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Refugees, trauma and Adversity-Activated Development

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Abstract
The nature of the refugee phenomenon is examined and the position of mental health professionals is located in relation to it. The various uses of the word 'trauma' are explored and its application to the refugee context is examined. It is proposed that refugees' response to adversity is not limited to being traumatized but includes resilience and Adversity-Activated Development (AAD). Particular emphasis is given to the distinction between resilience and AAD. The usefulness of the 'Trauma Grid' in the therapeutic process with refugees is also discussed. The Trauma Grid avoids global impressions and enables a more comprehensive and systematic way of identifying the individual refugee's functioning in the context of different levels, i.e. individual, family, community and society/culture. Finally, I discuss implications for therapeutic work with refugees.

Keywords: *Refugees, asylum seekers, trauma, 'Trauma Grid', Adversity-Activated Development, resilience*

Preliminary considerations

To begin with, it is important to remember the obvious fact that becoming a refugee[1] is not a psychological phenomenon *per se*; rather, it is exclusively a socio-political and legal one, with psychological implications. Ordinary people become refugees because they are forced, directly or indirectly, to abandon their homes as a result of certain political and/or military actions by some

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groups or the state and then they seek refuge in another geographical region or country. This means that people become refugees as a consequence of a certain set of socio-political circumstances, attempting to begin a new life using legal means in order to be allowed to settle in another location. In trying to complete the move from their home of origin to a new and safer home, the process that leads from dislocation to relocation, refugees have a multitude of needs. These needs are multi-faceted and multi-dimensional (Papadopoulos, 2001) and may cover the entire spectrum of human needs – from the basics of human survival (safety, food and shelter) to the higher ones in Maslow's (1943) hierarchy of needs, such as the need for love, belonging, status, self-esteem and self-actualization.

If they are fortunate enough during their ordeal of dislocation and relocation, refugees are offered humanitarian assistance to ensure, initially, their safety and basic survival and then their overall transition to their new lives. During this process they may require different types of help depending on their specific needs as they unfold. Having survived adversity and many struggles, refugees tend to be resilient and resourceful and, if they encounter reasonably facilitative conditions, the majority of them can and do manage on their own with minimal or no assistance. However, some refugees may require help with some or with most of their needs.

One way of conceptualizing the kind and amount of help refugees require is to relate it to the degree they are able to retain their capacity for resilience and resourcefulness. Once this capacity is negatively affected, then it is likely that they will need more help and in more areas of their functioning. It is reasonable to assume that this ability is related to what could be referred to as a 'psychological immune system'. Therefore, the more this 'system' is damaged, the more help the affected refugees are likely to require in ever more areas of their lives.

I mentioned at the outset the obvious fact that the phenomena of becoming and being a refugee are not, in themselves, of a psychological nature. This needs to be emphasized because there is a tendency by mental health professionals to approach the state of being a refugee as if it were a psychological, or indeed a psychopathological, state. Once this is established, it is then possible to examine more meaningfully the ways that mental health perspectives can be of relevance and, indeed, of benefit to the refugee situation. I would suggest that there are at least two possible ways that this can be done. The first relates to the way we consider the psychological implications of experiences during the entire process of dislocation and relocation; undeniably, each situation of need (e.g. for safety, medical attention, housing, financial support or anything else) can have a psychological impact on the person concerned. The second relates to the way that the 'psychological immune system' is damaged in a person; this is a highly individual matter because each human being has their own specific and idiosyncratic way of reacting to external devastating events. Yet this basic and undeniable psychological principle can be undermined by the usual theories of psychological trauma, which are based on the assumption that certain external events, on their own, are traumatic to all people; hence, they

are referred to as 'traumatic events' instead of being considered as 'traumatizing experiences' for some persons. The lack of distinction between the event itself and the impact or experience of the event is of crucial importance (Papadopoulos, 2005). Mental health professionals may be called upon to work with refugees in connection either with facets of the first category and/or with the second category. However, in both situations there is a danger of considering refugees as a homogeneous group of people, as if they belonged to a clearly defined psychological or psychiatric diagnostic category.

