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Corresponding Author:	Martyna Chrzescijanska, Ph.D. London, London UNITED KINGDOM
First Author:	Martyna Chrzescijanska, Ph.D.
Order of Authors:	Martyna Chrzescijanska, Ph.D.
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The narrative matrix: A narrative-hermeneutic approach in refugee care

Dr Martyna Chrzescijanska

London Metropolitan University, UK

Abstract:

This article presents an approach to refugee care that is based on a hermeneutic understanding of the meanings constituted by narratives in therapy. It proposes distinguishing psychotherapeutic models commonly used in therapy with refugees, such as Post-Traumatic Stress Disorder or Post-Traumatic Growth theories, from an approach that involves many different narratives in the form of multi-voiced conversation within the therapeutic setting. Such a concept, called here the narrative matrix, is discussed and presented as an alternative and efficient way of providing therapeutic support for refugees and asylum seekers. It discusses family therapy with refugees as an example of the narrative-hermeneutic approach that involves not only different voices from members of a family but different psychotherapeutic models.

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Introduction

This article aims to reflect upon the role of narratives in refugee care and the narrative nature of the therapeutic encounter with refugees. The discussion will be based on the distinction between grand narratives in psychotherapy and the hermeneutic-narrative approach in refugee care. It will be claimed here that psychotherapy as part of a societal discourse commonly uses expert knowledge in the form of grand narratives, defined as totalising and dominating structures of knowledge/power. It will also be claimed that understanding psychotherapy's involvement in discursive structure can have a positive impact on both practice and academic research. The proposed alternative here will be to understand the therapeutic encounter with refugees as *the narrative matrix*. The narrative matrix is a field of multiplied narratives involving, yet not exclusively, grand narratives as pre-knowledge that constitutes meanings emerging in the encounter. The proposed theory of the narrative-hermeneutic approach will draw on philosophical theories of the hermeneutic circle (Dilthey, 1988; Gadamer, 1991). The main hypothesis of this article is that as therapy with refugees is inevitably a multi-layered and multidimensional phenomenon, it requires involving many voices in an equal and liberal way in order to let the meanings emerge rather than imposing them. Family therapy will be discussed here as an example of such a perspective, called here the hermeneutic-narrative approach, that can be applied in the clinical setting.

Methodology

This paper employs philosophical theories to re-think the current situation and future perspectives in refugee care. The refugee context has already been discussed in terms of theory of discourses (Khosravinik, 2010) and social representations of refugees (Rajaram, 2002). Both the theory of grand narratives (Lyotard, 1984) and the ethics of the encounter with the other, proposed by Lévinas (1969), will be used to discuss the structure of psychotherapeutic knowledge applied in refugee care. The proposed idea of the narrative matrix will draw on the philosophy of hermeneutics and its conceptualisation of meaning creation in the conversation (Gadamer, 1991).

Background

It has been noted that the complexity of refugees' situation requires a more complex approach than a traditional psychotherapy model can offer (Papadopoulos, 2002, 2007). Due to cultural differences, mistrust of official services caused by negative past experience, the language

barrier, and many other reasons, therapy offered to refugees must be adjusted to the specific conditions that some (but not all) refugees and asylum seekers may share. Simultaneously, each case and person are different so therapy cannot use generalising models that would suit all. My intention here is to emphasise that 'a refugee' is not a fixed identity and each therapeutic encounter in refugee care is unique. To provide a framework for therapeutic encounters with refugees, we may discuss important factors that could bring more efficacy than other models used in therapy. For instance, it is already recognised that the therapy that is community-based and that aims to extend social networks is more efficient as a model supporting refugees in their process of adjustment to the new reality of a host country (Tyrer & Fazel, 2014). Similarly, privileging *emic* (an insider perspective from the refugees' culture) over *etic* perspectives is pivotal in refugee care (Westoby, 2007).

Psychiatry has been criticised as a Western system of thinking that, although it aspires to have universal meaning, is merely one of many systems of treatment in the world (ethnomedicinal models (Marsella & White, 2012)). Psychiatric categories cannot be simply transposed to other cultures where there are no equivalents of many categories such as post-traumatic stress disorder or depression (Pilgrim & Bentall, 1999). As Summerfield observed, although 'depression or PTSD, as they stand, simply cannot be universally valid diagnostic categories', the WHO still claims depression to be a worldwide problem (Summerfield, 2004: 236). It should also be emphasized that the medical discourse leads to pathologizing refugees' experience as it describes such experience in terms of a disease instead of 'ordinary human suffering' (Papadopoulos, 2007). Additionally, psychotherapy applied in refugee care needs to consider conceptualisations of mental health and healing in other cultures in order to involve these ideas in the process of a successful therapy (Kleinman & Good, 1984).

Furthermore, Western psychotherapy usually emphasises the self and individuality which may not be recognised as values in more collectivistic cultures where refugees very often come from. Therefore, in order for work with refugees to be effective, it may require a more open and creative approach than a typical 'talking cure' offered by an individual psychotherapeutic practice with a client. As being a refugee is not a mental state or mental disturbance, it may require a more holistic and psychosocial approach. Due to the complexity of the situation of refugees in host countries, involving not only mental, but also economic, social and political dimensions, the psychosocial approach has been recognised as the most suitable one (Nosè et al., 2017).

This article aims to follow this critique of the Western model of psychotherapy without denying it completely. It should be admitted that psychotherapy has developed models that are effective in working with refugees. One of these models is community-based and family-oriented therapy and this will be the main focus of this paper (Amias, Hughes, & Barratt, 2014).

Family therapy has turned out to be especially efficient as a means of 'restoring continuity' (De Haene at al., 2012). Very often, the family is the only thing that reconnects refugees with home and the past while they are in the host country. Secondly, contrary to trauma-based models, family therapy does not aim at re-telling traumatic experience but focuses rather on present relationships and building a stable network. It also corresponds with the psychosocial perspective that involves community as a support for refugees.

On the other hand, the narrative approach was recognised to be especially successful in cases of traumatic experience. It has been claimed that experience of massive atrocity causes the breakdown of narration and deprives individuals of the opportunity to construct meaning and coherence through language (Uehara et al., 2001). Although narrative therapy (e.g. White & Epston, 1990;de Haene et al., 2012) is successfully used in refugee care, the aim here is not to give an account of their practice and theory. The narrative is understood here in the broadest sense as any story that is told, including discourses and any forms of representation of experience with a plot or sequence of events. It should be considered that, as Papadopoulous observed, 'narrative, *de facto*, is part of any form of psychotherapy' (2002b: 3). Therefore, the narrative component in psychotherapy will be emphasised here but not as one coherent model of treatment but as a perspective that many models of therapy can use.

Grand narratives

The concept of grand narrativeswas introduced by post-structural and postmodern philosophy. Jean-François Lyotard (1984) focused on forms of knowledge production as oppressive and dominant structures that automatically deny any alternative narratives. Lyotard claimed that the new, postmodern condition makes the existence of such totalising narratives less possible. Grand narratives produced not only by science, political and religious ideologies and historiography, but also by philosophy itself, aim at such a description of the world that would be simultaneously objective, total and true. Lyotard claimed that as many alternative sources of knowledge in postmodernity give access to a multiplicity of (very often contradictory) voices, any single and homogenous narrative cannot uphold its supremacy. It can be observed,

however, that many disciplines still attempt to produce grand narratives while excluding other narratives as fake or less valuable.

It can be claimed that Western psychiatry and psychotherapy attempt to produce grand narratives by promoting one-size-fits-all theories that do not always embrace the complexity of individual experience. Power relations are exercised through the knowledge produced by psychotherapy in the form of theories that aim to explain 'a case'. Secondly, traditional psychotherapeutic and psychiatric models are based on a social structure with two agents: experts (holders of knowledge) and their clients (in need of help that can be provided by experts due to their knowledge). Not accidentally, psychotherapy and psychiatry seek legitimation of their status by identification with science. A theory regarded as 'scientific' may eventually receive the legitimate status of a grand narrative. It should be also noted that, in context of public health that psychotherapy has become part of, the scientific legitimacy of certain therapeutic models is reflected in access to public resources (Goldbeck-Wood & Fonagy, 2004). Therefore, it might be said that the system encourages and justifies seeking explanatory, scientific models that could be established as grand narratives in psychotherapy.

In Western society, grand narratives are means of knowledge. The traditional Western concept of knowledge is based on grand narratives that aim to provide an exhaustive and comprehensive answer. This concept is also based on the belief in a steady progression of knowledge that will ultimately lead to discovery of the truth through correction of errors and adding of new facts (Kuhn, 1970). However, the therapeutic care of Western origin does not necessarily match non-Western cultural experience. Lyotard's critique of grand narrative as a colonial tendency that is present in many disciplines is especially relevant in refugee care. Most psychotherapeutic models highlight individuality and development as values; and seek both the causes of negative symptoms and the future goals to achieve. These psychotherapy models are rooted in the particular cultural and social context that recognises and promotes particular values that might not be of high importance in other cultures and contexts.

