

Refugee families: issues of systemic supervision

Renos K. Papadopoulos^a

Families of refugees tend to evoke many powerful responses in all who come into contact with them. Loss and trauma, helplessness and victimhood, transition and change are some of the main themes that seem to dominate. In particular, in contact with mental health professionals, refugee families are more likely to be seen as 'traumatized' and their resilience less acknowledged. In this article I will endeavour to address some issues that contribute to this skewing of our perception of refugee families, especially in the context of supervision.

Introduction: Refugees and systems

The phenomenon of refugedness intersects a wide variety of dimensions and is by no means exclusively of a psychological nature; it involves issues of political (internal party politics as well as foreign policy), ethical, ethnic, religious, financial, sociological, ecological nature, to name but a few. Consequently, a single approach to refugees cannot possibly be sufficient to address its multifaceted complexity. Therefore, any psychological-therapeutic approach to refugees should include a means of taking into consideration the other interrelated dimensions, and it is for this reason that a systemic perspective is particularly apt for this kind of work. More specifically, some of the advantages of a systemic approach in working with refugees include the ability to address several interrelated systems as well as to avoid pathologizing the refugee suffering or psychologizing evil actions as in political decisions and actual atrocities (Papadopoulos and Hildebrand, 1997). The interrelated systems in this work include the systems where the clients belong, i.e. nuclear and extended family, school, community, ethnic, cultural and linguistic group, state, and the systems that form the relevant context, i.e. sociopolitical, ideological, ethical, religious,

^a Consultant Clinical Psychologist and Family Systems Psychotherapist, Tavistock Clinic, 120 Belsize Lane, London NW3 5BA, UK.

media, 'public opinion', etc. Moreover, the systemic approach is particularly useful in enabling therapists to locate themselves in the context of the service systems where they belong and as they interact with the other two groups of systems. The therapists' systems include the actual services and institutions where they are employed, along with their policies and practices, the ideologies of the aid industry, professional affiliations, therapeutic orientation, as well as their own personal background and history. Finally, systemic approaches are useful in working with refugees because they can sharpen the professionals' epistemological sensitivity and inform them about the interaction of the various narratives that each one of these systems uses to express itself (Papadopoulos, 1999a; Sveaass and Reichelt, 2001; Woodcock, 2001).

The noise that makes a difference

One of the main principles of systemic thinking, as applied to psychotherapeutic work, has been the distinction between information and data. According to Bateson's famous dictum, 'information is definable as a difference which makes a difference' (1971: 315). This means that not everything a therapist hears in a session or learns from the referring network matters or is helpful to the therapeutic process; thus therapists attempt to discern the relevant information from the background noise, from all the data that tend to overload them without offering clarity which would be useful to the therapeutic work. The key to this discrimination is based on the feedback process: therapists endeavour to watch out for evidence of a difference in the way they understand the family system, and in the way they interact with the family, after they become aware of a certain piece of information. For example, after hearing about the fact that a member of a refugee family was tortured, the therapist may actively seek to understand the way she now perceives the family in a different way and the ways that their interaction has been affected as a result of this new information. Needless to say, this awareness develops not only when therapists hear passively or observe something that comes from the family accidentally, but also when they themselves actively seek it out – their questions, interventions and overall position contribute to the elicitation of relevant information and the decrease of the noise produced by background data. In this way, one of the main functions of supervision is precisely to develop the therapists' skills to discriminate

between information and data and to increase their effectiveness in eliciting appropriate information.

Although the Batesonian terminology about difference, information and background noise is not used widely in current systemic thinking and practice, nevertheless the ideas that it conveys are valid and seem to remain, by and large, widely accepted. Every therapeutic approach and technique aims to maximize whatever it considers relevant information and to minimize the interference from background noise. However, what is perhaps more important about the distinction between information and data is what Bateson said about the noise itself. After clarifying that 'All that is not information . . . is noise', he characterized the noise as 'the only possible source of *new* patterns' (1967: 410). This is a rather astonishing comment about the noise and its potential value. What it means is that by pursuing what we perceive to be relevant information we tend to ignore other possible avenues which could reveal new patterns that could lead to creative ways of appreciating the situation. Understandably, the emphasis on the positive use of information has tended to downgrade the value of the background noise, and it is astounding to read that Bateson appreciated it as the 'possible source of *new* patterns'. Although it may be relatively easy to accept the value of this kind of noise on the theoretical level, it may be less obvious how this can be translated in the actual therapeutic work. Moreover, what could this potentially creative noise that makes a difference be in the context of working with refugees, and how can we access it?