In everyday language, the word 'refugee' is used to refer to a 'a displaced person', a person who 'seeks refuge in a foreign country . . . owing to religious persecution or political troubles' or '[s]omeone driven from his home by war or the fear of attack or persecution' (*Oxford English Dictionary*). The term 'refugee' has a highly specific legal connotation and is restricted to persons who have fled to another country and asked for asylum on the grounds of a 'well-founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion' (International Refugee Convention, 1951, article 1A.2). The confusion between the everyday and the legal definitions of the word refugee may complicate the already complex process from dislocation to relocation. More specifically, asylum seekers (and their professional helpers) may have expectations in terms of their rights as refugees which may clash with the legal formulation of their status as refugees; although the issue may be exclusively legal, nevertheless, it can also have significant practical and psychological effects on the persons concerned.

'Refugee trauma', psychological trauma, post-traumatic stress disorder and 'societal trauma'

The refugees' capacity for resilience and for accessing their own resourcefulness can be adversely affected if their 'psychological immune system' is damaged. This may occur as a result of a wide variety of possible factors before and during the dislocation–relocation process. Regardless of the specific nature of circumstances that initially trigger this damage, psychologists tend to use trauma theory to approach these phenomena as it seems that this theory (which is by no means a single and unified theory) approximates in the closest possible way to the nature of what actually occurs.

It is important to differentiate between what is referred to as 'refugee trauma' (e.g. Alcock, 2003; Boehnlein & Kinzie, 1995) and psychological trauma. The former is a general term that covers the whole spectrum of phenomena connected with the specific refugee reality and range of experiences; the latter refers to the psychological effect of being traumatized regardless of the external causes. It is logical to assume that involuntarily losing one's home is a difficult experience that may have adverse psychological implications. However, the term 'refugee trauma' implies something more than that – it presupposes that all those who experience this kind of adversity

will become psychologically traumatized. This presupposition is not valid because we know that each person perceives, digests and responds to external situations in a highly unique and individual way, and not all refugees are traumatized in a psychological or, even less so, in a psychopathological sense.

Psychological reactions to adversity and the devastating consequences of having to go into exile can vary enormously from individual to individual; each person experiences external devastating events in a very individual way that depends on a number of different factors. This means that the mere existence of certain devastating events should not lead to a conclusion that every person exposed to them is likely to be psychologically traumatized. At the same time, it would be equally correct to assume that the events that refugees experience must cause them some degree of psychological discomfort, upset, upheaval, turmoil, pain, disruption or even disturbance.

Another related notion widely used in these situations is that of 'societal trauma'. This kind of 'trauma' implies that a whole group of people, a community or even an entire society has been 'traumatized'. Societal trauma refers to a broader category of disturbance that society may experience as a result of different upheavals that affect (directly or indirectly, materially or psychologically) larger segments of society. These upheavals may be caused either by human intervention (e.g. war, unrest, oppression, persecution, population dislocation, economic collapse) or natural disaster (e.g. flood, earthquake, epidemic).

Trauma

Often, persons who have experienced adversity find it difficult to connect with their previous ways of being, to return to their previous way of life. The adversity experiences are so overwhelming that they tend to erase most previous experiences. This erasing is likely to create a sense of disorientation which may either spur them on to new ways of being or throw them off balance with detrimental effects.

Having differentiated the various types of trauma connected with the refugee situation, I now want to focus on the very term 'trauma'. In Greek, trauma means 'injury' or 'wound' and, metaphorically, in psychology and psychiatry refers to a psychological injury, a deficit, a pathological state. Recent etymological research (Papadopoulos 2000, 2001, 2002a, 2002b) reveals that the root verb *teiro* (which means 'to rub') has two connotations: to rub in and to rub *off*, or rub away. Thus, trauma would be the mark left on persons as a result of something being rubbed onto them. Then, in so far as the rubbing is of two kinds, we could have two different outcomes: from 'rubbing in' – an injury, a wound – and from 'rubbing off' or 'rubbing away' – a clean surface where previous marks were erased.