It is suggested here that some of well-known theories utilised to explain refugees and asylum seekers' experience and establish best approach to 'treatment' can be regarded as attempts in creating grand narratives. As it will be discussed in this article, these narratives stem from categories based on assumptions typical for Western thinking such as determined causality; linear development and teleology. As grand narratives they might be reductive and simplistic and as such exclude or marginalise other narratives.

Narrative of trauma

One of the most dominant current grand narratives promoted by the mental health service is the one that places refugees and asylum seekers in the role of traumatised victims. The current polarised discourse of refugees either presents them as helpless victims or as a threat to Western society. Logically, any service that aims to bring relief to and take care of refugees adopts the first narrative as a valid one, meaning that psychotherapy participates in a broader discourse of victimisation. As Papadopoulos claims: 'This means that there is a prevalent and indeed dominant discourse in society which makes people hold the conviction that when a person is exposed to adversity, automatically he or she is traumatised. Inevitably, refugees have not escaped this indiscriminate precept and hence there is a particularly strong belief that most refugees have been traumatized' (2002: 26).

As Papadopoulos (2002) showed, the refugee trauma discourse is an example of a reductive and simplified model based on a cause-effect relation where a particular event necessarily entails a particular result. In that case, the atrocity of refugee experience would necessarily cause trauma as a psychological reaction.

Taking for granted a determined causal connection is accompanied by the assumption of the objective status of disease. Psychiatric categories were created to describe mental states as though they were facts, without considering the socio-political contexts of their emergence. The history of post-traumatic stress disorder shows that many medical categories are socially constructed and can function only in a specific socio-political environment (Summerfield, 2004). PTSD as a category was created after the Vietnam war as part of the anti-war movement and changed the status of many veterans from perpetrators to traumatised victims (Summerfield, 2001). As is now claimed, the PTSD category has been overused and turned out to be too broad. Medical categories are not simply neutral descriptions of reality but possess an agency that enables them to influence this reality. For instance, PTSD may entail standardisation of victimhood and emphasis on negative outcomes as a psychological necessity.

Further, it can be observed that potentially pathologising grand narratives (such as PTSD and trauma narratives) strongly influence the concept of person. By placing a special emphasis on victimhood and its negative consequences, it excludes other possible responses such as resilience (Papadopoulos, 2002). As a result, the medical narrative may reinforce the societal discourse about refugees as helpless victims.

From the perspective of discourse analysis, supporting the patient's status as a victim may serve the purpose of maintaining the staff's position as holders of expertise and knowledge, and hence, power. Similarly, the victim narrative maintains the persecutor-victim-rescuer triad (Karpman, 1968), reducing the complexity of individual experience to one pattern with fixed and unchangeable roles.

Asylum seekers are expected to prove their victim identity; otherwise, their claims for asylum status will most likely be denied. Therefore, asylum seekers are pushed into identification with the traumatised victim role in order to be granted protection. Additionally, as Shuman and Bohmer (2004) have shown, in order to be given the status of a refugee, claimants are often expected to give a narrative that would represent their trauma as political and not merely as personal experience.

By supporting and promoting the grand narrative of trauma, psychotherapy may reinforce the discursive representation of refugees as necessarily traumatised, mentally disturbed and hopeless. Refusal to identify with this societal fantasy may cause social rejection: 'Construction of a refugee as innocent, sympathetic and powerless is the key in the shaping of Western public opinion, as it is virtually impossible to evoke sympathy for a victim who appears villainous, roguish, or unreceptive to a liberal reconstructionist project' (Gerhart et al., 2003: 29).

The trauma narrative that is commonly used in mental health services and media language is used to make sense of seemingly distant, and hence unthinkable, experience. It gives the illusionary impression that the 'refugee experience' can be grasped by medical language and by that means be dealt with. The label of 'trauma' almost brings comfort as it renders a situation thinkable.

Narrative of growth

Another psychotherapeutic model, although less commonly applied, in refugee care is based on the conviction that the atrocity experienced may lead to positive changes in human life. Just like the trauma narrative, the transformation narrative in refugee care is part of a broader psychotherapeutic discourse. The phenomenon of growth through adversity was discussed by many researchers and is known as 'adversarial growth' (Linley & Joseph, 2004), 'stress-related growth' (Park, Cohen, & Murch, 1996), 'posttraumatic growth' (Tedeschi & Calhoun, 1996) or 'Adversity-Activated Development (AAD)' (Papadopoulos, 2007). Some other models such as the process of individuation (Jung, 1923) and positive disintegration (Dąbrowski, 1964) belong to the same model of thinking that is based on two basic assumptions: 1) about the

developmental and progressive nature of things; and 2) suffering or disintegration as a part of a process of development.

Without doubt, developmental models interpret experience of atrocity not as a 'regression' that entails negative changes in life, but as part of a 'progressive' transformation that may have a therapeutic effect. In many cases, however, it might be more comforting to the public than those who have been subjected to atrocity. The model of growth through suffering reveals some assumptions upon which many psychotherapeutic theories are built. These are:

1) Purposeful dynamism—growth through suffering models are examples of teleological thinking in which each element has its purpose or goal.
2) Disintegration-integration dialectics—these describe disintegrative states in a framework of integration, giving privilege and supremacy to the latter. Therefore, they integrate events experienced as destructive into a broader process of growth through integration.
3) Growth and development—these take for granted the progressive nature of the world and human existence by using *a priori* categories of growth and development.

What is promoted by certain narratives as natural is socially constructed and might differ in other socio-political and cultural realities.

Just as in the case of trauma narratives, developmental narratives are examples of a model based on causation as either a deterministic or probabilistic relation in which two events must be linked by a causal relation in order to be intelligible. In the case of 'growth through disintegration' narratives, it is expected that a traumatic event will lead to growth. The developmental model derives from the Enlightenment project that aims at scientific explanation of the world as reasonable, i.e., having both a reason and purpose (Cassirer, 1979; Horkheimer & Adorno, 2002). This model enables one to think about what otherwise would be unthinkable by situating it within a framework of growth and development. Secondly, it stems from the religious conviction that suffering is a way to purification, spiritual growth or salvation (Park, 2005; Aldwin, 2007).

One of the well-recognised models used in refugee care is Posttraumatic Growth theory (Tedeshi & Calhoun, 2004). According to this theory, associated with the positive psychology movement, the traumatic experience can be a life-changing event that leads to growth and development. This theory was developed as a response to PTSD theory and although both models seem to be positioned in opposition to each other, on a structural level they serve a

similar purpose of: 1) thinking unthinkable experience; and 2) rendering experience meaningful. On a larger scale, both are attempts to create a coherent and intelligible account of individual experience that would explain and translate that experience into medical and scientific language. At the same time, both are at risk of turning into dominant models that might be imposed on others.

Grand narratives of psychotherapy as 'reducing the Other to the Same'

Currently, the refugee experience is usually described in terms of experience of 'the other', who is exotic and incomprehensible and very distant from the situation in the Western world. The focus on atrocity as the main highlight of the refugee experience reduces the refugee condition to one of suffering. The refugee experience is always an experience of 'the other', with their representation constructed in terms of either victimhood or threat. Therefore, it is usually experienced socially as *unthinkable*. As Agier puts it:

> We need to think through this unconsidered aspect of the state of the world, if we are to imagine and assist the transformation of these placeless spaces, these social worlds created by violent conflict, these chaotic socio-political states and forced displacements, and the way that so many of the world's population are left waiting in the margins of the world. (2008: VII)

The question that might be posed is how a society thinks what is unthinkable but can no longer be denied, as in the case of 'the refugee crisis'. As refugees are seen as potential beneficiaries of mental health services, the way their experience and status are constructed in psychotherapy will be analysed here in terms of social meaning-making.

The experience of having faced what is 'absolutely incomprehensible' may trigger a desire to make sense out of that experience. This desire for meaning pushes us into creating grand narratives as they explain experience in a coherent way and unify all elements into one homogenous story. The discussed psychotherapeutic theories used in refugee care, such as PTSD and PTG, are examples of narratives that are constructed in a process of seeking meaning and thinking the unthinkable.

Some psychotherapeutic narratives are based on a model in which what is socially seen as abnormal is included in what is seen as normal by using the category of a process. The unthinkable becomes bound up as part of a process, is deprived of its autonomy and depletes itself in the reduction of what is unknown to what is recognised.

