

# Do victims of violence need psychodynamic treatment?

**Yöke Rabaia, Viet Nguyen-Gillham & Rita Giacaman**

We wish to thank the editors of *Intervention* for the opportunity to comment on the article by Gaboulaud, et al. (2010): ‘Psychological support for Palestinian children and adults: an analysis of data from people referred to Médecins Sans Frontières programme for behavioural and emotional disorders in the occupied Palestinian territory’, in this issue. Gaboulaud, et al. present data related to a programme they conducted in the occupied Palestinian territory between November 2000 (the beginning of the second Palestinian uprising also known as ‘the second intifada’ or the ‘Aqsa intifada’) and January 2006 (when the Islamic movement Hamas won the democratic, Palestinian elections). The analysis of the data leads them to conclude that ‘*this type of individual psychological support [brief psychodynamic psychotherapy] can be a useful complement to a psychosocial approach at the community level.*’

We would like to offer four main comments related to selected conceptual and methodological issues in the article. The first pertains to the highly questionable usefulness of individual psychological therapy in a situation of collective distress.

In our reading of the data presented in the article, the most striking complaints appear to be ‘*fear*’ and ‘*sadness*’ (25.5% and 16.4%, respectively) as well as, for a quarter of the children, ‘*bedwetting*’. Given that the programme ‘was carried out during the conflict, and at the very moment of the *traumatising events*’ (authors’ italics), which are clearly

indicated in their Table 2 as events related to the Israeli occupation, it would appear that the patients who presented for treatment were victims of violence, rather than people with a psychological disorder.

The diagnoses of anxiety, mood, posttraumatic stress, and other psychiatric disorders used, are based on the DSM IV. The problem with using both the DSM III and the DSM IV in this context is that symptoms listed for some of the major disorders are not contextualised and allow an exclusion only in the case of bereavement. Even then the exclusion is only for a period of up to 2 months, when such symptoms are considered ‘*normal*’. The DSM’s narrow criteria risks the diagnosis of high numbers of false positives (Horwitz & Wakefield, 2007). One can question if the implementation of this programme, during a time of traumatising events, may have led to over-diagnosis and the pathologising of Palestinians as ‘*suffering from a disorder*’, when in fact, they were suffering from normal ‘*sadness*’ or justifiable ‘*fear*’. This bio-medicalised approach tends to fuse social suffering and misery with psychiatric symptoms, which can then be relieved through individual therapy. However, given the life events listed in their Table 2, this population had understandable reasons for feeling sad or afraid, and would likely have re-adjusted with time and normal support from family and community. The danger of labelling social suffering as a disorder lies not only in that it can, and does, lead to

inappropriate treatment modalities (such as therapy, or the provision of medication), but it can also obscure the cause of suffering, i.e. violation and injustice. At the same time, individual based therapies draw interventions away from addressing the root cause of this suffering; Israeli military occupation of Palestinian land and the restoration of justice.

Secondly, the methodology section of the article raises important questions and doubts about the appropriateness of the methodologies used. Such as, at both the theoretical and practical levels, for example, what does *'expatriate therapists with cultural competence'* mean? Why did the authors choose to use certain instruments and not others, namely, the Global Assessment of Functioning and the Children's Global Assessment scales? Were these instruments translated (not semantically, but for conceptual equivalence), piloted and adapted to the local context?

We share the authors' hesitation to ascribe the observed improvement of 80% of the patients to the therapy. In the authors' words; *'we do not know whether the observed reduction in symptoms can be attributed to the therapeutic intervention alone. It is possible that other factors, such as natural or spontaneous recovery, or changes in context have played a role.'* Given the lack of appropriate evaluation, we query if and how individual psychodynamic therapy might have contributed to the observed reduction in symptoms at all.

The authors do not deny that a psychosocial approach at the community level is important. Their point is that the psychodynamic therapy can be a useful complementary approach. However, it is unclear what their model of psychosocial assistance was, and so we are left to accept on trust that the individual psychodynamic therapy was a complementary technique. The question that still

remains is how, and to what extent, does psychodynamic psychotherapy lend itself or can it be adapted to the treatment of *'people suffering from normal fear or sadness'*?

Aside from the reservation regarding the mechanism of *'improvement'* of about 80% of the *'patients'*, the third point is related to the 20% who did not improve. These may have been exactly the population who really needed individual treatment, and in that sense we are surprised that the authors failed to engage with the question of why the psychodynamic therapy did not help them. Given the fact that MSF's mandate was to provide medical and psychological care to those affected by the violence and lacking medical support, we would like to know how they cared for the patients who did not respond to their treatment.

To conclude, we would like to refer to the authors' statement that *'those programmes that address the consequences of violence on an individual and community level should have two objectives. One, at an individual level, the programme must support and facilitate the process of the traumatised individual to reconnect to his/her environment, community and culture. At a community level, the programme needs to create an environment that facilitates the reintegration of individuals, or rather groups of traumatised individuals (De Jong, Komproe & Ommeren, 2003).'*

We would like to add another objective, that such programmes must have a capacity building factor as well as a measure of sustainability (Batniji, Rabaia, Nguyen-Gillham, Giacaman, Sarraj, Punamaki, Saab & Boyce, 2009).

The article describes the therapists working with translators, but makes no mention of training local counsellors or therapists in the course of this intervention programme. Although we are not entirely convinced that

this particular individual psychodynamic treatment modality was useful, we do not deny that there is a serious need and room within the Palestinian society for professional counsellors and psychologists. (Giacaman, 2004) As such, any international organisation working in the mental health field must ensure that they offer an intervention that includes not only a capacity building component, but also a sustainability and viable exit strategy.

## References

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*Yóke Rabaia conducts research at the Institute of Community and Public Health of Birzeit University, occupied Palestinian territory. email: ymeulen@gmail.com*

*Dr Viet Nguyen-Gillham is an expert in community based psychosocial work and worked at the Institute of Community and Public Health, Occupied Palestinian territory, in the period 2004–2008.*

*Dr Rita Giacaman is Professor and Programme Coordinator at the Institute of Community and Public Health of Birzeit University*