To begin with, it may be useful to differentiate between at least two types of background noise: one that emerges within the session and another that is part of the wider contexts within which the therapeutic work takes place. The two, of course, are interconnected. The first one refers to a micro level and it consists of all the specific background data about the clients and therapists that may not be considered of relevance in comparison to the focused information that is pursued; for example, the fact that a refugee family had two dogs and a cat back at home may not be perceived relevant by the therapist who is focusing, at the time, on the father's difficulties in adjusting to their new life in the UK. The second type of background noise refers to a macro level and consists of the wider narratives in the sociopolitical contexts; for example, the fact that the Indian authorities use the term 'militancy' rather than 'terrorism' to refer to the actions of secessionist groups in their subcontinent.

This fact may not be of relevance to the therapeutic work with the refugee family from that region unless it is specifically focused upon.

Therapists and refugee workers, like all other citizens, are exposed to the wider societal narratives about refugees which address not only the psychological plight of the fleeing people but also a host of other aspects of the whole mosaic that contains the refugee condition. Among the many narratives of this kind, perhaps the most relevant ones are the versions of the dominant stories about the political and military conflict that forced these people to become refugees, and the versions of the receiving country's attitude towards that particular group of asylum seekers.

Within the past decade, our world has been overwhelmed by images of destruction in several parts of the world: Azerbaijan, Georgia, Armenia, Croatia, Bosnia, Rwanda, Chechnya, Kosovo, Timor, to name the main ones. Inevitably, the specific range of positions (political, strategic, moral, financial, etc.) that each country adopts in relation to each one of these conflicts affects the framework within which therapists formulate their own work with refugees from that conflict zone. Although healthcare workers respond professionally to their clients, inevitably, the wider societal narratives impact on the specific ways that their response is formulated. Ultimately, it is unavoidable that the overall political climate affects the ways professionals perceive and carry out their roles in relation to refugee care (cf. Papadopoulos, 1997, 1998, 2000a, 2000b; Papadopoulos and Hildebrand, 1997; Preston, 1999; Vernez, 1991).

Thus, Bateson's claim that the noise (in addition to the expected benefits of the focused information) is capable of creating new patterns can be of great value to the practical context of refugee work. This means that not only the focused information that is addressed intentionally in therapy but also the wider perspectives within which the therapeutic work is located influences what occurs in therapy and how workers and refugees relate to each other. For example, in recent years, Serbian refugees in the UK have been living under the cloud of the predominant hostile attitude towards Serbia and this must have affected their work with therapists. According to this example, although the background noise of the anti-Serbian political climate may not always have been in the forefront of the therapist's and Serbian refugees' consciousness, if focused upon, it could have provided new and useful information for the therapeutic encounter.

Moreover, in addition to the various shades of political issues, there is another important domain that seems to determine a therapist's perception as to what is relevant information in working with refugees. This is less tangible, but equally, if not more significant: this is about the wider societal discourse on what could be called the 'refugee trauma'. Much has been written about the controversy about trauma and specifically the 'refugee trauma' (Arroyo and Eth, 1996; Bentovim, 1992; Caruth, 1996; Eisenbruch, 1991; Friedman and Jaranson, 1992; Gorman, 2000; Herman, 1992; Joseph and Yule, 1997; LaCapra, 2000; Lebowitz and Newman, 1996; Marsella, 1992; Marsella, *et al.*, 1996; O'Brien, 1998; Papadopoulos, 1998, 1999b, 2000a, 2000b, in press; Shephard, 2000; Tedeschi and Calhoun, 1995; Yehuda and McFarlane, 1995; Young, 1997; Yule, 1999; Zur, 1996). Papadopoulos and Hildebrand argued that the usual way professionals tend to conceptualize refugees was within a 'pathology or deficit model' (1997: 209). This echoes similar perspectives developed by other authors (cf. Bracken and Petty, 1998; Muecke, 1992; Summerfield, 1999, 2001). The trauma discourse in refugees is so widespread that it pervades our whole social fabric. The media, politicians, and the general public have been saturated by the trauma discourse to the extent that all assume that, more or less, all refugees are 'traumatized'. The word 'trauma' has acquired an almost magic quality because it has an enormous impact on all of us. It tends to mobilize people into action – the public gives money generously to all people who have been 'traumatized', politicians take various forms of action (from offering aid to ordering military action) when faced with the movement of massive proportions of 'traumatized' population, professionals and services tend to accede to the requests made by or on the behalf of 'traumatized' persons, etc. Inevitably, the pervasive 'trauma' discourse forms an unavoidable background noise in every therapeutic endeavour with refugees. In this sense, it could be argued that this particular type of noise would certainly make a difference to the way we work and supervise work with refugees.