This is what Emmanuel Lévinas, the French-Jewish philosopher, described as 'reducing the Other to the Same' (Lévinas, 1969). Western philosophy created an ontology, or, as Lévinas called it, an ego-logy, because it was unable to cope with the Other as 'absolutely other'. Since the Other, as absolutely other from the Self, cannot be comprehended, any attempt to understand it can only lead to reducing it without any real understanding. Lévinas' philosophy, which was mostly a theory of ethics, can also be applied in the therapeutic field, especially in refugee care. It can be claimed that the great psychotherapeutic theories are attempts to capture and tame suffering as the absolute Other and, as result, reduce what is unthinkable to the Same. In that case, 'The Same' would be a psychotherapeutic model of either growth or trauma, tamed categories that give a false sense of understanding.

Lévinas claimed that what is individual cannot be accurately described in terms of the universal model. Theories such as the PTSD or PTG models, in light of his ideas, only give an illusion of the ability to explain what otherwise would be unthinkable but as such they also give feelings of control and comfort. However, the ethical, hence truly therapeutic, encounter with the other cannot be mediated by any model. It is a face-to-face encounter in which the otherness cannot be comprehended (*erkennung*) but can be recognised (*anerkennung*). According to Lévinas, ethical encounter cannot be reduced to comprehension (Critchly & Bernasconi, 2002).

In other words, although models are useful and to some extent necessary tools in psychotherapy, there are some problems with such models that should be addressed:

The crucial aspect that is missed in any psychotherapeutic model is individuality. The model is always general and theoretical, while the human experience, especially suffering, is always individual, embodied and real. Secondly, grand narratives are rarely embodied as they are usually mental and linguistic. Last but not least, the individual experience is untransferable and cannot be fully grasped by rational means of comprehension.

Models in psychotherapy are used as means of comprehension. Once they are treated as an accurate description giving insight into experience or one-size-fits-all models, they become grand narratives, a rational and totalising structure imposed on individual experience.

The narrative-hermeneutic approach

Described here, the hermeneutic-narrative perspective is a fruit of the changing landscape of thought in the 20th century. Transformations in social sciences, art and other disciplines turned

out to shift human understanding of knowledge from an objective and rational standpoint toward theories that highlight intersubjectivity and relativity.

These theories shifting toward relativism, including postmodernist theories of discourse (Foucault, 1977) and deconstruction (Derrida, 1978), were echoed by changes in psychotherapy. Many theories such as Freudian psychoanalysis became regarded as overly unitary and comprising one-size-fits-all models. The anti-psychiatry movement from the 1960s strongly rejected psychotherapeutic models based on the dichotomy between normal and pathological and proposed replacing such a model with existential models of understanding and feeling into the situation of the patient (Laing, 1969).

Other influential theories were related to the post-colonial studies that developed a critical stance towards models introduced in the Western world claiming the right to universality (Fanon, 1970; Said, 1978). The category of universality was opposed to multiplicity of narratives. The colonial and imperialist worldview was strongly based on the idea of linear development and a universal world history. Post-colonial studies, on the other hand, as 'new approaches to history have discredited the idea of a single linear progression, focusing on "a multiplicity of often conflicting and frequently parallel narratives"' (Loomba, 1998: 33). Post-colonialism is still an important academic area that aims to tell the story from other than the Western world's perspectives (Chakrabarty, 2000).

Hermeneutics is defined as 'the theory or philosophy of the interpretation of meaning' (Bleicher, 1980: 1). Hermeneutic theory had a huge influence on forming understanding of the role of social studies throughout the twentieth century as a discipline separate from the natural sciences. In the broadest sense, hermeneutics is a theory of communication.

Although the theory of hermeneutics was developed by many different authors, its understanding, as proposed by Wilhelm Dilthey (1989) and Hans-Georg Gadamer (1991), will be the main reference point in this paper. Understanding of someone's else experience is possible through transposition. This requires a minimum of similar experience that enables one to re-experience somebody's else experience. While in the creative process we move from lived experience to expression, in understanding we move in the opposite direction, from expression to experience. In the case of refugee care, understanding would mean moving from expression of experience (for instance, a story about past events that is told) to those experiences that a therapist can resonate with based on his own past. Some of the experience lived by refugees may be very distant (such as the war or losing a home) for a therapist to identify with and some

may be familiar and possible to relate to on the basis of universality of human experience (for instance, bereavement; feeling of fear or loss).

If Dilthey believed that understanding is possible because of the universal embedding in life of both a subject and object, Gadamer emphasised the historical condition of an interpreter and, on the other hand, embedment in a particular historicity of the text. Ultimate and absolute meaning does not exist but is a product of mediation between both sides that participate in a dialogue. Similarly, in an encounter with refugee families, both sides are situated in a particular context. They may share some values and views but understanding does not come from discovery thereof but rather through intersubjective co-creation of a dialogue.

To bridge the gap between the views of both philosophers in the context of refugee care, we may say that some universal sympathy is necessary to understand a refugee's situation but historical and cultural contexts must be taken into account. The key category in Gadamer's hermeneutics is pre-judgment or fore-structures—in German, *Vorurteile*. According to Gadamer, all understanding begins with fore-structures or pre-understanding. Recognition of one's situation in the hermeneutic circle is a key factor in hermeneutic understanding. What Gadamer called 'a horizon of understanding' and what is usually explained as the subjective situatedness, is not static or unchangeable, however. Some fore-structures can be rejected and some others adapted, which changes a subject's standpoint. Hermeneutic theory of interpretation proposes revealing these fore-structures and contexts of situatedness instead of vain attempts to seek eternal truth and objective meaning that would be revealed despite prejudices. In other words, our prejudices participate in our understanding. They cannot be completely rejected but can be met by other fore-structures 'on the horizon of understanding'.

Hermeneutics rejects the objective status of meaning. For Gadamer, meaning is a result of the fusion of horizons. Hermeneutics also sees understanding as an ongoing process. Meanings are neither purely subjective nor objective but are rendered in a dialogue, ongoing conversation that engages many voices: 'Only in conversation, only in confrontation with another's thought that could also come to dwell within us, can we hope to get beyond the limits of our present horizon. For this reason, philosophical hermeneutics recognises no principle higher than dialogue' (Grondin, 1994: 124).

Consequently, from a hermeneutic perspective, grand narratives such as trauma or growth theories, do not provide models that enable understanding of refugees' experience but constitute fore-structures of a process of understanding that emerges in the encounter. No single theory

can guarantee understanding or re-experiencing of somebody's else experience. Meaning, as a product of an encounter, is not dependent on the accuracy of fore-structures used to understand somebody's experience. It is rendered through resonating and relating to this experience.

Grand narratives as part of a narrative matrix

Lyotard suggested that grand narratives should be replaced with *petits récits,* 'little narratives', such as stories of everyday life and of marginalised people (1984, p.60). If this was applied to psychotherapy, it could mean rejection of any theoretical perspectives that would be replaced with 'individual cases'. The alternative would be treating the existing theories not as explanatory, meta-theories that are used by experts to give the final explanation of the 'case' and instead thinking of them as part of multi-layered matrix consisting of many different yet equal narratives. In such matrix, psychotherapeutic theories (including psychiatric diagnosis) would be one of many equal narratives.

The narrative-hermeneutic approach does not reject grand narratives but rather includes them in the narrative matrix model based on multiplicity. The hermeneutic method denies the objective status of grand narratives that would come from the 'manifestation of Reason' as perceived by the Enlightenment. It recognises them as embedded in historical and cultural contexts, thus constituting horizons of understanding. In the hermeneutic-narrative approach, grand narratives become stories within the narrative matrix and may have a healing impact as part of the therapeutic conversation. This may occur when such narratives lose their supremacy status and, instead of explaining, take part in minding the experience in the therapeutic setting.

The narrative matrix integrates coherent single stories (such as grand narratives) into a multiplicity of possible narratives that are not necessarily coherent with each other. Their number is infinite so that the matrix is open to conflicts, paradoxes and discontinuity. The hermeneutic-narrative approach does not deny the reality that lacks coherence but perceives it in the form of a conversation between heterogeneous elements in the safe therapeutic space. Inconsistency very often occurs in family therapy where members may hold very different versions of reality and the therapist usually uses a theory to explain the family story that emerges. In the narrative-hermeneutic approach, a coherent and shared narrative does not mean it has to be a true narrative. It may mean that it represses other, minor voices. Therefore, the narrative matrix allows incoherence and multiplicity.

The hermeneutic approach admits that we all hold preconceived schemas that are inevitable in the process of recognition. Psychotherapeutic theories are regarded as such fore-structures that accompany the psychotherapist when s/he enters the therapeutic setting. The psychotherapist may be trained in, for instance, psychoanalytic, existential or behaviourist models of thinking, each of which certainly has its personal prejudices and both personal and professional pre-experience that constitute the way they enter the narrative matrix. Therefore, the psychotherapist contributes their own narratives that, in the hermeneutic-narrative approach, cannot be treated as superior.

