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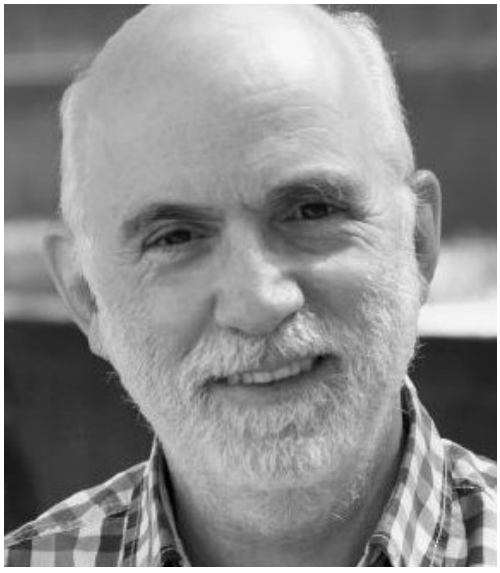
Keynote Speaker:
Professor Renos Papadopoulos

"Therapeutic Applications in Humanitarian Contexts"

PROFESSOR RENOS PAPADOPOULOS



Renos K. Papadopoulos, Ph.D. is Professor of Analytical Psychology in the Department of Psychosocial and Psychoanalytic Studies, Director of the 'Centre for Trauma, Asylum and Refugees' and of the postgraduate programmes in 'Refugee Care', a member of the 'Human Rights Centre', of the 'Transitional Justice Network' and of the 'Armed Conflict and Crisis Hub' all at the University of Essex, as well as Honorary Clinical Psychologist and Systemic Family Psychotherapist at the Tavistock Clinic. He is a practising Clinical Psychologist, Family Therapist and Jungian Psychoanalyst who spent most of his professional life training and supervising specialists in these three spheres. As consultant to numerous organisations, he has been working with refugees, tortured persons, trafficked people, and other survivors of political violence and disasters in many countries. His writings have appeared in sixteen languages. Recently, he has been given Awards by the European Family Therapy Association for Lifetime 'Outstanding contribution to the field of Family Therapy and Systemic Practice', by the University of Essex for the best 'International Research Impact', by two Mexican Foundations for his 'exceptional work with vulnerable children and families in Mexico' and by the International Association for Jungian Studies for his Lifetime contribution to the Jungian field. His last book, on 'Involuntary Dislocation' is hailed as inaugurating a new paradigm in conceptualising and addressing phenomena of uprootedness.

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Introduction by Professor Nevena Calovska

And now we're delighted to welcome Renos Papadopoulos to give his keynote presentation. Good evening. I'm sure that all of you know who Renos Papadopoulos is, and I'm very honoured and very privileged to have been able to meet him many, many, years ago and to work in projects that he coordinated in Yugoslavia. Well, Renos has several professional identities. He is a Jungian psychoanalyst; he is also a systemic family therapist and a clinical psychologist. He is Professor in the Centre for Psychosocial and Psychoanalytic Studies at the University of Essex in the UK, Director of the 'Centre for Trauma, Asylum and Refugees' as well as in charge of postgraduate studies in Refugee Care (as he calls it), all at the same university. He has been working all over the world and he has also worked in many different contexts and settings. He developed his unique 'psychosocial' approach, over the years, which is based on creating a human therapeutic encounter without pathologizing human suffering. And this is so relevant especially in times of emotionally charged moments as we are experiencing today.

So, Renos, I know that this is only a little segment of what you have done, but, as a therapist and personally I'm grateful for all your work; for the books that you have written; and I want to draw attention to his last book, which was published several months ago, called '*Involuntary Dislocation*',[1] in which he speaks about what I think he's ready to share with us today.

Renos Papadopoulos:

Thank you so much! I want to start by saying what a great privilege it is for me to have been invited to this remarkable event and have the opportunity to share with you some of my thinking and experiences in this field.

From what you have seen on the programme, I am here to talk about 'Therapeutic applications in humanitarian contexts', relating them to hope, which is the central theme of our conference.

My concern is that, if we are not clear about what we do and how we judiciously conceptualize what we are thinking and what we are doing, this hope can be 'for the wrong thing', as they say.

So, I am starting with Aristotle, who reminds us that hope is not just an abstraction. Instead, he claims that genuine hope is generated when one experiences real fear of a possibly negative outcome. Then, you hope; otherwise, hope is just idle thinking. Moreover, genuine hope (for him) refers to when one has the courage to act in pursuit of the hoped-for positive outcome, despite the real fear and dangers that may be involved. If these two conditions are not present, according to Aristotle, hope amounts to abstract youthful fantasies.

