Sleeping on the Enemy's Couch:

Psychotherapy across Ethnic Boundaries in Israel

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Abstract

This paper discusses the impact of the Jewish-Arab conflict on overt and covert layers of therapeutic encounters that take place across boundaries between the two nationalities. We refer mainly to the prevalent case of Arab patients treated by Jewish therapists. We discuss the implications of intergroup tension, cultural differences, and status disparities on the therapeutic dynamics. Our focus is on the effect of these variables on the processes of transference and counter-transference, on perceptions and interpretations of behaviors, on sources of resistance, and on the inability of therapists to take the patients' perspective. Side by side with the psychoanalytical approach, the article utilizes various social-psychological theories, mainly social identity theory, in deriving insights regarding tensions between the interpersonal/therapeutic dimension and the intergroup dimension. Recommendations for improving therapies in the discussed case are suggested.

Key words: Psychotherapy, ethnic mismatch, transference, Jewish-Arab conflict, Social Identity Theory.

Introduction

This paper deals with issues that arise in connection with therapy across boundaries between the Jewish majority and the Palestinian-Arab minority in Israel, emphasizing the impact of the conflict between the two groups on overt and covert layers of the therapeutic process. We focus here on the more prevalent case of Jewish therapists (who constitute part of the stronger and higher-status group) and Palestinian-Arab patients (who are part of the

weaker and lower-status group). As will be argued hereafter, this issue is a fairly complex state of affairs because the asymmetry inherent in the therapist-patient relationship is confounded by an asymmetry resulting from several other factors, of which the major ones are therapist-patient ethnic mismatch (Sue, 1998; Flaskerud, 1990; Karlsson, 2005; Farsimadan, Draghi-Lorenz, & Ellis, 2007) and power and status disparities between their two respective groups (Tajfel, 1982; Turner, 1985; Rouhana & Fiske, 1995; Maoz, 2000; Suleiman, 2004). To simplify the discussion, we will disregard many social identities of therapists and patients, including gender and religious identities, and focus solely on the patient-therapist ethno-national mismatch.

Side by side with the psychoanalytical discussion, we will refer to social psychology theories and research results, particularly those dealing with collective identities and intergroup relationships in situations of conflict. We will discuss, in detail, several biases among therapists and patients deriving from the affiliation of each to a different ethno-national group. We will focus particularly on various sources of resistance by patients and on therapists' difficulty in taking the patients' perspectives.

A major issue we will debate here concerns the tension between the individual therapeutic dimension and the collective intergroup dimension. This deliberation is important because of the particularly strong impact of the collective dimension on the therapeutic dynamics in the case under discussion, as a result of the continuous severe conflict between the Jewish and Palestinian-Arab nations and the existence of two conflicting if not mutually exclusive narratives. In the last part of the paper, we will stress the effect these factors have on the processes of transference and counter- transference.

Major Points of Asymmetry

As stated above, the therapist-patient relationship is asymmetrical by definition. The power and control therapists yield over patients encompass at least three aspects of asymmetry:

(1) therapists determine the rules and limits of the therapeutic situation; (2) the therapeutic relationship is based on the premise that patients constitute the weak, tormented side, seeking help, whereas therapists are the strong, knowledgeable side, capable of helping patients and extricating them from their afflictions; and (3) patients expose themselves, their personal lives, and their inner world to the therapist, whereas therapists, as decreed by the rules of the encounter, mostly conceal such information about themselves (Kitron, 1991).

The asymmetry attributed to ethnic mismatch includes language mismatch, mismatch of norms as well as cultural and social codes, mismatch of interpersonal communication patterns (Haj-Yahia & Roer-Strier, 1999), such as disparate use of body language, and more. We will now discuss language mismatch and incompatible social norms, which we believe constitute major components of ethnic mismatch.