At the same time, the hermeneutic approach may establish some criteria that are decisive for a therapeutic narrative while avoiding the struggle to discover 'the truth' (a narrative that would be the most accurate in an objective sense). These can be, for instance, the efficacy of the therapeutic process; coherence and consensus among contributors; and conformity with other systems and narratives (Phillips, 1998). Alternatively, criteria can be outlined as aims of psychotherapy. These can be, for instance, improving the patient's sense of self in regard to resilience, security, creativity, autonomy or capacity for intimacy (Holmes, 1990: 52). These criteria can be set up in the therapeutic setting as guidelines and inspiration for the process.

This leads us to the final definition of the narrative matrix. The narrative matrix is the field that enables an ongoing process of multi-voiced conversation and brings a multiplicity of narratives without privileging any, unless doing so is justified by a healing effect. Gadamer described the hermeneutic circle in terms of a variety of voices: 'Our historical consciousness is always filled with a variety of voices in which the echo of the past is heard. Only in the multifariousness of such voices does it exist' (1991:11). The narrative matrix would be an approach in therapy that treats all narratives and voices as equal, including the psychotherapeutic theories, supervision's interpretations, participants' narratives and understandings (that might be informed by the cultural and religious backgrounds), etc. In such an approach, there would no 'experts' and 'clients' but many storytellers.

Family therapy with refugees can be regarded as a good example of such a narrative matrix as an 'interactional exchange of narratives' (Papadopoulos, 2002b: 1). Not only do various voices from a family participate in the narrative matrix of the family therapy setting, but also all voices of people directly or indirectly involved in it. These are not only a therapist, but also a supervisor, the reflective or supervision team. These are also 'invisible' voices that come to the therapy in the form of cultural, political and social contexts. Finally, all discourses, current and past, constitute the narrative matrix.

Family therapy with refugees as the narrative matrix

It is proposed here to think about family therapy with refugees as an example of the therapeutic narrative matrix. When we speak about narratives in terms of family therapy as an example of the narrative matrix, we may choose to use a term 'voices' instead, as many of them may be marginalised and initially almost unheard and therefore not achieve a form of 'narrative'. Therapy with families from a refugee background can be considered in terms of interwoven voices in the process of negotiating meanings. This may happen only when all voices are treated equally and a safe space is created for their emergence. Therefore, the narrative matrix is an alternative way of dealing with grand narratives as voices attempting to dominate and rather impose meanings than meet them on the horizon where other voices emerge.

The family itself creates the multi-voiced environment and interactive field. It is not in itself therapeutic, however. The task of mental health services is not to provide a good model (grand narrative) but rather to provide space for a natural conversation and expression of narratives in many forms. As shown in previous chapters, grand narrative models, based on the assumption that there is a universal truth to be discovered, cannot embrace 'the other' as revealing the difference. They are necessarily homogenous as they reduce the difference to sameness. It is believed that the case was 'understood' but in fact multiplicity of voices were replaced with one dominant narrative.

Although family therapy involves only a few participants directly, it can be seen as a micro scale of a larger community that engages many other narratives such as social, cultural and political narratives. All of these different narratives emerge in the narrative matrix and must be contained within the therapeutic space. In the hermeneutic-narrative approach, none of these narratives is more legitimate than another—they interact with each other, negotiate meanings and create (or not) a therapeutic effect. The hermeneutic-narrative perspective does not necessarily seek a coherent meta-narrative as a result of the interactions between many alternative stories. The narrative matrix does not reveal a coherent trauma story or a coherent transformation story. These narratives are part of the narrative matrix where a therapeutic model is just one of many layers.

In the case of refugee care, it is important to consider power relations reflected in therapeutic grand narratives that dominate other voices. This might come from the level of language

proficiency and necessity to involve interpreters (who in the process of translating may add another layer of narratives generated by what is ‘lost in translation’) but also cultural beliefs. Some voices can be easily dominated or even lost due to gender imbalances and how gender roles in patriarchal societies shape the legitimacy of male and female voices. The authoritative figure of therapist may also discourage the family members from voicing their narratives and, as a result, subordinate them to psychotherapeutic grand narratives (for instance, a PTSD narrative).

The function of family therapy as the narrative matrix would be to reinforce and create space for all voices, particularly those that might be marginalised, rather than imposing own therapeutic grand narratives onto the family.

The case of Salim, the 23-year-old Afghani (Maroney et al., 2014) could be a good example of application of narrative matrix in family therapy. Salim was diagnosed with PTSD but his family believed that Salim’s mental problems, especially the voices that he heard, were caused by *shaitan* (satan) and medical treatment could not be successful. Salim found some relief in creative activities such as painting but his family felt it was waste of time. In this case the narrative matrix was mostly constituted of opposing narratives: psychiatric diagnosis and cultural belief in spirits; family’s sense of shame and son’s resistance and creativity despite difficulties; occupation therapy’s focus on daily activities and personal development and the lack of recognition of importance of them in the narrative hold by the family.

Despite the fact that different narratives in the narrative matrix are rarely coherent with each other, the narrative-hermeneutic approach recognises importance of all of them as a part of the narrative matrix. Therefore, singling out one narrative as a superior would not bring the therapeutic effect. For instance, a medical narrative on Salim’s condition should not exclude a cultural belief in possession by spirits (*jinn*) as a cause of his condition. Both of them may spark a conversation through mediation process and the meaning would emerge in the fusion of their horizons.

Family therapy might be a good example of the narrative matrix in therapy but it is not an exclusive one. Any therapy involving community and including different voices and narratives can be an example of the narrative matrix. The main idea is that the therapeutic effect does not come from finding an accurate model of treatment but from creating a safe space for a variety of narratives.

Discussion

The discussed narrative-hermeneutic approach is a proposition of understanding what constitutes effective and therapeutic support for refugees. However, several critical suggestions can be made.

1. *Although the narrative-hermeneutic approach criticises psychotherapeutic models as grand narratives, it is also a model of psychotherapy*. It must be borne in mind that the narrative matrix theory even as a meta-narrative is still a narrative. As such, it proposes a self-reflective stance for other models, including the narrative-hermeneutic approach itself. As a model, it draws on reflective anthropology that proposes anthropological practice as self-reflective and aware of its own involvement in different contexts and subjectivity of perception. Saying this, the narrative-hermeneutic approach is also a part of societal discourse, embedded in its own historicity.
2. *The narrative-hermeneutic approach stems from philosophy and as a theory it cannot be applied in therapeutic practice.* Philosophy applied to psychotherapy can help to re-think therapeutic practice and the assumptions on which it is built. Therefore, if it cannot be applied directly, it is an important tool for self-reflection of psychotherapy and refugee care. As such, it proposes a meta-narrative in psychotherapy using philosophical tools of analysis.
3. *Categories such as PTSD and PTG function in refugee care and are efficient as therapeutic models.* It is not claimed here that these categories should be refuted. As with any psychotherapeutic or psychiatric category, they might be useful tools if used in a reflective and sensitive way. As stated, they also constitute fore-structures of therapeutic understanding. They should not, however, dominate the narrative as grand narratives.

Conclusions

One of the aims of this article was to demonstrate how psychotherapy, including therapy with refugees, is involved in societal discourses. Foucauldian theory can be used to show the connection between knowledge and power relations. Theories and psychiatric categories such

as PTSD and PTG, if used in a reductive way, can be part of the totalising and colonising knowledge in the form of grand narratives. Although they are used as a mode of comprehension, they might reduce what is unknown or 'unthinkable' to well-known models and categories.

Alternatively to discourse analysis, a synthetic model can be used where not only a structure of discourse or grand narrative is exposed but different narratives are multiplied and confronted with each other. Contrary to grand narratives that aim to provide explanation in the form of a coherent, single and universal narrative, the narrative matrix is constituted of a variety of multi-layered voices stemming from different sources. They constitute meanings through mediation and conversation mode, in what Gadamer called the *fusion of horizons*.

In the case of family therapy with refugees, which is regarded here as an example of such a narrative matrix, narratives may come from different agents such as different members of a family, a psychotherapist, a supervisor or members of a supervision group or reflection team. There are also many social, cultural and political narratives and discourses that are present in the narrative matrix. The main idea behind narrative matrix theory is that the psychotherapeutic model that is used is not a superior form of knowledge but one voice among many narratives. It will differ depending on the method, personal and professional experience of the psychotherapist, etc. It is important than none of these 'voices' dominates other voices; they should rather be interwoven and create new patterns.

Using the narrative matrix is particularly important when providing support for refugees. The intercultural setting of therapy with refugees requires a less homogenous model than traditional Western psychotherapy can offer. Secondly, therapy with refugees is naturally multi-voiced and multi-layered, so social, political and cultural contexts cannot simply be denied. As refugees' experience may seem 'distant' for many psychotherapists from a Western background, there is a temptation to use a single model or category that would provide an illusion of comprehension. This can potentially dominate other voices, coming from asylum seekers.

