Peace and Conflict: Journal of Peace Psychology

Sleeping on the Enemy's Couch: Psychotherapy Across Ethnic Boundaries in Israel

Ramzi Suleiman and Yifat Agat-Galili

Online First Publication, January 12, 2015. http://dx.doi.org/10.1037/pac0000072

Peace and Conflict: Journal of Peace Psychology

1078-1919/15/$12.00 http://dx.doi.org/10.1037/pac0000072

Sleeping on the Enemy's Couch: Psychotherapy Across Ethnic Boundaries in Israel

Ramzi Suleiman
University of Haifa and Al Quds University

Yifat Agat-Galili
University of Haifa

This article discusses the impact of the Jewish−Arab conflict on overt and covert layers of therapeutic encounters that take place across boundaries between the 2 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. We focus on the effect of these variables on the processes of transference and countertransference, 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, we use various social-psychological theories, mainly social identity theory, to derive insights regarding tensions between the interpersonal/therapeutic dimension and the intergroup dimension. Recommendations for improving therapies in the case discussed are suggested.

Keywords: psychotherapy, ethnic mismatch, transference, Jewish−Arab conflict, social identity theory

This article deals with issues that arise in 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 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). We argue that 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 other factors, of which the principal ones are the therapist−patient ethnic mismatch (S. Sue, 1998; Flaskerud, 1990; Karlsson, 2005; Farsimadan, Draghi-Lorenz, & Ellis, 2007) and the power and status disparities between the two groups (Tajfel, 1982; Turner, 1985; Rouhana & Fiske, 1995; Maoz, 2000; Suleiman, 2004). To simplify the discussion, we disregard many social identities of therapists and patients, including gender and religious identities, and focus solely on the patient−therapist ethnonational mismatch.

Side by side with the psychoanalytical discussion, we will discuss social psychology theories and research results, particularly those dealing with collective identities and intergroup relationships in situations of conflict. We will detail several biases among therapists and patients deriving from their affiliations with different ethnonational groups. We will focus particularly on various sources of patients' resistance and on therapists' difficulty in taking patients' perspectives.

We will assess the tension between the individual therapeutic dimension and the collective intergroup dimension. This deliberation is important because of the particularly strong im-

RAMZI SULEIMAN is a professor at the Department of Psychology, University of Haifa, and an adjunct professor at the Department of Philosophy, Al Quds University. He holds a PhD in psychology and an MSC in electrical engineering. His research interests include the study of social identity and intergroup behavior, cooperation, fairness, and relativity and astrophysics.

YIFAT AGAT-GALILI completed her MA in clinical neuropsychology at the University of Haifa, where she serves as a research assistant.

WE THANK the editor and three anonymous reviewers for helpful remarks.

CORRESPONDENCE CONCERNING THIS ARTICLE should be addressed to Ramzi Suleiman, Department of Psychology, University of Haifa, Haifa 31905, Israel. E-mail: Suleiman@psy.haifa.ac.il

pact of the collective dimension on the therapeutic dynamics in the case under discussion, as a result of the continuous and severe conflict between the Jewish and Palestinian−Arab nations and the existence of two conflicting if not mutually exclusive narratives. Finally, we will examine the effect these factors have on the processes of transference and countertransference.

Major Points of Asymmetry

The therapist−patient relationship is asymmetrical by definition. The power and control therapists yield over patients encompass at least three aspects of asymmetry: (a) therapists determine the rules and limits of the therapeutic situation; (b) 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 (c) 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, norms as well as cultural and social codes, and interpersonal communication patterns (Haj-Yahia & Roer-Strier, 1999), such as disparate use of body language. In the next two sections, we 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, 2002). In the therapeutic encounter, when therapists and patients belong to different nationalities (in this case, one is Jewish and the other is 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 in Israel, 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 experiences, have led 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) has supported 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 & Ayçiçeği-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 ethnic and language matching of therapists and patients has shown mixed results. S. Sue, Fujino, Hu, Takeuchi, and Zane (1991) collected data on matched and mismatched therapist−patient dyads in the United States. The two types of therapeutic relationships were assessed using outcomes measures such as length of therapy, rate of dropout after the first session, and outcome of therapy. Among Asian Americans, but less so among Mexican Americans, patient−therapist dyads matched for ethnicity or language (or both ethnicity and language) scored higher than mismatched dyads on each measure

explored. Among African Americans, a similar difference was found for length of therapy, but not 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 even make allowances for aspects related to cultural norms and values in Palestinian−Arab society. Nashef and Bar-Hanin (2010) noted 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 relates 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 authority figures from early childhood. Dwairy (2006) has referred to an interesting issue on "authoritarian" transference. He has stated 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) has noted 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 even to 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 in Israel 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 status 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 role 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 the patient, with a subsequent detrimental impact on the quality of care. Much evidence supports this hypothesis. For example, Galinsky, Magee, Inesi, and Gruenfeld (2006) found a negative correlation between people's sense of power in social relationships and their perspective taking, as measured by the Interpersonal Reactivity Index (Davis, 1983). These researchers also found that subjects manipulated to feel they had power were less capable of recognizing emotions in others' facial expressions, compared with subjects with a neutral manipulation toward power.