Language Mismatch

The language in which therapeutic discourse is conducted is crucial. The superior status of the Hebrew language in Israel and, by contrast, the inferior status of Arabic, notwithstanding its official status, is uncontested (Brosh, 1993; Amara, 2002; Amara, Mar'i, & Mar'i, 2002). In the therapeutic encounter, when therapists and patients belong to different nationalities (in this case, one is Jewish and the other Palestinian-Arab), therapeutic conversations will be held in the language of the hegemonic group, in this case, Hebrew. Although many Jews claim the choice of Hebrew in such circumstances is a practical one, because Palestinian-Arabs mostly speak Hebrew whereas most Jews do not speak Arabic, this argument only serves to reinforce the fact that the Hebrew language has an almost absolute predominance over the Arabic language.

Conducting the therapeutic encounter in Hebrew might make it difficult for Palestinian-Arab patients to express themselves emotionally and might detract from their ability to successfully reveal emotionally charged contents in general and those related to early

childhood experiences in particular. Our interviews with Arab and Jewish therapists, as well as our personal experience, lead us to conclude that Palestinian-Arabs face difficulties in experiencing and expressing their emotions in Hebrew. A recent study on the topic (Nashef & Bar-Hanin, 2010) supports this conjecture, as do many studies on expressing emotions in a foreign language, particularly emotions related to early childhood (see, e.g., Pell et al., 2009; Caldwell-Harris & Aycicegi-Dinn, 2009; Harris et al., 2003). Moreover, a second language might limit one's ability to form free associations and connect with hidden parts of oneself (Basch-Kahre, 1984). When patients are prevented from using their first language, they might have difficulty translating their problems and troubles into words, and as a result, they might feel alienated from the encounter and the therapist, thereby increasing the risk of negative transference (Kitron, 1991). Nonetheless, at times, conducting a therapeutic conversation in a language that is not the patient's first language might have the secondary benefit of creating a sense of distance and thus affording protection from contents that might be experienced as mentally intimidating.

Notably, empirical research on the issue of ethnic and language matching of therapists and patients shows mixed results. Sue et al. (Sue, Fujino, Hu, Takeuchi, & Zane, 1991) collected data on matched and mismatched therapist-patient dyads in the United States. Comparisons between the two types of therapeutic relationships referred to criteria such as length of therapy, rate of dropout after the first session, and outcome of therapy. Among Asiatic Americans, but less so among Mexican Americans, patient-therapist dyads matched for ethnicity or language (or both ethnicity and language) were found to score higher than mismatched dyads on each of the measures explored. Among Afro-Americans, a similar difference was found for length of therapy, but none was found for rate of dropout after the first session or for therapy outcome.

Cultural Mismatch

When treating Palestinian-Arab patients, therapists need to be aware of and sometimes even make allowances for aspects related to cultural norms and values in Palestinian-Arab society. Nashef and Bar-Hanin (2010) mention that in the Arab culture, emotions are considered intimate and are not discussed with or revealed to strangers, especially negative feelings, for which disclosure might be detrimental to the social support available. Social adaptation in traditional Arab society requires keeping one's feelings to oneself and even repressing them. In this society, social awareness and emphases on interpersonal relationships are more important than self-awareness (Nashef & Bar-Hanin, 2010; Dwairy, 1998).

Another cultural distinction is related to authority, including that of the therapist. The custom in traditional Arab society requires one to treat figures of authority with reverence and respect. Thus, therapists must take care to refrain from unnecessarily interpreting signs of authoritarian attitude by Palestinian-Arab patients as indicating an authoritarian personality type. Of course, therapists should not do the exact opposite and attribute all authoritarian behavior to cultural differences; rather, they must be aware of these differences when raising hypotheses about patients' possible problematic attitudes toward figures of authority from early childhood. Dwairy (2006) refers to an interesting issue regarding "authoritarian" transference. He states that in addition to transference deriving from authoritarian relationship patterns in early childhood, relating to therapists as strong authorities might have to do with transference to the national dimension, whereby Palestinian-Arab patients perceive Jewish therapists as representatives of their hegemonic group and respond to them with submission and a sense of inferiority.

Masalha (1999) states that Palestinian-Arab patients, in a manner that resembles patients from similar cultures, often prefer structured and guided therapy to unguided therapy. In this context as well, we believe the main issue is the need to remain aware that such preferences

may exist, and to sometimes even make allowances for them, rather than necessarily design the treatment plan around them.