The case of Zahra

To illustrate some of these issues, utilizing the systems around one individual I shall use the case of an educational psychologist's work with Zahra, a 10-year-old girl from East Africa.

The educational psychologist (EP) approached me for supervision when she felt that her work with Zahra was 'not making progress' and 'felt impotent' in her 'attempts to help'. To begin with, I was rather surprised to see that the child was referred to as a refugee although she had already been in this country for six years. I was told that Zahra

came to England with her father and brother in order to escape the violence in her country. The tribe to which her family belonged were apparently being very badly treated and it is thought that Zahra would have been exposed to a high level of trauma and violence there. Her mother was ill at the time of Zahra's departure and was planning to join the rest of the family; however she died in the refugee camp before she could make the journey to England.

Zahra, when seen by the EP, was living with her paternal uncle, his wife and their own children. Zahra's father lived in London but looked after her brother who was handicapped. It was unclear why Zahra did not live with them, but it was suggested that her father could not manage both children himself and therefore asked his brother to care for Zahra. Her father maintained regular contact with Zahra. Her family felt she could not make sense of her mother's death (she was about 4 years old at the time) although they also accepted that they have never discussed this with her.

In school, Zahra's teachers were concerned that she was still not speaking at all (at school), nor did she seem able to understand much of what was happening in the classroom. As a consequence, her academic progress was being severely hindered. In referring Zahra to an educational psychologist, the school was particularly concerned about the impact of her 'traumatic experiences' on her current mental and emotional state, as well as her learning.

In my supervision, I encouraged the EP to look beyond the focus on Zahra's trauma and think about her as she would of any other pupil. Gradually, the EP realized that her preoccupation with Zahra's 'trauma' and 'refugee' status prevented her from seeing the totality of Zahra's predicament in the context of her family situation. Moreover, the EP began to appreciate the role that other factors played in Zahra's condition, i.e. cultural differences and deprivation, the loss of both her parents (through death and separation) and her sense of a fragmented family. These contributed in creating important shifts in her work with Zahra.

The refugee trauma as noise and information

Although, of course, each case has its unique features, Zahra's predicament is fairly typical of the type that I am often called upon to supervise. Whenever persons have a refugee background, however remote, there is a tendency to connect their present difficulties with the fact that originally they came to this country as refugees. Nobody would argue that these two variables may not be connected, but what is important to appreciate is how quickly this connection is made without investigating the specific features and circumstances of each case.

According to Zahra's referral, the school was understandably concerned that her 'academic progress was severely hindered'. The reason we are given is that she did not speak 'at all [at school], nor did she seem able to understand much of what was happening in the classroom'. One tangible cause the school saw was that she was a refugee and 'it is thought that Zahra would have been exposed to a high level of trauma and violence' in her country of origin, because 'the tribe to which her family belonged were apparently being very badly treated'. It is interesting to observe that all these connections were formulated in a hypothetical way and yet they led to a concrete action – a referral to a psychologist to investigate 'the way in which her traumatic experiences in her country of origin were impacting on her current mental and emotional state, as well as her learning'. What should be of further interest is how the other pieces of information about her life were not taken into consideration at all. I am referring to the fact that this girl of 10 had lost her mother at the age of 4, did not live with her own father but with her paternal uncle and his family, had a 'handicapped' brother who was cared for by her father and she seemed to be surrounded by adults who did not address these enormous losses in her life. What is also important is that she had been in this country for six years and, despite all her obvious tragic current circumstances, the main attention was turned to the trauma that hypothetically she may have suffered during possible armed conflict in her country of origin.

To date, it has not been established as to whether or not Zahra was indeed exposed to any atrocities. However, what is of note is how easily we tend to use the refugee trauma hypothesis as the possible main cause and how we tend to discard and assign a background noise status to other considerations, regardless of their apparent relevance. Trauma seems to offer tangible and clear

'evidence' which is most welcome in situations of unclarity, unbearable suffering and messy feelings and situations.