Therefore, we need to look for new models of working that will be more efficient and diversified in order to provide possibly the best support for those that may need it.

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The narrative matrix: A narrative-hermeneutic approach in refugee care

Dr Martyna Chrzescijanska

London Metropolitan University , UK

Abstract:

This article presents an approach to refugee care that is based on a hermeneutic understanding of the meanings constituted by narratives in therapy. It proposes distinguishing psychotherapeutic models commonly used in therapy with refugees, such as Post-Traumatic Stress Disorder or Post-Traumatic Growth theories, from an approach that involves many different narratives in the form of multi-voiced conversation within the therapeutic setting. Such a concept, called here the narrative matrix, is discussed and presented as an alternative and efficient way of providing therapeutic support for refugees and asylum seekers. It discusses family therapy with refugees as an example of the narrative-hermeneutic approach that involves not only different voices from members of a family but different psychotherapeutic models.

Key words:

family therapy; hermeneutics; narratives; therapy; refugee care

Word count:

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Introduction

This article aims to reflect upon the role of narratives in refugee care and the narrative nature of the therapeutic encounter with refugees. The discussion will be based on the distinction between grand narratives in psychotherapy and the hermeneutic-narrative approach in refugee care. It will be claimed here that psychotherapy as part of a societal discourse commonly uses expert knowledge in the form of grand narratives, defined as totalising and dominating structures of knowledge/power. It will also be claimed that understanding psychotherapy's involvement in discursive structure can have a positive impact on both practice and academic research. The proposed alternative here will be to understand the therapeutic encounter with refugees as *the narrative matrix*. The narrative matrix is a field of multiplied narratives involving, yet not exclusively, grand narratives as pre-knowledge that constitutes meanings emerging in the encounter. The proposed theory of the narrative-hermeneutic approach will draw on philosophical theories of the hermeneutic circle (Dilthey, 1988; Gadamer, 1991). The main hypothesis of this article is that as therapy with refugees is inevitably a multi-layered and multidimensional phenomenon, it requires involving many voices in an equal and liberal way in order to let the meanings emerge rather than imposing them. Family therapy will be discussed here as an example of such a perspective, called here the hermeneutic-narrative approach, that can be applied in the clinical setting.

Methodology

This paper employs philosophical theories to re-think the current situation and future perspectives in refugee care. The refugee context has already been discussed in terms of theory of discourses (Khosravinik, 2010) and social representations of refugees (Rajaram, 2002). Both the theory of grand narratives (Lyotard, 1984) and the ethics of the encounter with the other, proposed by Lévinas (1969), will be used to discuss the structure of psychotherapeutic knowledge applied in refugee care. The proposed idea of the narrative matrix will draw on the philosophy of hermeneutics and its conceptualisation of meaning creation in the conversation (Gadamer, 1991).

Background

It has been noted that the complexity of refugees' situation requires a more complex approach than a traditional psychotherapy model can offer (Papadopoulos, 2002, 2007). Due to cultural differences, mistrust of official services caused by negative past experience, the language

barrier, and many other reasons, therapy offered to refugees must be adjusted to the specific conditions that some (but not all) refugees and asylum seekers may share. Simultaneously, each case and person are different so therapy cannot use generalising models that would suit all. My intention here is to emphasise that 'a refugee' is not a fixed identity and each therapeutic encounter in refugee care is unique. To provide a framework for therapeutic encounters with refugees, we may discuss important factors that could bring more efficacy than other models used in therapy. For instance, it is already recognised that the therapy that is community-based and that aims to extend social networks is more efficient as a model supporting refugees in their process of adjustment to the new reality of a host country (Tyrer & Fazel, 2014). Similarly, privileging *emic* (an insider perspective from the refugees' culture) over *etic* perspectives is pivotal in refugee care (Westoby, 2007).

Psychiatry has been criticised as a Western system of thinking that, although it aspires to have universal meaning, is merely one of many systems of treatment in the world (ethnomedicinal models (Marsella & White, 2012)). Psychiatric categories cannot be simply transposed to other cultures where there are no equivalents of many categories such as post-traumatic stress disorder or depression (Pilgrim & Bentall, 1999). As Summerfield observed, although 'depression or PTSD, as they stand, simply cannot be universally valid diagnostic categories', the WHO still claims depression to be a worldwide problem (Summerfield, 2004: 236). It should also be emphasized that the medical discourse leads to pathologizing refugees' experience as it describes such experience in terms of a disease instead of 'ordinary human suffering' (Papadopoulos, 2007). Additionally, psychotherapy applied in refugee care needs to consider conceptualisations of mental health and healing in other cultures in order to involve these ideas in the process of a successful therapy (Kleinman & Good, 1984).

Furthermore, Western psychotherapy usually emphasises the self and individuality which may not be recognised as values in more collectivistic cultures where refugees very often come from. Therefore, in order for work with refugees to be effective, it may require a more open and creative approach than a typical 'talking cure' offered by an individual psychotherapeutic practice with a client. As being a refugee is not a mental state or mental disturbance, it may require a more holistic and psychosocial approach. Due to the complexity of the situation of refugees in host countries, involving not only mental, but also economic, social and political dimensions, the psychosocial approach has been recognised as the most suitable one (Nosè et al., 2017).

This article aims to follow this critique of the Western model of psychotherapy without denying it completely. It should be admitted that psychotherapy has developed models that are effective in working with refugees. One of these models is community-based and family-oriented therapy and this will be the main focus of this paper (Amias, Hughes, & Barratt, 2014).

Family therapy has turned out to be especially efficient as a means of 'restoring continuity' (De Haene at al., 2012). Very often, the family is the only thing that reconnects refugees with home and the past while they are in the host country. Secondly, contrary to trauma-based models, family therapy does not aim at re-telling traumatic experience but focuses rather on present relationships and building a stable network. It also corresponds with the psychosocial perspective that involves community as a support for refugees.

On the other hand, the narrative approach was recognised to be especially successful in cases of traumatic experience. It has been claimed that experience of massive atrocity causes the breakdown of narration and deprives individuals of the opportunity to construct meaning and coherence through language (Uehara et al., 2001). Although narrative therapy (e.g. White & Epston, 1990;de Haene et al., 2012) is successfully used in refugee care, the aim here is not to give an account of their practice and theory. The narrative is understood here in the broadest sense as any story that is told, including discourses and any forms of representation of experience with a plot or sequence of events. It should be considered that, as Papadopoulous observed, 'narrative, *de facto*, is part of any form of psychotherapy' (2002b: 3). Therefore, the narrative component in psychotherapy will be emphasised here but not as one coherent model of treatment but as a perspective that many models of therapy can use.

Grand narratives

The concept of grand narrativeswas introduced by post-structural and postmodern philosophy. Jean-François Lyotard (1984) focused on forms of knowledge production as oppressive and dominant structures that automatically deny any alternative narratives. Lyotard claimed that the new, postmodern condition makes the existence of such totalising narratives less possible. Grand narratives produced not only by science, political and religious ideologies and historiography, but also by philosophy itself, aim at such a description of the world that would be simultaneously objective, total and true. Lyotard claimed that as many alternative sources of knowledge in postmodernity give access to a multiplicity of (very often contradictory) voices, any single and homogenous narrative cannot uphold its supremacy. It can be observed,

however, that many disciplines still attempt to produce grand narratives while excluding other narratives as fake or less valuable.

It can be claimed that Western psychiatry and psychotherapy attempt to produce grand narratives by promoting one-size-fits-all theories that do not always embrace the complexity of individual experience. Power relations are exercised through the knowledge produced by psychotherapy in the form of theories that aim to explain ‘a case’. Secondly, traditional psychotherapeutic and psychiatric models are based on a social structure with two agents: experts (holders of knowledge) and their clients (in need of help that can be provided by experts due to their knowledge). Not accidentally, psychotherapy and psychiatry seek legitimation of their status by identification with science. A theory regarded as ‘scientific’ may eventually receive the legitimate status of a grand narrative. It should be also noted that, in context of public health that psychotherapy has become part of, the scientific legitimacy of certain therapeutic models is reflected in access to public resources (Goldbeck-Wood & Fonagy, 2004). Therefore, it might be said that the system encourages and justifies seeking explanatory, scientific models that could be established as grand narratives in psychotherapy.

In Western society, grand narratives are means of knowledge. The traditional Western concept of knowledge is based on grand narratives that aim to provide an exhaustive and comprehensive answer. This concept is also based on the belief in a steady progression of knowledge that will ultimately lead to discovery of the truth through correction of errors and adding of new facts (Kuhn, 1970). However, the therapeutic care of Western origin does not necessarily match non-Western cultural experience. Lyotard’s critique of grand narrative as a colonial tendency that is present in many disciplines is especially relevant in refugee care. Most psychotherapeutic models highlight individuality and development as values; and seek both the causes of negative symptoms and the future goals to achieve. These psychotherapy models are rooted in the particular cultural and social context that recognises and promotes particular values that might not be of high importance in other cultures and contexts.

