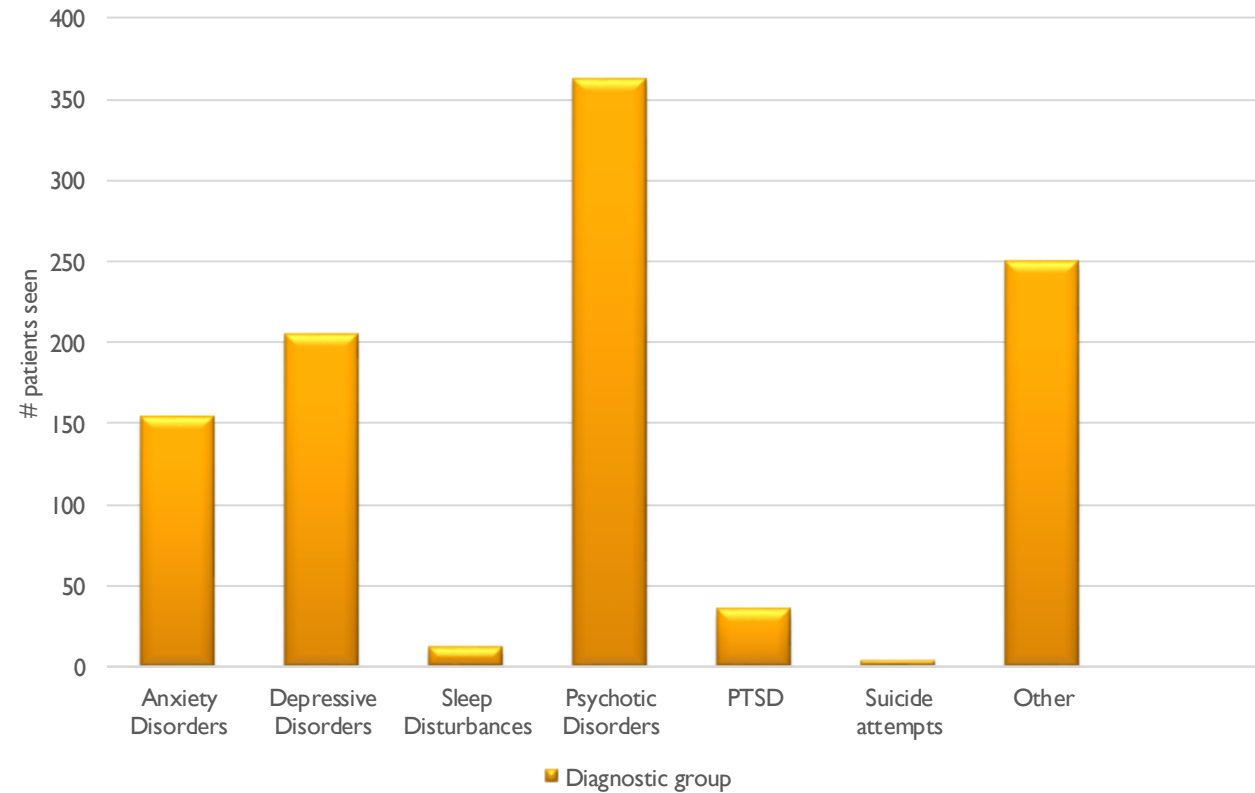


HCW REFLECTIONS IN JULY 2025

- *“I’m really struggling these days Sometimes I feel like I just want to be martyred and leave this world behind, I feel so tired, and everything is so heavy. I’m trying to stay strong and keep going, but it’s really hard. May Allah give us patience and strength 🙏🙏” - June 24*
- *“Peace be upon you, sister. How are you? I am not well. Today, the planes targeted our neighbors’ house without any warning. Ten martyrs were killed — their bodies were in pieces. I was collecting their body parts in bags. By Allah, I am exhausted. I seek forgiveness from Allah the Almighty and repent to Him.” – July 4*
- *“In the morning we woke up to a terrifying nightmare. Corpses and body parts were lying next to and on top of my family’s tents after a bombardment of a tent next to them, killing children and women. My brothers’ children saw the body parts, blood and shrapnel and they are scared now. There are no words to describe this crime.” - July 8*
- *“Two days ago, I didn't want you to make the transfer. I was afraid that I would be martyred and the money would be left around my neck.” - July 8*