It is evident that in the case of Zahra, the refugee trauma was the main focus of investigation on behalf of the school and initially, as well as by the EP. Under closer scrutiny we may discern a very curious phenomenon. The refugee trauma was the information that the therapeutic work sought to elicit and yet at the same time it is evident that the refugee trauma was the background noise in the first place which gave rise to the choice of this focus. In other words, the macro-level background noise slipped into becoming the main theme of the therapeutic focus. By doing this, it bypassed all other possible and even more obvious foci (e.g. that Zahra lived with another family and not her own and that this fact was not accounted for by anyone). This puzzle is of paramount importance in supervision. By focusing on this very puzzle, the supervisor, in effect, encourages and indeed joins the supervisee in tracing back this process and thus initiates the exploration of the wider narratives within which therapy had been located. More specifically, it is most instructive to observe, in action, how the refugee trauma narrative shapes the referring network, the therapist and the supervisor.

In the case of this supervision, although the psychologist-supervisee was expecting a long process of learning about refugees, she was able, within a short period of time, to realize that her own existing expertise was sufficient to work fruitfully with Zahra. It is as if the background ideology of refugee trauma (as one could call it) had a paralysing effect on her and, once this was lifted, her own creativity and resourcefulness were unlocked.

Refugee trauma and its phases

As we saw in the case of Zahra, the implicit hypothesis that organized the professional systems' thinking and actions was not about her painful experiences of not living with her father and brother, or of losing her mother at an early age but about the possibility of her witnessing war atrocities. Thus therapists, under the background influence of the trauma narrative, seem to be under pressure to tease out the details of the trauma which is assumed to have been caused by the refugees' exposure to war atrocities.

Privileging this kind of 'knowledge' is a consequence of the 'refugee trauma' narrative, following the exclusively pathological way that trauma is understood today. Yet, as we know, trauma is not

necessarily a mark of pathology (Papadopoulos, 2000b); it is a neutral word which suggests that a strong emotional experience has taken place and which has left some mark – either a mark of injury or of cleansing and renewal. Trauma is the mark, the emblem of that experience regardless of its nature or value, of its positive or negative connotation. Powerful experiences may indeed injure or rejuvenate a person. However, according to our common use of the term today, only the negative connotation has survived, and although it makes perfect sense that a positive outcome may also be the case, it has become impossible for us to consider anything constructive and affirmative when we think of the refugee trauma nowadays.

However, if we were to examine more carefully the sequence of the ‘refugee trauma’, we would discern a number of distinct phases that are not all about the devastating events that may have occurred. More specifically, the predominant way of understanding trauma is in a simplistic mono-causal way, as if it were a line which divided a person’s life into two parts: before and after the exposure to war atrocities (see Figure 1). This way of understanding the refugee trauma implies that life before the line was fine and unproblematic and only the devastating events of the war atrocities count. It is as if only these events could be responsible for producing ‘the’ unique piece of information that would make a difference in understanding a refugee’s present predicament. Without denying the reality or the painful impact of such events, it is important to acknowledge that not all refugees have experienced such atrocities. Many hear about the imminent danger and flee in time. Yet it is compelling to comprehend human pain in terms of some concrete evidence that raw violence had occurred, which was the actual source and cause

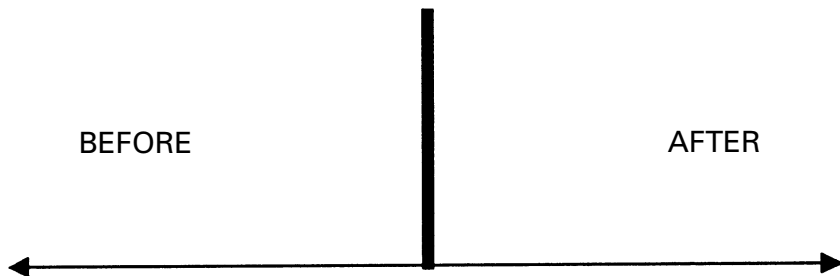


Figure 1

of the refugee's present suffering. This concretization is one of the seeming benefits of the refugee trauma narrative.

In short, I would argue that the dividing line is not just one point in time but consists of at least two phases. The first is the phase of what could be called devastating events, and the second the phase of survival (see Figure 2). The first covers the period of war atrocities, for those refugees that experience such events. This phase is followed by the phase of survival during which refugees are no longer in physical danger from enemy action. They are safe and protected in sanctioned places, living in tents or in abandoned schools, factories or other large buildings. However, although their lives are no longer threatened, this does not mean that this phase is free from any intense suffering. On the contrary. During this phase, refugees are disoriented, disempowered and helpless. They may not know where members of their family are, where they will go, what will happen to them, and they wait for their fate to be decided by politicians, international organizations and warlords. They do not follow their usual daily routine and do not perform their usual roles; instead, they sit aimlessly waiting for long and empty periods of time, sometimes even for years without their usual support systems in their original community. This can be a most distressing and indeed 'traumatic' phase, which is usually ignored, especially when the emphasis is on the exciting and tangible phase of the devastating events.