It is suggested here that some of well-known theories utilised to explain refugees and asylum seekers’ experience and establish best approach to ‘treatment’ can be regarded as attempts in creating grand narratives. As it will be discussed in this article, these narratives stem from categories based on assumptions typical for Western thinking such as determined causality; linear development and teleology. As grand narratives they might be reductive and simplistic and as such exclude or marginalise other narratives.

Narrative of trauma

One of the most dominant current grand narratives promoted by the mental health service is the one that places refugees and asylum seekers in the role of traumatised victims. The current polarised discourse of refugees either presents them as helpless victims or as a threat to Western society. Logically, any service that aims to bring relief to and take care of refugees adopts the first narrative as a valid one, meaning that psychotherapy participates in a broader discourse of victimisation. As Papadopoulos claims: ‘This means that there is a prevalent and indeed dominant discourse in society which makes people hold the conviction that when a person is exposed to adversity, automatically he or she is traumatised. Inevitably, refugees have not escaped this indiscriminate precept and hence there is a particularly strong belief that most refugees have been traumatized’ (2002: 26).

As Papadopoulos (2002) showed, the refugee trauma discourse is an example of a reductive and simplified model based on a cause-effect relation where a particular event necessarily entails a particular result. In that case, the atrocity of refugee experience would necessarily cause trauma as a psychological reaction.

Taking for granted a determined causal connection is accompanied by the assumption of the objective status of disease. Psychiatric categories were created to describe mental states as though they were facts, without considering the socio-political contexts of their emergence. The history of post-traumatic stress disorder shows that many medical categories are socially constructed and can function only in a specific socio-political environment (Summerfield, 2004). PTSD as a category was created after the Vietnam war as part of the anti-war movement and changed the status of many veterans from perpetrators to traumatised victims (Summerfield, 2001). As is now claimed, the PTSD category has been overused and turned out to be too broad. Medical categories are not simply neutral descriptions of reality but possess an agency that enables them to influence this reality. For instance, PTSD may entail standardisation of victimhood and emphasis on negative outcomes as a psychological necessity.

Further, it can be observed that potentially pathologising grand narratives (such as PTSD and trauma narratives) strongly influence the concept of person. By placing a special emphasis on victimhood and its negative consequences, it excludes other possible responses such as resilience (Papadopoulos, 2002). As a result, the medical narrative may reinforce the societal discourse about refugees as helpless victims.

From the perspective of discourse analysis, supporting the patient's status as a victim may serve the purpose of maintaining the staff's position as holders of expertise and knowledge, and hence, power. Similarly, the victim narrative maintains the persecutor-victim-rescuer triad (Karpman, 1968), reducing the complexity of individual experience to one pattern with fixed and unchangeable roles.

Asylum seekers are expected to prove their victim identity; otherwise, their claims for asylum status will most likely be denied. Therefore, asylum seekers are pushed into identification with the traumatised victim role in order to be granted protection. Additionally, as Shuman and Bohmer (2004) have shown, in order to be given the status of a refugee, claimants are often expected to give a narrative that would represent their trauma as political and not merely as personal experience.

By supporting and promoting the grand narrative of trauma, psychotherapy may reinforce the discursive representation of refugees as necessarily traumatised, mentally disturbed and hopeless. Refusal to identify with this societal fantasy may cause social rejection: 'Construction of a refugee as innocent, sympathetic and powerless is the key in the shaping of Western public opinion, as it is virtually impossible to evoke sympathy for a victim who appears villainous, roguish, or unreceptive to a liberal reconstructionist project' (Gerhart et al., 2003: 29).

The trauma narrative that is commonly used in mental health services and media language is used to make sense of seemingly distant, and hence unthinkable, experience. It gives the illusionary impression that the 'refugee experience' can be grasped by medical language and by that means be dealt with. The label of 'trauma' almost brings comfort as it renders a situation thinkable.

Narrative of growth

Another psychotherapeutic model, although less commonly applied, in refugee care is based on the conviction that the atrocity experienced may lead to positive changes in human life. Just like the trauma narrative, the transformation narrative in refugee care is part of a broader psychotherapeutic discourse. The phenomenon of growth through adversity was discussed by many researchers and is known as 'adversarial growth' (Linley & Joseph, 2004), 'stress-related growth' (Park, Cohen, & Murch, 1996), 'posttraumatic growth' (Tedeschi & Calhoun, 1996) or 'Adversity-Activated Development (AAD)' (Papadopoulos, 2007). Some other models such as the process of individuation (Jung, 1923) and positive disintegration (Dąbrowski, 1964) belong to the same model of thinking that is based on two basic assumptions: 1) about the

developmental and progressive nature of things; and 2) suffering or disintegration as a part of a process of development.

Without doubt, developmental models interpret experience of atrocity not as a ‘regression’ that entails negative changes in life, but as part of a ‘progressive’ transformation that may have a therapeutic effect. In many cases, however, it might be more comforting to the public than those who have been subjected to atrocity. The model of growth through suffering reveals some assumptions upon which many psychotherapeutic theories are built. These are:

1) Purposeful dynamism—growth through suffering models are examples of teleological thinking in which each element has its purpose or goal.
2) Disintegration-integration dialectics—these describe disintegrative states in a framework of integration, giving privilege and supremacy to the latter. Therefore, they integrate events experienced as destructive into a broader process of growth through integration.
3) Growth and development—these take for granted the progressive nature of the world and human existence by using *a priori* categories of growth and development.

What is promoted by certain narratives as natural is socially constructed and might differ in other socio-political and cultural realities.

Just as in the case of trauma narratives, developmental narratives are examples of a model based on causation as either a deterministic or probabilistic relation in which two events must be linked by a causal relation in order to be intelligible. In the case of ‘growth through disintegration’ narratives, it is expected that a traumatic event will lead to growth. The developmental model derives from the Enlightenment project that aims at scientific explanation of the world as reasonable, i.e., having both a reason and purpose (Cassirer, 1979; Horkheimer & Adorno, 2002). This model enables one to think about what otherwise would be unthinkable by situating it within a framework of growth and development. Secondly, it stems from the religious conviction that suffering is a way to purification, spiritual growth or salvation (Park, 2005; Aldwin, 2007).

One of the well-recognised models used in refugee care is Posttraumatic Growth theory (Tedeshi & Calhoun, 2004). According to this theory, associated with the positive psychology movement, the traumatic experience can be a life-changing event that leads to growth and development. This theory was developed as a response to PTSD theory and although both models seem to be positioned in opposition to each other, on a structural level they serve a

similar purpose of: 1) thinking unthinkable experience; and 2) rendering experience meaningful. On a larger scale, both are attempts to create a coherent and intelligible account of individual experience that would explain and translate that experience into medical and scientific language. At the same time, both are at risk of turning into dominant models that might be imposed on others.

Grand narratives of psychotherapy as 'reducing the Other to the Same'

Currently, the refugee experience is usually described in terms of experience of 'the other', who is exotic and incomprehensible and very distant from the situation in the Western world. The focus on atrocity as the main highlight of the refugee experience reduces the refugee condition to one of suffering. The refugee experience is always an experience of 'the other', with their representation constructed in terms of either victimhood or threat. Therefore, it is usually experienced socially as *unthinkable*. As Agier puts it:

> We need to think through this unconsidered aspect of the state of the world, if we are to imagine and assist the transformation of these placeless spaces, these social worlds created by violent conflict, these chaotic socio-political states and forced displacements, and the way that so many of the world's population are left waiting in the margins of the world. (2008: VII)

The question that might be posed is how a society thinks what is unthinkable but can no longer be denied, as in the case of 'the refugee crisis'. As refugees are seen as potential beneficiaries of mental health services, the way their experience and status are constructed in psychotherapy will be analysed here in terms of social meaning-making.

The experience of having faced what is 'absolutely incomprehensible' may trigger a desire to make sense out of that experience. This desire for meaning pushes us into creating grand narratives as they explain experience in a coherent way and unify all elements into one homogenous story. The discussed psychotherapeutic theories used in refugee care, such as PTSD and PTG, are examples of narratives that are constructed in a process of seeking meaning and thinking the unthinkable.

Some psychotherapeutic narratives are based on a model in which what is socially seen as abnormal is included in what is seen as normal by using the category of a process. The unthinkable becomes bound up as part of a process, is deprived of its autonomy and depletes itself in the reduction of what is unknown to what is recognised.