The other point that I want to raise as a starting point, are the thoughts of T.S. Eliot (who received the Nobel Prize in Literature in 1948). He says, *"I said to my soul, be still, and wait without hope. For hope would be for the wrong thing"*.[2]

1. Papadopoulos, R. K. (2021). *Involuntary Dislocation. Home, Trauma, Resilience and Adversity-Activated Development*. London and New York: Routledge.
2. T. S. Eliot (1939). *East Coker: Four Quartets*.

So, he reminds us that stillness is quite important. This is what we would call 'therapeutic reflection', not rushing to do something because there is a perceived need. But, instead, to pause, to reflect, to be still, to understand clearly what is happening, and our action to follow proper conceptualisation of the situation. Otherwise, hope can be 'for the wrong thing'. Better not to hope at all than hope 'for the wrong thing'.

In this context, I want us to be reminded of what our sister discipline, psychology, has done. (I don't know whether you consider psychology to be sister or step-sister or whatever other relationship to psychotherapy). I am reminded of George Miller's, APA Presidential Address, in 1969, when he introduced his famous dictum, *"Giving Psychology Away"*. [3] That was a vision, that conveyed the hope for psychology, at the time, when he 'could imagine nothing that would be more relevant to human welfare, and nothing that could pose a greater challenge to the next generation of psychologists, than to discover how to best 'give psychology away''. In other words, to make it more accessible and popular, to give it to the people. And, for him, this would have created a new and different public conception of what is humanly possible and humanly desirable.

But, of course, he was fully aware that 'giving psychology away' would 'not be a simple task'. So, against this background, we need to also consider the development of psychotherapy: have we also given psychotherapy away? And should we or, could we? And what is the hope connected with this?

In order to ponder over these matters, we need to be reminded that psychotherapy has changed radically over the last 50 years, due to the interactions between the internal theoretical developments in psychotherapy itself, the organizational necessities, as well as the external realities in the world around us. And it is imperative to examine the consequences of these interactions in order to better appreciate the dilemmas that we are facing today. More specifically, what has been the impact the external realities in the world around us have been exerting on psychotherapy? The announcement in the conference earlier today, just before my presentation, reminds us of the effects of the external realities and their complexities on our work and conceptualisation of our position in our societies today.

Psychotherapy as a profession, as a body of theories, as a cluster of practices, and, above all, its position in society has changed radically over the last 50 years. Even earlier, psychotherapy had moved away from its initial roots, which, were the medical connections, focusing on pathology, but also the links with philosophical traditions, as well as spiritual practices.

Before we go further, let us delineate, at least three forms of understanding the therapeutic enterprises. The first and the easiest one (that used to be the traditional one for many years), is in terms of schools, approaches and ideologies. As we all know, the main ones are the psychodynamic, the behavioural, the humanistic, and the systemic: all of these terms refer to what we call 'modalities'. Each one of these is based on a reasonably coherent theoretical system, which dictates the correspond-

3. George A. Miller (1920–2012). In his 1969, APA Presidential Address, he could imagine nothing '*that would be more relevant to human welfare, and nothing that could pose a greater challenge to the next generation of psychologists, than to discover how to best* ***give psychology away****.'* This would create a '*new and different conception of what is humanly possible and humanly desirable'. 'I am keenly aware that* ***giving psychology away*** *will be no simple task.'*

ing trainings and shapes the institutions that manage the promotion of these approaches.

Nevertheless, we should not forget that, within the last 50 years, and even much less than that, we have witnessed a wide proliferation of, what I would call, 'freestanding' techniques. These are specific sets of applied procedures, toolkits, etc. They include, The Tree of Life, Narrative Exposure Therapy, EMDR, Schema Therapy, etc. These do not necessarily connect with large theoretical frameworks (or at least they were not connected when they first emerged) and their trainings and their institutions are different from those of the traditional 'schools of psychotherapy'. Some of these started as simply one or two week-end 'trainings' and gradually developed into more substantial 'approaches'.

Finally, the third form is what I would identify as a 'Therapeutic Framework'. This is neither a big school or a set of techniques but a cluster of basic therapeutic principles that can be applied creatively in each given setting. This is what I will try to present now. I have developed this specific framework over many years as a result of the interaction between my professional trainings and practice (in clinical psychology, systemic family therapy and Jungian psychoanalysis), my academic teaching and research and, above all, as all these are grounded in the realities of my work in many countries, responding to a wide variety of needs in different settings, in situations of severe forms of collective adversity. The basic principles of this 'Framework' are formed by an acute sense of epistemological scrutiny of how the key relevant phenomena and processes are conceptualised: what contributes to such formulation of our presuppositions and how these affect our practices and the identities of those whom we are called upon to help. What I need to emphasise is that this framework, not being either a 'school of psychotherapy' or a 'freestanding' technique, can be used by anyone and in conjunction with any other therapeutic system or technique. This means that it can serve as an added guiding perspective to enhance any existing therapeutic approach.