These two phases are not the only ones that constitute the refugee trauma. In addition, at least two more may be identified.



Figure 2

These are the phases of anticipation and adjustment (see Figure 3). The phase of anticipation comes before the devastating events, in what is usually considered to be the 'pre-traumatic period', if trauma is understood to refer exclusively to the devastating events. During this phase of uncertainty, people hear of the imminent danger and embark on the painful process of guessing which decision would be the correct one for all members of their family and for everything else taken into consideration. Without solid structures to rely upon, they have to make decisions that often mark the fate not only of themselves but also their whole extended family for generations to come. Should they flee or stay? Should they take all their possessions or some of them, and which ones? Should they all go together or separate into smaller groups and take different routes? 'This is a most "traumatic" phase because due to the overall chaotic circumstances and the breakdown of positive authority, law and order, there are no guidelines or predictions that apply to such a situation' (Papadopoulos, 2000b). There are many refugees who suffer more from this phase in subsequent years than from any other phase. Recriminations, blame of each other and the agonizing 'what if' questions can torment refugees throughout the rest of their lives about the decisions they reached during this phase. Finally, the phase of survival is followed by another period, that of adjustment which refers to the most difficult time after they arrive

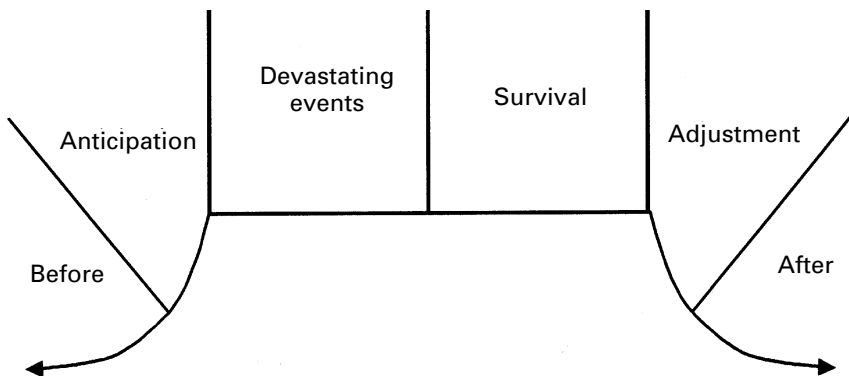


Figure 3

in the receiving country to begin their new lives. The expectations and high hopes are often crashed by the harsh reality that is filled by disorientation, helplessness, bitterness, anger, and ambivalence towards the refugee workers and all other agencies that try to help them (Papadopoulos, 1999a). Moreover, conflict and rivalry among aid organizations and services may make them pawns in other battles of a different nature where the rules are less graspable than open warfare.

Refugee trauma implications

As we have seen, the idea of 'refugee trauma' defined in a mono-causal way and referring to the phase of devastating events can offer a simple, convenient and discrete way of conceptualizing human suffering under otherwise difficult circumstances. Such a simplified formula can be most consoling in addressing highly complex situations which are not only difficult to grasp intellectually but also painful emotionally as well as confusing epistemologically. However, the simplification that the 'refugee trauma' discourse offers can do violence to an already multifaceted and multidimensional field such as the refugee situation. Despite the misleading 'self-evident' situation, as we have seen, the source, the cause of refugee trauma is not just one single and identifiable event. Moreover, our justified abhorrence of the atrocities that are considered the cause of refugee trauma may force us into creating a simplistic causal relation between the atrocities and the 'trauma', thus ignoring the possibility of a non-pathological response to the condemnable atrocities. In other words, the epistemological confusion between morality and pathology may lead to uniform pathologization of the refugee situation. All systemic complexities are ignored when we see refugees simply as an indiscriminate group of traumatized individuals.

Other interrelated implications of accepting this widespread and predominant version of the 'refugee trauma' discourse include the distance created between therapists and the suffering refugees, the fostering of dependence, the diminishment of psychological complexities, the setting up of polarized situations, the creation of victim-saviour dyads, and the denial of resilience and other positive outcomes. Although it is impossible to address all these implications in any detail in the context of this article, it would suffice to outline their basic parameters. Most of these implications are interrelated with each other and the one follows from the other.