With reference to the trauma approach to refugees, these two meanings of trauma have important consequences. The first meaning of trauma (rubbing in and resulting in injury) is by far the dominant one in use. We consider persons who become refugees as being *traumatized* and in need

of help, which, of course, may be true. However, if we are not careful, this very reasonable approach can have some fairly negative consequences, such as learned helplessness or other iatrogenic effects. The second meaning of trauma (rubbing off, rubbing away, resulting in the acquisition of new perspectives on life) is less noticeable, although not less possible. It is well known that following a difficult and intense experience, people may respond in ways that emphasize the renewing rather than the injurious effects of the experience. Despite (or even because of) the pain, disorientation, disruption, devastation and loss, people may still feel that the very same 'traumatic' experience also made them re-evaluate their priorities in life, change their life-styles and acquire new values – all in all, experiencing a substantial change and renewal in their lives. Having come so close to death or having experienced the unbearable anguish of substantial losses, people often emerge transformed, re-viewing life, themselves and their relationships. This means that, paradoxically, despite their negative nature, devastating experiences (regardless of the degree of their harshness and destructive impact) may also help people reshuffle their lives and imbue them with new meaning. Therefore, logically, the range of possible effects from trauma must fall into three categories: negative, positive and neutral. At the outset it must be emphasized that each possibility may not be exclusive. This means that, despite the fact that a person is traumatized, he or she may also gain from the experience.

Negative effects of trauma

The first negative effect is the actual psychological injury that can lead to a genuine pathological condition of shorter or longer duration. There is no doubt that certain people are indeed traumatized by the devastating effects of external events such as destruction of their homes, killing of their loved ones, loss of property, community or personal status. However, within this category we can identify at least three degrees of severity:

1. *Ordinary human suffering (OHS)*: this is the most common and human response to tragedies in life. Suffering occurs when our expectations of a smooth life are not fulfilled. This does not always amount to a pathological condition; suffering is part of life and it is not always necessary to locate it in a medical or pathological context. Persons with sufficiently intact psychological immune systems are able to 'digest' adversity within the context of a healthy philosophy of life in addition to making use of the resources of various support systems within their family and community.
2. *Distressful psychological reaction (DPR)*: this is a more severe form of OHS and it involves a stronger experience of discomfort. However, DPR does not always require specialist attention. Distressful experiences are not uncommon in life and ordinary human resilience can deal with them effectively without the need of any professional intervention.

3. *Psychiatric disorder (PD)*: this is the severest form of the negative consequences of exposure to adversity and it certainly requires specialist professional treatment. The most common type of this effect is post-traumatic stress disorder (PTSD) and most of the literature on refugees experiencing trauma tends to be focused on this disorder.

The differentiation between these three different types of negative effects of being exposed to adverse situations in the context of the refugee situation means that not all traumatic experiences are of the PTSD type, which the majority of the literature seems to suggest.

Positive effects of trauma

The second category of possible responses to adversity by refugees refers to phenomena that tend to be neglected by mainstream professional theories and practices. Undoubtedly, there are refugees who not only survive the inhuman and cruel conditions they have endured with a significant degree of intactness but, moreover, they become strengthened by their particular exposure to adversity. It is for this reason that this response has been termed 'Adversity-Activated Development' (AAD) (Papadopoulos, 2004, 2006). AAD refers to the positive developments that are a direct result of being exposed to adversity. There are endless accounts of individuals and groups who found meaning in their suffering and were able to transmute their negative experiences in a positive way, finding new strength and experiencing transformative renewal. Such accounts are not just moving testimonies of the strength of the human spirit but they also challenge the predominant societal discourse of trauma (that implies that trauma is pathological and requires specialist attention) and the tendency to medicalize and pathologize human suffering. Once they realize that they have survived the initial and life-threatening adversity, refugees have the opportunity to begin to appreciate life in its own right; it is not uncommon that in the light of this new transformation, refugees percieve their previous lives as relatively meaningless. Nevertheless, this seemingly paradoxical outcome may create awkward moral dilemmas and complexities when mental health professionals work with such refugees, as one does not wish to focus on the positive outcomes of despicable acts of political violence. This means that other considerations (e.g. legal or ethical) may prevent therapists from acknowledging fully any AAD responses in refugees who are in psychological treatment.

Transforming adversity into positive development is a phenomenon that has always been known to humans. It is interesting to note that these ideas entered the specialist trauma literature relatively late. However, psychologists such as Carl Jung, Victor Frankl and others identified these phenomena using different terminologies much earlier than this specialist literature appeared. Using his personal experiences of being a concentration camp inmate during the Second World War, Frankl (1959) demonstrated how giving meaning to suffering can be transformative. Jung emphasized the positive meaning of symptoms and

argued that pathology is the individual's attempt to redress certain imbalances in their psychological world (e.g. Jung 1931, 1943, 1945, 1951).

