

# When words are not enough . . . psychodynamic psychotherapy in chronic conflict settings

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The field of mental health and psychosocial support is now globally recognised as a valid element of humanitarian aid. Médecins Sans Frontières has been a leader in this work for many years. On reflecting on the article by Gaboulaud et al. (2010), we pose the following questions (detailed below): How would psychodynamic psychotherapy have to be adapted to the Palestinian context? What is the role of interpreters? How effective and sustainable was the work?

## **How was psychodynamic psychotherapy adapted to the Palestinian context?**

It was a brave step by the authors to put psychodynamic psychotherapy under investigation. One question that arises is why this form of therapy was identified as the most appropriate intervention for this particular population? The therapeutic techniques of psychodynamic psychotherapy are based on interpretation, the conscious interplay with the unconscious, transference, counter-transference and the emphasis of developmental experiences shaping adult personality. A tantalising reference is made to the object relations school of Winnicott, who emphasised the relationship between the mother and child, but how do these dynamics work with the primary presenting issues (bed wetting, fear, etc) in the context of chronic conflict in the occupied Palestinian territory?

Within an Arab context, the western concept of 'I' as an autonomous separate individual is more likely to be 'we'. Networks and systems of interpersonal family, tribal and civil relations are more collectively understood in the Arab culture. Working with individuals may not be reflective of Arab culture: even if it does not stigmatise the individual, it does focus attention on a 'problem' being with the individual, rather than a reflection of the overall social and political contextual environment. Moreover, psychodynamic psychotherapy is based on the principles that difficulties experienced in adult life originate in childhood and that methods of adaptation to deal with childhood difficulties may no longer be effective for an adult. So it would be highly relevant to learn how this core principle has been adapted, especially in working with children as young as four years of age. For readers, it would also be interesting to have a description of the team training, of the adaptation process of the instruments, and of the discharge requirements. In general: what trans-cultural adaptations were made, and on what basis and how?

## **What was the role of the therapist and interpreter?**

Psychodynamic psychotherapy relies on the interpersonal client/therapist relationship more than other forms of depth psychology.

However, neither the role of the therapist, nor the role of the interpreter are mentioned in this work. This is perhaps even more relevant given the importance of literal interpretation and ‘free association’. For a therapy that is based on the conviction that life issues and dynamics will re-emerge within the context of the client/therapist relationship as *transference* and *counter-transference*, a core component of this article should include a discussion of the dynamics of using an interpreter. In particular, when one also has the ownership of the history and the story of the occupied Palestinian territory within those dynamics. The working *dyad* (client/therapist) becomes a *triad* of three. The interpreter is the point of transference and counter-transference and not the therapist. Yet, the interpreter remains a non-person in the article. Did the interpreter receive any specific training? How is the supervision structured to include the interpreter? Was the therapeutic model adapted in consideration of this triad?

### **Was the therapy useful for all?**

The limitations of the therapy were well elucidated though the article would have benefited from some reflective comments on other variables. All individuals were eligible for therapy, though there is no mention of what percentage were felt to be inappropriate for the rigours of psychodynamic therapy and what other service might have been made available. We miss a comparative analysis of (non/other) treatment results. We would be interested to know how much the authors attribute improvements to psychotropic drugs, therapeutic techniques, or the therapeutic relationships? What were the main reasons for ending therapy? Were

there any involvement and/or hand-over to other social support services? This kind of intervention may be both more sustainable, and probably more accessible, if it was integrated into the primary health services. In small communities, to have home visits can lead to stigma, misinformation and gossip of ‘*problem families*’. Therefore, it is important for the authors not to point to the Intifada as a reason for the populations’ sufferings and stress. The approach and framework appears not to encourage client participation or empowerment. The client is profiled as completely passive. And if there is one thing Arabs are not, it is completely passive. . .

### **Reference**

- Gaboulaud, V., Reynaud, C., Moro, M.R., Roptin, J., Lachal, C., Brown, V. & Baubet, T. (2010) Psychological support for Palestinian children and adults: an analysis of data from people referred to the Médecins Sans Frontières programme for behavioural and emotional disorders in the occupied Palestinian territory. *Intervention 8*: this issue.

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