Involuntary dislocation adversities

Contents

‘Refugee trauma’: a problematic concept

The very term ‘refugee trauma’ suggests the simple causality of the problematic Stimulus–Response (S-R) formula. This term is based on the two assumptions that (a) there is a distinctive set of adverse conditions that all refugees are exposed to, and (b) these adversities result in a typical type of ‘trauma’ that refugees experience. Obviously, not all refugees are exposed to the same set of adversities, and, more importantly, it cannot be assumed that all refugees would experience these realities in the same way, even if they were to be exposed to the identical adversities. Despite the fact that these observations are self-evident, the conviction about the validity of the ‘refugee trauma’ persists (e.g. Boehnlein & Kinzie, 1995; George, 2010; Mollica, 2001; Nickerson et al., 2015; Papadopoulos, 1998, 2001a, 2002a, 2002b, 2007).

The idea of ‘refugee trauma’ is confused and confusing because it entails a comparable tautological fallacy to what was identified in the previous chapter, i.e. refugees are ‘traumatised’ because they are exposed to a ‘(refugee) trauma’ (referring, incorrectly, to a set of adverse events and experiences), and the set of events is considered ‘traumatic’ because refugees developed a ‘trauma’ by being exposed to it. Another fallacy is that because the typical events and circumstances that refugees tend to be exposed to are indeed detrimental, inhuman, damaging, criminal, and negative in some respect, inevitably they will also have, exclusively, a ‘traumatising’ effect on those who are exposed to them. Finally, there is another lack of differentiation, between *distress* and *disorder* (Horwitz, 2007). Even if a person exposed to certain types of adversities experiences various forms of distress, suffering, disorientation, etc., why are these considered to be ‘traumatic’? Especially if trauma is understood to be of the PTSD type, which refers to a psychiatric disorder, an actual form of pathological dysfunctionality. In effect, such lack of differentiation amounts to pathologisation of human suffering.

In order to avoid such unclarities, we need to develop a more precise discernment of these processes as well as select appropriate language to address them. Accordingly, it is imperative to differentiate the complexities involved by being reminded of the five constitutive elements of this process (as discussed in Chapter 1), i.e. (a) events, (b) experiences of events, (c) impact of the experience, (d) response to the impact, and (e) communication of all of the above. This means that we need to appreciate these elements as being actual successive stages of the process from dislocation to relocation: not as abstract chronological landmarks, but as phases full of new experiences which substantially reshape a person. This reshaping affects not only one’s psychological or mental functioning but also the entire person, including, *inter alia*, alterations in one’s outlook to life and human nature, in one’s sense of self and identity, and in many aspects of how one conceptualises key events and experiences. Accordingly, the term ‘refugee trauma’ cannot possibly convey the multiplicity of such changes.

In order to fully appreciate the role of these five stages, we need to relate them to two other sets of phases that affect people during the involuntary dislocation

process. The first refers to the impact of the actual chain of events, and the second to the epistemic processing of the relevant events and experiences.

Phases of involuntary dislocation

Traditionally, the relevant literature has identified three main stages of the refugee and migration process: pre-flight, flight and post-flight or variations of this, e.g. 'pre-migration, migration, postmigration' (Bhugra & Jones, 2001), 'predisplacement and postdisplacement' (Porter & Haslam, 2005), 'pre-migration, transit, post-migration' (Scwheitzer et al., 2007), 'pre-migration or departure, transit or intermediate stage, and resettlement stage' (Pine & Drachman, 2005). In addition, other classifications have been used, such as Agier's three stages: 'stage of destruction', 'confinement', 'moment of action' (Agier, 2008); Stein's nine stages: 'perception of a threat; decision to flee; the period of extreme danger and flight; reaching safety; camp behavior; repatriation, settlement or resettlement; the early and late stages of resettlement; adjustment and acculturation' (Stein, 1981); and Hynes' slight modification of Stein's eight stages: 'The Period of Threat, The Decision to Flee, In Flight, Reaching Safety and a Place of Asylum, Refugee Camp Experience, Reception Into a Host Country, Resettlement, PostResettlement' (Hynes, 2003).

Most individuals feel that their lives were divided sharply by their dislocation, in terms of the *before* and *after* their big ordeal. This is not untrue. However, the question is: what are the actual sequences of events and their impact on people that produced this radical split between the *before* and the *after*? Over the years, I have come to identify four main phases: Anticipation, Devastating Events, Survival, and Adjustment (Papadopoulos, 2001a, 2001b, 2002a, 2010a).

To begin with, the predominant perception in society is that the most 'traumatic' experiences are those that are associated with the events that caused the actual dislocation in the first place. Still today, the events that lead up to the dislocation tend to be privileged, even among professionals, as being the main cause of 'refugee trauma'. For example, Heide, Mooren, and Kleber (2016) argue that 'many refugees, almost by definition, . . . [suffer from complex trauma], having left their country of origin because of persecution, war, or organised violence'. Without a doubt, these are events of a severely distressing nature, but limiting our focus only to these ones prevents us from appreciating the complexity of the entire dislocation process.

By identifying the phase of Anticipation, attention is directed towards examining what happens before people abandon their homes. In most situations, people know or sense that there is an impending danger, and they are faced with not only the fear of what is going to happen to them, their loved ones, their property etc., but also the enormous pressures to make critical, life-and-death decisions as to how to act. At the same time, they are also being plagued by most painful unknowns, unable to answer agonising questions: will they be able to return or

not? is it better for all of them to leave together or for some of them to remain behind and protect their properties? which direction is safer? etc. The pressure on them is enormous because they are not unaware that their decisions are likely to affect not only their own survival but also the future of their families for generations to come.

Connecting these phases with the two involuntary dislocation moments that were identified in Chapter 2 (i.e. the dislodgement from the experience of 'feeling at home' within one's home spaces and the subsequent actual physical movement away from these spaces), we appreciate that the phase of Anticipation often consists of two sub-phases: the first refers to the time when they are still not certain whether their home spaces continue to be experienced as safe and home-like as before and the second includes all their reactions to accepting the reality of their initial dislodgement. Therefore, it is during this phase that they sense the momentous impact of the life-changing shift that the first moment produces.

The phase of Devastating Events encompasses everything that happens when some of the fears that had arisen during the Anticipation phase become a reality, i.e. when the acts of violence explode and when brutalisation and destruction demolish the previous order of things. Coming after the Anticipation, this phase includes all the calamitous and catastrophic actions that make it impossible for people not to abandon their homes. It is during this phase that the most serious and perilous threats to life occur, e.g. killing, rape, torture, destruction of property.

Four interrelated observations need to be made about this phase.

(a) This is the phase that includes actions with a direct and most detrimental impact on people; possibly the most tangible events and circumstances that can be clearly identified, documented, and consequently characterised and condemned as criminal, as violations of human rights, as inhuman.
(b) This is the phase that is usually referred to as 'the trauma' or the phase of the 'traumatic events'.
(c) As a result of the two preceding observations, it is the narrative which accounts for the events and experiences of this particular phase that is usually understood as conveying not only the 'trauma story', but also the very essence of the affected person's plight. This means that when workers want to facilitate fleeing people to articulate their unique narrative, it is mainly the story that narrates the incidents of this phase that they are attempting to piece together. As a result, the affected person's narrative of this phase acquires the status of *the* 'personal story' which serves as the accepted 'identity card' of that particular person, becoming the currency for all interactions with most services that offer assistance. These interactions are not limited to those between that individual and the services she or he interacts with, but also include communications among the referring network itself, i.e. when one service refers the identified individual to another service. Unavoidably, this specific narrative that becomes the unique marker of that particular individual

is a co-construction between the person and the services and organisations that she or he interacts with.

(d) In reality, not all involuntarily dislocated persons experience such a phase. A lot of them, sensing the impending danger, flee before they are exposed to any forms of actual violence. This poses enormous problems for such individuals because they are unable to make use of the accepted currency of such communications with their helpers. Moreover, intentionally or unintentionally, a ranking order seems to emerge (among both beneficiaries and helpers) as to who has the most severe 'trauma story', creating a seemingly logical linking between the degree of severity of the devastating events, the degree of damage inflicted on the affected persons, and the amount of assistance they will require. As discussed in the first chapter, this apparently logical equation is deeply flawed, mainly because it ignores the complexity of the way events are experienced.

The phase of Survival is characterised by the termination of the previous phase. Now people are safe and have survived all the destructiveness of the Devastating Events. Although during this phase people are indeed free from physical attacks and no longer experience serious threat to their lives, this can nevertheless also be a most unsettling period in its own right due to experiencing their lives as being turned upside down and full of uncertainties. Having been compelled to reluctantly abandon their home spaces, and having endured the ferocity of the Devastating Events, people often languish in limbo during this phase. Typically, this phase covers the time when people are under protection in some safe location, such as temporary refugee camps, where they are not masters of their own destiny or even of their own daily routines. Not uncommonly, they wait for indefinite periods, living in an unknown state with regard to past, present, and future; unclear of what happened to their family and friends, of how to spend each day, of when they will be moved and where to, etc.

Finally, the phase of Adjustment covers the entire period of when the involuntarily dislocated persons settle in a new location which is meant to become their new home, at least for a period of time. The challenges they face are enormous, and several have already been addressed. It is not easy for involuntarily dislocated people to grasp the realities of their new place, new ways of being, new language, new codes of interpersonal relating, new status, etc. while struggling to hold all these together in the context of a coherent sense of self, to digest what they have endured, and to plan for their future. It is indeed a most arduous task to strive to connect meaningfully with their new environment (geographical, cultural, educational, etc.) while processing all their adverse experiences, past and present.

The concept of 'adjustment' is problematic because it points to a unidirectional effort, implying that it is the involuntarily dislocated persons who have to fit into their new contexts. Other terms used for this phase are equally awkward, e.g. adaptation, integration, acculturation, assimilation. Without entering into a comparative evaluation of them, it needs to be said that to varying degrees, all of them

(each with a different emphasis) suggest the newcomers' own effort to fit into their new environment. Perhaps the term 'integration' leaves open the possibility of some mutuality, but even that one has its own questionable implications.

What should not be forgotten is that it is only relatively recently (over the last couple of decades) that the relevant literature started appreciating the importance of this phase. Earlier, the emphasis was almost exclusively on the 'trauma' of the Devastating Events phase, taking it for granted that the difficulties people encounter in their receiving countries are inconsequential.

Identifying these four phases not only offers a more differentiated and accurate understanding of what the affected individuals actually go through but also reminds us that each of these phases can be 'traumatising' in its own specific way. When considering *the* causes of the 'refugee trauma', it should be remembered that they are not a product of one phase. Each phase constitutes a distinct universe in its own right, within which the affected persons perceive themselves and others in a unique way, experiencing their fears and aspirations, their worldview, their past, present, and future in a distinct way. Each phase affects them in their totality, i.e. the intrapsychic and interpersonal as well as socio-political facets of their being. In short, it is not an exaggeration to argue that the affected individuals experience themselves as having a different sense of personal identity during each one of these phases.