PSYCHIATRIC PRESENTATIONS

- Notably high percentage of psychotic disorders
- Notably low percentage of PTSD



MEDICATION & TREATMENT CHALLENGES

- Drug shortages > forced med changes
- “mish mutawafir” “badeel”
- Relapse/destabilization due to inconsistent access
- Ethical distress: knowing the right med, but not having it



A group of people are gathered in a meeting room. A man on the left is pointing towards a screen. In the center, a group of people, including two women in hijabs, are looking at a computer monitor. A man on the right is writing on a document. The room contains cardboard boxes, a desk, and a whiteboard.

COPING STRATEGIES: VISITING VS. LOCAL STAFF

- Visiting psychiatrist stress reactions - guilt, helplessness, trauma exposure
- Gaza colleagues grounded in faith and collective strength but exhausted and traumatized
- Gender differences in emotional expression and support seeking



WHAT WORKED, WHAT DIDN'T

- What worked: cultural humility, narrative, listening, spiritual integration
- What didn't work: rigid western psychiatric models, trauma protocols that didn't resonate

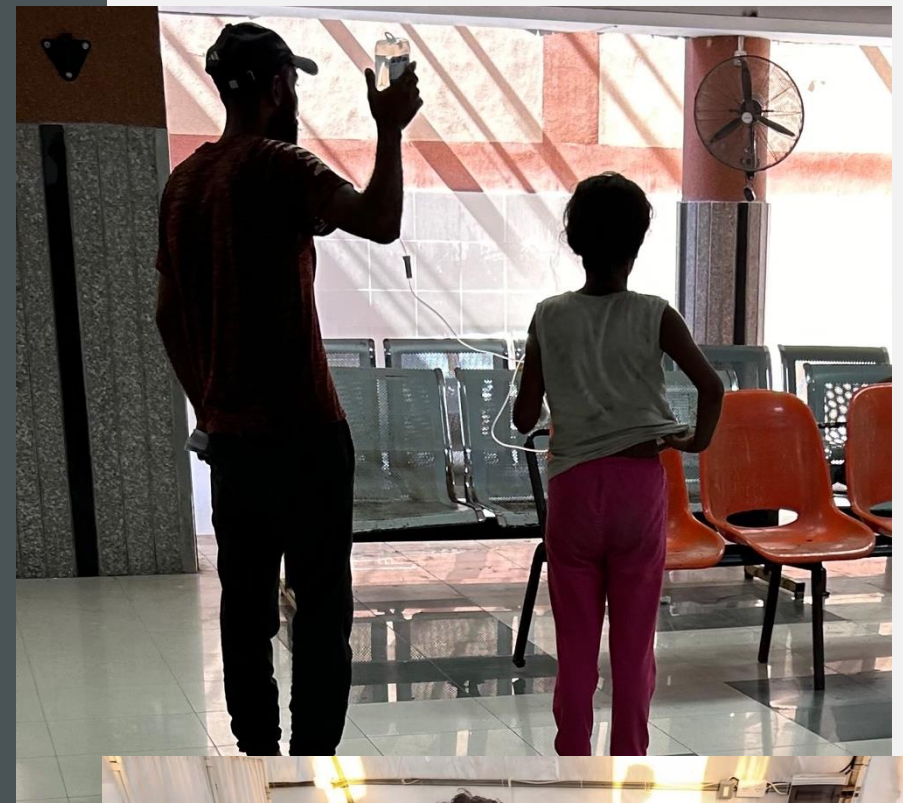


LIMITATIONS OF WESTERN PSYCHIATRY IN GENOCIDE SETTINGS

- Individualized care misaligned with collective trauma
- Assumes privacy, safety, and continuity — absent in active war
- Medicalizes suffering instead of honoring survival responses
- Trauma protocols ineffective during ongoing atrocities
- Culturally disconnected from faith, community, resistance narratives