With the good intentions of assisting the suffering refugees, once we adopt unquestionably the 'refugee trauma' discourse, we are likely to find ourselves entangled in most of these implications. By assuming that the refugee has been inexorably traumatized by war atrocities we create a barrier between them, their suffering and us who have not been exposed to that kind of atrocity; this is a paradoxical mechanism that keeps at bay those people whom we want to assist. If they suffer from something that was caused by a unique historical event that is so foreign to their therapists in the receiving country, then this differentiation creates a gap that is difficult to bridge. In conjunction with the assumption that the refugees are so damaged and their resilience or other positive qualities are not discernible, then inevitably, they will need to rely entirely on their therapists' assistance in ways that foster cycles of dependence. Such cycles are difficult to break because the more therapists and other aid workers try to help, the more they tend to locate their client refugees as helpless and dependent persons. Another vicious circle that is set up by implicitly adopting this version of refugee trauma is the potentially lethal interlocking of victim-saviour positions. If the refugee is seen as just a victim, invariably the position of the saviour is going to be evoked in the therapists. It is fairly impossible to sit in front of victims without feelings of saving them not emerging in the therapist. However, this scenario does not stop here; the dyad of victim-saviour must also produce the position of a perpetrator, violator. Saviours do not save victims without an attempt to protect them from their violators. Although it is appropriate for therapists to reject abstract neutrality and to express their abhorrence against atrocities and to condemn those individuals and groups that have been responsible for such abominable actions, the systemic triangle does not stop there. It is very likely that therapists and refugees, under these conditions, will extend this condemnation against other violators the system will create. Thus it is not uncommon for this victim-saviour couple to keep on producing increasingly more enemies that they will need to defend themselves against, such as the managers of the therapists' services and other individuals and bodies that do not offer the kind of unconditional support which the couple expects and demands.

The denial of complexity (which the 'refugee trauma' promotes) may also deprive therapeutic work in these contexts from accessing the totality of psychological functions and abilities of refugees. Ultimately, human beings have the capacity to process internally

and within their families and communities painful events and experiences, and to transform them into potentially growthful potentialities. Therapeutic work that is focused too closely on the refugee trauma as a mono-causal pathological phenomenon will fail to capitalize on this potential; the positive use of the role of imagination, symbolization as well as the whole transference-countertransference matrix can be underestimated or completely ignored. In systemically informed work with refugees this potentiality is equally present, especially when the systemic interconnections among the various positions in such vicious circles and the other interrelated dimensions and systems are addressed.

Thus, paradoxically, in working with refugees, by increasing the level of complexity, despite the pressure to keep things 'simple', new patterns may emerge that can produce not only epistemological clarity but also free both therapists and refugees from falling into fixed, sterile and polarized positions.

What and how can knowledge be supervised?

Therapists and other refugee workers, under the imperceptible influence of the refugee trauma discourse, tend to feel that they cannot work effectively with this group of clients unless they have some privileged knowledge. Therapists tend to feel that unless they 'know what actually happened' to their clients they are not able to assist. From the above discussion, it emerges that they must be referring to two types of knowledge: one is about the details of the war atrocities that it is believed were the cause of the trauma, and the other is specialist knowledge about the intricacies of this unique group of people which therapists believe are going to be indispensable for their work with refugees. It is important for the systemic supervisors to appreciate the genuine nature of this need for both kinds of knowledge; however, at the same time, it is equally important not to attempt to provide this desired knowledge. This need in therapists is a product of an erroneous epistemology which does not indicate a failing or any deficiency in the therapist but is a product of the wider professional and societal narratives about the 'refugee trauma'.

As we have seen, the 'refugee trauma' discourse can create an astonishing blindness to facets of our clinical work which, under other conditions (if they were not referring to the refugee situation), would have been easily identified and appropriately

addressed. In this way, working with refugees constitutes specialist work only insofar as it is imperative to disentangle the various interconnected systems so that clinical clarity will emerge. Ultimately, as supervisors in these contexts, our task is to fathom out the way this work positions us as therapists (Papadopoulos, 1999a) and as supervisors. The trauma discourse along with the specific multidimensional nature of the refugeedom creates a certain type of confusion that can easily have a paralytic effect on both therapists and supervisors alike.