However, the very fact that a person experiences oneself in successively different 'universes' has also another effect. In addition to (and not instead of) all the suffering and disorientation, they also experience another obvious reality: that despite all the upheavals and all their transformation, in some sense, they remain the same person. This self-evident realisation can have a remarkable impact on them, over and above all the other effects discussed here. Experiencing the continuity of oneself through a series of successive and drastic changes, sensing and distinguishing what remains stable about oneself despite all the profound alterations, can lead to invaluable insights, which can lead to equally profound positive developments.

Ultimately, it is essential that when considering the complexities of the dislocation-relocation process we keep in mind all three sets of stages: the 'two moments' ('internal' and 'external') as well as the 'six segments' (also from Chapter 1: in addition to the 'two moments', the searching for new home spaces, locating them, inhabiting them, and endeavouring to make sense of the entire process). Without this 'discerning complexity', we are likely to fall into the epistemological traps of various forms of oversimplification.

The sequential, constructed process of the adversity impact

In order to appreciate the effects of adversities on involuntarily dislocated individuals, it is essential to disentangle epistemologically the very process of how adversity impacts on people in general. Building on what has already been explored in

this book, the first differentiation that needs to be made is between the *initial reaction*, when one is exposed to any form of adversity, and the *lasting effects* that tend to be associated with the *mark* adversity leaves on a person.

It is reasonable to expect, by and large, that adverse events produce adverse impacts on people. When ordinary civilians barely manage to escape carnage and destruction, it is inevitable that they will be petrified, have physical reactions, e.g. shaking, screaming, hyperventilating, etc. All these are *appropriate responses to adverse circumstances*. The opposite would have been inappropriate, i.e. to remain unmoved without being affected by such life-threatening events.

My argument is that whatever immediate reactions one has to such devastating events would be appropriate and understandable. Even psychotic tendencies of distorting reality, paranoid states of suspecting everybody as a potential attacker, bouts of depressive withdrawal – all of these would fall into the same category, i.e. of appropriate responses to adverse circumstances. One may object to accepting all such reactions as appropriate and may insist on considering certain reactions as disproportional to that particular type of adversity and, therefore, as signs of real pathology.

It is precisely in response to such objections that the criteria for diagnosing PTSD, according to the latest Diagnostic and Statistical Manual (DSM 5) of the American Psychiatric Association, specify the 'duration' that we should allow before the symptoms are diagnosed as PTSD. First, it clarifies that all the identified symptoms need to persist 'more than one month' and then, in relation to 'delayed expression': 'full diagnosis is not met until at least six months after the trauma(s), although onset of symptoms may occur immediately'. This clarification is extremely important and is an admission that any symptoms, within at least one and then six months after the actual exposure to adversity, should be accepted as falling within the 'normal' range of reactions. This, of course, does not mean that such reactions, behaviours, feelings etc. are not debilitating and obnoxious for the sufferer. The point is that, regardless of their distressing nature and unbearableness, they still fall within the range of what is expected, given that the person was exposed to such devastating forms of adversity. Considering all forms of *distress* as manifestations of (psychiatric) *disorder* is a grave epistemological error.

What matters most is what follows after those initial reactions. Inevitably, these *reactions* will have a profound *impact* on the person and on the others around him/her. Not only the original *events and circumstances of adversity*, but the *reactions* themselves will *impact* all concerned. What does it mean to the affected persons themselves, and to others close to them, that they have such reactions/'symptoms'? What does it mean, for example, for a father who previously always faced difficulties calmly and efficiently and now cries incessantly, is unable to sleep properly, worries all the time, does not let any member of his family out of his sight, etc.? What *impact* will these *reactions* have on him and his family? In short, when facing such uncharacteristic behaviour (which is the reaction to the adverse events), the affected persons would either perceive them as 'appropriate responses to adverse circumstances' or as indications that they are now disturbed to a degree

that requires specialist psychological or even psychiatric attention. Needless to say, there are many more positions in between these two extreme polarities.

What determines the way the affected persons perceive these *reactions* as well as the original adverse *events and circumstances*? What factors affect whether expressions of *distress* are perceived as a *disorder*?

The example of the two Bosnian men who came to London as refugees (discussed in Chapter 1) is indicative of what I am examining here. As a reminder, they were affected by their overall experiences in diametrically different ways, although they were exposed to the same forms of adversity, exhibited the same initial reactions, and benefitted from identical types of reception in the UK: one adopted the identity of a passive victim, feeling that he was scarred for life, whereas the other one came out of his ordeal feeling strengthened by his ability to overcome adversity, adopting the identity of a very active survivor.

This means that the two different ultimate outcomes are not directly and causally produced (based on the simplistic S-R formula) either by the original events or by their initial reactions, all of which were identical. Instead, they are the products of how their initial reactions were *perceived and processed* by each man and by those close to them within the context of the wider societal narratives. Therefore, the lasting *mark* adversity has on a person depends on the *meaning* that is given to the initial reactions and symptoms. By meaning, here I understand the overall sense one has about the cluster of reactions to the adversity, e.g. are they perceived as appropriate and understandable under the circumstances or are they taken as signs of pathological disturbance? The term *meaning* is used here not as the outcome of a conscious, cognitive deliberation that can be articulated clearly in logical language. Instead, it refers to the general sense one has, mainly non-consciously, about a phenomenon (Papadopoulos, 2020). This meaning is the by-product of a number of factors and processes that will be discussed now.

The key implication of my central argument here is that these lasting effects should be understood as a *mediated* response, which comes after the initial reaction to the adversity. More precisely, this *mediated* response is a *constructed* response, formed by what I term Meaning Attribution Processes (MAPs). In the case of the two Bosnian men, whereas the first man constructed a meaning of his *distressing reaction to his adversities* as a *disorder*, the second man *construed* the very same *distress* as a normal response to abnormal circumstances and used it to spur him on in life.

Meaning Attribution Processes

The Meaning Attribution Processes include all the conscious and non-conscious interactions of a wide network of factors that contribute to the specific way one experiences and responds to adversity and to the initial reactions to adversity. As we have seen, this experience and response follow two sequential steps: the first refers to the unavoidable reaction to the adversity events, and the second (and most important one) includes the way the initial reactions and symptoms

are perceived and responded to. Therefore, it is more accurate to understand this entire process not merely as the impact of some factors on how one experiences adversity, but rather as a series of interactive *processes* between (a) the external adverse realities and (b) the contributing factors that affect how these realities are perceived and processed, in the context of (c) the wider societal discourses about these phenomena.

These factors include at least the following categories, which, although they overlap, should be differentiated and each understood in its own right.

(a) Personal factors

These include all the variables that would constitute the O in the S-O-R formula (O for organism), i.e. everything that comprises the uniqueness of a person. These would include a person's unique physical, intellectual, psychological, and other characteristics; personal history; coping mechanisms; strengths and weaknesses in relation to many relevant variables; the person's status and educational background, etc. – in fact, all the pertinent personality features that existed before a person was exposed to adversity, i.e. the equivalent of what is referred to a 'pre-morbid' personality (when one examines the onset of a psychiatric disorder). In addition to this, within this category also fall all the phenomena that were discussed earlier in the book, i.e. *polymorphous helplessness*, *onto-ecological unsettledness*, *nostalgic disorientation*, and *victim identity*. Although all of these have a relational component, constructed in the interaction with one's wider family, community, and social contexts, they nevertheless refer to the state of a person. It is obvious that a person with a firm victim identity will experience and deal with a certain adversity differently from another person who does not have such an identity. In short, this category encompasses all the idiosyncrasies of a person that emanate from one's personal characteristics, history, and interactions.

(b) Relational factors

These refer to the various forms of active and potential interactional networks that a person engages with, both positively and negatively. Of particular relevance here are the various forms of *support systems* that are available to a person. One specific way of understanding these systems is by means of 'social capital', which refers to the positive gains from relationships with others. Social capital is comparable to financial capital, which is needed in order to carry out important transactions that further one's objectives in life. Similarly, social capital is needed to carry out the necessary social interactions to further one's engagement in social life. Analogous to accumulating financial capital to be spent whenever one needs it, accruing social capital can be used subsequently, whenever required.

> A key notion is that social capital exists only within relationships . . . it is a feature of the social context . . . as opposed to human capital, which is an

> individual attribute. . . . All definitions are based on the principle that social capital provides advantages to those who have access to it.
>
> (Conrad, 2008, p. 54; see also Baron, 2000; Field, 2016; Lewandowski, 2009)

'Human capital' is characterised by 'what you know', such as 'experience, education, skills, knowledge, ideas', but social capital by 'who[m] you know', as in 'resources of trust, relationships, and contact networks' (Luthans et al., 2004, p. 46). Therefore, human capital would fall under the category of 'personal factors'.

Social capital is particularly applicable in the context of involuntarily dislocated persons (e.g. Beiser & Hou, 2017; Colletta & Cullen, 2000; Elliott & Yusuf, 2014; Newman et al., 2018; Pittaway et al., 2016). Relating meaningfully to other people in times of dislocation, when a multitude of needs arise, can be of great benefit. Social capital's key relational characteristics can fairly effectively mitigate against many ill effects of involuntary dislocation, e.g. *polymorphous helplessness*, *nostalgic disorientation*, etc.

***Family* and *social factors* can be considered as subcategories of this group that address *relational factors*.**

Family

Ordinarily, the family is potentially the foremost source of support throughout one's life. The supportive presence of the family is particularly welcome and beneficial during adverse times, especially during the process of involuntary dislocation (BPS, 2018; Papadopoulos, 1999, 2001b, 2002b, in press; Papadopoulos & Hildebrand, 1997; Voulgaridou et al., 2006). The family can potentially provide much needed support to its members, including: general stabilising support to bear their experiences of dislocation as well as specific support in dealing with particular types of adverse situations; moderating their perceptions of adversity, thus avoiding overestimating or underestimating it; tempering their estimations of their achievements and failures; enabling them to learn from their experiences, specifically, by becoming aware of how they have survived adversities; facilitating family members to maintain and develop fruitful connections and relationships with persons and organisations outside the family.

Yet, not all families are in a position to provide all these beneficial effects to all family members, all the time, and under all conditions. During the hardships of involuntary dislocation, the family may suffer from disruptive experiences that may take various forms (Rousseau et al., 2001; Segal & Mayadas, 2005; Weine, 2011), including: remaining focused on objective difficulties, they may overlook internal family dynamics and specific needs of vulnerable family members; during the dislocation process, family members may separate, experiencing their ordeal differently, with fewer shared experiences, resulting in deeper splits in the family; also, new roles, identities, alliances, divisions, and imbalances may emerge within the family, leading to unpredictable detrimental effects (Papadopoulos, 2020, in press).

All the above indicate that the family, constituting perhaps the most central structure of a person's systemic belonging, mediates between the wider contingencies of adversity and the person's individual experience of them. Families are not only affected negatively by involuntary dislocation but may also develop new forms of internal family cohesion, uniting their members together to face external threats.