Bias in Perceptions of the Outgroup

Various social psychology theories concur that members of the outgroup are perceived and treated in a manner characterized by motivational bias and perceptual and cognitive distor-

tion, particularly in 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 ingroup will treat individuals from the outgroup as prototypes representative of their group rather than as singular individuals. They perceive members of the outgroup 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 this 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 outgroup.

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

In the therapeutic situation, despite maintaining professional 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 by 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, because they are concerned about the therapist's stereotypical inclinations.

Between the Individual and the Collective

One of the main dilemmas in relationships between Jewish therapists and Palestinian–Arab patients is 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 stigmata. 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 opposing 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 or her membership in a social group with a unique social identity. A fitting attitude toward the patient's collective identity and toward his or her affiliation with a different social and cultural group might emphasize the significance of embracing a culturally sensitive approach (Nashef & Bar-Hanin, 2010; Dwairy, 1998; D. W. 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 essential to nurturing empathy and to 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 a patient's circumstances. Masalha (1999) has noted 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 resist-

ing therapy. Dwairy (1998) has cautioned against interpreting various behavioral manifestations, such as speaking little during therapy, as signs of behavioral and emotional difficulties of patients. He has noted 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) went even further and warned that patients might perceive a therapist's lack of sensitivity to their cultural attributes as a threat to 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) has asserted that slightly adjusted psychodynamic psychotherapy might also be appropriate for working with Palestinian−Arab patients. Masalha has also argued 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 adapt standard techniques to their patients' cultural backgrounds. He has contended, for example, that efficient treatment is unattainable if therapists formulate patients' psychological problems in medical terms 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 concerns 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 about 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 in therapeutic decisions related to this issue, we will describe the hypothetical case of a Palestinian−Arab student treated by a Jewish therapist for anxieties and adjustment difficulties. During intake sessions, she presents as anxious, shy, and unassertive. Constructing a suitable treatment plan for such a patient would 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 coping with repressive figures in her close and more distant environment, while disregarding the 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 and reinforcing the patient's 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 to support the treatment plan should be considered.

Another approach involves the goals of the therapy. Masalha (1999) has noted 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 has contended 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.

D. W. Sue and Sue (2003) have argued 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 solving realistic problems, such as those related to housing difficulties, financial support, and complications with educational and social institutions; and receiving help solving such problems is often a prerequisite 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; D. W. Sue & Sue, 2003).

Therapy as a Place of Encounter between Conflictual Narratives

One of the important features of therapeutic encounters involving Jewish therapists and Palestinian–Arab patients, or vice versa, is that both sides belong to groups that are party to a continuous, intractable conflict (Bar-Tal, 1998; 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 ingroup and outgroup. One of the major implications of the collective narrative in situations of conflict is the delegitimization of the collective narrative of the conflictual outgroup (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; Heim, Qouta, 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 exclusionary or hurtful to the other. In this context, Nashef and Bar-Hanin (2010) have offered 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 Countertransference in Ethnically Mismatched Patient−Therapist Dyads

Both therapist and patient bring 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, various 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 concept, 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 assumes 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 collective identity and those of the therapist might treat their therapist as a representative of his or her nationality and project onto the therapist all the stereotypical schemes of this nationality. As a result, the stereotype of the therapist's collective identity might overshadow his or her individual identity, that is, his or her patient's perception of the therapist as an individual. The emergence 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 countertransference as well. Yet another type of countertransference 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 countertransference 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 the dependence of Palestinian−Arab patients on their families as a problem with deindividuation, emotional immaturity, or regressive tendencies, whereas, in fact, it might constitute fairly normative behavior in Arab society.