Power and Status Asymmetry

The two groups discussed here have many features of power and status asymmetry. The Jewish group is the hegemonic group that controls almost all shared resources, as well as decision-making hubs in all fields of life (Suleiman, 2004). By virtue of Israel's definition as a Jewish state, Jewish identity, language, culture, and historical narrative are hegemonic and fully legitimized. By contrast, the status and legitimacy of Palestinian identity and historical narrative, as well as of Arab culture and the Arabic language, are precarious and exist on the margins of the social and cultural space, as a consequence and manifestation of the marginality of Palestinians in Israel (Amara, 2002; Salomon, 2004).

In the context of encounters between Jewish therapists and Palestinian-Arab patients, the power instilled in therapists by virtue of their status in the therapeutic relationship seems to be augmented by an additional source of power as members of the stronger and higher-status group. In such cases, therapists' power may be expected to grow, creating a large disparity within therapist-patient power relations. One possible effect is the reinforcement of the social distance between the therapist and patient, with a subsequent detrimental impact on the quality of care. Much evidence supports this hypothesis. For example, Galinsky et al. (Galinsky, Magee, Inesi, & Gruenfeld, 2006) found a negative correlation between people's sense of power in social relationships and their perspective taking, as measured by Davis's Interpersonal Reactivity Index (Davis, 1983). These researchers also found that subjects manipulated to feel they had lots of power were less capable of recognizing emotions in others' facial expressions, compared to subjects with a neutral manipulation toward power.

Bias in perceptions of the out-group

Various social psychology theories concur in contending that members of the out-group are perceived and treated in a manner characterized by motivational bias and perceptual and cognitive distortion, particularly in situations of intergroup conflict. The social identity theory, developed by Henry Tajfel (e.g., Tajfel, 1982, 1981), as well as the continuum hypothesis (Tajfel & Turner, 1986), predict that in situations of conflict, individuals from the in-group will treat individuals from the out-group as prototypes representative of their group rather than as singular individuals. They perceive members of the out-group as resembling each other, "indistinct items within a uniform social category" (Tajfel, 1981, p. 243). Moreover, they display a large degree of uniformity in their views of the latter and their behaviors toward them. According to the theory, processes such as depersonalization, dehumanization, and stereotypical perception are private instances of a more general phenomenon of "lack of differentiation" between different members of the out-group.

A lot of empirical evidence shows that members of the in-group perceive members of the out-group stereotypically and relate to them in a more negative manner than to members of the in-group. Thus, for example, Howard and Rothbart (1980) found that people formed more positive, complex, and accurate impressions among their peers in the in-group than among their peers in the out-group. Similarly, Otten and Moskowitz (2000) found that people have more positive feelings toward peers from their in-group and expect members of their in-group to share their views and values with them more than members of the out-group (Robbins & Krueger, 2005).

In the therapeutic situation, despite maintaining rules of encounter and the therapeutic contract, hermetically sealing the consulting room and preventing external crisis relationships from interfering with the therapy would be difficult. Stereotypical attitudes by therapists as well as patients are not infrequent, and in fact, it is reasonable to assume that

Palestinian-Arab patients might have difficulty sharing intimate, sensitive, and complex topics with Jewish therapists, concerned as they may be about the therapist's stereotypical inclinations.

Between the individual and the collective

One of the main dilemmas regarding relationships between Jewish therapists and Palestinian-Arab patients concerns the dilemmas created by tension between the interpersonal and the intergroup dimensions. One approach, which we call the "individualist-humanist approach," contends that in the case under discussion, and in therapy involving ethnic mismatch in general, patients' 'otherness," and in particular their different national or ethnic identities, should be disregarded. Instead, the therapist should embrace a "humanist" approach with no group-affiliation stigmas. Conversations with several therapists have shown that Jewish therapists working with Arab patients tend to separate events in the consulting room from the social and political context. Therapists report that some patients prefer this course and that both sides amplify it in times of war and terror attacks, which arouse a great deal of political tension between the two nationalities. In such times, both sides prefer to avoid speaking of events occurring outside the consulting room. One Jewish therapist told us that in such times, she feels that any mention of political issues is potentially explosive and is best left outside the consulting room.