What is discussed here is not limited to well-functioning, ideal families. Every family faces difficulties, conflict, manageable and unmanageable differences, and various forms of disjuncture. My argument is that despite whatever difficulties they may face and their own internal state of disharmony, most families can potentially provide all the beneficial effects outlined here as well as all the negative ones. Moreover, in terms of form and composition, what is discussed here is not restricted to traditional nuclear families of one or two parents with their own children; it applies to all forms of families, e.g. single parent, reconstituted, etc. Finally, attention needs to be given to different definitions of families in different cultures and circumstances. During involuntary dislocation, of particular importance are not only different types of extended families, e.g. family members in different parts of the world and from past times, but also the variety of less-typical forms of families. For example, in certain cultures, a neighbour may be considered, and even called, 'an uncle' by a surviving child who lost all the members of her/his own nuclear family. These blurred boundaries of who is a family member and who is not, and according to what criteria families are defined, are especially sensitive issues that require careful consideration, not least because of the overlapping definitions between legal systems in different countries and the cultural and experiential lived realities.

Community/social factors

By extending the family factors, we can understand the ways the wider community and the multiplicity of social factors combine together to contribute to the unique manner in which individuals experience these adversities. However, when considering these factors, what should not be ignored is a new dimension that has added a substantial and novel perspective on how meaning is constructed in these situations. This refers to the digital environments, technospaces, and various other forms of social media, the internet, and the overall information and communication technologies (ICT). These new practices have been emerging extremely rapidly, connecting individuals, family members, and others in ways that affect decisively how involuntarily dislocated persons experience their predicament (cf. Andrade & Doolin, 2016; Shariati et al., 2017). These new technologies and practices have developed new terminologies, such as:

- 'Fractured information landscapes' and 'individual and community information resilience': these refer to various forms of interrupted and incomplete information about the new places refugees find themselves in, which may

also negatively affect the ways refugees experience the continuity of their own past, which in turn impact on their ability to articulate coherent narratives about their past. Conversely, 'information resilience' refers to the capacity of individuals or communities to withstand this fracturing and to find effective ways of combating it (e.g. Lloyd, 2017; Lloyd et al., 2017).

- 'Family imaginary': this refers to new forms of 'imagining' the composition and reality of one's family, and the ways such experiences affect people on the move, (e.g. Robertson et al., 2016).
- 'Connected presence': this refers to various forms of experiencing the presence of others though the use of social media and other ICT forms (e.g. Licoppe, 2004).
- 'Co-presence': this seems to be a variation of 'connected presence', when a person experiences the presence of another person through forms of virtual realities (e.g. Zhao, 2003).

Through these varieties of virtual connections, new forms of family, community, and social relationships are developed that can be pivotal in affecting involuntarily dislocated persons' experience of the adversities of their predicament. Moreover, even outside the ICT realm, the fluidity of boundaries between family and other social groupings has become looser, intermingling family members, friends, and wider social connections and creating new combinations. A typical example of this is reflected by the new term *framily*, which is a neologism blending 'family' and 'friends', referring to persons one considers as family due not to blood relation but close friendship.

This subcategory should also include not only real and virtual communities but also what Anderson (2006) called 'imagined communities', which are formed by people joined together by a sense of belonging. The role of 'imagined communities has not been sufficiently explored in relation to involuntary dislocation (cf. Chavez, 1991; Malkki, 1994). Involuntarily dislocated persons themselves create many such 'imagined communities' but are also assigned to various forms of such communities by others.

Despite inevitable overlaps, there is merit in grouping together the family, social, and community factors under the category of 'relational factors'.

(c) Gender, race, age, ethnicity, class, disability, poverty

These are grouped together because, usually, they come under the rubric of demographic data. If taken only as demographic information, their value is underestimated. However, each one of these factors can also affect decisively the way meaning is attributed to the events and experiences of those events during the involuntary dislocation process (e.g. Manthorpe & Hettiaratchy, 1993; McInnes et al., 1999; Pease, 2009; Pittaway & Bartolomei, 2001; Sundquist, 1995).

Within this broad category we can include what are referred to as 'social graces'. British systemic family therapists John Burnham and Alison Roper-Hall

developed a group of factors that they considered crucial in understanding the complexities of families and coined the acronym GGRRAAACCEEESSS, standing for Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation, Spirituality (Burnham, 2013, 2018; Divac & Heaphy, 2005). These 'social graces' were conceived in the context of family therapy interventions, yet they can also be considered as factors that mediate between the events and circumstances of adversities refugees are exposed to and the way they experience them.

(d) Power position

This group of factors encompasses all forms of power inequality that most involuntarily dislocated persons experience, in one way or another. Persons and groups that have been experiencing various forms of marginalisation would be additionally burdened whenever they experience the various dislocation adversities. It is also possible that those who endured political subjugation over long periods of time may develop effective strategies of dealing with adversity that equip them to find better ways to cope with the actual refugee adversities. Whatever the case may be, becoming aware of issues of power increases our understanding of the factors that contribute to the way a person and a community experience the adverse events and circumstances of involuntary dislocation (e.g. Georgiou, 2017; Kisiara, 2015; Lammers, 2007; Mollica et al., 2001; Pittaway & Bartolomei, 2001; Tascon, 2004).

Of particular relevance in the same category of power is the lethal combination of helplessness, isolation, and humiliation (e.g. Fangen, 2006; O'Neill, 2007; Zeno, 2017). It is very trying for anybody to bear any one of these three injurious conditions, especially during the process of involuntary dislocation. However, having to cope with all three makes it even more intolerable because the one reinforces the other, creating an extremely obnoxious cocktail of toxic conditions, often leading to violent outbursts against others and/or against oneself (with self-destructive acts). The feeling of lack of power and control becomes exacerbated by these three conditions, and this is the reason that they are often considered to create the conditions that lead to radicalisation (e.g. Ahmed, 2015; Varvin, 2005). Experiencing the combination of lack of control with lack of respect (in humiliation) and lack of support (in isolation) often produce this particularly toxic form of helplessness.

(e) Predictability, anticipated duration, and lasting effects

The way individuals experience their dislocation adversities as well as their own reactions to these is also affected by how predictable both of these can be. Unpredictability exacerbates uncertainty, which is one of the most malignant feelings during involuntary dislocation. This dictates the importance of providing as clear

and reliable information as possible to the affected persons about the reality, duration, and even likely impact of the adverse conditions they are about to face. Nobody expects to predict all the situations and anticipate every hardship under such fluid and often chaotic conditions. Nevertheless, even the smallest piece of correct information that can assist one to anticipate with some degree of confidence helps enormously in increasing the sense of control and in reducing unavoidable forms of uncertainty.

(f) Set systems of meaning

At critical times, when the working reality of *onto-ecological settledness* becomes unsettled, the person is driven to adopt and utilise a new sense of meaning of the basic givens about oneself and one's life. Constructing meaningful new ways of relating to fundamental questions (e.g. how can I lead my life now after all these losses? what should my life priorities now be?) during times of upheaval such as involuntary dislocation is not an easy feat. Therefore, resorting to an established and pre-existing system of meaning that can provide answers or at least signposted directions to most facets of these crucial issues becomes an attractive option.

Set systems of meaning are existing clusters of collectively shared principles, perceptions, values, etc. that are predominantly of a specific nature, e.g. political, religious, moral, and provide meaning for facets of one's life. For example, workers often hear refugees say that what happened to them was 'Allah's will' or that it was Allah's way of 'punishing' or 'testing' them. These convey that the individuals give a specific religious meaning to their suffering and overall predicament. Others perceive their situation using political systems of meaning. For example, Nelson Mandela succeeded in not only enduring his 27 years of brutal incarceration but also thriving and inspiring the whole world, because he was totally imbued by the spirit of his political convictions, fighting against the South African government's policies of racial discrimination. Although theoretically a person may utilise a wide variety of systems to attribute meaning to their predicaments, in reality the choice is ultimately limited by the many personal and circumstantial factors (e.g. Brune et al., 2002; Eiroá Orosa et al., 2011; Papadopoulos, 2006, 2020; Pierce & Gibbons, 2012). It is unfortunate that the relevant literature has not yet attributed the deserved attention to the importance that set systems of meaning have in affecting the way involuntarily dislocated persons experience their adversities and their responses to them.

(g) Current conditions, circumstances, and relationships

With the excessive and not always unjustified focus on the past and the future of involuntary dislocation, the present often tends to be underestimated. The conditions that persons are exposed to now also affect the way they experience their

adversity and their reactions to it (cf. the role of 'daily stressors' in Chapter 9). If persons now live under dismal conditions with a lack of safety and without satisfactory human relationships, understanding, and support, and are met with hostility and suspicion by unfriendly people, these current settings will obviously substantially affect the way they experience their overall involuntary dislocation adversity. Conversely, if they are welcomed by people who relate to them with warmth and understanding, they are likely to experience their dislocation differently and more positively.

(h) Future prospects and hope

Equally important to the present is the future, also markedly affecting the way involuntary dislocated persons experience their overall predicament. The realistic prospects of what is going to happen to them in the near and distant future is not a hypothetical abstraction. It matters a great deal to individuals if, for example, they are stuck in a refugee camp languishing for decades without any realistic prospect of resettlement or repatriation, or if they are living temporarily in a reception centre, waiting for a more permanent arrangement. The presence or absence of viable hope based on feasible prospects for the future considerably affects the way involuntarily dislocated persons experience their adversities (past and present) and their reactions to them (e.g. Gilman et al., 2012; Janoff-Bulman, 1989; Kwon, 2015; Snyder, 2002).

(i) A host of socio-political, cultural, legal factors

This last group of factors includes all the noticeable and unnoticeable factors, discourses, and narratives that are present in particular communities and in the wider society as well as the endless list of more specific socio-economic, political, legal, cultural, linguistic, religious, and many other factors that bestow meaning to the dislocation events and the ways these are experienced. Different factors will contribute to experiencing the same events and circumstances of dislocation differently from person to person. There is a voluminous literature of how such cultural factors affect the perception and experience of involuntary dislocation (e.g. Edge et al., 2014; Hsu et al., 2004; Hussain & Bhushan, 2011; Papadopoulos & Gionakis, 2018; Watters, 2001; Kirmayer et al., 2011).

Epistemological punctuation; mark and sign

Having examined the various factors that comprise the Meaning Attribution Processes (MAPs), it is now possible to summarise and map out the sequence of the impact that the involuntary dislocation adversities have on individuals, families, and communities, building on the elements of the overall experience of adversity, developed in Chapter 1, i.e. (a) the *event/s*, (b) *reactions* to the events, (c) the *impact* that the reactions have on those affected by the event, (d) the *response* to

the whole experience, and, finally, (e) the *communication* to others of any aspect from this entire experience.