Returning to the seismic changes in the psychotherapy field over the last half century or so, it is important to appreciate that psychotherapy needed to adapt itself to the various external adverse situations that required its assistance, e.g. earthquakes, tsunamis, pandemics, wars, and now the war in Ukraine.

An honest observation would reveal, very clearly, that the old and established schools of psychotherapy, in their traditional form, have proven to be unable to adequately respond to these humanitarian emergencies in terms of their theory, practice and organization. For example, you cannot take practitioners of a pure psychodynamic theory, and put them in those situations and expect them to improvise how to adapt their theories to the completely different sets of circumstances that such severe forms of collective adversity present. Hence, all schools and pure theories needed to be adapted to fit into these new situations, outside the consulting room and away from the mental health clinics and services where they originated from.

Therefore, there is a need for conceptualising new forms of psychological health and distress, and for the development of novel therapeutic practices to effectively address the consequences of these adversities. The predominant terms today in these contexts are 'trauma', 'well-being', both as part of a new realm that is termed 'psychosocial'. Consequently, a truly enormous 'industry' has emerged addressing 'trauma' in 'psychosocial interventions.' I do call it an 'industry', because it is one of the biggest existing actual industries in the world today, in terms of financial power, number of people engaged in

it, and its overall impact in society. Let us not underestimate the importance of the 'psychosocial industry.'

The term 'Psychosocial Interventions' emerged, mainly, since the Armenian earthquake in 1988. It gained a great deal of impetus with the Palestinian uprisings, and then it gathered additional momentum from the efforts to address the consequences of the military conflicts during the break-up of Yugoslavia. The explicit attempt has been to address, not only the material and medical, but also the psychological and social aspects of people in distress: in short, to grasp the totality of human beings.

It needs to be clarified that the 'psychosocial' does not refer to any single, unified or clearly identified school or technique. Instead, there is a wide collection of approaches, each one of them with a distinct and different emphasis. There are 'psychosocial' interventions with a predominantly medical emphasis, others with a predominant human rights emphasis, others with a psychological, or social, or arts, or community, or whatever other emphasis.

So, the question that we need to ask is whether psychotherapy has been 'given away' by psychotherapists, or *snatched* away, or whether it *leaked* away. 'Psychosocial interventions', in effect, are a hybrid and an unplanned enterprise that emerged out of necessity. There is nothing wrong about this. The task for us, as psychotherapists, is to contribute to making such improvised constructions and practices best suited to the intended purpose, using our existing psychotherapeutic expertise. We need to collaborate with them and improve them in the best possible way.

George Miller was fervently advocating for the 'de-professionalization' of psychology. That was his key slogan that remained as a motto for psychologists for many years. *"We need to go out and teach other disciplines the basic principles of psychology!" "Psychologists should stop treating patients and clients and, instead, become consultants, helping others, non-psychologists, work with them."* My argument is that although no comparable war-cry existed in psychotherapy, what in fact happened was not dissimilar to psychology. My claim is that, in the context of psychotherapy, it was the necessities derived from the humanitarian catastrophes that brought about the 'de-professionalisation' of psychotherapy.

In the social media (in the '*Influencer Garbage*') I found a characteristic observation: *"The elite language of therapy used to be closely guarded, as it began as a niche set of terms and definitions in academic circles. However, in recent years, therapy speech, therapy-speak, has bled out into the mainstream discourse."*

So, these people are saying that psychotherapy hasn't been 'snatched' or 'leaked-out', but it has 'bled out'. Is this a good or a bad thing? Is this a development that brings hope or not?

To begin with, let us examine the current landscape. What is the situation that we are dealing with? When we are considering the humanitarian emergencies in this context, we are referring to a unique phenomenon and we need to appreciate its specific nature and effects. The best word to describe it is that it is 'overwhelming', both in terms of its nature as well as its impact.

The nature of such events (i.e. the severe forms of collective adversity) and their impact affect everybody; not only the people we try to care for, but also, they affect us, our theories, the way we conceptualize things, our societies in their entirety. They even affect the way we assume that certain phenomena are 'facts' or 'factoids' (to use Normal Mailer's term of 'facts which have no existence before appearing' in a relevant publication). Is the 'slogan-ish' claim that whole societies are 'traumatised' a 'fact' or a 'factoid'?

These phenomena move us into unexpected positions developing unpredicted perceptions and experiences, beyond the familiar and predictable. The suffering, losses, destructiveness, disorientation, unfamiliarity, complexity, all have an overwhelming effect on all of us. When we are overwhelmed by all these emotionally charged experiences, plus all the pressing needs, it is as if a big dark cloud descends on us, clouding our perceptions at all levels. Yet, as human beings, we have an unrelenting need to understand.