In the last two decades, the trauma literature has experienced an influx of these ideas using different terminologies to address the same positive response to adversity. These include terms such as stress-related growth, crisis-related growth or development, thriving in adversity, post-trauma growth, positive transformation following trauma, positive transformation of suffering, to name but a few (see Affleck & Tennen, 1996; Folkman, 1997; Harvey, 1996). It seems that the predominant term in this field is post-traumatic growth (PTG) (see Tedeschi & Calhoun, 1996; Tedeschi, Park, & Calhoun, 1998) and it may be instructive to examine the differences between AAD and PTG.

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; refugees may still experience adverse conditions (or even traumatizing ones) after their initial psychological disruption of dislocation (i.e. initial 'trauma'). As is known, refugees may experience further adversity (of a different kind) during the process of relocation in their new and safe location (Silove, McIntosh, & Becker, 1993).
   (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 ADD 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.

More specifically, AAD is characterized by the emergence of:

- Positive, 'growthful' developments which are a direct result of the experiences gained from being exposed to adversity/'trauma'.
- New elements – characteristics which did not exist prior to the adversity.

It is important to emphasize that these new and positive characteristics are not always known to the individual him/herself. Often, they may be visible to others and they should be noticeable to mental health professionals.

Individuals are not always aware of them as their attention tends to be turned to the direction of deficit, what they had lost, their pain, their 'trauma'. This predominant direction is particularly accentuated when they seek help and they wish, as part of the overall culture of service provision, to emphasize their deficits and losses rather than their gains.

Adversity-Activated Development (AAD) is generated because adversity exposes the limits of individuals. When adversity strikes, it pushes people to the edge of (and even over) their previous understanding and expectations. Usually people feel that their lives have come to an end and they do not know how to proceed. This reaching of limits can be experienced as transformational in so far as it may then open up new horizons beyond what was previously planned or even imagined. When AAD is triggered off then new perceptions emerge of oneself (of one's identity), of one's relationships and, ultimately, of one's meaning and purpose of life. Consequently, a new epistemology (a new way of understanding how one knows) emerges which is the sum total of all new perceptions that lead to the acquisition of a new way of understanding, speaking, relating about oneself, others and life itself.

The third possible response refugees may have to adversity is that of resilience.

Neutral responses to trauma

It is important to emphasize that existing literature does not distinguish between AAD and resilience. Anything that does not fall within the negative spectrum of effects tends to be termed 'resilience', yet it is also important to differentiate between AAD and resilience.

Resilience is a term that in physics refers to the ability of a body not to alter after being subjected to different severe conditions – that is why resilience is here classed as a 'neutral' response. By extension, we refer to objects (such as a car, for example) as resilient if they can endure adverse conditions. Then, metaphorically, we refer to a person, a family or a community as resilient if they withstand pressures and do not alter their basic values, skills or abilities. The key characteristic of resilience is that it retains qualities that existed before, whereas AAD introduces new characteristics that did not exist before the adversity.

Despite being exposed to the most devastating nature of the events, not everybody is crushed by them. In fact, the majority of individuals do not require professional attention because a great deal of their healthy functioning remains intact and unaffected by the devastation; that is, it does not change – either negatively or positively. It is indeed remarkable to see the dignity and resilience of the human spirit triumphing over the most appalling conditions of degradation, helplessness, humiliation, actual injury and loss. In the last couple of decades, professional attention to issues of resilience in this field (but also in the wider sphere of mental health care) has increased dramatically (Cicchetti & Luthar, 2003; Clarke & Clarke, 2003; Werner & Smith, 1992; Wolin & Wolin, 1993).

The Trauma Grid

In order to systematize the variety of responses to adversity, I devised the following 'Trauma Grid', tabulating the various combinations of trauma effects across different levels and perspectives (Papadopoulos, 2004). The grid offers a framework of three possible effects of trauma – positive, negative and neutral – and assists the therapist to hold in mind the totality of each individual's experiences as they relate to the wider network of interrelationships across the different defining contexts.