(a) Following exposure to adversity, a person would, naturally, *react*. Regardless of the nature of the reaction and the resulting psychological or even psychiatric symptoms a person may exhibit, these should be understood as 'normal reactions to abnormal circumstances'.
(b) Whatever the reactions may be, they will have an *impact* on the person concerned as well as on all those who interact with him or her. This impact depends on how the *reactions* are perceived and processed, i.e. given meaning.
(c) Both the reactions to the adversity as well as the impact these reactions would have on all implicated parties cannot be based on a simplistic and causal S-R formula; instead, the *meaning* given to them will be *mediated* by the intervening variables of the various clusters of MAPs, which are unique for each person.
(d) Consequently, the lasting effects of the involuntary dislocation adversities will also be the product of the MAPs, i.e. they constitute a *constructed* and *mediated* response, not causally dictated by the adversity itself.

Within the framework that is developed here, the majority of trauma theories can be understood as referring only to the first two steps of this sequence, i.e. the adversity and the initial reaction to the adversity. What the trauma discourses purport to show are the alleged effects (i.e. the 'traumatic' experiences) of the adversities, which are assumed to be their causes. Yet, **this is only the beginning of a longer process**. Stopping our observation at this point is an arbitrary and, in effect, inappropriate *epistemological punctuation*. This means that if we place a full-stop, a period, after the initial reaction, all we are left to examine is, simply, how the first step of this sequence causes the second, i.e. how adversity causes 'trauma', how 'trauma' is the causal effect of adversity, of the 'stressor'. Such a punctuation freezes time inappropriately and narrows our unit of observation only to the direct effects of the devastating events encountered during involuntary dislocation; these effects are only the initial reactions, i.e. the normal responses to abnormal circumstances. Such an observation is not wrong, as such, but it is incomplete and, therefore, can be misleading. It is a *pars pro toto* observation, i.e. one part mistakenly taken to represent the whole.

However, if we were to follow the full sequence, i.e. place a comma or a semicolon after the second moment, our vistas will be widened, expecting to observe the longer sequence of the same process. Then, we observe that the very initial reaction, i.e. the direct *effect* of the adversity, itself acts as a *cause* of further effects. In other words (using the etymological understanding developed in the preceding chapter of 'trauma' as both a *mark* and a *sign*), we observe that the 'trauma' (i.e. the initial reaction to adversity) is not only the *mark* (i.e. the effect) that is caused by the adversity, but also constitutes a *sign* of what follows, signalling the direction of what subsequently unfolds. What unfolds includes, foremost, the obvious fact that whatever the initial reaction to the adversity may have been,

it will inescapably have an *impact* on everybody concerned (the sufferer and others, i.e. all the *Interactional Matrix of Intervention* actors).

Like all causality in social sciences, it is limiting to observe only one segment of the *causal chain*, which consists of a series of *successive links* between cause and effect, i.e. the effect of a cause itself becomes the cause of further effects, etc. For example, if a father, under pressure from the dislocation adversities (original cause) reacts with uncontrollable rage (original effect – mark of the original adversity), his very rage (now also as a new cause, a sign, e.g. sign 1) will have an impact on his family and even on himself (new effects, mark 2), this very impact, e.g. his family members become frightened and he becomes defensive (now also becomes a new cause, sign 2) which will produce new effects, etc. This means that his rage will be perceived and processed in certain ways and will be given a certain meaning, consciously or not which will have a new set of effects. Accordingly, he may be perceived, for example, by his family and himself as 'losing his mind' (i.e. meaning attributed to his reaction), which, in turn, acting as another cause, will have a further effect/impact on his family and himself, resulting, e.g. in the break-up of the family or in strengthening their family bond. Thus, the lasting effect, the final outcome, so to speak, will be determined by the complexities of the Meaning Attribution Processes (and how these affect all the implicated actors of the *Interactional Matrix of Intervention*) and not by the nature of the initial adversities the father was exposed to, or by the nature of his own initial reactions to them (i.e. his rage).

Although even a simple epistemological reflection reveals the veracity of this understanding, it is still difficult to accept its validity, whenever one is confronted by the real pressures generated by the adversity that demand a simplistic causal-reductive and linear epistemology. Moreover, what we also observe is that this construction works *reciprocally*: once a settled meaning is constructed by this chain of cause and effect, then this meaning is used to give new meaning to the original adversity.

For example, a Syrian young man who had an easy-going life before the war in his home country fled, and after several years of facing impossible obstacles, living in inhuman conditions, and coming very close to death on several occasions, finally arrived in the UK. After about a year of settling in his receiving country, he started reflecting on his life as a whole, unprompted, and told me that now he appreciates that life is very 'precious' and he does not want to waste it. Also, he said that however 'stupid' it may sound, 'it was good' for him to have gone through those hardships because they made him 'a changed man'. During his perilous journey, he hated every minute of it, i.e. he experienced the events and circumstances of his adversity in a most negative way. Yet, on settling in the UK and after gaining a new meaning of his overall ordeal from that new perspective, he re-viewed the same adversities, giving them an opposite meaning (a positive one), saying that his easy-going life back home before he fled was a 'waste', and he was grateful that his tribulations 'taught' him 'what real life is'. This shows that the seemingly logical linearity that 'the past dictates the present' can also be understood reciprocally, i.e. that 'the present also dictates the past'.

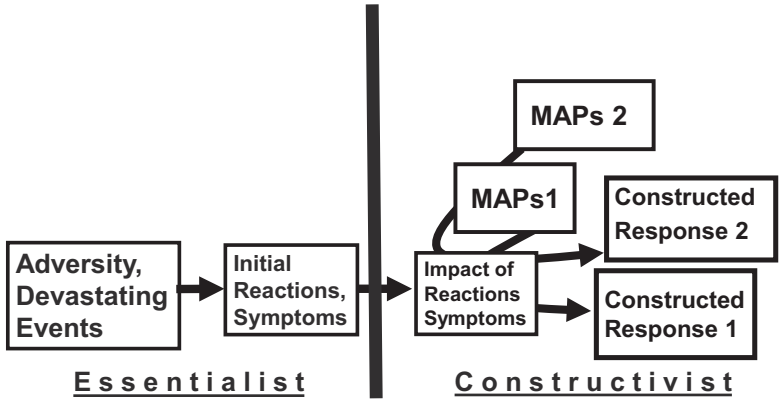

Figure 10.1 Constructed (prolonged) response to adversity

This reciprocity is in line with the circular epistemology of systemic thinking in therapeutic interventions where the limitations of simple causal-reductive epistemology is considered as inappropriately restrictive (cf. Bateson, 1971; Beck, 2019; Becvar & Becvar, 1996; Keeney, 1981).

The duration of each sequential link cannot possibly be fixed in an absolute sense. The implication of the PTSD duration criteria is that distressing reactions to adversities are inevitable, regardless of whether they fall into the pathological spectrum or not. Adversities, as discussed above, will unsettle the *onto-ecological settledness* of a person to varying degrees. The way that particular form of *unsettledness* will be perceived and processed will depend on the MAPs, which will also determine its meaning and long-term effects, whether pathological or not.

Finally, it should be remembered that the sequential steps of the MAPs do not necessarily coincide with the moments, segments, or phases of the involuntary dislocation, discussed above. Whatever 'lasting effects' the involuntary dislocation will have, they may begin and/or be modified during any one of these stages.

The range of impacts from adversity: the Adversity Grid

Everything addressed above, in effect, constitutes the framework this book proposes, within which the adversities of involuntary dislocation can be examined.

Based on the actual lived realities, field experience, and common sense, we need to identify that, following exposure to adversity, certain aspects of a person, family, or community will change and others will not; and then, of those that will change, some would be (considered) negative and others positive. In order to examine systematically all these possible outcomes, I developed the Adversity Grid, which, over the years, has undergone several modifications.

Initially, in crystallising my experiences of the trauma complexities, I named this working framework 'Trauma Grid' (Papadopoulos, 2004, 2005a, 2005b, 2007, 2008, 2010a, 2012), but then I renamed it 'Adversity Grid' (Papadopoulos, 2015, 2019; Papadopoulos & Gionakis, 2018). Although discussing the successive reformulations of this Grid is beyond the scope of this book, it is important to note that the change of its name was the result of the gradual appreciation that trauma is only one of the many possible consequences of one's exposure to adversity. Moreover, considering further the problematic nature of the term 'trauma', I replaced it with 'Adversity', because it is the range of responses to adversity that the Grid methodically differentiates.

The identified *oversimplification* and *polarisation* that result from the overwhelming feeling generated by the ill effects of involuntary dislocation (e.g. *polymorphous helplessness*, *onto-ecological unsettledness*, *nostalgic disorientation*) distort reality by reducing or destroying complexity. According to my rhetorical expression, 'the first casualty of trauma is complexity'. Therefore, by mapping out all the possible adversity impacts, in effect, we restore discerning complexity.

Adversity Grid
Range of responses to adversity

	Negative			*Unchanged*		*Positive*
	Psychiatric disorders	*Distressful psychological reactions*	*Ordinary human suffering*	*Negative*	*Positive Resilient strengths*	*Adversity activated development*
Individual						
Family						
Community						
Society/ Culture						

Source: (Papadopoulos, 2015, 2019)

(a) Negative responses to adversity

These include the effects of adversity that are loosely understood as 'the trauma', i.e. losses, pain, confusion, psychological, and even psychiatric damage of various types and intensity. This is the category of reactions and symptoms that is taken for granted that people develop by being exposed to adversity. However, not all negative responses are of the same severity and intensity. The following three gradations of severity should be differentiated:

(i) Psychiatric disorders (PD)

The most severe form of this category of negative outcomes is when a person develops an actual psychiatric disorder that is clearly diagnosable according to the

recognised criteria of the two main psychiatric nosological classification systems, i.e. the Diagnostic and Statistical Manual of the American Psychiatric Association (DSM 5) and the International Classification of Disorders (ICD 12) of the World Health Organisation. This subcategory includes all the psychiatric disorders that a person may develop as a result of being exposed to the dislocation adversities. The widely accepted belief that everybody who is exposed to severe forms of adversity develops psychiatric disorders (as discussed in the previous chapter) needs to be examined with caution. For example, two systematic and rigorous studies that analysed a large number of data produced results that do not support the generally accepted view.

Researchers investigated the risk of PTSD and Non-Affective Psychotic Disorder (NAPD) among a sample of 52,561 refugees in Sweden, between 1 January 1997 and 31 December 2011. These refugees were divided into two groups: those who were resettled from refugee camps (Group A) and those who were former asylum seekers (Group B). Their results showed that only 1.9% of the A Group, and only 2.1% of the B Group, suffered from PTSD, and with reference to NAPD, the percentages were 1.0% and 0.7%, respectively (Duggal et al., 2019). In another investigation, a meta-analysis of 38 studies involving 39,518 adult IDPs and refugees from 21 countries, showed a staggering range of variation, between 3% and 88% for PTSD, between 5% and 80% for depression, and between 1% and 81% for anxiety disorders! The authors concluded that 'this systematic review indicates that the heterogeneity in prevalence rates is caused by methodological differences', and they recommended 'that future public mental health research goes beyond the assessment of PTSD, depression, and anxiety disorders and consider a broader inclusive definition of the psychological consequences of armed conflict' (Morina et al., 2018). The inconclusive results show how different methodological designs produce wildly different results, thus invalidating claims of large percentages of psychiatric disorders following exposure to adversity.