Some of the ways I have found useful in eliciting clearer awareness of our 'positioning' (cf. Harré and van Langenhove, 1998) and of the effects of the trauma discourse in supervising work with refugees have included the following. Inviting the supervisees:

- 1 To map out the various agencies involved in the work and then to consider the ways they are interconnected in terms of their remit and main concerns; subsequently, to consider the ways the supervisees are positioned as a result of these interconnections.
- 2 To consider how differently the refugee family could have been conceptualized by their service/agency and themselves (supervisees), had they not been refugees.
- 3 To consider how differently the family would have been conceptualized had the supervisees possessed the two types of desired knowledge, i.e. knowledge about the 'causes' of 'trauma', and expert knowledge about the 'speciality' of refugee work.
- 4 To reverse the 'pathology' model and see the refugee family not (only) as a source of 'problems' but as an example of human resilience; more specifically, to identify the various aspects of resilience they exhibit, as well as what we could learn from them.
- 5 To consider how similar or different other families with whom they work (who are not refugees) would have reacted had they been refugees.
- 6 To consider the range of wider discourses that impact on their therapeutic relationship and to identify other concerns in addition to or instead of the pressure for the two kinds of knowledge.

Ultimately, as Zahra's case has demonstrated, systemic supervision in this field may not be about helping therapists to develop specialist techniques in order to extract information from their refugee clients about the causes of their trauma, nor about acquiring sophisticated forms of expertise in this field. As Bateson put it, 'Evidently,

the nature of 'meaning,' pattern, redundancy, information and the like, depends upon where we sit' (1967: 407). In this way, systemic supervision with refugees can be effective when we throw some light on where the wider discourses, which mostly appear as background noise, make us sit.

Acknowledgement

I wish to thank Andrea Smollan for allowing me to include parts of her account of my supervision of her work with Zahra.

References

- Arroyo, W. and Eth, S. (1996) Post-Traumatic Stress Disorder and other stress reactions. In R.J. Apfel and B. Simon (eds) *Minefields in Their Hearts: Mental Health of Children in War and Communal Violence* (pp. 52–74). New Haven, CT: Yale University Press.
- Bateson, G. (1967) Cybernetic explanation. In *Steps to an Ecology of Mind*. New York: Balantine (1972).
- Bateson, G. (1971) The cybernetics of 'Self': a theory of alcoholism. In *Steps to an Ecology of Mind*. New York: Balantine (1972).
- Bentovim, A. (1992) *Trauma Organised Systems*. London: Karnac.
- Bracken, P.J. and Petty, C. (eds) (1998). *Rethinking the Trauma of War*. London: Free Association Books.
- Caruth, C. (1996) *Unclaimed Experience. Trauma, Narrative and History*. Baltimore, MD: The Johns Hopkins University Press.
- Eisenbruch, M. (1991) From post-traumatic stress disorder to cultural bereavement: diagnosis of Southeast Asian refugees. *Social Sciences and Medicine*, **33**: 673–680.
- Friedman, M. and Jaranson, J. (1992) The applicability of the PTSD concept to refugees. In A.J. Marsella *et al.* (eds) *Amidst Peril and Pain. The Mental Health and Social Wellbeing of the World's Refugees* (pp. 207–228). Washington, DC: American Psychological Association.
- Gorman, J. (2000) *Understanding Post-traumatic Stress Disorder*. London: Mind Publications.
- Harré, R. and van Langenhove, L. (1998) New directions for positioning theory. In R. Harré (ed.) *Positioning Theory. Moral Contexts of International Action*. Oxford: Blackwell.
- Herman, J.L. (1992) *Trauma and Recovery. The Aftermath of Violence: From Domestic Abuse to Political Terror*. New York: Basic Books.
- Joseph, S. and Yule, W. (1997) *Post-Traumatic Stress Disorder. A Psychosocial Perspective and Treatment*. London: Wiley.
- LaCapra, D. (2000) *Writing History, Writing Trauma*. Baltimore, MD: The Johns Hopkins University Press.
- Lebowitz, L. and Newman, E. (1996) The role of cognitive-affective themes in the assessment and treatment of trauma reactions. *Clinical Psychology and Psychotherapy*, **3**: 196–207.