Then, inevitably, the way we develop our understanding, under such conditions, becomes 'defective'; the way we construct formulations and comprehend these phenomena tends to become oversimplified and polarized. This means that, in these circumstances, we are made to abandon complexity. Then, in turn, the lack of complexity creates additional problems in all spheres and for all of us. These simplified polarizations fray our discourses, degenerating them and flooding them with simplistic and polarised slogans: 'Refugees Welcome', 'Refugees Out'; 'Bad Refugees', 'Good Migrants'; 'Resilient refugees', 'Traumatized refugees'; 'Vulnerable refugees', 'Dangerous refugees'; 'Refugees as Survivors', 'Refugees as Victims'; etc. The very field is highly polarised: One group of practitioners focus exclusively on 'trauma' ('Trauma-informed approaches'), and another exclusively on 'resilience' ('Strengths-based approaches').

The entire discourse in these situations is polarised through and through. Ultimately, our own perception of our own abilities and effectiveness also tends to become polarised making us believe that we are either omnipotent ('We can do Everything') or impotent ('We can do Nothing').

Whenever we are overwhelmed, the resulting effect is that our very *processing function* becomes hindered. Regardless of our personal history, psychological make up, life attachments, regardless of our beliefs, our styles of being, everyone's processing capacity is very likely to be diminished, as a result of being exposed to these overwhelming events and experiences.

By processing, here, I am not referring only to cognitive or emotional processing, but also to what could be termed 'existential processing'. In other words, when our capacity to process these phenomena deteriorates, it affects not only our perceptions but also our values, our beliefs, our very identity, our entire being. Our epistemological clarity and position in relation to all these phenomena become defective, so to speak. Epistemology does not only refer to cognition, it refers to the entire way we conceptualise ourselves as human beings, in relation to the events and experiences that confront us.

Therefore, when we are exposed to these types of adverse situations, we need to remember the actual fact that we do become overwhelmed and our processing capacity is negatively affected; we need to keep this in mind as a corrective factor. We need to calculate our 'margin of error' in the way we process such phenomena. Whereas ordinarily we consider and process, consciously or unconsciously, all aspects and shades, positive and negative effects, when we are overwhelmed and our processing becomes diminished, we are made to oversimplify and polarise at all levels, and we lose complexity: 'We have no space to think', as we say in psychotherapy. Accordingly, we tend to develop what 'impulsive conceptualization': compulsively, we try to think of something that appears reasonable. Invariably, we fall into what I call 'epistemological acting-out'. In other words, feeling overwhelmed puts pressure on us to formulate any plausible 'understanding' (regardless of how accurate or appropriate it may be), so that we

alleviate our own unbearable uneasiness at being unable to grasp and process the complexity of the adverse phenomena that confront us.

Other types of consequences that defective processing has on us include 'partial understanding' and 'mis-associations'. The Latin expression *'pars pro toto'* refers to the logical fallacy that was identified by ancient philosophers, denoting the mistaken understanding that takes one part of a phenomenon as if it grasps the entirety of the phenomenon.

Mis-associations refer to the mistaken associations that are characteristic of 'conspiracy theories': one takes a little bit of a half-truth here, a little bit of a half-truth there, puts them together and then claims that the resulting concoction is true and valid, whereas its veracity is questionable, to say the least. However, such mis-associations provide people with the confidence that they possess a solid understanding of a complex situation. This, ill-conceived, confidence provides an effective antidote to the unbearable discomfort that the feeling of being overwhelmed creates.

All consequences of defective processing, in effect, distort reality, and when we distort reality, it is impossible to plan and act effectively.

Here are two examples. Although there are clear diagnostic criteria for PTSD, we all witness the tendency to take one or two of the PTSD symptoms (e.g. flashbacks, alterations in arousal and reactivity) and claim that the person suffers from PTSD. This is an obvious example of *pars pro toto*, taking one part and considering it as if it is the whole. This is the effect of 'defective processing' due to being overwhelmed by the severe forms of collective adversity and one of us is immune from this epistemological trap.

Another example, again about PTSD, relates to the dimension of time. The DSM-5 specifically stipulates that the identified symptoms need to persist 'for more than one month'. This means that we cannot diagnose PTSD until we confirm that the relevant symptoms persist for over a month. Moreover, the DSM-5 also demands that we should not forget that there are 'delayed expressions' and, consequently, *'Full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately'*. In effect, this means that PTSD cannot be properly diagnosed before these one month and six months periods of waiting are respected by the clinician. Yet, what we witness is that we all rush to diagnose PTSD as quickly as possible, even after one day. After any severe form of collective adversity, e.g. a terrorist attack, everyone claims that those affected by the attack "suffer from PTSD". Undeniably, the affected people are experiencing an enormous amount of suffering and distress. But do we need to call their distress PTSD in order to give it validity?