Moreover, there is even compelling evidence that most of those who develop psychiatric disorders had already suffered from various forms of mental illness before their exposure to their dislocation adversities (e.g. Cardozo et al., 2004; Hauff & Vaglum, 1993; Mezey, 1960). Yet again, what needs to be taken seriously into consideration here is the actual time dimension. As discussed earlier, even the most disturbing reaction to adversity, in the early stages, should be accepted as an appropriate response to abnormal circumstances.

By far the most common and most researched psychiatric disorder in this category is PTSD. However, there are others that may also result from such exposure, e.g. various stress reactions (DSM5 and ICD), as well as depressive disorder or anxiety (e.g. Acarturk et al., 2018; Euteneuer & Schäfer, 2018; Lumley et al., 2018; Reavell & Fazil, 2017), and even psychotic symptoms (e.g. Dapunt et al., 2017; Parrett & Mason, 2010; Rhodes et al., 2016). In addition, other psychiatric conditions have been identified in relation to refugees, such as Disorders of Extreme Stress Not Otherwise Specified (DESNOS) (Van der Kolk et al., 2005), and Enduring Personality Change After Catastrophic Experience (EPCACE) (e.g. Tanaka et al., 2018).

(ii) Distressful psychological reactions (DPR)

This subcategory includes all the psychological and even psychiatric symptoms that a person may experience that are not sufficient in number or frequency or timing to fulfil the criteria for an identifiable psychiatric disorder. This means that if, for example, individuals experience symptoms of intrusion, avoidance, negative changes in mood etc. but do not experience any changes in arousal and reactivity, those individuals cannot be diagnosed as suffering from PTSD. However, this does not mean that they are feeling fine and are not affected negatively by their experienced adversity. This subcategory addresses precisely concerns expressed by Morina et al. (2018), i.e. that we need to discern additional negative outcomes, beyond the psychiatric ones, that refugees experience.

The possibility of differentiating the various levels of severity of negative outcomes that the Adversity Grid introduces presents the opportunity of identifying another shade of negative outcomes, thus avoiding sharply polarised perceptions of seeing affected persons as either suffering psychiatrically or not. It is for this reason that I introduced the subcategory of distressful psychological reactions (DPR), i.e. to refer to a type of (still) negative outcomes which, however, are less severe than the first subcategory (i.e. that of psychiatric disorders). Accordingly, the DPR includes all those negative and indeed distressing psychological and possibly psychiatric symptoms which, in their totality, are not as debilitating as the dysfunctionality that psychiatric disorders engender.

(iii) Ordinary human suffering (OHS)

The last subcategory of negative outcomes refers to what I term ‘ordinary human suffering’, and it is the most common response to adversities. It reminds us that people can be affected negatively by their dislocation adversities in ways that cannot be characterised as of either psychiatric or even psychological in nature. The overwhelming majority of people who are exposed to these types of adversities take them in their stride, while still experiencing them as unquestionably having negative effects on them.

The challenge is to appreciate human suffering for what it is without necessarily perceiving it as either a manifestation of psychological problems or psychiatric disorders. In our current societies, human suffering seems not to become visible unless clothed within psychological or psychiatric garments. Although this appears to be a topic of philosophical concern, we cannot shy away from it; instead, we should engage with this concern because it is of vital importance in understanding judiciously the wide range of the adversity outcomes.

It is indeed lamentable that human suffering appears to have no currency in our world today. It is an indictment of our value and belief systems and worldview, in general, that human suffering does not appear to have substance on its own. In earlier times, the capacity to address the finer nuances of human suffering had been the hallmark of advanced and finer cultural sensitivity. From Aeschylus, Sophocles, and Euripides to Shakespeare and Dostoyevsky, the aim

had been to discern the various shades and modulations of human suffering in their own right, in order to delve into the suffering mysteries, explore the depths of its meaning, and appreciate the human dignity in suffering (e.g. Benjamin & Snow, 2012; Corbí, 2012; Diehl, 2009; Gantt, 2000; Malpas & Lickiss, 2012; Pullman, 2012).

Considering the current slogan that 'suffering is optional' and, moreover, a 'problem' that needs to be eliminated at all costs, before even endeavouring to decipher its meaning, is a sign of the barbarity of our own times. Condemning any examination of suffering as a morbid pursuit that needs to be avoided is a sign of how far our technological and pragmatic preoccupations are in danger of leading us astray, away from our own humanity.

The fact is that the vast majority of involuntarily dislocated individuals do not turn to psychology and psychiatry for a 'cure'. This is not because they are 'uneducated', 'unsophisticated', or 'not psychologically minded', as it is often considered by many health professionals. Without needing to psychologise or pathologise their own predicament, such individuals perceive it in terms of various forms of life tragedies, as public tragedies, as catastrophic tribulations and afflictions, etc. and respond to these calamities by giving them various meanings within the scope of life or public or collective misfortunes.

Most cultures and set systems of collective meaning not only have specific ways of perceiving and conceptualising such tragedies, but also include corresponding rituals to address them and heal their painful consequences. It is for this reason that the ancient Greek tragedy was examined in this book, i.e. in order to provide an example of how such embedded systems of collective meaning can function within their own communities. Although that particular form of transmuting human suffering into deeper appreciation of the human condition is no longer available to us today, there are still many other systems that perform comparable functions within their own constituencies. These include systems of meaning that people actively engage with (ritualistically or not) of political, religious, ethical nature, etc.

The phenomena of human suffering that this book has identified, e.g. public tragedies, *polymorphous helplessness*, *onto-ecological unsettledness*, *nostalgic disorientation*, are examples of the impact adversity may have on individuals that can be included in this subcategory of 'ordinary human suffering'. All of these are forms of 'appropriate responses to inappropriate circumstances' that, although they can be distressing to varying degrees, constitute neither psychiatric conditions nor psychological problems.

(b) Unchanged responses to adversity

This category simply reminds us of the obvious reality that not everything people do and feel after being exposed to adversity is the result of their exposure to that particular adversity. There is a host of (positive and negative) personal qualities, behaviours, relationships, habits, etc. that remain unchanged, regardless of the

adverse events and experiences. This category is important because given the undeniable fact that involuntary dislocation, along with all its accompanying adversities, unsettledness, and disorientation, is a period of tremendous change in one's life, the tendency is to ignore the reality that there are also many aspects of the affected people's way of being that basically do not change. By blocking out and denying all the unchanged parts of a person, family, community, and society, obviously we distort reality. Inevitably, there is complexity here, too, and there are gradations of change, i.e. some aspects change more and others less. Also, the earlier discussion of what constitutes *change* and the differentiation between *essentialist* and *constructivist* definitions of change should not be forgotten.

An additional useful differentiation is the subdivision of this 'unchanged' category into those facets of a person that are considered by the same individual and/or by others as negative and those that are accepted as positive. Examples of 'unchanged negatives' would be of a person who tends to be suspicious of other people, or of marital conflict, both of which may have existed before the adversity struck and continued unchanged after the adversity. What is of far greater interest is the subcategory of 'unchanged positives', because here are included all the characteristics that are usually referred to as *resilient*.

Following the long preoccupation with the concept of 'trauma', especially since PTSD was introduced in 1980, it seems that a new era started with a new preoccupation; the concept of resilience began to dominate not only the academic and professional fields but also the wider culture, similarly to the way trauma had been influencing our wider societal discourses for decades. This shift is understandable. After delving into the endless facets of the pathological reactions involved in trauma, it was expected that attention would be diverted to exploring, equally intensively, what contributes to the prevention of trauma or, at least, to the lessening of its detrimental impact. However, unlike trauma, which essentially is supposed to be a medical and psychological–psychiatric phenomenon, the concept of resilience has been of direct relevance to a much wider range of scientific disciplines as well as spheres of human activity, e.g. from physics and ecology to economics, management, and education. This wide range of applications makes resilience a much richer concept but also more elusive in terms of grasping its meaning. Exploring the history and definitions of resilience is beyond the scope of this book. There are many worthy studies that perform this task most aptly, e.g. Agaibi (2005); Bonanno and Diminich (2013); Fletcher and Sarkar (2013); Garcia-Dia et al. (2013); Manyena (2006); Southwick et al. (2014); and Windle (2011), to mention but a few.

According to the OED, resilience is defined as 'the quality or fact of being able to recover quickly or easily from, or resist being affected by, a misfortune, shock, illness, etc.; robustness; adaptability'. In the sphere of psychosocial studies, with reference to adversity survivors and in particular the wider field of involuntary dislocation, resilience has been used with various meanings, each of them emphasising different aspects of the central concept. I propose that we can identify

the following five distinct (but also overlapping) categories of how resilience is understood (explicitly or implicitly).

(a) Emphasis on *retaining* existing positive functions, qualities, characteristics, behaviours, relationships etc. that were present before the exposure to adversity and continue to exist, more or less unchanged: this could be understood as the quality of *stability*.
(b) Emphasis on *returning speedily* to one's previous equilibrium following the disruptive upheavals brought by adversity: this could be understood as the quality of *recovery*.
(c) Emphasis on *tolerating* the various forms of instability created by the adverse changes: this could be understood as the quality of *tolerance*, which also refers to the ability of minimising the harmful effects of this instability, i.e. limiting the damage inflicted by the adversity.
(d) Emphasis on *adapting* to the new changes, contexts, realities, pressures, challenges, and opportunities that adversity activates: this could be understood as the quality of *flexibility* or *adaptability*.
(e) Emphasis on *developing* new ways of being: this could be understood as the quality of *transformational ability*.

Apparently, the term resilience was first used in physics to refer to the ability of a body not to alter after being subjected to various severe adverse conditions. For example, if a mobile phone, after being dropped on the ground, continues functioning in the same way as it did before, despite the impact of hitting the ground after the fall, then that phone was resilient to that fall. This definition corresponds to the first of the five, above, and it is the definition that I have found to be the most appropriate one in working in this field. Thus, I understand resilient features to be those positive functions, qualities, characteristics, relationships, behaviours, and abilities which were retained from the times before a person was exposed to adversity and despite that exposure.

It is difficult to grasp resilience as a noun, as a phenomenon, referring to an intangible concept of a generalised state of being. Hence, it is more appropriate to use the adjective 'resilient' because it refers to identifiable entities that it qualifies as being resilient. That same mobile phone may not be *resilient to* another type of impact, another form of adversity, or under different conditions. This means that resilience is not absolute but contingent on specific contexts, e.g. type of adversity, support systems at the time. If it is not used in relation to something specific, resilience becomes a hollow ideal state, which may have an inspirational function and be of aspirational value but would be of no real worth in relation to actual practical use in this field. The advantages of my proposed definition include the following:

Above all, it constitutes an *operational definition* (Ennis, 1964), insofar as it refers to an understanding that is reached after following specific and tangible procedures, which are perceptible because this definition refers to *what has*

already been achieved. Hence, the task to identify these resilient characteristics consists of tracing, in a collaborative co-investigation with the adversity survivor, all the *relevant strengths and resources that were retained* despite the exposure to adversity. This relational and empowering element of this definition is in contrast to the majority of other definitions that are reached exclusively by experts who study the affected persons. Experience shows that once this procedure of arriving at the *resilient strengths and resources* of a person, a family, a community etc. is followed, then invariably all the other forms of resilience, as understood by the other definitions, would also follow.

