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ORIGINAL PAPER

A First-Person Account of Using Mindfulness as a Therapeutic Tool in the Palestinian Territories

Alessandra Pigni

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Abstract This is a personal account of the clinical work done in the Palestinian Territories by a clinical psychologist working with an international medical Non Governmental Organization (NGO). In her interventions the author used mindfulness-based therapy with people who suffered from severe psychological distress due to the political conflict. Such interventions can be therapeutic and heal deep suffering, whilst offering clients coping strategies when possibly facing other traumatic events in a situation of "chronic emergency" such as the one that people have to face in a country that has been under military occupation for over 40 years. Using a case study approach, the author discusses the intervention with two women, one suffering from post-traumatic stress disorder (PTSD) following the loss of her baby after being kept at a military check-point, and the other suffering from depression following the killing of her son. The mindfulness-based intervention allowed them to explore a therapeutic approach which helped them to overcome their symptoms and "get unstuck".

Keywords Mindfulness-based therapy · Political violence · Trauma · Israel · Palestine

Introduction

I would like to share my experience as a clinical psychologist in the Palestinian Territories where I spent 6 months providing short to medium term (10–15 sessions) mindfulness-based psychotherapy to people who suffered from severe psychological symptoms following traumatic events. I worked in the West Bank during the weeks of the war in Gaza (December 2008–January. 2009), a time when I witnessed a surge in psychological distress in the population. Our project was based in Nablus and served the Nablus district which includes the city itself, a number of refugee camps, and villages.

Nablus is an Arab town which has suffered greatly due to the Israeli military occupation since the beginning of the Second Intifada (2000). The city is surrounded by seven checkpoints and only those with the appropriate permit are allowed to leave the town. Psychologically this makes Nablus quite claustrophobic and ghetto-like. On top of this, the city has witnessed a huge amount of political violence in the last 8 years and has been considered the "capital" of terrorism on one side and a stronghold of resistance on the other. In this context of "ongoing emergency," I was employed by an international medical Non Governmental Organization (NGO) which provided free, confidential, neutral, and independent medical, social, and psychological care to the traumatised population.

I became aware that the amount of trauma that my clients were facing, and the cultural background they lived in, needed something which would provide them with tools that they could use once the therapy was over. I also realised that the Western model of talking about traumatic events, exploring symptoms, and analysing losses (of their house or land, of a relative or a close friend) was not necessarily conducive to a mind shift. In general, clients were keen to talk about their suffering to a psychologist for two to three sessions, then they expected some problem-solving tools, or something they could rely on in-between sessions and when the therapy was over.

When dealing with traumatised people, who may or may not suffer from PTSD, talking and going over the trauma

A. Pigni (✉)
25 Essex Street, Oxford OX4 3AW, UK
e-mail: alexapigni@gmail.com

does not necessarily lead to an improvement in the client's well-being. My experience tells me that the Western "talking cure" works in some contexts if coupled with other approaches, such as mindfulness-based cognitive therapy (MBCT) which addresses the body, the breath, muscle relaxation and sound meditation, awareness of the present moment, acceptance and a "compassionate attitude" towards oneself and others (Chödrön 2005a). The idea is to approach the traumatic events from a phenomenological standpoint, looking at things as they are. This is what mindfulness is: "the awareness that emerges through paying attention, on purpose, in the present moment, and non-judgmentally to things as they are" (Williams et al. 2007, p. 47). I was aware that, in an ongoing emergency context such as the one in the Palestinian Territories, as long as the military occupation existed, the change had to come from within.

Thus, the way I structured the therapy relied on a mix of talking and active listening and mindfulness. The first one or two sessions were devoted to assessment in order to evaluate whether the client was in the target group and if the symptoms were severe. I worked with a skilled interpreter and the process was smooth, roles were clear, and the clients were introduced to our therapeutic work in simple terms. During the assessment, I took a case history paying particular attention to the major traumatic events and the symptoms through which the clients expressed their suffering. The psychological suffering had often somatic manifestations, such as insomnia, headaches, muscle pain, and tension. Anxiety and fear run high due to the unpredictability of the context, and enuresis and aggressive behaviors were common among children.