An opposite approach claims that "humanist" attitudes toward a person from another national or ethnic group are deficient if they do not target the whole person; that is, they must be inclusive of the collective parts of the patient's personality, defined by virtue of his membership in a social group with a unique social identity. A fitting attitude toward the patient's collective identity and toward his affiliation with a different social and cultural group might choose to stress the significance of embracing a culturally sensitive approach (Nashef & Bar-Hanin, 2010; Dwairy, 1998; Sue & Sue, 2003). These researchers and others

believe the therapist must be as familiar as possible with patients' social and cultural environments. Such familiarity is most essential for nurturing empathy, as well as for one's ability to take into account the patient's perspective. Moreover, understanding the patient's perspective might help the therapist avoid misguided interpretations prevalent among those not familiar with patients' circumstances. Masalha (1999) states that therapists should take great care when interpreting tardiness that emerges in the context of working with Palestinian-Arab patients; being late to the clinic, particularly when located in an adjacent Jewish city, might be the inevitable consequence of irregular transportation rather than of deeper psychological reasons related to resisting therapy. Dwairy (1998) cautions against interpreting various behavioral manifestations, such as speaking little during therapy, as signs of behavioral and emotional difficulties of patients. He says that speaking sparingly is not necessarily a sign of resistance and that it might be a way of expressing feelings of respect toward the therapist, as is customary in Palestinian-Arab society when people are in the presence of authority figures. Another example, cited by Nashef and Bar-Hanin (2010), is the tendency to avoid expressing emotions, which Western therapists might attribute to emotional difficulties, despite being a normative response in traditional Palestinian-Arab society, where avoiding emotional displays in the presence of others is customary. Nashef and Bar-Hanin (2010) go even further and warn that patients might perceive a therapist's lack of sensitivity to their cultural attributes as a threat against their culture and as the therapist's unconscious enforcement of Western culture.

Contrary to approaches that emphasize the need to develop and embrace a culturally adapted therapeutic model, Masalha (1999) believes that slightly adjusted psychodynamic psychotherapy might also be appropriate for working with Palestinian-Arab patients. Masalha argues that social and cultural variables affect individuals' psychopathology, particularly their behavioral styles and symptoms of pressure and repression. However, in his opinion, although therapists must be culturally sensitive, they should not change

standard techniques to adapt them to their patients' cultural backgrounds. He believes, for example, that efficient treatment is unattainable if therapists formulate patients' psychological problems in medical terms in order to avoid making the patients feel shame. In his opinion, therapists cannot provide full psychodynamic treatment if they abandon techniques of insight or reflection in favor of cultural considerations.

Despite the importance of therapists' cultural sensitivity and of their familiarity with the cultural codes of a patient's society, we emphasize the importance of avoiding excessive use of "intercultural" explanations that might prevent Jewish therapists from helping Palestinian-Arab patients because of their concern about seeming culturally insensitive. A disproportionate use of "cultural" explanations might prevent therapists from using vital transference material to reflect to their patients' styles or patterns characteristic of their behavior. Thus, in the examples cited above, instead of only interpreting the inclination to use words sparingly as a courteous behavior customary within Palestinian-Arab society, therapists can view such behavior as a type of transference of patients' attitudes toward significant authority figures in their lives. Such a view might facilitate better resolution of patients' concerns and anxieties concerning such authority figures. Therapists would miss this possibility if they only attributed the inclination to spare words to cultural differences per se.