By adhering to this definition of the *resilient strengths and resources* and the collaborative way of identifying them, one inadvertently counteracts the negative implications of the trauma discourse that tends to pin the victim identity onto the adversity survivors. By showing them what they have already achieved (and despite all their suffering, disorientation, and other psychological and psychiatric symptoms), adversity survivors acquire a more holistic and appropriate sense of themselves, strengthening their own sense of human dignity.

Finally, the function of this procedure is not to register the adversity survivors' resilient strengths and resources for some administrative purposes or for the scientific interest of the investigators; instead, it has a therapeutic value for the survivors themselves, insofar as the worker should then find ways of actively and practically enabling the adversity survivor to engage in ways that involve and actualise those resilient strengths and resources.

(c) Positive responses to adversity

What is often neglected is the appreciation that, in addition to (and not instead of) the negative responses to adversity and those qualities and characteristics that remained unchanged, every person who is exposed to forms of adversity also gains something from these experiences. The saying in most languages and cultures, 'whatever does not kill you, makes you stronger', conveys the reality that the experience of all the adversities and devastating circumstances, insofar as one survives them, also has a positively transformative power. These positive gains need to be differentiated from the *resilient strengths and resources*; whereas the former are new strengths that did not exist before, the latter were existing positives that were retained from before the exposure to adversity.

Considering positive outcomes when one is exposed to severe forms of adversity at first appears to be an oxymoron. Moreover, it would definitely be offensive to expect one to readily identify positive effects from their ordeal, let alone expect them to even learn from their predicament. The key here is the differentiation between the reality of the positive impacts of adversity and the manner in which one ascertains them. The fact that it is inappropriate and disrespectful to demand that the adversity survivors tell us about their gains from their calamitous experiences does not mean that these gains are not real. What is required is an

epistemological agility to differentiate between these two and a sensitive method of accessing these new strengths.

Addressing the way one arrives at the realisation of these new positives following adversity begins with the respectful and perceptive way we (as workers in this field) sense the survivors' narrative mood and atmosphere, and appreciate that it is a product of many difficult and confusing feelings, e.g. outrage, anguish, disorientation. Aware of the tendency, under the circumstances, to oversimplify and polarise, we would accept the adversity survivors' narrative as effectively being their 'trauma story'; this suggests that, unavoidably, it will selectively emphasise the negative effects and traumatising experiences, while ignoring everything else that does not fit within this skewed perception. This weighting is perfectly understandable for such a type of narrative, given the adversity circumstances.

However, once we become aware that this is, indeed, a 'trauma narrative', which inevitably must be distorted and incomplete, the sensible next move would be to examine the full implications of this, starting by accepting it for what it is and noting that it will need to be adjusted according to the appropriate 'margin of error'. Consequently, keeping in mind the Adversity Grid as a guiding framework, we would endeavour to also discern the other two adversity outcomes, i.e. those resilient qualities that remained unchanged in a person as well as the positive responses that temporarily remain unacknowledged due to the imbalanced formulation of such a narrative.

Needless to say, for therapeutic purposes, it would be grossly inappropriate to move into exploring the other outcomes, apart from the negative ones, while our interlocutor is still deeply enwrapped in their 'trauma narrative', with all the accompanying painful feelings. Both our therapeutic sensitivity as well as our epistemological agility would help us appreciate that, under the multiple pressures of the entirety of the situation, it would be impossible for the individual concerned to be able to afford, for the time being, the complexity of perceiving the negative as well as any positive outcomes at the same time. This means that it is up to us, as helpers, listeners, and facilitators, to widen the scope of our own perception and attempt to fill in the gaps that the understandably biased and pruned 'trauma narrative' cannot possibly encompass. The way to achieve this is by expanding our own observations, scanning the wider picture, locating it within broader contexts, listening to the silences, reading in between the lines, and deepening our understanding of what the presented narrative also includes but has been pushed to the margins, while always continuing to connect more deeply with their human pain.

These are arduous but not impossible tasks. Often, the pressures on us and our own human limitations to bear the pain of the 'trauma narrative' restrict our ability to connect with the totality of the dislocated individuals, limiting our communication only to the verbal content of what they say. Thus, for example, we hear clearly and empathise with the horrific experiences they describe – but at the same time, we imperceptibly overlook how that very same 'trauma story' also conveys (without explicitly spelling it out), for example, an incredible collection of other remarkably positive characteristics such as resourcefulness, fortitude, courage,

compassion, endurance, magnanimity, loyalty, etc. Although their conscious aim of telling us their story may often focus on impressing on us the horrors of their unprocessed fears, their disbelief at what had befallen them, their plea for certain concrete assistance and for human understanding, it is up to us whether we have the capacity to also hear and witness all the other facets of their complexity, uniqueness, and totality, which would include discerning the wider range of impacts adversity had on them, from what they say and present.

From a therapeutic perspective, it is difficult not to be overwhelmed by the enormity of the human pain and disorientation of their 'trauma narrative'. Often, this is unavoidable. This is not a fatal error. On the contrary: if we know ourselves reasonably well and trust that we can bear it, we should allow ourselves to accompany them into the depths of their *polymorphous helplessness*, as long as we succeed also in holding on to our therapeutic position and gradually regain our epistemological vigilance that will enable us to interact with them therapeutically.

Once we recover our epistemological composure, it is then possible to begin to examine more closely the totality of the affected individuals' situation (i.e. not only the initially emphasised negative effects) and to engage with the whole individual in front of us, with not only the presenting victimised person but also the resourceful survivor. Needless to say, all our communications that gently help them extend their own battered and narrowed perception to encompass the wider aspects of their being should be conducted with the appropriate therapeutic sensitivity, introducing themes at the right time and using the right language, within the context of one's preferred therapeutic approach.

Despite all their negative reactions to their horrific adversities, insofar as the individuals concerned have survived the life-threatening situations, axiomatically, we have to accept that they have found some new way of being, however, temporary, precarious, or incomplete. Understandably, this achievement is not visible to them (and to most of those around them) because, as I say, 'the trauma story screeches', not allowing one to hear and perceive anything else, especially anything positive.

Nevertheless, if we were only able to create the appropriate *space* to look for the positive responses, we will find many clues as to where and how these can be found. Invariably, and especially after the affected individuals get a solid feeling that their trauma story was heard and genuinely *witnessed* by us, they begin to also express a completely new type of predicament: e.g. that having come so close to death, or having watched everything they had worked for being destroyed, or having endured so many losses, now they wonder what their life is about, what goals could and should they possibly have now? As discussed earlier (Chapter 4), when people are confronted with such unpredictable and painful situations, they become 'philosophers', i.e. pondering over existential and philosophical questions, and it is precisely this space for such questions that we need to gently and respectfully open up for them.

These cries of desperation, however inarticulate they may be, in effect constitute the early signs of the emergence of novel insights that the affected people

develop to view themselves and their world around them. Such agonising expressions indicate that a shift has taken place and space is beginning to be created for a new phase in their lives, for a refreshing re-conceptualisation of fundamental existential issues. These eternal and 'unanswerable questions' (meditations about the human condition), which most likely had never even entered their mind before, constitute a testimony to the dawning of a new awareness, however embryonic it may be. In short, these questions mark the departure from the familiar ways of seeing themselves, their purpose in life etc. and indicate that they are now struggling to seek new and satisfactory answers. It is by entering *with them* into this space that we can co-explore this new territory that will inevitably include the identification of their gains from adversity.

The positive outcomes following exposure to dislocation adversities are not restricted to the emergence of what could be understood as new 'meaning of life' or a re-energised *Weltanschauung*, i.e. a new worldview, in some abstract way. Once our epistemological vistas expand, we will witness the endless examples of their positive impacts from adversity, in real life, not only in individuals but also in families and communities. Then, considering the totality of their new situation (i.e. the adversities they had endured, their reactions and responses to them as well as their emerging new vistas), adversity survivors often come to realise the shortcomings of their previous lives, e.g. that they were locked in the pursuit of their own self-interests and materialistic gains, oblivious to their fellow citizens' suffering, wasting their lives in meaningless routines, marooned in life-less relationships, etc. Such realisations make them move forward with new purpose and zest for life, e.g. deepening their human relationships, developing new and more fulfilling occupations, acquiring compassion for the suffering of others. Accordingly, they become determined to adopt more meaningful life goals, e.g. spending more quality time with their loved ones, volunteering in organisations to assist the more vulnerable members of society, etc. All these represent fundamental changes which were initiated by their very exposure to adversity.

It is on the basis of all the above that I have termed the positive outcomes from adversity as *Adversity-Activated Development* (AAD), because they refer precisely to those positive transformative aspects of development that are specifically activated by the same adversity that also led to all the negative effects.

To clarify further, in contrast to the *resilient strengths and resources*, AAD refers to the new positives and strengths that did not exist before the adversity struck and were *activated by* the very adversity, whereas the resilient strengths refer to the positives that existed before the adversity and were retained, i.e. they persisted in surviving *despite* the adversity. In contrast, the AAD is an outcome that emerges *due to* the adversity.

More specifically, AAD refers to all new strengths, positive qualities, developments, and improvements, all the constructive functions, characteristics, behaviours, and relationships that are activated as a direct result of the very exposure to adversity. AAD can be compared to endorphins, which are substances (opioid neuropeptides and peptide hormones) produced by both the central and peripheral

nervous systems, resulting in minimising the sense of pain and increasing the sense of euphoria. Endorphins are secreted when the body is in a state of exertion and stress, not unlike AAD, which is also activated when adversity strikes.