This is what Emmanuel Lévinas, the French-Jewish philosopher, described as 'reducing the Other to the Same' (Lévinas, 1969). Western philosophy created an ontology, or, as Lévinas called it, an ego-logy, because it was unable to cope with the Other as 'absolutely other'. Since the Other, as absolutely other from the Self, cannot be comprehended, any attempt to understand it can only lead to reducing it without any real understanding. Lévinas' philosophy, which was mostly a theory of ethics, can also be applied in the therapeutic field, especially in refugee care. It can be claimed that the great psychotherapeutic theories are attempts to capture and tame suffering as the absolute Other and, as result, reduce what is unthinkable to the Same. In that case, 'The Same' would be a psychotherapeutic model of either growth or trauma, tamed categories that give a false sense of understanding.

Lévinas claimed that what is individual cannot be accurately described in terms of the universal model. Theories such as the PTSD or PTG models, in light of his ideas, only give an illusion of the ability to explain what otherwise would be unthinkable but as such they also give feelings of control and comfort. However, the ethical, hence truly therapeutic, encounter with the other cannot be mediated by any model. It is a face-to-face encounter in which the otherness cannot be comprehended (*erkennung*) but can be recognised (*anerkennung*). According to Lévinas, ethical encounter cannot be reduced to comprehension (Critchly & Bernasconi, 2002).

In other words, although models are useful and to some extent necessary tools in psychotherapy, there are some problems with such models that should be addressed:

The crucial aspect that is missed in any psychotherapeutic model is individuality. The model is always general and theoretical, while the human experience, especially suffering, is always individual, embodied and real. Secondly, grand narratives are rarely embodied as they are usually mental and linguistic. Last but not least, the individual experience is untransferable and cannot be fully grasped by rational means of comprehension.

Models in psychotherapy are used as means of comprehension. Once they are treated as an accurate description giving insight into experience or one-size-fits-all models, they become grand narratives, a rational and totalising structure imposed on individual experience.

The narrative-hermeneutic approach

Described here, the hermeneutic-narrative perspective is a fruit of the changing landscape of thought in the 20th century. Transformations in social sciences, art and other disciplines turned

out to shift human understanding of knowledge from an objective and rational standpoint toward theories that highlight intersubjectivity and relativity.

These theories shifting toward relativism, including postmodernist theories of discourse (Foucault, 1977) and deconstruction (Derrida, 1978), were echoed by changes in psychotherapy. Many theories such as Freudian psychoanalysis became regarded as overly unitary and comprising one-size-fits-all models. The anti-psychiatry movement from the 1960s strongly rejected psychotherapeutic models based on the dichotomy between normal and pathological and proposed replacing such a model with existential models of understanding and feeling into the situation of the patient (Laing, 1969).

Other influential theories were related to the post-colonial studies that developed a critical stance towards models introduced in the Western world claiming the right to universality (Fanon, 1970; Said, 1978). The category of universality was opposed to multiplicity of narratives. The colonial and imperialist worldview was strongly based on the idea of linear development and a universal world history. Post-colonial studies, on the other hand, as 'new approaches to history have discredited the idea of a single linear progression, focusing on "a multiplicity of often conflicting and frequently parallel narratives"' (Loomba, 1998: 33). Post-colonialism is still an important academic area that aims to tell the story from other than the Western world's perspectives (Chakrabarty, 2000).

Hermeneutics is defined as 'the theory or philosophy of the interpretation of meaning' (Bleicher, 1980: 1). Hermeneutic theory had a huge influence on forming understanding of the role of social studies throughout the twentieth century as a discipline separate from the natural sciences. In the broadest sense, hermeneutics is a theory of communication.

Although the theory of hermeneutics was developed by many different authors, its understanding, as proposed by Wilhelm Dilthey (1989) and Hans-Georg Gadamer (1991), will be the main reference point in this paper. Understanding of someone's else experience is possible through transposition. This requires a minimum of similar experience that enables one to re-experience somebody's else experience. While in the creative process we move from lived experience to expression, in understanding we move in the opposite direction, from expression to experience. In the case of refugee care, understanding would mean moving from expression of experience (for instance, a story about past events that is told) to those experiences that a therapist can resonate with based on his own past. Some of the experience lived by refugees may be very distant (such as the war or losing a home) for a therapist to identify with and some

may be familiar and possible to relate to on the basis of universality of human experience (for instance, bereavement; feeling of fear or loss).

If Dilthey believed that understanding is possible because of the universal embedding in life of both a subject and object, Gadamer emphasised the historical condition of an interpreter and, on the other hand, embedment in a particular historicity of the text. Ultimate and absolute meaning does not exist but is a product of mediation between both sides that participate in a dialogue. Similarly, in an encounter with refugee families, both sides are situated in a particular context. They may share some values and views but understanding does not come from discovery thereof but rather through intersubjective co-creation of a dialogue.

To bridge the gap between the views of both philosophers in the context of refugee care, we may say that some universal sympathy is necessary to understand a refugee's situation but historical and cultural contexts must be taken into account. The key category in Gadamer's hermeneutics is pre-judgment or fore-structures—in German, *Vorurteile*. According to Gadamer, all understanding begins with fore-structures or pre-understanding. Recognition of one's situation in the hermeneutic circle is a key factor in hermeneutic understanding. What Gadamer called 'a horizon of understanding' and what is usually explained as the subjective situatedness, is not static or unchangeable, however. Some fore-structures can be rejected and some others adapted, which changes a subject's standpoint. Hermeneutic theory of interpretation proposes revealing these fore-structures and contexts of situatedness instead of vain attempts to seek eternal truth and objective meaning that would be revealed despite prejudices. In other words, our prejudices participate in our understanding. They cannot be completely rejected but can be met by other fore-structures 'on the horizon of understanding'.

Hermeneutics rejects the objective status of meaning. For Gadamer, meaning is a result of the fusion of horizons. Hermeneutics also sees understanding as an ongoing process. Meanings are neither purely subjective nor objective but are rendered in a dialogue, ongoing conversation that engages many voices: 'Only in conversation, only in confrontation with another's thought that could also come to dwell within us, can we hope to get beyond the limits of our present horizon. For this reason, philosophical hermeneutics recognises no principle higher than dialogue' (Grondin, 1994: 124).

Consequently, from a hermeneutic perspective, grand narratives such as trauma or growth theories, do not provide models that enable understanding of refugees' experience but constitute fore-structures of a process of understanding that emerges in the encounter. No single theory

can guarantee understanding or re-experiencing of somebody's else experience. Meaning, as a product of an encounter, is not dependent on the accuracy of fore-structures used to understand somebody's experience. It is rendered through resonating and relating to this experience.

Grand narratives as part of a narrative matrix

Lyotard suggested that grand narratives should be replaced with *petits récits,* 'little narratives', such as stories of everyday life and of marginalised people (1984, p.60). If this was applied to psychotherapy, it could mean rejection of any theoretical perspectives that would be replaced with 'individual cases'. The alternative would be treating the existing theories not as explanatory, meta-theories that are used by experts to give the final explanation of the 'case' and instead thinking of them as part of multi-layered matrix consisting of many different yet equal narratives. In such matrix, psychotherapeutic theories (including psychiatric diagnosis) would be one of many equal narratives.

The narrative-hermeneutic approach does not reject grand narratives but rather includes them in the narrative matrix model based on multiplicity. The hermeneutic method denies the objective status of grand narratives that would come from the 'manifestation of Reason' as perceived by the Enlightenment. It recognises them as embedded in historical and cultural contexts, thus constituting horizons of understanding. In the hermeneutic-narrative approach, grand narratives become stories within the narrative matrix and may have a healing impact as part of the therapeutic conversation. This may occur when such narratives lose their supremacy status and, instead of explaining, take part in minding the experience in the therapeutic setting.

The narrative matrix integrates coherent single stories (such as grand narratives) into a multiplicity of possible narratives that are not necessarily coherent with each other. Their number is infinite so that the matrix is open to conflicts, paradoxes and discontinuity. The hermeneutic-narrative approach does not deny the reality that lacks coherence but perceives it in the form of a conversation between heterogeneous elements in the safe therapeutic space. Inconsistency very often occurs in family therapy where members may hold very different versions of reality and the therapist usually uses a theory to explain the family story that emerges. In the narrative-hermeneutic approach, a coherent and shared narrative does not mean it has to be a true narrative. It may mean that it represses other, minor voices. Therefore, the narrative matrix allows incoherence and multiplicity.

The hermeneutic approach admits that we all hold preconceived schemas that are inevitable in the process of recognition. Psychotherapeutic theories are regarded as such fore-structures that accompany the psychotherapist when s/he enters the therapeutic setting. The psychotherapist may be trained in, for instance, psychoanalytic, existential or behaviourist models of thinking, each of which certainly has its personal prejudices and both personal and professional pre-experience that constitute the way they enter the narrative matrix. Therefore, the psychotherapist contributes their own narratives that, in the hermeneutic-narrative approach, cannot be treated as superior.