Another epistemological trap that comes from being overwhelmed is the deceptive 'clarity' of 'causal thinking'. According to this simplistic formula, adversity 'causes' trauma. Undoubtedly, this sounds reasonable. After all, we are surrounded by the lived realities of such causal thinking, which systemic thinkers term it 'linear epistemology'. If you stop holding an item in your hand, it will drop on the ground. If people do not eat, they will get hungry, and if this persists, they may die. These two examples convey the clear cause-effect reality, which is definitely very valid. However, what appears logical and inevitable with regard to physical and biological realities, is not always logical and inevitable with regard to human experiences and, in general, in social sciences.

Let us pause and reflect and process things properly. We are human beings and not just physical bodies reacting passively to physical forces that are subjected to, according to the laws of physics. As human beings, we make use

of the various Meaning Attribution Processes that are part of our lives. We make meaning of these situations, and different meanings produce different effects from the same situations; also, the time dimension matters and, overall, there is more complexity than the physical laws of cause and effect. It should be remembered that resorting to simplified perceptions is the result of 'impulsive conceptualization' and 'epistemological acting out'.

Let us be reminded of what these 'Meaning Attribution Processes' (MAPs) are [4]. They are very well known; they encompass all the factors that affect the way we experience events: starting from one's personal history, relational supporting systems, gender, age, etc. There are so many studies of how our experiences of events are mediated by all of these factors. Yet, we all tend to forget them and when we see a person being exposed to some adversity, immediately we claim that that person will be traumatized, regardless of any other considerations.

Other MAPs include the factor of power positions: again, voluminous research demonstrates how power positions in human relationships affect the way one experiences adversity. Others include the 'set meaning systems, used to account for the events and for the experiences of these events'. For example, a lot of people that I work with, in different parts of the world, say to me, *"It was Allah's will that these [adverse events] happened to me"*. Very clearly these people have an existing 'set system of meaning' that contributes decisively to the way they perceive events and experiences, and this happens automatically. They do not sit down and ask themselves, *"How am I going to interpret this?"* This *is* the way they perceive events from the very beginning. How do we position ourselves, as psychotherapists, in relation to these phenomena? We cannot ignore the meaning people give to their experiences and impose our own therapeutic ideology over them. We need to respect their set systems of meaning and find creative ways of interacting with them.

Other MAPs include 'Hope and lack of hope'. Hope matters a great deal, as our conference testifies. We should not only focus on the past but also on the present and the future, on the circumstances under which people live now and the aspirations they have for the future. In addition, a host of other socio-political, cultural, economic, legal and many other factors contribute decisively to the way one experiences the events they are exposed to. Despite this, we persist with our over-simplified formula of causal thinking and say, *"Oh, you have been exposed to this severely adverse situation, therefore you are now traumatised"*.

In short, all the MAPs contribute substantially to the way we experience, not only events, but even our own experiences of these events. Our experience of events is not based on objective laws or predictably logical deductions, which are decipherable only by trained psychotherapists.

In order to rectify the tendency to oversimply our perceptions and experiences, when we are overwhelmed by severe forms of adversity, I introduced the 'Adversity Grid' (see below). I developed it over the years, and it is now used widely in many parts of the world and by many NGOs and International Organisations, including the United Nations, in many settings. The

4. Factors affecting the experience of events: Meaning Attribution Processes (MAPs): Personal; Relational; Power Positions; Circumstances of actual devastating event; Set meaning systems used to account for events and the experience of these events; Hope and lack of hope; Current conditions, circumstances and relationships; Future prospects; PLUS host of socio-political, cultural, economic, legal factors (Social Discourse on Trauma), etc.

Adversity Grid Range of consequences of exposure to adversity						
Levels	***Negative***			***Unchanged***		***Positive***
	Psychiatric Disorders (e.g. PTSD)	Distressful Psycho-logical Reactions	Ordinary Human Suffering	Negative	Positive (Resil-ience)	Adversity-Activated Develop-ment
Individual						
Family						
Community						
Society/culture						

'Adversity Grid' is a framework (not a school of psychotherapy or a technique) that reminds us of the wide spectrum of consequences when we are exposed to adversity, thus helping us restore appropriate complexity and avoid polarisation. Specifically, it identifies three main groups of such consequences: the negative ones, the positive ones and the unchanged. It also enables us to identify these three consequences at different relevant levels, i.e. the individual, family, community, wider society, etc. Ordinarily, we tend to focus exclusively on the negative consequences, which are real and important. We certainly need to identify these if we are going to provide any help in such situations. However, we should not forget that these are not the only consequences. Focusing only on these and ignoring the other two groups of consequences amounts to an oversimplification and polarisation of our perception and discourses.