- Marsella, A.J. (1992) Ethno-cultural diversity and the international refugee. Challenges for the global community. In A.J. Marsella *et al.* (eds) *Amidst Peril and Pain. The Mental Health and Social Wellbeing of the World's Refugees*. Washington, DC: American Psychological Association.
- Marsella, A.J. *et al.* (1996) Ethnocultural aspects of PTSD: an overview of issues and research directions. In A.J. Marsella *et al.* (eds) *Ethnocultural Aspects of Post-traumatic Stress Disorder. Issues, Research and Clinical Applications* (pp. 105–129). Washington, DC: American Psychological Association.
- Muecke, M. (1992) A new paradigm for refugee health problems. *Social Science and Medicine*, **35**: 515–523.
- O'Brien, L.S. (1998) *Traumatic Events and Mental Health*. Cambridge: Cambridge University Press.
- Papadopoulos, R.K. (1997) Individual identity and collective narratives of conflict. *Harvest: Journal for Jungian Studies*, **43**: 7–26.
- Papadopoulos, R.K. (1998) Destructiveness, atrocities and healing: epistemological and clinical reflections. *Journal of Analytical Psychology*, **43**: 455–477.
- Papadopoulos, R.K. (1999a) Working with families of Bosnian medical evacuees: therapeutic dilemmas. *Clinical Child Psychology and Psychiatry*, **4**: 107–120.
- Papadopoulos, R.K. (1999b) Storied community as secure base. Response to the paper by Nancy Caro Hollander 'Exile: paradoxes of loss and creativity'. *The British Journal of Psychotherapy*, **15**: 322–332.
- Papadopoulos, R.K. (2000a) 'Factionalism and interethnic conflict: narratives in myth and politics'. In T. Singer (ed.) *The Vision Thing. Myth, Politics and Psyche in the World*. London and New York: Routledge.
- Papadopoulos, R.K. (2000b) A matter of shades: trauma and psychosocial work in Kosovo. In N. Losi (ed.) *Psychosocial and Trauma Response in War-Torn Societies; the Case of Kosovo*. Geneva: IOM.
- Papadopoulos, R.K. (2001) Refugees, therapists and trauma: systemic reflections. *Context: The Magazine of the Association for Family Therapy*, **54**: 5–8. Special edition on refugees, edited by Gill Gorell Barnes and Renos K. Papadopoulos.
- Papadopoulos, R.K. (in press) Narratives of translating – interpreting with refugees; the subjugation of individual discourses. In R. Tribe and H. Raval (eds) *Working with Interpreters in Mental Health*. London: Routledge.
- Papadopoulos, R.K. and Hildebrand, J. (1997) Is home where the heart is? Narratives of oppositional discourses in refugee families. In R.K. Papadopoulos and J. Byng-Hall (eds) *Multiple Voices: Narrative in Systemic Family Psychotherapy* (pp. 206–236). London: Duckworth.
- Preston, R. (1999) Researching repatriation and reconstruction; who is researching what and why? In R. Black and K. Koser (eds) *The End of the Refugee Cycle? Refugee Repatriation and Reconstruction*. New York: Berghahn Books.
- Shephard, B. (2000) *A War of Nerves. Soldiers and Psychiatrists 1914–1994*. London: Cape.
- Summerfield, D. (1999) A critique of seven assumptions behind psychological trauma programmes in war-affected areas. *Social Sciences and Medicine*, **48**: 1449–1462.
- Summerfield, D. (2001) The invention of post-traumatic stress disorder and the social usefulness of a psychiatric category. *The British Medical Journal*, **322**: 95–98.

- Sveaass, N. and Reichelt, S. (2001) Refugee families in therapy: from referrals to therapeutic conversations. *Journal of Family Therapy*, **23**: 119–136.
- Tedeschi, R.G. and Calhoun, L.G. (1995) *Trauma and Transformation. Growing in the Aftermath of Suffering*. New York: Sage.
- Vernez, G. (1991) Current global refugee situation and international public policy. *American Psychologist*, **46**: 627–631.
- Woodcock, J. (2001) Threads from the labyrinth: therapy with survivors of war and political oppression. *Journal of Family Therapy*, **23**: 136–154.
- Yehuda, R. and McFarlane, A.C. (1995) Conflict between current knowledge about posttraumatic stress disorder and its original conceptual basis. Available on the *Trauma Information Pages* at <http://www.trauma-pages.com/yehuda95.htm>
- Young, A. (1997) *The Harmony of Illusions. Inventing Post-Traumatic Stress Disorder*. Princeton, NJ: Princeton University Press.
- Yule, W. (1999) *Post-Traumatic Stress Disorder. Concepts and Therapy*. London: John Wiley.
- Zur, J. (1996) From PTSD to voices in context: from an ‘experience-far’ to ‘experience-near’ understanding of responses to war and atrocity across cultures. *International Journal of Social Psychiatry*, **42**: 305–317.