Another type of countertransference 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 as 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, with complete disregard for their national collective self, constitutes a type of countertransference 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 as 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 is necessary as well. Basch-Kahre (1984) took a similar stance and argued that therapists who work with patients belonging to ethnic groups different from 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 article has discussed therapeutic encounters across conflictual boundaries between the Jewish majority and the Palestinian−Arab minority in Israel. One of the major dilemmas with which we have dealt refers to the tension in ethnically mismatched patient−therapist dyads between the interpersonal/therapeutic dimension and the intergroup dimension. Besides the theoretical value of discussing this intriguing situation, the present analysis has a practical application, because the hypothetical case we presented, of an adult Palestinian−Arab client and Jewish therapist, is a common situation. Palestinian−Arabs in Israel mostly seek out Jewish therapists. The basis for this preference could be attributed to two circumstances: First, in a society where "mental problems" have a strong negative stigmata, people seeking mental health support will suspect that attending Palestinian therapists' clinics 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 Palestinian or Arab professional experts is very small, which makes an accredited Jewish therapist a better choice, despite the language barrier and the ethnic difference.

As we mentioned in the Introduction section, 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 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 add considerable complexity. We contend that the discussed dimensions and the complexity of their interaction justify our choice, particularly in a first attempt to analyze the therapeutic setting we discuss from the perspective of social identity theory and the social psychology of intergroup relations.

On the practical side, we caution that overfocusing on the interpersonal dimension, while disregarding the "otherness" of patients who belong to a different ethnonational 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 have pointed to the possible downside of using the culturally sensitive conservative approach, which overemphasizes patients' "otherness." We suggest that excessive use of "cultural" explanations might prevent therapists who belong to nationalities different from their patients from using vital transference material in the therapeutic process. Our conclusion 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 necessi-

tates 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 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. 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.

References

Amara, M. (2002). The place of Arabic in Israel. *International Journal of the Sociology of Language, 158,* 53–68.

Amara, M., & Mar'i, A. R. (2002). *Language education policy: The Arab minority in Israel*. Dordrecht, The Netherlands: Kluwer Academic Publishers.

Bar-Tal, D. (1998). Societal beliefs in times of intractable conflict: The Israeli case. *International Journal of Conflict Management, 9,* 22–50. http://dx.doi.org/10.1108/eb022803

Bar-Tal, D. (2000). From intractable conflict through conflict resolution to reconciliation: Psychological analysis. *Political Psychology, 21,* 351–365. http://dx.doi.org/10.1111/0162-895X.00192

Basch-Kahre, E. (1984). On difficulties arising in transference and counter-transference when analyst and analysand have different socio-cultural backgrounds. *International Review of Psycho-Analysis, 11,* 61–67.

Brosh, H. (1993). The influence of language status on language acquisition: Arabic in the Israeli setting. *Foreign Language Annals, 26,* 347–358. http://dx.doi.org/10.1111/j.1944-9720.1993.tb02291.x

Caldwell-Harris, C. L., & Ayçiçeği-Dinn, A. (2009). Emotion and lying in a non-native language. *International Journal of Psychophysiology, 71,* 193–204. http://dx.doi.org/10.1016/j.ijpsycho.2008.09.006

Davis, M. H. (1983). Measuring individual differences in empathy: Evidence for a multidimensional approach. *Journal of Personality and Social Psychology, 44,* 113–126. http://dx.doi.org/10.1037/0022-3514.44.1.113

Dwairy, M. (1998). *Cross-cultural counseling: The Arab Palestinian case*. New York, NY: Haworth Press.

Dwairy, M. (2006). *Counseling and psychotherapy with Arabs and Muslims: A culturally sensitive approach.* New York, NY: Teachers College Press.

Farsimadan, F., Draghi-Lorenz, R., & Ellis, J. (2007). Process and outcome of therapy in ethnically similar and dissimilar therapeutic dyads. *Psychotherapy Research, 17,* 567–575. http://dx.doi.org/10.1080/10503300601139996

Flaskerud, J. H. (1990). Matching client and therapist ethnicity, language, and gender: A review of research. *Issues in Mental Health Nursing, 11,* 321–336. http://dx.doi.org/10.3109/01612849009006520

Galinsky, A. D., Magee, J. C., Inesi, M. E., & Gruenfeld, D. H. (2006). Power and perspectives not taken. *Psychological Science, 17,* 1068–1074. http://dx.doi.org/10.1111/j.1467-9280.2006.01824.x

Haj-Yahia, M., & Roer-Strier, D. (1999). On the encounter between Jewish supervisors and Arab supervisees in Israel. *The Clinical Supervisor, 18,* 17–37. http://dx.doi.org/10.1300/J001v18n02_02

Harris, C. L., Aycicegi, A., & Gleason, J. B. (2003). Taboo words and reprimands elicit greater autonomic reactivity in a first than in a second language. *Applied Psycholinguistics, 4,* 561–578.