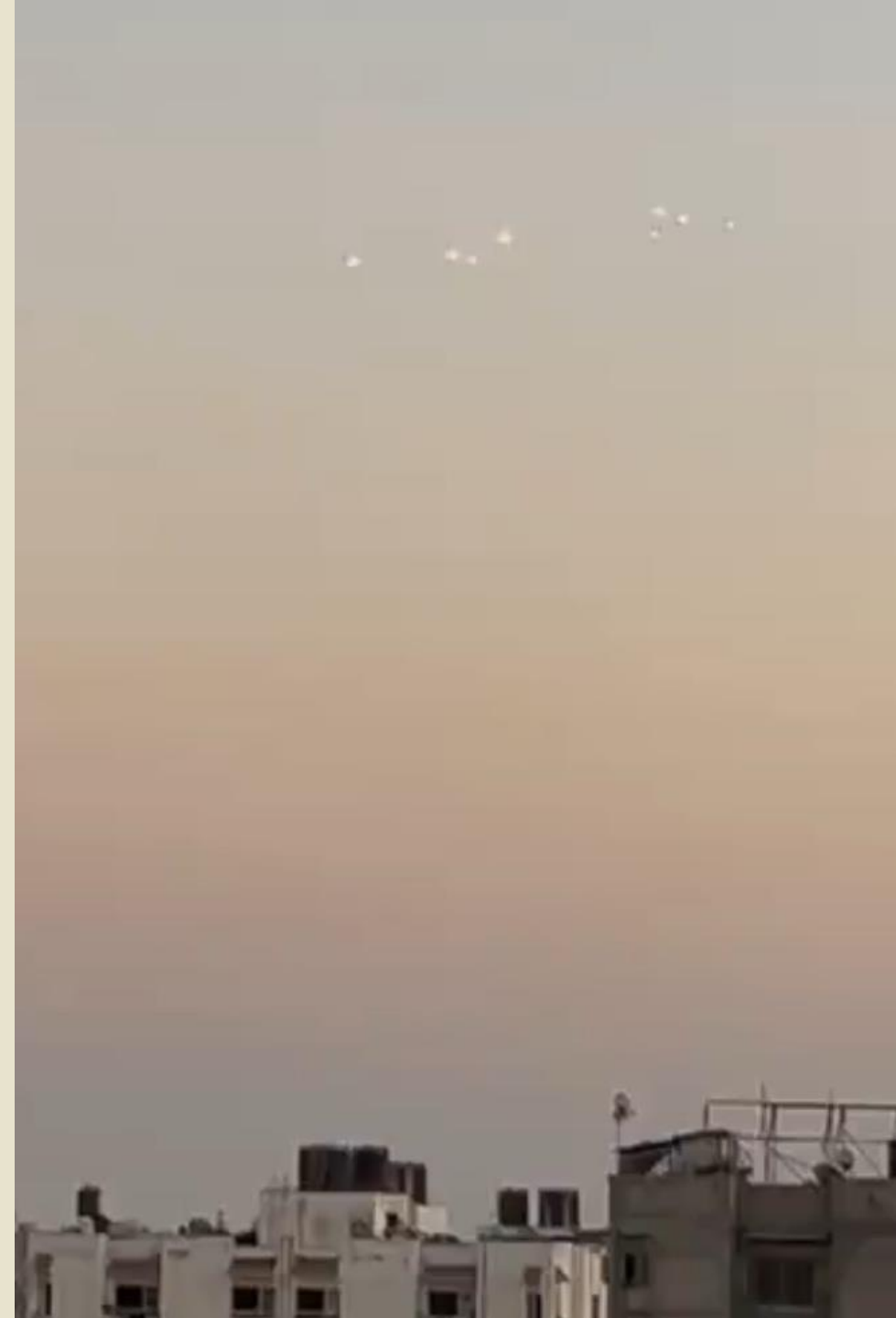
MENTAL HEALTH–SURVIVAL HYBRID MODELS

- * Prioritize function and survival, not symptom elimination
- * Embed psychological support into survival efforts
- * Leverage faith, spirituality, and cultural coping
- * Flexible, rapid, community-based interventions
- * Build peer support networks and train non-specialists



RETHINKING PSYCHIATRIC PRACTICE IN GENOCIDE

- “Traditional” doesn’t apply in unprecedented destruction
- Need for:
 - Culturally rooted frameworks
 - Collected trauma interventions
 - Mental health-survival hybrid approaches





THANK YOU / Q&A

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Welcome collaboration