In a Muslim country, where "the concept of working to improve the self is generally non-existent" and "Arabs are not familiar with non-directive insight therapy" (Dwairy 1998, p. 124), the novelty of the mindfulness approach brought about curiosity, clients were happy to try out something simple, which did not clash with their values and gave them the chance to learn 'skills' that could be useful in the future when the therapy was over. As pointed out by Dwairy in his work on counselling within the Palestinian culture, "clients are more focused on their complaints and are less aware of their mood and emotions. They find it difficult to talk about their emotions, or personal lives" (p. 124). In accord with Dwairy's observations, my experience confirmed that clients in the Palestinian Arab culture tend to describe their suffering in somatic terms using metaphoric expressions. Somatisation seemed culturally more acceptable and carried less of a stigma and therefore made the psychological suffering expressed through the body more like a "proper" illness which needed cure (therefore socially acceptable), rather than a psychological distress.

The role of religious beliefs needs to be taken into account when dealing with Muslim clients. In fact, "based on the belief that life, as well as the future, are in the hands of Allah, clients do no assume responsibility for their pathological actions" (West, cited in Dwairy 1998, p. 124) and "they place responsibility for change on the therapist" (p. 124). In light of these considerations, I thought that a mindfulness-based approach would be far more beneficial in a culture and society where talking has more of a social value as a means to please others and meet their expectations, and people find it difficult to give voice to their emotions, feelings and suffering. Since the body is the channel by which the suffering is expressed through somatisation, it seemed to me that an approach that placed the body at the centre of the therapy without pathologizing it, could be a suitable way to work through the suffering.

Events

I worked with families and individuals, and my clients included men, women and children. All of them had witnessed either political violence and some had one or more of their family members killed in the Second Intifada, had their house destroyed or violently searched by the Israeli soldiers, their land taken by the Israeli settlers, had relatives in prison or had been in prison themselves. I also worked with clients who suffered because of the inter-Palestinian conflict (Hamas vs. Fatah).

Symptoms

Most clients exposed to the political violence suffered from generalised anxiety disorder and depression-related symptoms. They presented symptoms such as insomnia, irritability, muscular tension related to anxiety, and other psychosomatic manifestations such as headache, fear, and a sense of helplessness. PTSD was not the most prevalent diagnosis even though people had been clearly exposed to traumatic events. A misunderstanding seems to have emerged when dealing with traumatised people who are too often labelled as suffering from PTSD when, in fact, they have witnessed one or more traumatic events, but do not fulfil all the DSM-IV-TR criteria for such diagnosis.

Case Studies

Mindfulness and PTSD

I met Amina, a woman in her early 40s, after her husband referred her to our service. Married with five children, Amina had been feeling psychologically and physically unsettled since she lost her baby 2 years before. When

7 months pregnant, one day she was not feeling very well and her husband suggested a visit to the hospital. Coming from a West Bank village, they had to cross a military checkpoint where they were held for over 2 h by the Israeli soldiers. After such a long wait, the woman was bleeding and when they finally reached the hospital the doctors decided to undertake an emergency caesarean section. The baby lived only for a few hours.

Following this traumatic event my client started to develop PTSD symptoms: flashbacks, intrusive memories of the episode at the checkpoint dealing with soldiers, insomnia/disturbed sleep with nightmares, muscular pain and frequent headaches, irritability, hyper-vigilance, anxiety, and fear of soldiers. Following the loss of the baby, her family home was also targeted by Israeli forces on a number of occasions, thus raising her level of anxiety. When I visited her for the first time, Amina took me to the guest room, where the curtains were drawn and we sat in a semi-dark environment. As she told her story, she was crying, recalling how the soldiers had shown no mercy, how she lost her baby, and could have no more since then. She showed me all the medication she had been taking for various conditions, including her migraine and hypertension. She told me how every day, when darkness came, she frantically moved from one window of her house to another to check whether there were soldiers around. Her level of anxiety was very high.

I spent the first three sessions listening to her, building trust and normalising her initial reaction. She had lost her baby and was without the possibility of having more, she felt a deep sense of loss. The symptoms she experienced were a normal reaction to an abnormal situation: the event at the checkpoint, but also the ongoing presence of the soldiers around her house and the occupation by Israeli settlers of her olive groves which as a consequence of this occupation her family was not allowed to harvest any more. Although it was now 2 years since the loss of her baby, her persistent symptoms needed psychological attention. How to tackle such a deep trauma in a context where the trigger (soldiers, military presence, settlers) was constantly there and the outward situation was not likely to change?