Hein, F. A., Qouta, S., Thabet, A., & el Sarraj, E. (1993). Trauma and mental health of children in Gaza [Letter]. *British Medical Journal, 306,* 1130–1131. http://dx.doi.org/10.1136/bmj.306.6885.1130-c

Howard, J. W., & Rothbart, M. (1980). Social categorization and memory for in-group and out-group behavior. *Journal of Personality and Social Psychology, 38,* 301–310. http://dx.doi.org/10.1037/0022-3514.38.2.301

Karlsson, R. (2005). Ethnic matching between therapist and patient in psychotherapy: An overview of findings, together with methodological and conceptual issues. *Cultural Diversity and Ethnic Minority Psychology, 11,* 113–129. http://dx.doi.org/10.1037/1099-9809.11.2.113

Kitron, D. (1991). Transference and countertransference implications of psychotherapy conducted in a foreign language [Hebrew]. *Sihot/Dialogue: Israel Journal of Psychotherapy, 6,* 67–73.

Maoz, I. (2000). Power relations in intergroup encounters: A case study of Jewish–Arab encounters in Israel. *International Journal of Intercultural Relations, 24,* 259–277. http://dx.doi.org/10.1016/S0147-1767(99)00035-8

Masalha, S. (1999). Psychodynamic psychotherapy as applied in an Arab village clinic. *Clinical Psychology Review, 19,* 987–997. http://dx.doi.org/10.1016/S0272-7358(99)00007-0

Nashef, Y., & Bar-Hanin, T. (2010). The sociopolitical context of therapist−client, supervisor−supervisee relationships in the Jewish−Arab dyad [Hebrew]. In G. Weil (Ed.), *Educational psychology in a multicultural society* (pp. 127–145). Jerusalem, Israel: Israel Publications Department, Ministry of Education.

Otten, S., & Moskowitz, G. B. (2000). Evidence for implicit evaluative in-group bias: Affect-biased spontaneous trait inference in a minimal group paradigm. *Journal of Experimental Social Psychology, 36,* 77–89. http://dx.doi.org/10.1006/jesp.1999.1399

Pell, M. D., Monetta, L., Paulmann, S., & Kotz, S. A. (2009). Recognizing emotions in a foreign language. *Journal of Nonverbal Behavior, 33,* 107–120. http://dx.doi.org/10.1007/s10919-008-0065-7

Robbins, J. M., & Krueger, J. I. (2005). Social projection to ingroups and outgroups: A review and meta-analysis. *Personality and Social Psychology Review, 9,* 32–47. http://dx.doi.org/10.1207/s15327957pspr0901_3

Rouhana, N., & Fiske, S. (1995). Perception of power, threat, and conflict intensity in asymmetric intergroup conflict. *Journal of Conflict Resolution, 39,* 49–81. http://dx.doi.org/10.1177/0022002795039001003

Salomon, G. (2004). A narrative-based view of coexistence education. *Journal of Social Issues, 60,* 273–287. http://dx.doi.org/10.1111/j.0022-4537.2004.00118.x

Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). Hoboken, NJ: John Wiley & Sons.

Sue, S. (1998). In search of cultural competence in psychotherapy and counseling. *American Psychologist, 53,* 440–448. http://dx.doi.org/10.1037/0003-066X.53.4.440

Sue, S., Fujino, D. C., Hu, L.-T., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59,* 533–540. http://dx.doi.org/10.1037/0022-006X.59.4.533

Suleiman, R. (2004). Planned encounters between Jewish and Palestinian Israelis: A social-psychological perspective. *Journal of Social Issues, 60,* 323–337. http://dx.doi.org/10.1111/j.0022-4537.2004.00113.x

Tajfel, H. (1981). *Human groups and social categories: Studies in social psychology*. New York, NY: Cambridge University Press.

Tajfel, H. (1982). Social psychology of intergroup relations. *Annual Review of Psychology, 33,* 1–39. http://dx.doi.org/10.1146/annurev.ps.33.020182.000245

Tajfel, H., & Turner, J. (1986). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *Psychology of intergroup relations* (pp. 7–24). Monterey, CA: Brooks/Cole.

Turner, J. C. (1985). Social categorization and self-concept: A social cognitive theory of group behavior. In J. E. Lawler (Ed.), *Advances in group processes* (Vol. 2, pp. 77–122). Greenwich, CT: JAI Press.