Even within the category of 'Negative consequences', it is important to make finer differentiations and introduce further complexity. Not all negative consequences are of the same severity and not all of them affect people in the same negative way. For example, a psychiatric disorder implies severe forms of dysfunctionality, and it is vastly different from when one experiences some milder form of distress and suffering. There is an enormous difference between distress and disorder (i.e. psychiatric disorder), and it is imperative to make these finer distinctions with regard to the severity of the negative consequences of being exposed to adversity. The 'Adversity Grid' identifies at least three: the most severe (e.g. psychiatric disorders), moderately severe (debilitating psychological symptoms that do not amount to an identifiable psychiatric disorder), and least severe (all forms of 'ordinary' human suffering and discomfort).

At the same time, we need to remind ourselves, that there are a lot of unchanged qualities in every person who is exposed to adversity: positive and negative qualities. It is these positive unchanged qualities that I characterise as 'resilient'. 'Resilience' is a term that is used widely, understood according to an endless array of definitions. I have a very clear and operational definition of resilience: referring to those positive strengths (qualities, characteristics, relationships, etc.) that existed before the exposure to adversity, and were retained, despite the exposure to adversity, i.e. they proved to be resilient to the impact of adversity. These are the unchanged 'parts' of a person, of a family, of a community, etc. that

have been retained, despite the exposure to adversity.

Hence, when we begin to assist people in these contexts, instead of focusing only on their 'trauma', we should not forget that they also retain some of their existing strengths, and it is imperative for us to also identify, acknowledge and validate these 'parts' of them. Moreover, my argument is that everybody does not only retain existing strengths that they had before their exposure to adversity, but also develops some new strengths, which were specifically activated by the exposure to adversity. These new strengths I call 'Adversity Activated Development'. These also exist and we should also endeavour to identify and work with. According to the saying that exists in most languages and cultures: *"Whatever does not kill you, strengthens you"*. This conveys a reality that is experienced by all, in all contexts and at all times, and our theories and practices need to find ways of incorporating it.

To sum up, we need to be reminded that people retain some resilient parts, i.e. existing positive qualities, characteristics, behaviours, functioning, relationships that were retained from before the exposure to adversity; this means that these survived the exposure to adversity, whereas the 'Adversity-Activated Development' (AAD) refers to the new positive qualities, characteristics, behaviours, functioning, relationships, etc., that did not exist before the exposure of adversity, but were acquired and activated specifically by the very exposure to adversity.

There are so many examples of AAD, not only from my own therapeutic experience and clinical work, but also from my work in the field, in refugee camps and transitional spaces in so many countries. Moreover, often we hear of such remarkable AAD stories. I am reminded of Martine Wright, an English woman who was injured during a terrorist attack in the London underground in 2005, and she wrote the book *'Unbroken'*[5]. She was trapped for over an hour underground having lost 80% of her blood as well as both legs above the knees and spent a painful year of rehabilitation including learning how to walk again on prosthetics. Yet, she not only was able to resume her life, but her adversity gave her a completely new impetus and meaning. She writes that,

> *"In some ways it was the best thing that ever happened to me. No, I can't say 'best' thing. That's not quite right. It was the most life-changing thing that has had such profound and positive effects. It may sound absolutely mad to say that … But … I truly, truly believe that good can come out of bad. … But my life now is so amazing. I've had the opportunity to do so much, meet so many people. I don't think I would turn that clock back if I had the chance."*

From an ordinary and logical perspective, it does sound 'absolutely mad' to consider that she is pleased that she experienced such a severely life-threatening calamity. Yet we need to appreciate that she is referring to different realities and dimensions. In relation to experiencing losses and damages and symptoms, Martine has been overwhelmed by the most horrendous injuries and negative changes. Yet, that very adversity brought her to appreciate life in a completely new context; her very adversity opened up for her new perspectives of meaning, which she experiences so powerfully positive and life transforming (in a growth-ful sense) that, for her, they outweigh all the negative consequences that her adversity brought about in her.

5. Martine Wright (2017). *Unbroken: My story of survival from 7/7 Bombings to Paralympic success*. Simon & Schuster.

Martine is not unique in experiencing such positive life transformation following exposure to catastrophic adversity, i.e. AAD. Based on my experiences in this field, my strong claim is that every human being, when exposed to adversity, also experiences such positive transformations. However, not everyone has the possibility of actualising such forms of 'Adversity-Activated Development' because of several factors: firstly, the people who are appointed to care for them tend to focus exclusively only on their injuries (physical and psychological), ignoring all other consequences that the 'Adversity Grid' enables us to appreciate. Then, the wider discourses in this field tend also to overlook anything that is not 'traumatic', and they are not sensitive to the wide spectrum of consequences of being exposed to adversity that also include positive ones: retained strengths (i.e. resilient resources) and new strengths (Adversity-Activated Development). Inevitably, tragically and paradoxically, the survivors themselves tend to ignore anything that does not fall into the category of negative consequences, for many reasons. These include the secondary benefits that they enjoy by focusing exclusively on their losses and suffering, and the organisational structure of our services that attend to their needs.