At the same time, the hermeneutic approach may establish some criteria that are decisive for a therapeutic narrative while avoiding the struggle to discover 'the truth' (a narrative that would be the most accurate in an objective sense). These can be, for instance, the efficacy of the therapeutic process; coherence and consensus among contributors; and conformity with other systems and narratives (Phillips, 1998). Alternatively, criteria can be outlined as aims of psychotherapy. These can be, for instance, improving the patient's sense of self in regard to resilience, security, creativity, autonomy or capacity for intimacy (Holmes, 1990: 52). These criteria can be set up in the therapeutic setting as guidelines and inspiration for the process.

This leads us to the final definition of the narrative matrix. The narrative matrix is the field that enables an ongoing process of multi-voiced conversation and brings a multiplicity of narratives without privileging any, unless doing so is justified by a healing effect. Gadamer described the hermeneutic circle in terms of a variety of voices: 'Our historical consciousness is always filled with a variety of voices in which the echo of the past is heard. Only in the multifariousness of such voices does it exist' (1991:11). The narrative matrix would be an approach in therapy that treats all narratives and voices as equal, including the psychotherapeutic theories, supervision's interpretations, participants' narratives and understandings (that might be informed by the cultural and religious backgrounds), etc. In such an approach, there would no 'experts' and 'clients' but many storytellers.

Family therapy with refugees can be regarded as a good example of such a narrative matrix as an 'interactional exchange of narratives' (Papadopoulos, 2002b: 1). Not only do various voices from a family participate in the narrative matrix of the family therapy setting, but also all voices of people directly or indirectly involved in it. These are not only a therapist, but also a supervisor, the reflective or supervision team. These are also 'invisible' voices that come to the therapy in the form of cultural, political and social contexts. Finally, all discourses, current and past, constitute the narrative matrix.

Family therapy with refugees as the narrative matrix

It is proposed here to think about family therapy with refugees as an example of the therapeutic narrative matrix. When we speak about narratives in terms of family therapy as an example of the narrative matrix, we may choose to use a term 'voices' instead, as many of them may be marginalised and initially almost unheard and therefore not achieve a form of 'narrative'. Therapy with families from a refugee background can be considered in terms of interwoven voices in the process of negotiating meanings. This may happen only when all voices are treated equally and a safe space is created for their emergence. Therefore, the narrative matrix is an alternative way of dealing with grand narratives as voices attempting to dominate and rather impose meanings than meet them on the horizon where other voices emerge.

The family itself creates the multi-voiced environment and interactive field. It is not in itself therapeutic, however. The task of mental health services is not to provide a good model (grand narrative) but rather to provide space for a natural conversation and expression of narratives in many forms. As shown in previous chapters, grand narrative models, based on the assumption that there is a universal truth to be discovered, cannot embrace 'the other' as revealing the difference. They are necessarily homogenous as they reduce the difference to sameness. It is believed that the case was 'understood' but in fact multiplicity of voices were replaced with one dominant narrative.

Although family therapy involves only a few participants directly, it can be seen as a micro scale of a larger community that engages many other narratives such as social, cultural and political narratives. All of these different narratives emerge in the narrative matrix and must be contained within the therapeutic space. In the hermeneutic-narrative approach, none of these narratives is more legitimate than another—they interact with each other, negotiate meanings and create (or not) a therapeutic effect. The hermeneutic-narrative perspective does not necessarily seek a coherent meta-narrative as a result of the interactions between many alternative stories. The narrative matrix does not reveal a coherent trauma story or a coherent transformation story. These narratives are part of the narrative matrix where a therapeutic model is just one of many layers.

In the case of refugee care, it is important to consider power relations reflected in therapeutic grand narratives that dominate other voices. This might come from the level of language

proficiency and necessity to involve interpreters (who in the process of translating may add another layer of narratives generated by what is 'lost in translation') but also cultural beliefs. Some voices can be easily dominated or even lost due to gender imbalances and how gender roles in patriarchal societies shape the legitimacy of male and female voices. The authoritative figure of therapist may also discourage the family members from voicing their narratives and, as a result, subordinate them to psychotherapeutic grand narratives (for instance, a PTSD narrative).

The function of family therapy as the narrative matrix would be to reinforce and create space for all voices, particularly those that might be marginalised, rather than imposing own therapeutic grand narratives onto the family.

The case of Salim, the 23-year-old Afghani (Maroney et al., 2014) could be a good example of application of narrative matrix in family therapy. Salim was diagnosed with PTSD but his family believed that Salim's mental problems, especially the voices that he heard, were caused by *shaitan* (satan) and medical treatment could not be successful. Salim found some relief in creative activities such as painting but his family felt it was waste of time. In this case the narrative matrix was mostly constituted of opposing narratives: psychiatric diagnosis and cultural belief in spirits; family's sense of shame and son's resistance and creativity despite difficulties; occupation therapy's focus on daily activities and personal development and the lack of recognition of importance of them in the narrative hold by the family.

Despite the fact that different narratives in the narrative matrix are rarely coherent with each other, the narrative-hermeneutic approach recognises importance of all of them as a part of the narrative matrix. Therefore, singling out one narrative as a superior would not bring the therapeutic effect. For instance, a medical narrative on Salim's condition should not exclude a cultural belief in possession by spirits (*jinn*) as a cause of his condition. Both of them may spark a conversation through mediation process and the meaning would emerge in the fusion of their horizons.

Family therapy might be a good example of the narrative matrix in therapy but it is not an exclusive one. Any therapy involving community and including different voices and narratives can be an example of the narrative matrix. The main idea is that the therapeutic effect does not come from finding an accurate model of treatment but from creating a safe space for a variety of narratives.

Discussion

The discussed narrative-hermeneutic approach is a proposition of understanding what constitutes effective and therapeutic support for refugees. However, several critical suggestions can be made.

1. *Although the narrative-hermeneutic approach criticises psychotherapeutic models as grand narratives, it is also a model of psychotherapy*. It must be borne in mind that the narrative matrix theory even as a meta-narrative is still a narrative. As such, it proposes a self-reflective stance for other models, including the narrative-hermeneutic approach itself. As a model, it draws on reflective anthropology that proposes anthropological practice as self-reflective and aware of its own involvement in different contexts and subjectivity of perception. Saying this, the narrative-hermeneutic approach is also a part of societal discourse, embedded in its own historicity.
2. *The narrative-hermeneutic approach stems from philosophy and as a theory it cannot be applied in therapeutic practice.* Philosophy applied to psychotherapy can help to re-think therapeutic practice and the assumptions on which it is built. Therefore, if it cannot be applied directly, it is an important tool for self-reflection of psychotherapy and refugee care. As such, it proposes a meta-narrative in psychotherapy using philosophical tools of analysis.
3. *Categories such as PTSD and PTG function in refugee care and are efficient as therapeutic models.* It is not claimed here that these categories should be refuted. As with any psychotherapeutic or psychiatric category, they might be useful tools if used in a reflective and sensitive way. As stated, they also constitute fore-structures of therapeutic understanding. They should not, however, dominate the narrative as grand narratives.

Conclusions

One of the aims of this article was to demonstrate how psychotherapy, including therapy with refugees, is involved in societal discourses. Foucauldian theory can be used to show the connection between knowledge and power relations. Theories and psychiatric categories such

as PTSD and PTG, if used in a reductive way, can be part of the totalising and colonising knowledge in the form of grand narratives. Although they are used as a mode of comprehension, they might reduce what is unknown or 'unthinkable' to well-known models and categories.

Alternatively to discourse analysis, a synthetic model can be used where not only a structure of discourse or grand narrative is exposed but different narratives are multiplied and confronted with each other. Contrary to grand narratives that aim to provide explanation in the form of a coherent, single and universal narrative, the narrative matrix is constituted of a variety of multi-layered voices stemming from different sources. They constitute meanings through mediation and conversation mode, in what Gadamer called the *fusion of horizons*.

In the case of family therapy with refugees, which is regarded here as an example of such a narrative matrix, narratives may come from different agents such as different members of a family, a psychotherapist, a supervisor or members of a supervision group or reflection team. There are also many social, cultural and political narratives and discourses that are present in the narrative matrix. The main idea behind narrative matrix theory is that the psychotherapeutic model that is used is not a superior form of knowledge but one voice among many narratives. It will differ depending on the method, personal and professional experience of the psychotherapist, etc. It is important than none of these 'voices' dominates other voices; they should rather be interwoven and create new patterns.

Using the narrative matrix is particularly important when providing support for refugees. The intercultural setting of therapy with refugees requires a less homogenous model than traditional Western psychotherapy can offer. Secondly, therapy with refugees is naturally multi-voiced and multi-layered, so social, political and cultural contexts cannot simply be denied. As refugees' experience may seem 'distant' for many psychotherapists from a Western background, there is a temptation to use a single model or category that would provide an illusion of comprehension. This can potentially dominate other voices, coming from asylum seekers.

Therefore, we need to look for new models of working that will be more efficient and diversified in order to provide possibly the best support for those that may need it.

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