After three sessions, which allowed Amina to talk about her suffering, I introduced mindfulness. I took a slow approach as I was aware of her experience of flashbacks which I did not want to trigger through the meditation and of the cultural differences which made a silent practice potentially a threat in a context where silent reflection is uncommon. I explained to Amina that to help her with her insomnia and anxiety I wanted to propose a simple exercise which I called a relaxation practice. Awareness was the point but the relaxation was an appealing by-product of the body scan. In a sitting position I asked her to observe her breath and then move onto observing the thoughts, worries, fears and images that popped up in her mind and let them go, by labelling these thoughts, and by simply saying "thinking" (Chödrön 2005b). I also introduced sound mindfulness and invited Amina to listen to the sounds inside and outside the room. The first time I guided her through the practice she really dwelled into it and I allowed about 20 min of mindfulness in our session. I left her with instruction in Arabic to continue the practice twice a day for 15 min in the morning and before going to sleep.

Following the first mindfulness session, Amina welcomed me with a big smile and told me how she had been practising the mindfulness exercise every day with the help of her husband and how he started practising it as well. She found it useful to lower her anxiety level and to fall asleep at night.

After six sessions since the beginning of the therapy, Amina told me that it was now the time of the olive harvest. We had a 2 week break in between sessions and, when we met again, Amina gave me an account of her work in the olive grove, of how Israeli settlers had taken over her land and the Israeli soldiers prevented her family from harvesting it for the last 10 years. But this year, she said, the soldiers told us we could harvest the olives. Once again, however, the settlers attacked people and the army watched helplessly. Amina told me how she approached the soldiers, how she was not afraid of them anymore, because she saw them as young men who were probably afraid of the settlers themselves. I thought this was a very good example of practising compassion. Amina was now expressing new feelings and a new awareness, not the sheer pain any more. She was angry at the settlers who cursed the Prophet, and hit her elderly mother. She told me how blessed she felt for having such a beautiful family, and for not being afraid of the soldiers any more, for being able to sleep, and not having all the muscular pain she had in the past. When night fell she was not moving from one window to the other anymore with the fear of soldiers.

Another four sessions followed in between which Amina kept practicing mindfulness on a daily basis. Our last session was a striking contrast to the first one. No more dark rooms with drawn curtains, but a session which took place in her front garden while she was baking bread on shot tones in the Palestinian tradition. The day was bright and in this very unconventional setting I accepted bread, olives, cheese, and olive oil—a sign of Palestinian gratitude. She apologised that she was busy. As a psychologist, to see that a client does not need therapy anymore and is capable of engaging in her everyday life is what makes my work worthwhile.

Mindfulness and Depression

Laila was a woman in her 50s from Nablus. Her son had been killed by the Israeli soldiers 3 years before. Her

husband asked for psychological intervention: his wife was crying every day since the death of her son, she suffered from insomnia, was easily irritable, would not go out, suffered from headaches and pain all over the body, and ruminative and intrusive thoughts were always present.

When I first heard her story, I found myself wondering how on earth I could help a mother to overcome the grief of the loss of a son. Nothing gave Laila hope, nothing interested her, and hearing her tell her story and crying surrounded by her son's giant portrait and photos gave me the impression that her son had been killed 3 days and not 3 years before. Her insomnia was very severe, and I considered asking our doctor to prescribe some sleeping tablets, but she was not keen on the idea and did not want to take any medication at all. The tools that I took out of my toolkit were MBCT and the teachings of the Buddhist *ani*, Pema Chödrön, in particular from her work *Start where you* are and *Getting unstuck* and the research and writings on depression by Williams et al. (2007).

Acceptance and reframing her attitude were essential in order to work through her suffering. But how can a mother overcome the loss of a son? I was struggling with the idea myself as someone young I knew well had just been killed in a car accident. I found myself having to contain Laila's grief and my own.

The key was in finding an alternative to rumination. Rumination means "becoming fruitlessly preoccupied with the fact that we are unhappy and with the causes, meanings and consequences of our unhappiness" (Williams et al. 2007, p. 43). As Crane (2009) points out "analogous to a car spinning in a muddy rut, the ruminative thinking cycle digs us deeper into well-worn, habitual mental grooves or ruts" (p. 32). As a result we get stuck.

Laila and I worked together for eight sessions using a combination of mindfulness, reframing, and working on the positive elements of her life; namely, the presence of her two grandchildren. She loved to have her late son's children visit her once a week, but she would not visit them because it was too painful to go to her son's house. "When I am with them" she said, "it's the only time when I can forget my son." Her face brightened up when she talked about her grandchildren.