This leads us to examine another type of complexity, with regard to who is a 'victim'. It is essential to make another crucial differentiation between perceiving people as being 'victims' of the specific set of circumstances that victimised them, as opposed to people acquiring a 'victim identity'. It is an undeniable fact that Martine is a 'victim' of the terrorist attack. People can be 'victims' of war, earthquakes, political oppression, etc. This is a legitimate way of defining who is a 'victim'. However, imperceptibly, and as a consequence of the epistemological confusion and inappropriate processing that are created by becoming overwhelmed, we tend to slip into perceiving them in their totality as victims (i.e. *pars pro toto*), thus, unintentionally, installing in them a 'victim identity'. Therefore, we should have the epistemological acumen and agility to see Martine as a 'victim' of those specific events, but not as a 'victim' in her totality, but as a 'survivor' of that adversity, and even more, as a transformed person *because* of that adversity.

This differentiation requires appropriate processing and is not possible when we are overwhelmed and impulsively resort to 'epistemological acting out', polarising our perceptions, seeing people either as 'victims' or 'survivors'. As we know very well, people with a 'victim identity' tend to become passive, overdependent on their helpers, lacking responsibility, they are disempowered and, overall, they experience all the ill effects of 'learned helplessness'. Tragically, it is us, their helpers, that inadvertently 'help' them to 'learn' this helplessness by imperceptibly adhering to the dominant oversimplified discourses that do not allow us to discern the wide range of consequences of being exposed to adversity but, instead, focus exclusively on their 'damaged-ness'.

We need to restore appropriate complexity in our discourses and, therefore, we need to make as many correct and fine differentiations as possible. Another crucial differentiation, that has already been mentioned, is between distress and disorder. It is undisputed that when experiencing adversity, inevitably, people experience various forms of distress. This is a normal response to abnormal circumstances, and it is different from when people exhibit psychiatric disorders, which refer to inappropriate responses to abnormal circumstances: inappropriate, in terms of the symptoms persisting over certain periods of times and affecting wider aspects of their functioning.

We should be acutely aware of the dangers inherent in the fact that our therapeutic care systems tend to 'reward vulnerability'; the more vulnerable one is, the more assistance and benefits and attention they receive. This often leads to the paradox that, in order to assist people, first we need to 'victimise' them by focusing exclusively on their deficits and ignoring their complexity, uniqueness and totality.

Again, by using the 'Adversity Grid' as a guiding framework, we can appreciate their vulnerabilities and we can attend to them, without ignoring their retained strengths (i.e. resilience) and their new strengths (Adversity-Activated Development). This is what constitutes a properly *holistic* approach: seeing people in their totality and not focusing on only one part of them, distorting our perception of them and installing a victim identity in them. By falling prey to conceptualisations that lack complexity, inadvertently, we risk harming further those we want to assist.

It is instructive to familiarise ourselves with perspectives in social sciences that warn us against blindly following 'Politics of Pity' or practices of 'Spectatorship of Suffering'. We need to admit that often, we 'parade' people's suffering in order to solicit assistance for them: *"Please help these poor people, pity them because they are traumatised and vulnerable ..."*. No, our stance should be clear that we want people to be helped because they deserve it; it is an integral part of their human rights to receive such assistance, with dignity and not by peddling their 'traumatisation'.

Another related danger is the tendency to, inadvertently, promote what I call 'positive dehumanization'. We are clearly aware of the nature of dehumanisation, i.e. when people are dehumanised by acts of cruelty and various forms of oppression and abuse. However, we should also be aware that by focusing exclusively on the survivors' damaged-ness and by using it as a 'facilitative' means to help them, in effect, we engage in another form of dehumanisation, which is the result of an ill-conceived 'positive' attempt to help them.

A particularly difficult and very delicate differentiation that also needs to be made, is about the demonisation of perpetrators as opposed to holding them accountable for their unacceptable actions. Unequivocally, we should condemn out-rightly all those who commit any forms of abuse and oppression, and they violate other people's human rights. However, we should be fully aware of the difference between demonisation and condemnation. The theme of our conference is Hope. The very profession of psychotherapy is based on the axiomatic belief that human beings can change, and they can transform positively. This means that every human being, even those who committed the worst atrocities, potentially can develop insight and change. The entire literature on forgiveness is full of dramatic examples of such unbelievably positive transformations. 'Demonisation' means that we fix an indelible monster identity on the perpetrators, comparable to the way we, inadvertently, fix a 'victim identity' onto those we want to help. Such fixation of negative identities, as we know, perpetuates the problem, and prevents people from moving forward.