Finding the balance between a therapeutic approach focusing on the patients and their needs and sufficiently emphasizing their cultural diversity and that of their society is a complex task requiring thought and situation-dependent solutions. To illuminate the various dilemmas involved in therapeutic decisions related to this issue, we will refer to the hypothetical case of a Palestinian-Arab student treated by a Jewish therapist for anxieties and adjustment difficulties. In intake sessions, she presents as anxious, shy, and unassertive. Constructing a suitable treatment plan for such a patient would require a focus on personal empowerment,

as well as on the patient's anxieties and adjustment difficulties, while remaining aware of and sensitive to social rules and norms governing women within Palestinian-Arab society. An approach that overemphasizes cultural sensitivity would risk attributing the patient's shyness and lack of assertiveness to her cultural background and would not do enough to help her cope with them. By contrast, on the other extreme, the therapist could suggest to the patient methods of self-empowerment and of coping with repressive figures in her close and more distant environment, while disregarding possible implications of embracing a rebellious behavioral style for the patient's social relationships as well as potential negative mental consequences of intensifying her conflict with the social environment. The first option might retain the patient's "inner struggle" as the price of sustaining her "ceasefire" with society. By contrast, the second option might generate an "inner peace," at the same time sowing the seeds of an arduous struggle with her external environment, which might in turn have a negative effect on her mental state. A third option, which seems the most desirable, is to construct a treatment plan directed, among other things, at personal empowerment of the patient and reinforcing her self-confidence and assertiveness, while equipping her with tools and behavioral styles that might help her manage potential conflicts with her environment in a manner that stresses a negotiating approach rather than an aggressive and contrarian approach.

Moreover, balancing therapeutic needs and intercultural aspects may require therapists to employ flexibility and creativity in constructing the treatment plan. For example, the possibility of combining personal therapy with family therapy in which major figures in the patient's social environment might be recruited in support of the treatment plan should be considered.

Another point related to the issue under discussion involves the goals of the therapy. Masalha (1999) states that therapists who work with Western patients might discover their

main role is to help their patients establish relationships with significant others in their life, including family and community members; however, therapists who work with non-Western populations will often discover their main role is to help patients uncover their individualism. Masalha contends that many patients enter the therapeutic relationship carrying the heavy burden of family commitments. In his opinion, therapists must help patients relieve themselves of this burden by identifying their personal needs and aspirations. Sue and Sue (2003) state that patients who belong to minority groups and to disadvantaged sectors are usually interested in finding short-term rather than long-term solutions. In addition, patients who belong to these groups mostly need help with solving realistic problems, such as those related to housing difficulties, financial support, complications with educational and social institutions, and so on, and receiving help with solving such problems is often a requisite for creating appropriate conditions for initiating psychological treatment (Nashef & Bar-Hanin, 2010). Cultural insensitivity and lack of familiarity with the patient's social environment might lead to misinterpretation of traits such as helplessness, dependence, or feelings of inferiority, and the attribution of such traits to states of depression, insensitivity, or passive resistance, while they may in fact be related to difficult socioeconomic circumstances and financial hardships (Nashef & Bar-Hanin, 2010; Sue & Sue, 2003).

Therapy as a place of encounter between conflictual narratives

One of the important features of therapeutic encounters featuring Jewish therapists and Palestinian-Arab patients, or vice versa, is that both sides belong to groups that are in the midst of a continuous intractable conflict (Bar-Tal, 1993; Bar-Tal, 2000). In such circumstances, contradictive conflictual collective narratives underlie the realistic conflict between the two groups (Salomon, 2004). The collective narrative is how group members perceive historical events, beliefs, or images of their in-group and out-group. One of the

major implications of the collective narrative in situations of conflict is the delegitimization of the collective narrative of the conflictual out-group (Salomon, 2004). Group members' commitment to their collective narrative, as well as the intensity of their disagreement and contradiction, are particularly prominent in times of crisis, such as violent confrontations between Jews and Palestinians in Israel or in the occupied territories, or armed conflict between Israel and neighboring Arab countries (Salomon, 2004; Abu Heim, Quota, Thabet, & El Sarraj, 1993). The tension between the collective narratives will presumably be manifested in therapeutic interactions between therapists and patients belonging to the two nationalities as well. This tension may find expression in disparaging or insensitive attitudes toward historical events central to others, such as the Holocaust on the one hand, and the Nakbah, on the other, or in use of terms and definitions that may sound "natural" and obvious to one side but might be experienced as exclusionary or hurtful by the other. In this context, Nashef and Bar-Hanin (2010) offer several interesting examples. They mention Jewish therapists or instructors who use the term "minorities" to refer to Palestinian citizens of Israel, a usage that might upset Palestinian-Arab patients. Another example is the Jewish tendency to use the term "territories" or "Judea and Samaria" rather than "occupied territories" or the term "terrorist" rather than "fighter." As stated, using such diverse and even conflicting terms derives from the existence of two contradictive narratives. Such usage might lead to feelings of alienation, suspicion, anger, or mistrust in the therapist-patient relationship.