The trauma grid

	Negative effects				
	INJURY, WOUND			*Neutral effects*	*Positive effects*
Levels	Psychiatric disorders (PD), PTSD	Distressful psychological reactions (DPR)	Ordinary human suffering (OHS)	RESILIENCE	ADVERSITY-ACTIVATED DEVELOPMENT (AAD)
Individual					
Family					
Community					
Society/culture					

The 'Trauma Grid' can be useful as it can remind therapists that:

- in addition to negative consequences (that may include an actual psychiatric disorder such as PTSD), there are many other possible responses that refugees may have, such as resilience and AAD. However, refugees may not be able to access these easily, especially as they are located within a counselling setting where they are expected to address their 'problems', their 'trauma'.
- it is essential to expand their perception of their refugee clients; that is, to see each individual in terms of their differentiated functions and responses, not as being wholly and exclusively resilient – or not – or as wholly and exclusively traumatized – or not. More specifically, the grid assists therapists to appreciate that, whereas a person may be traumatized with reference to certain functions and responses, under certain circumstances and conditions and at certain times, the very same person may also be resilient in relation to other functions (e.g. he/she may still be able to look after her/his own hygiene or he/she may be able to hold down a job).
- no individuals are alone and every person can be affected by their family, community and culture in positive and/or negative ways. Even the most isolated individuals and even those who have lost their entire family are still susceptible to the impact their families have on them now. Wider community ideology or views often affect (positively or negatively) refugees in a more direct way. Certain resilient

functions in the family or community may also affect individual refugees beyond their own conscious awareness of their impact.

- wider community and cultural contexts are not abstract terms but matter a great deal as they are active in forming at least part of the meaning systems of each individual. In difficult situations and adverse circumstances, the collective meaning tends to influence the individuals' value system much more than individuals are aware of.

Often, it is thought that there is a chronological progression from the negative to the neutral and then to the positive effects of adversity. This means that refugees may respond negatively to adversity at first, then they may regain certain functions that are resilient to change and finally they may develop AAD functions the further they are removed chronologically from the time of the original exposure to adversity. However, this sequential progress (regardless of how logical it may sound) may not be valid for everybody. The grid reminds therapists to explore the entire range of the refugees' functioning in order to discern the entire spectrum of possible nuances at any given time. This means that refugees may exhibit different positive and different negative responses simultaneously. Needless to say, as with all conceptual tools to comprehend complex phenomena, the grid does not suggest the existence of absolute and exclusive categories and divisions but it provides a useful framework to be utilized creatively in the therapeutic interaction with refugees.

Conclusion

Mental health professionals have a great deal to offer refugees as long as there is a clear understanding of the complexities involved. These complexities include the way the refugee predicament is construed by the wider society and by the systemic interconnections between mental health systems and refugees. If these connections are not properly understood, there is a danger that mental health professionals may unwittingly fall into a position that fails to distinguish the various overlapping epistemologies involved and they may end up pathologizing human suffering.

AAD is suggested in order to increase the level of differentiation of non-pathological responses to adversity. However, it requires further investigation. Therapeutic work is enormously helped if therapists identify not only the difficulties, the problems, the pathology, the trauma but also the strengths and the specific ways that each individual exhibits AAD functions. In addition, it is important that resilient functions are also discerned. However, both AAD and resilience require extremely delicate ways of being introduced into the therapeutic process with refugees. A mere identification of them, performed as a bureaucratic exercise, is likely to have more detrimental than beneficial effect. Therapists need to respect deeply the pain, disorientation, losses, trauma and all the other negative effects that refugees have from their exposure to adversity and it is in the context of this respect that they can then introduce their observations about resilient and AAD functions;

this needs to be done at the right time and using highly sensitive and appropriate language within the context of a suitable therapeutic interaction with refugees.

I suggest the Trauma Grid provides a framework for therapists to identify, in a comprehensive and systematic way, the various possible responses and functions of each refugee, family and community. Finally, it should not be forgotten that, in so far as one of the effects of trauma is oversimplification and an attack on complexity, the grid offers a means to retain complexity and differentiation.

Note

[1] The term 'refugee' will be used to refer to both asylum seekers and refugees.