I happen to be a trustee of a charity that works with prisoners. Undoubtedly, these are people who committed illegal acts, a lot of them serious and abhorrent crimes. Yet, they are human beings, and it depends on us how we treat them, and whether we see the hope of transformation in them, and so, we create the conditions for them to move forward and change. The examples I have witnessed of such positive transformations are most incredible and most moving.

Adversity survivors need to be treated with utter respect and from a position of humility, and not just as damaged people that we have been called upon to repair them, to fix them. I often say that they are like philosophers, because they ponder over the most fundamental human questions. If we create the appropriate space in our work with them, and we do not only focus exclusively on their 'trauma', every single adversity survivor will engage, however clumsily, in wondering about key questions of the human condition: *"Why did this happen to me?"*; *"Why people can be so cruel to one another?"*; *"Now, that I have come so close to death and I lost so much, I wonder what is the meaning of my life; from now on, what shall I be doing that can be meaningful and not waste my life?"*; etc. They are troubled by real existential questions about the nature of life and death, about the meaning of life, about the value of human relationships, about the purpose of daily pursuits, etc. Their profound experiences from being exposed to severe forms of adversity disrupt their ordinary worries and their routine of everydayness, and position them at a vantage point from where they view life afresh. These situations lead people to 'find God or lose God': they are so radically transformative. In other words, these situations make them question their very existence and they are ready for a reshuffling of their priorities and values; they are primed for a genuine 'reset', to use the currently trendy term.

If this uniquely transformative opportunity is grasped, at least by us, then they have real hope for radical changes in their lives. It is essential that we understand our responsibility in relation to this task and appreciate that the transformative possibility begins with our own very conceptualisation of all these phenomena: if we see them just as damaged people, and our role as simply to mend them, then they will miss out on this irreplaceable opportunity.

All this leads us to appreciate that as psychotherapists, we need to be well conversant in at least two 'languages', two paradigms: the language of 'damage and repair'; and the language of 'painful incomprehension'. The first is clearly understood by all. It is this language that our trainings use to help us learn and practice our profession, to make us become experts and assist people in their hour of need, and help them improve their quality of life. In effect, to repair their various forms of 'impairment' and facilitate a smoother functioning. This language parallels the traditional medical discourse of an expert attending to a patient's bodily malfunction. We need to respect this language, we need to learn it properly, and to practice it to the best of our abilities. However, if we limit our interactions with the adversity survivors only to this type of language, then, we are depriving them of the other dimension that can introduce substantial life transformations.

However, working with the language of 'painful incomprehension' requires a completely different mindset: to begin with, we need to adjust our own position as 'experts'. We cannot possibly be experts about another human being's existential position and values. Our role, here, is to create space and enable them to articulate these inarticulate and unanswerable questions that they are hardly even aware of. In relation to this task, our role is to validate the importance that they are troubled by such questions concerning the human condition, interacting with them with humility, using ordinary language without jargon or flowery hyperboles. Our role here is not to answer these existential questions, but create the space and conditions for them to emerge, in the first place, and then for us to validate them.

Returning to George Miller and his vision to 'give psychology away', can we say that he realised it? His intention was to develop people's capacity to 'predict and control behaviour'.

Obviously, we can easily ascertain that we are far from any substantial progress in relation to these aspirations. In the realm of our own profession, psychotherapy, have we allowed it to be 'bled away' or was it 'snatched away'? The fusion of psychotherapeutic insights and language into the 'psychosocial' interventions in humanitarian emergencies seems to have been the result of a two-way process: psychotherapists stretching their professional theories and practices to become increasingly more relevant to such adverse situations, but also non-psychotherapists borrowing liberally from psychotherapy to enrich their own efforts.

Valuable knowledge and sensitivities cannot be controlled and should be generously shared. At the same time, we do have responsibility to minimise (as much as possible) the damage inflicted by the irresponsible proliferation of psychotherapeutic jargon: of 'therapy speak', of 'psycho-babble'. In addition, we need to grasp and maximise the opportunities that are emerging from the loosening of the boundaries between 'proper psychotherapy' and these widely used therapeutic interventions in humanitarian emergencies. We can achieve this by increasing the level of complexity and limit the oversimplification and polarisation in this field. Moreover, we need to eschew pretensions of superiority and engage on, more equal terms, in genuine dialogue, with all relevant related fields, such as philosophical traditions and spiritual practices and develop more coherent and collaborative ventures.

Ultimately, hope needs to be grounded onto our awareness of our own limitations, of the enormity of the task, of the destructive realities not only around us, but also inside us, and between us. Hope needs to be the product of our courage and epistemological acumen and flexibility to grapple with complexity, avoiding simplification and polarisation, avoiding victimisation of sufferers and demonisation of perpetrators.

It is then that hope, according to Aristotle, will be real and not just abstract youthful fantasies, and according to T.S Eliot, hope will not be 'for the wrong thing'.

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