The positive response from adversity has been known throughout human history. Shakespeare captured most sensitively the dual effects of adversity, calling them both sweet as well as venomous:

> Sweet are the uses of adversity
> Which, like the toad, ugly and venomous,
> Wears yet a precious jewel in his head.
> (*As You Like It*, II.1)

With the relatively recent movement of positive psychology, new interest was generated around the processes that AAD addresses, using various names such as stress-related growth, adversarial growth, crisis-related growth or development, thriving in adversity, post-trauma growth, positive transformation following trauma, and positive transformation of suffering, to name but a few (e.g. Affleck & Tennen, 1996; Folkman, 1997; Harvey, 1996; Linley & Joseph, 2004). However, the most dominant term has been that of 'Post Traumatic Growth' (PTG) (e.g. Tedeschi & Calhoun, 1996; Tedeschi et al., 1998), and therefore it is important to identify its similarities with and differences from AAD. In an earlier paper, I differentiated the following:

1. The central point of departure for PTG is trauma. PTG assumes that everybody who is experiencing PTG must have been traumatized. AAD is not based on this assumption. By making use of adversity as its base rather than trauma, AAD makes the subtle but important differentiation between being exposed to adversity and being traumatized.
2. PTG assumes that 'growth' occurs after the trauma; the post in PTG echoes the post in PTSD. AAD is not based on this assumption because
   (a) the adversity may still continue, and
   (b) the positive effects may have been experienced even during (not after) the period of adversity. There are many accounts of persons who had developed AAD responses during the initial phase of maximum adversity.
3. PTG uses the term 'growth' to refer to the positive effects, whereas AAD uses 'development'. Apart from the fact that 'growth' may also have a negative connotation as in 'morbid formation' such as cancer, with its organic image growth suggests a degree of inevitability, whereas 'development' is a more neutral term that allows for a wider variation of positive responses.

(Papadopoulos, 2007, p. 307)

Further considerations about the Adversity Grid

The Adversity Grid is not a psychometric test or an inventory or a quantifiable assessment tool. Instead, it is a framework that enables both workers and the survivors of any adversity to differentiate the wide range of responses to adversity, freeing them from a locked epistemological position that allows them to perceive only one type of effect. It allows for the differentiation between distress and disorder. It facilitates better *processing* of all the adversity events, reactions, and lasting impacts by minimising the *overwhelmingness* that consumes all *Interactional Matrix of Intervention* actors. It restores complexity which was damaged (if not abolished) by the adversity, building a *discerning complexity* and minimising the *confusing complexity*. It counteracts the simplifications, polarisations, and generalisations that are endemic whenever adversity strikes. It prevents the development of *victim identity* in adversity survivors. It avoids their dehumanisation by creating a context within which they can be perceived holistically in their complexity, uniqueness, and totality. All these features of the Adversity Grid constitute an effective antidote to the detrimental consequences of the traditional trauma discourses, which tend to construe adversity survivors as helpless and damaged victims, as mono-dimensional caricatures of trauma. The Grid restores such survivors as three-dimensional persons, giving them their human dignity.

Thus, the approach that emerges from the Adversity Grid represents a form of empowerment for the adversity survivors which is based on reality and substance and not on noble aspirations or idealised formulations (e.g. Calvès, 2009; Edge et al., 2014). Adopting a vantage point from which not only the pain and suffering but also all the strengths (both old and new) are visible epitomises what genuine empowerment should be. Sustainable empowerment cannot be charitably granted by an outside authority; it has to come from the adversity survivors themselves beginning with the realisation of what they have already achieved, and not when they are instructed by experts about what they should be striving to achieve.

The Grid specifies that it also accounts for the adversity impacts in the context of families, communities, and wider society and culture. These groups are often considered as suffering from comparable 'traumatising' experiences as those that the individuals suffer from. Obviously, it is not possible to diagnose any group of people with an actual psychiatric disorder; such a diagnosis can only be reached in relation to one individual, following careful clinical examination. Yet, often we come across expressions that a group of people, i.e. family, community, and even a society at large are 'traumatised', as if they all suffer from various *psychiatric-like* 'symptoms' such as the ones included in the DSM criteria for PTSD, e.g. 'intense or prolonged distress after exposure to traumatic reminders', 'persistent effortful avoidance of distressing trauma-related stimuli after the event', or 'markedly diminished interest in (pre-traumatic) significant activities', etc.

This issue is very delicate. There are serious methodological difficulties in ascribing to societies and other collective structures psychological problems that apply to individuals (Kansteiner, 2002; Papadopoulos, 2002c, 2010b, 2016). The

Grid is not 'measuring' the level of distress in society. What it does, though, is access the impressions and convictions people have about how adversity has affected their communities or society.

The same can be said about the unchanged characteristics of families, communities, and wider societies. Of particular interest are the positive effects. Whereas it is easier to understand AAD in the context of families and communities, it should not be forgotten that the same can also be discerned with reference to wider societies and cultures. For example, Germany has often been praised for succeeding in benefitting from their WWII 'trauma' by developing many new positive characteristics which were activated precisely because of their own experiences of severe adversity. The German post-war multiculturalism can be considered as an AAD manifestation. The fact that the German constitution (article 16a of the Basic Law, right up until 1993) guaranteed the automatic granting of asylum to all politically persecuted individuals can be seen as a concrete example of such AAD, i.e. as a positive gain from their Nazi 'traumatising' experiences. Therefore, it makes sense to include not only the family and community but also the wider society and culture as units that we should consider in relation to adversity outcomes. Again, these understandings are not claimed to be scientific measurements of actual gains in societies following adversity, but they reflect the changed beliefs and perceptions of the affected populations. The convictions people have about how their societies responded to adversity matters a great deal to all implicated parties.

Another question about the Adversity Grid is the temporal sequence of the three categories of responses to adversity. It appears to be logical to assume that they follow a neat chronological progression, i.e. survivors first experience severe forms of distress, then they become aware of their existing strengths and retained resources, and only after a long time they would possibly develop and recognise their AAD. This assumption needs a nuanced understanding, i.e. to differentiate between what actually happens and whether affected people are aware of the wide spectrum of what happens. It does not mean that the other two impacts (resilient functions and AAD) do not co-exist with the negative responses, right from the beginning. They may not always be accessible to the survivors themselves or to others due to the various factors that have already been discussed here, e.g. as 'trauma story screeches' and due to the dominant societal trauma discourses all other but negative impacts tend to be overlooked. However, once one creates the conditions for them to become noticeable, it is possible to realise that they co-existed all along. I have heard from many persons who were tortured that even during the time they were tortured, in addition to their excruciating pain, fear, and all the other negative effects, they were also marvelling at their own strength of being able to bear their predicament, thus revising previous estimations they had of their own strength and stamina before they were tortured.

Although simplistic techniques are not useful, my experience has nevertheless shown that two key questions can be valuable in facilitating the perception of the resilient functions and AAD. This does not mean that we necessarily need to ask

these questions, but we can certainly keep them in mind. When the adversity survivors narrate their 'trauma story' and their total focus is on their pain and losses and disorientation, etc., and all we see is their brokenness and despair, if we were to ask ourselves 'Would *I* have been able to survive what they went through?', the answer would open up the space to reveal to us their strengths and resources. Then, if we were to find an appropriate way for them to ask of themselves, 'before the adversity, did I think that I would have been able to have the strength and resourcefulness to survive the ordeal that I have gone through?', the answer to that question will open up their AAD space. The overwhelming majority of adversity survivors that I have interacted with did not believe that they had the resources, prior to the onset of their adversity, to survive the ordeal which they survived. One of the new strengths that AAD introduces is the actual development of one's awareness of their own resourcefulness.

Adversity Grid administration and applications

The Adversity Grid can be applied in a wide variety of contexts and by anybody who wishes to gauge the impacts of adversity on individuals, families, communities, and wider societies, for either assessment or therapeutic purposes. The three-dimensionality of the Grid (positive and negative impacts plus unchanged states) across several levels (i.e. individual, family, community, society) provides a framework that enables a holistic and contextualised understanding of the effects of adversity.

Insofar as it is not intended to be a standardised tool, the Grid is flexible and can be modified to serve many purposes. The levels can be altered to include the most relevant ones in a given situation. For example, if the family or community or society are not applicable in certain contexts, they can be replaced with more suitable ones, e.g. work team, organisation, specific work sector; family, parish, wider community, as long as they represent different levels of broadness of human groups. Even the number of levels can be altered to accommodate the required needs and specific focus, e.g. including only individual and workplace.

Another modification that can be made is to replace the three negative effects with another three which would be more appropriate to the situation. If the negative effects are not tapping issues of mental health, there is no need to retain the psychiatric and psychological gradations; instead, they can be replaced with either simple gradations of severity (i.e. 'Most Severe', 'Moderately Severe', and 'Least Severe') or with any other specified degrees of severity of negative effects. Similarly, degrees of development may be added to AAD. In certain contexts, it may be relevant to differentiate between positive gains from adversity that are insignificant from those that are substantial, with more transformational effects. Accordingly, the AAD section can be subdivided into two or even three gradations of AAD importance. Finally, a fourth category of responses to adversity may be added, those that were not perceived as positive or negative or unchanged; in the original formulation of the Adversity Grid, I named those 'Neutral' (Papadopoulos, 2004, 2007).

The dimension of time may also be introduced by adding different layers of the same Grid. Graphically, this can be represented three-dimensionally, making the Grid into a cube, each layer representing different relevant chronological times or phases. For example, in the context of involuntarily dislocated persons, it can be useful to obtain four Grids, each one differentiating the responses to adversity during each phase, i.e. Anticipation, Devastating Events, Survival, and Adjustment.

The Adversity Grid can be administered in various ways. It can be used by anyone to explore the range of their own responses to adversity, beyond the obvious impact that is readily apparent to them. Self-administering the Grid enhances self-reflection. Moreover, it is particularly beneficial when administered successively over a period of time, at intervals that would be suitable for each given situation. Such successive administrations provide the user with a discerning awareness of the changes (positive and negative) that occurred over time but also, after further reflection, of the actions and circumstances that led to those changes. This is a potent and tangible means of empowering the user, counteracting unhelpful power dynamics that are inevitably fostered whenever 'experts' administer it to 'clients'. Accordingly, 'clients' increase their sense of self-mastery by learning from their own experience.

The Adversity Grid is particularly valuable when workers/therapists use it on themselves (by self-administration or by others), especially when they are engaged in distressing settings. In these situations, the most dominant way their predicament is understood by professionals and by society at large is in terms of various forms of 'burnout' or 'vicarious traumatisation'. The rationale being that working with 'traumatised' people or in 'traumatising' situations inevitably leads to self-traumatisation. This is precisely the identical reasoning that is applied to clients/beneficiaries, i.e. the erroneous S-R formula. Thus, everything that was discussed about trauma in this book applies here, too, and the Adversity Grid can provide also the workers/therapists with a holistic perspective of their own predicament. This enables them to develop an awareness of *discerning complexity*, appreciating the wide spectrum of their own responses to the adversity of working in those settings. Using the Adversity Grid framework frees them from an incomplete and skewed perception of themselves which is overwhelmed by their 'trauma experiences' and which disregards their own retained strengths and their AAD. Workers in a wide variety of contexts have been using the Grid as an effective antidote to 'burnout' and 'vicarious traumatisation'. Of particular benefit to them is becoming aware of their own AAD which is activated specifically by their exposure to their work adversities. This is a much-neglected area, which has been clouded over by the 'trauma' and 'burnout' discourses. The concept of 'vicarious resilience' addresses comparable phenomena (e.g. Hernández et al., 2007; Pack, 2014).