With this woman what seemed particularly important was to allow her to see that forgetting her son was not the way to heal, because this would mean setting herself up for an impossible task. In the course of the sessions, I guided her to do a 10 min sitting meditation which helped her to release the tension—initially her muscles were so tense that she could barely unclench her fists. Her reaction was not of immediate trust. She thought that the body-scan was a strange exercise, she did not like to have her eyes closed and her whole attitude towards the therapeutic work was that her grief was so huge, that other counsellors had tried but failed to help her, and that she was wasting my time.

Laila was stuck and was going round in circles. She kept telling me that she tried to forget, but she could not. In my mindfulness practice, I came across Chödrön's (2005b) teachings' *Getting unstuck* where she reported a story by the Dalai Lama. In the book, *The Art of Happiness,* Howard Cutler, a psychotherapist, engages in a dialogue with the Dalai Lama and asks him if he ever regretted anything about his past. The Dalai Lama told this story: an elderly monk asked him if he could follow a particularly demanding yoga practice. The Dalai Lama advised him against this. The following day, the elderly monk committed suicide. Like this, he thought, he would have been born in a younger body and would have been able to follow that practice. "How did you get rid of that awful feeling?" Cutler asked the Dalai Lama. After a long pause the Dalai Lama replied: "I didn't". This was groundbreaking for me. This fitted perfectly with mindfulness, and with not trying to fix the problems at all costs and work out solutions. This applied to Laila. There was no way she was going to get rid of the memory of her son, and every attempt would have created more and more frustration and suffering. I brought this to the therapy, exploring the possibility that forgetting was not an option.

In the course of the last two sessions, a woman with a different awareness was sitting in front of me. She told me how she started to go out and how she was now sleeping much better. She offered me a very wise analysis of her situation, and the changes she went through. She described how the atmosphere around her was not so heavy because she was not always nervous and tense any more; now that she was feeling better, the people around her seemed more caring. In our last session, which took place in a different room—an interesting change of setting as with Amina—where we were not surrounded by her son's portraits any more, Laila told me that she was ready to visit her grandchildren in their own home. She did not cry at all and her fists were not clenched any more.

Conclusions

Through my therapeutic work with Palestinian families, I realised that the talking cure, especially if focused on past events, can achieve some short-term results giving clients the chance to offload and being listened to, but the question from most of my Palestinian clients was "what to do then?". I have been practising meditation and mindfulness for a number of years now, and it has been a very therapeutic and enriching experience, and this is how I came to the idea of integrating it in my practice with clients. I also drew from my experience of philosophical counselling

where I used a concept that is very similar to the one found in mindfulness called "stepping back" (Crane 2009). Stepping back means looking at your situation and its difficulties with an outer look, as if it happened to someone else. It is used in philosophical counselling as a tool to observe "naked reality" (Chödrön 2005b) with some distance. With respect to this, mindfulness and phenomenology both aim at "looking at things as they are."

When I started introducing mindfulness in my practice in Palestine, I began to see a shift in my clients and in myself as a therapist. Most of them were open to it. I presented it as a simple practice that would help them to relax and be aware of their body, their thoughts, and the environment around them. At the end of each session I would check how the experience was for them and would leave instructions in Arabic, and encourage them to practice it at least once a day for 10 min. My clients were curious about it, and I suspect they benefited from simply having a silent space that was just theirs. In the large Palestinian families I worked with, this was very unusual. A mindfulness-based approach gave my clients a new opportunity which they embraced with curiosity. Amina and Laila, one suffering from PTSD and the other from depression, learned through mindfulness to be with their bodily experience, to infuse their practice with a sense of acceptance and gentleness, to settle and calm the mind, and develop a new relationship with their experience (Crane 2009, p. 117). It would be appropriate to follow-up these clients to assess the impact that the mindfulness-based therapy had in the medium-to-long term.

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References

Chödrön, P. (2005a). *Start where you are: How to accept yourself and others*. London, UK: Harper Collins Publishers.

Chödrön, P. (2005b). *Getting unstuck: Breaking your habitual patterns and encountering naked reality*. Boulder, Colorado: Sounds True.

Crane, R. (2009). *Mindfulness-based cognitive therapy*. New York: Routledge.

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

Williams, M., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guilford Press.