References

Affleck, G., & Tennen, H. (1996). Construing benefits from adversity: Adaptational significance and dispositional underpinnings. *Journal of Personality*, *64*(4), 899–922.

Alcock, M. (2003). Refugee trauma: The assault on meaning. *Psychodynamic Practice*, *9*(3), 291–306.

Boehnlein, J. K., & Kinzie, J. D. (1995). Refugee trauma. *Transcultural Psychiatric Research Review*, *32*, 223–51.

Cicchetti, D., & Luthar, S. S (2003). *Resilience and vulnerability: Adaptation in the context of childhood adversities*. Cambridge: Cambridge University Press.

Clarke, A., & Clarke, A. (2003). *Human resilience: A fifty year quest*. London: Jessica Kingsley.

Folkman, S. (1997). Positive psychological states and coping with severe stress. *Social Science and Medicine*, *45*, 1207–21.

Frankl, V. (1959). *Man's search for meaning*. New York: Washington Square Press.

Harvey, M. (1996). An ecological view of psychological trauma and trauma recovery. *Journal of Traumatic Stress*, *9*, 3–23.

International Refugee Convention (1951). Available at: http://www.unhchr.ch/html/menu3/b/o_c_ref.htm

Jung, C. G. (1931). The aims of psychotherapy. *Collected Works*, Vol. 16. London: Routledge & Kegan Paul.

Jung, C. G. (1943). Psychotherapy and a philosophy of life. *Collected Works*, Vol. 16. London: Routledge.

Jung, C. G. (1945). Psychotherapy today. *Collected Works*, Vol. 16. London: Routledge.

Jung, C. G. (1951). Fundamental questions of psychotherapy. *Collected Works*, Vol. 16. London: Routledge.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review*, *50*, 370–96.

Oxford English Dictionary. Available at: http://www.oed.com/

Papadopoulos, R. K. (2000). A matter of shades: Trauma and psychosocial work in Kosovo. In N. Losi (Ed.), *Psychosocial and trauma response in war-torn societies: The case of Kosovo* (pp. 87–102). Geneva: International Organisation for Migration.

Papadopoulos, R. K. (2001). Refugees, therapists and trauma: Systemic reflections. *Context: The Magazine of the Association for Family Therapy*, *54*, 5–8. Special issue on refugees, ed. G. Gorell Barnes and R. K Papadopoulos.

Papadopoulos, R. K. (2002a). 'But how can I help if I don't know?' Supervising work with refugee families. In D. Campbell & B. Mason (Eds.), *Perspectives on supervision* (pp. 157–80). London: Karnac.

Papadopoulos, R. K. (2002b). Refugees, home and trauma. In R. K. Papadopoulos (Ed.), *Therapeutic care for refugees: No place like home* (pp. 9–39). London: Karnac.

Papadopoulos, R. K. (2004). Trauma in a systemic perspective: Theoretical, organizational and clinical dimensions. Paper presented at the 14th Congress of the International Family Therapy Association, Istanbul.

Papadopoulos, R. K. (2005). Political violence, trauma and mental health interventions. In D. Kalmanowitz & B. Lloyd (Eds.), *Art therapy and political violence: With art, without illusion* (pp. 35–59). Tavistock Clinic Series, London: Brunner-Routledge.

Papadopoulos, R. K. (2006). Terrorism and panic. *Psychotherapy and politics international*, *4*(2), 90–100.

Silove, D., McIntosh, P., & Becker, R. (1993). Risk of retraumatisation of asylum seekers in Australia. *Australian and New Zealand Journal of Psychiatry*, *27*(4), 606–12.

Tedeschi, R. G., & Calhoun, L. G. (1996). The post-traumatic growth inventory: Measuring the positive legacy of trauma. *Journal of Traumatic Stress*, *9*, 455–71.

Tedeschi, R. G., Park, C. & Calhoun, L. G. (Eds) (1998). *Post-traumatic growth: Theory and research in the aftermath of crisis*. Mahwah, NJ: Erlbaum.

Werner, E. E., & Smith, R. S. (1992). *Overcoming the odds*. Ithaca, NY: Cornell University Press.

Wolin, S., & Wolin, S. (1993). *The resilient self*. New York: Villiard Books.