Transference and counter-transference in ethnically mismatched patient-therapist dyads

Both therapist and patient bring with them to the therapeutic interaction a wide range of personal and social identities, each of which can influence the therapeutic dynamics. Aside from therapists' professional-therapeutic identity and idiosyncratic personality traits, they

also belong to a certain group defined by nationality, gender, religion, socioeconomic status, and more. Similarly, patients bring, aside from their personal identity, a variety of social identities. Thus, the encounter between therapist and patient, motivated by providing support and professional mental help, is in fact also an encounter between myriad identities with many complex interactions.

According to this conception, encounters between Jewish therapists and Palestinian-Arab patients are not only encounters between people seeking professional mental help and professionals authorized to provide it, but also between Jews and Palestinian-Arabs. This fact has significant implications for the development of a therapeutic relationship based to a large degree on trust. Even if one can assume Palestinian-Arab patients will attempt to avoid the dissonance deriving from the national identity of a Jewish therapist, the success of such attempts will probably be only partial, and the therapist's national identity will remain present, whether consciously or unconsciously. Such a process of transference to the dimension of national identities might be detrimental to patients' trusting and open relationship with their therapist (Nashef & Bar-Hanin, 2010). The emergence of such mistrust might impede the possibility of positive transference and thus significantly hinder treatment progress.

A deep process of transference to the dimension of national identities is more probable in circumstances of enhanced intergroup conflict, which may potentially divert all interaction between Jews and Palestinian-Arabs from the interpersonal to the intergroup (Tajfel & Turner, 1986). Patients who are strongly aware of their own components of collective identity and those of the therapist might treat their therapist as a representative of his nationality and project onto him all their stereotypical schemes of this nationality. As a result, the stereotype of the therapist's collective identity might overshadow his individual identity, that is, his patients' perception of him as an individual. The emergence

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of such a process of transference might have a disruptive impact on the therapeutic relationship.

The effect of the national-collective dimension on the therapeutic interaction is relevant for processes of counter-transference as well. Yet another type of counter-transference may derive from the therapist's cultural insensitivity or unfamiliarity with the patient's social and cultural climate. Such insensitivity or disregard might result in a process of counter-transference whereby therapists work according to standards suitable for their own society and culture but not for those of the patient. Moreover, therapists might misattribute patients' views and emotional responses. Thus, for example, Jewish therapists might interpret dependence of Palestinian-Arab patients on their family as a problem with de-individuation, emotional immaturity, or regressive tendencies, whereas in fact, it might constitute fairly normative behavior in Arab society.

Another type of counter-transference is related to the political views of Jewish therapists regarding the Israeli-Palestinian conflict. Jewish therapists on the left side of the political continuum would probably interpret complaints voiced by Arab patients regarding racial slurs aimed at them and at Palestinians in general as stemming from a factual situation and expressing authentic views and feelings. By contrast, Jewish therapists on the right side of the political continuum may interpret the same as manifestations of transference, unrealistic anxieties, rationalizations, and the like. We believe that focusing on the individual self of Palestinian-Arab patients, in complete disregard of their national- collective self, constitutes a type of counter-transference expressing therapists' indifference toward a major component of patients' identity and their inability to treat patients as whole individuals.