There are no prescribed procedures for using the Adversity Grid, and users should feel free to use their own sensitivity and ingenuity to devise methods that are best suited for their own purposes. Here are some of the different variations: when not self-administering the Grid, the most profitable way is for the users and

their worker/therapists to explore *collaboratively* the range of responses to adversity, without adhering to a 'testing style' of question-and-answer. The worker/therapists may opt to discuss the Grid with the users and then give it to them (in hard copy or digital format) to reflect on it on their own, returning at a later stage to discuss what they came up with. The writing may be done by either the worker/therapists or the users, themselves. In any case, it is not practical to write inside the rectangle spaces of the actual Grid; there is not sufficient space. Instead, each category can be codified on separate sheets of paper (or in a suitably prepared document on the computer), allowing sufficient space to write down the responses/reflections. Ordinarily, the Grid can be completed over several meetings/sessions, unless other priorities dictate shorter completion. The Grid may also be used just as a framework for exploration without even writing anything down, and it may also be used by the worker/therapists for their own orientation and without even showing it or discussing it with their clients/beneficiaries. Usually, if not self-administered, the Grid is explored and completed by two persons together; however, a worker/therapist may also use it with more than one person, e.g. a couple, a family, or a school class. Another form of administration is to give it to a group of people (e.g. sub-groups in a refugee camp such as teenagers or parents) for them to use it as a framework for group exploration.

The Adversity Grid has been and can be used for various purposes. In psychotherapy (with individuals or families or groups), it can be administered at suitable intervals either to enhance the work or to monitor its progress. In all cases, it can form the background framework of all therapists, to remind them of the range of responses to adversity, countering oversimplification and polarisation, the common symptoms of 'confusing complexity'. It can also be used for assessment or research purposes, in the context of any form of adversity. For example, it was used to ascertain the psychosocial changes in adolescents and young adults with congenital heart disease and their parents (Kaisar et al., 2012). Also, it has been used for large-scale assessments of target populations, gauging the range of impacts the 'frozen conflict' has had on children in Abkhazia (Papadopoulos & Maiky, 2015). The Grid has formed the background framework for 'Rapid Assessment' by the International Organisation for Migration e.g. in Haiti (after the earthquake), the Middle East (following the Iraq and Syrian wars), South Sudan, and the Caucuses (IOM, 2019).

Being theory-neutral, the big advantage of the Adversity Grid is that it can be used by all workers, regardless of their own particular training and theoretical preference, as a supplement to any other type of work, e.g. therapeutic or humanitarian. Finally, although it is based on the conceptual complexities developed above, in its final formulation, the Grid can be conveyed in very simple terms, understandable by anyone, and it can be used by anyone without requiring much training.

The Adversity Grid epitomises, in a tangible way, the framework that this book proposes.

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Epilogue

Synergic Therapeutic Complexity and being therapeutic

In his novel *Ignorance*, Milan Kundera (2002) noted that although in German the word *Nostalgie* does exist, the Germans rarely use it when they refer to the desire for something absent; instead, he observes, it is the word *Sehnsucht* that is used, which does not only suggest a *nostos*, i.e. a yearning for a past or ideal state. *Sehnsucht*, of course, also conveys an open-ended yearning for anything that would denote a sense of fulfilment, 'something that has never existed', a 'new adventure' (p. 7).

In his tragedy *The Suppliants*, Aeschylus (523–456 BC) has the king of Argos asking the foreign women (who, avoiding forced marriage, fled Egypt, arrived in his kingdom, and pleaded for refuge, threatening suicide if he refused them) to explain what they were saying: 'Your words are riddling; come, explain in simple speech' (l. 464).

Although they are separated by nearly two and a half millennia and they refer to completely different contexts, both expressions convey a basic fact in relation to involuntary dislocation: that it is difficult to capture this phenomenon in logical and explicable language. The whole experience is riddled with riddles, inconsistencies, and paradoxes, making communication problematic and thorny, pricking and hurting people on all sides. The central *riddle* is how to combine the one side of involuntary dislocation that refers to clear and tangible losses, violation of human rights, distresses, and even psychiatric disorders with its other side, which refers to something that 'has never existed' and cannot be explained 'in simple speech'.

These quotations epitomise what this book has revealed: that the phenomenon of involuntary dislocation consists of both of these two 'sides' (named here, *inter alia*, as 'essentialist' and 'constructivist' perspectives). Whereas the first can be more easily understood and explained, the second one appears to be more of a *riddle*. Whereas the first has easily comprehended implications, i.e. attending to and repairing damage that was inflicted, the second one appears confused and, hence, it tends to be ignored. As Kundera wonders, how can we desire to find what is missing if we do not know what is missing? Yet the desire persists, unmistakeably, for something more than the mere fixing and repairing. Although Kundera understands *nostos* in a rather concrete way, i.e. return to the lost home, this book does not share his interpretation and, therefore, does not require *Sehnsucht* in order to go beyond the idea of a return to the familiar. This book has shown that *nostos*

implies a radical transformation of both the mind and the heart, and the *nostalgic disorientation* is not for a mere return and replacement of what was lost, but for a new *onto-ecological settledness*, for developing substantially new perspectives to life, for a 'new adventure', which Kundera dares to utter.

Consequently, each side has its own language: whereas the legal, psychiatric, humanitarian, reparation, and political discourse has clarity, following linear epistemology, based on well-defined causes and effects, the 'other side' can only be expressed in a language that can accommodate ambiguities, silences, and dilemmas, as well as the *algos* (pain) of the yearning for an unknown *nostos*, within an elusive *spacetime*. Therefore, it would not be far-fetched if we designate this 'other language' as *poetic*.

The 'other language' is what people struggle to articulate when they are shaken to the core of their being by severe forms of adversity. The adversity, shattering forever their previous settled sense of being (regardless of how fulfilled they were), sets two demands, unrelated to each other: to repair the resulting harm, and to re-view their lives and life in general. As I have argued here, their predicament turns them into 'philosophers', troubled about vital questions of life and death, about the meaning of suffering and destruction, about nothing less than the meaning of life itself, launching them onto the Sisyphean task of devising a language fit to enunciate such desires for 'something that has never existed'.

Whereas the first language (the language of repair) is not incorrect, and it is immensely useful, it is nevertheless insufficient to grasp the totality of the involuntary dislocation phenomena. It represents only one part of the whole (*pars pro toto*). The same can also be said about the 'other language', which nostalgically grapples with incomprehensibility. Therefore, the eternal *riddle* of the involuntarily dislocated persons' language is how to connect two discourses that not only are incompatible, but where the one ignores the existence of the other. Reflecting on Aeschylus' word for 'riddle', I note that he uses the word *enigma* (αἴνιγμα), which refers to much more than simply an obscure, puzzling, and unintelligible utterance. An *enigma* is difficult to understand, not because it is vague and murky but precisely because, according to its etymological meaning, it 'speak[s] words full of content, . . . [thus, making it] difficult to understand' (Beekes, 2010, p. 40). Hence, the overall language of the involuntary dislocation phenomena is 'riddling' not because it is meaningless, but because it contains too many meanings, and at different levels.

No wonder that communication among all the various actors of involuntary dislocation remains problematical and thorny, indeed piercing and 'traumatising' everyone concerned. As we saw, it was William James who characterised psychological trauma as a 'thorn in the spirit', and he was not misguided. In the context of what I am discussing here, it is indeed 'traumatising' for those seeking asylum not to feel heard. We know what trauma of the body is; we think that we know what constitutes trauma of the 'psyche'; but what is a trauma to the 'spirit'? How can it not be 'traumatising' to interact with helpers who, in contrast, speak with confidence a language that conveys precise aims and objectives and predetermined 'project deliverables'? How can their communication not be thorny? Their

well-meaning helpers want to 'empower' them by developing and expressing their own voice, which is a noble undertaking (and which, after all, is required by the projects' ethical stipulations . . .). But which is their own voice?

This book has endeavoured to articulate the key elements of this voice, of the 'other language', of the *poetics of nostalgic disorientation/incomprehension*. The challenge for anybody who works with involuntarily dislocated persons, in any capacity, is to become conversant with this language, starting by acknowledging its very existence and differentiating it from the language of repair. By doing so, an approach to working in this field emerges that is characterised by what I have termed 'Synergic Therapeutic Complexity'.

It is *synergic* because the workers, discerning the strengths of the involuntarily dislocated persons (the old, existing, and retained ones, i.e. the *resilient resources*, as well as the new ones, Adversity-Activated Development), find ways of activating and actualising them through collaborative interaction with the affected persons. It is *therapeutic* because such an approach has an unmistakable therapeutic effect, regardless of whether it is part of an explicit psychotherapy or part of any other facilitative contact.

Here, another important differentiation, between 'doing psychotherapy' and 'being therapeutic', needs to be made (Papadopoulos, 2002, 2016). Whereas the former refers to the specific psychotherapeutic work that is provided by professionals who are suitably trained in one of the accepted forms of psychotherapy, the latter can be offered by anyone who works in this field, regardless of their work remit. Whereas the former is offered only to those involuntarily dislocated persons who suffer from specific psychological difficulties or psychiatric disorders (and who constitute a small minority of the affected population), the latter should characterise any professional/work interaction with anyone who was involuntary dislocated.

Finally, this approach (as developed in this book) emphasises the restoration of complexity, i.e. by developing a *discerning complexity* while countering *confusing complexity*.

The language of repair, in effect, is based on the general principles of what I would characterise as a *mechanistic* approach, whereas the *poetics of nostalgic disorientation*/*incomprehension* lead to the *synergic* approach.

The following table contrasts the two approaches in order to facilitate further differentiation.

Mechanistic approach	*Synergic approach*
I am the expert: I know; you don't know	Both of us 'know' and do not 'know'
I am fixing an item that offers no response, no feedback	I am collaborating with a person that I can relate to, and interact with, using feedback
Deductively, I use general laws and principles	Inductively, I use complexity, uniqueness, and totality

Mechanistic approach	*Synergic approach*
I am repairing a damage, a fault, a pathology	I am attending to the adversity's negative effects on individuals, within the context of the individuals' complexity, uniqueness, and totality that, naturally, also include positive effects
The item I try to repair does not have the capacity for self-correction, self-regulation, self-renewal, self-transcendence	The person I try to assist is a human being (!) with all the *autopoietic* capabilities! A person is a creator!
I am focusing on repairing just you	I am also attending to the relevant wider contexts (societal narratives, etc.)
My expertise is in repairing you	My expertise is in collaborating with you, co-exploring your weaknesses *and* your strengths, and working *synergically* with you!

In short, once the approach of Synergic Therapeutic Complexity is understood, we appreciate that, as workers in this field, we can locate ourselves in a position from which we view the involuntarily dislocated individuals not as unnamed refugees or people we need to repair, but as human beings at a particularly difficult juncture in their life's quest, capable of their own self-development. Our task, then, is to *synergically* collaborate with them, assisting them to appreciate their own resources, without ignoring the damages and suffering the adversity inflicted on them. To achieve this, we need to extend the language of repair, embrace the 'new adventure', and venture into the poetics of ambiguity, where the Adversity Grid serves as the best compass in this new odyssey.

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