We recommend treating questions related to patients' national identity as a legitimate subject in and of itself rather than a pattern of defensive reaction to threatening intimate

content. Explicit attention to the dimension of collective identity makes it possible to work with the transference process as applicable to stereotypical perceptions of Palestinian-Arab patients by Jewish therapists. In addition, in contrast to the classical approach that interprets patients' attitudes toward the subject of collective identity as expressing contents related to their inner world, or as transference relationships, we maintain that relating to the realistic context of the identity issue as well is necessary. Basch-Kahre (1984) takes a similar stance and states that therapists who work with patients belonging to different ethnic groups than their own must not hurry to interpret different behaviors as manifestations of transference that are considered normative behaviors in patients' cultures. In most cases, working with such materials and learning to perceive realistic expressions of the identity issue might help Palestinian-Arab patients understand that their problems are at least partially linked to their status as excluded and discriminated minorities. In addition, working with such materials is a way of awarding patients hegemonic recognition with the power to constitute a platform for therapeutic dialogue. Often, after attaining such recognition, patients seem more capable of dealing with their problems and personal lives.

Summary and concluding remarks

This paper discusses therapeutic encounters across conflictual boundaries between the Jewish majority and the Palestinian-Arab minority in Israel. One of the major dilemmas with which the paper deals refers to the tension in ethnically mismatched patient-therapist dyads between the interpersonal/therapeutic dimension and the intergroup dimension. Besides the theoretical value in discussing this intriguing situation, the present analysis has a practical value, because the discussed case of an adult Palestinian-Arab client and Jewish therapist is the most encountered situation. Palestinian-Arabs in Israel will mostly seek out Jewish therapists. This preference could be attributed to two main reasons: First and foremost, in a society where "mental problems" are strong negative stigmas, mental-help seekers will suspect

that attending a Palestinian therapist's clinic in their hometowns might attract notice, leading to their stigmatization as "mentally disturbed" or even "crazy." Second, because the practice of clinical psychology is relatively new among Palestinian-Arabs, the number of professional experts in the field is very small, which makes a Jewish accredited therapist a better choice, despite the language barrier and the ethnic difference.

As mentioned in the introduction, in the present analysis, we chose to ignore diversity of the national groups to which the "Jewish therapist" and the "Palestinian-Arab client" belong. We are aware of the significance of gender, religious, and other identities on the interactions taking place in the discussed therapeutic setting. Nonetheless, we believe that the juxtaposition of more identities on the interaction between the role identity (therapist/client) and the national identity (Jewish/Palestinian) would have added considerable complexity. We contend that the discussed dimensions and the complexity of their interaction justify the choice made, particularly in a first attempt to analyze the therapeutic setting discussed in the paper from the perspective of social identity theory and the social psychology of intergroup relations.

On the practical side, we caution that over-focusing on the interpersonal dimension, while disregarding the "otherness" of patients who belong to a different ethno-national group (the individualist-humanist approach), is a deficient course of action that might be detrimental to therapists' empathic ability and their capacity to take the patient's perspective. Moreover, it might cause misinterpretation by the therapist because of unfamiliarity with the patient's circumstances. The therapist's insensitivity to patients' social and cultural facets might threaten to erase the patient's culture and unconsciously enforce the therapist's Western culture. At the same time, we point to the possible downside of utilizing the culturally sensitive conservative approach, which overemphasizes patients' "otherness." We suggest that excessive use of "cultural" explanations might prevent therapists who belong to different nationalities than their patients from using vital transference material in service of the therapeutic process. Our conclusion on this issue is that a rational approach is

necessary, balancing a therapeutic attitude focusing on patients and their needs with proper consideration of their social and cultural diversity. Importantly, maintaining a balance between treating the personal and treating the collective necessitates the therapist's constant sensitivity and attention. Thus, for example, therapists should avoid situations in which exaggerated efforts to understand and express empathy deprive patients of the possibility to express anger. Besides the therapeutic benefit of expressing anger, being able to express their anger and frustration in the presence of Jewish therapists is particularly important for Palestinian-Arab patients, because in this specific case, Jewish therapists are not only professional authorities, but also representatives of the ruling Jewish majority. We conclude with the understanding that the encounter between therapist and patient also constitutes an encounter between multiple identities and the many complex interactions between them, with significant implications for the emergence of a therapeutic relationship, based as it is to a large degree on trust.

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