16
Clinical Supervision and Culture: a Challenge in the Treatment of Persons Traumatized by Persecution and Violence

Ton Haans, Johan Lansen & Han ten Brummelhuis

What is Clinical Supervision?

Supervision has become a familiar element in teaching and training of future mental health professionals all over the world. Psychiatrists, psychotherapists, social workers, counsellors and other professionals know supervision as a regular part of their education. Besides this professionals often realize that, even after many years of practice, it can be helpful to go through some supervision again. Learning a profession does not end with certification and registration.

But what do we mean when we talk about 'supervision'? In this article we prefer to talk about 'clinical supervision', which differs significantly from administrative supervision. Administrative supervision is a form of quality control, an evaluation by a senior professional who incorporates the right way of doing things; it is an administrative control within a hierarchic organization. But clinical supervision is something else. Here the relation is based on shared reflection by the supervisor and supervisee and not on instructions within a professional hierarchy. Educational supervision incorporates both elements; on one hand it is a quality control of the senior professional supervisor who trains the junior supervisee in the do's and don'ts of the profession. On the other hand the supervisor warrants an increasing capacity of self-reflection and independence in the supervisee.

The shared reflection in clinical supervision is between an expert, preferably an outsider, and another professional, the supervisee, and it is focused on the supervisee's work. Its aim is to help the supervisee to acquire more cognitive, emotional and methodical depth and skill. Supervision should lead to a more independent position of the supervisee, based on his competence – and we assume that the supervisee's clients will benefit from this increase in competence as well (W. Lammers, personal communication; see also Lansen & Haans 2004, p. 330).

We can describe clinical supervision as a form of hands-on learning, learning from concrete practical experience by the combined reflection of supervisee and supervisor. They reconstruct what has occurred in a treatment. They examine together the meaning of what has happened, what they did themselves, what interpretations they gave and they also assess their own feelings – a process that is

highly based on their intuition and on a whole domain of common assumptions and understandings, in other words on the culture they share.

The challenging question of this article is indeed what will happen – or what has to be done – when the element of cultural difference is introduced in clinical supervision, when the life experiences of the patient are located in another culture or when patient plus supervisee come from a different culture? Will this result in a lack of common understanding and mislead the interpretative work? Theoretically this may sound as an unsolvable problem, but in practice therapists are confronted with it everyday. They are forced to find immediate solutions when they meet refugees who fled terror and violence in their own country or when they participate in international relief organizations that attempt to reduce the suffering caused by international conflicts or disasters.

Let us first explain why the problem is challenging for theoretical reasons. Culture and supervision are closely connected in at least two ways. First, clinical supervision can be seen as something that has its origin in western cultural values. But does this mean that its validity is limited to the West? Supervision is based on autonomy of thought, critical reflection and thinking beyond or even against our self-interest. In this sense it is part of an achievement of western humanistic culture. Other cultures may have similar traditions of radical reflection, but they are not institutionalized in the medical and social professions. Clinical supervision is part of an approach which is defined as scientific and it contributes to a professional identity. This does not mean that it is widely used and acknowledged; in fact it is marginal and sometimes disputed. Although we may argue that clinical supervision is 'western-bound', it does not imply that individual autonomy of thought and critical reflection only work in a western environment. In this article we hope to demonstrate its wider and general value.

Second, clinical supervision necessarily works with material that is formed by, in the first place, a patient's culture, but also by a supervisee's and a supervisor's culture. Despite differences in, among others, religion, education, class, generation, gender and so on, understanding the life events and experiences of their clients is something that is within the reach of most therapists who treat patients from their own culture. Psychiatrists and therapists in Western Europe, the USA, and Canada (and their western-educated counterparts in many other countries) have a common corpus of more or less accepted ideas that excludes many other interpretations held by other groups or in other societies, e.g. explanations in terms of astrology, karma or the influence of spirits.

When we state that supervision works with cultural material, 'culture' has an ambiguous sense. To avoid confusion we have to distinguish between culture as a universal human characteristic that enables – and not constricts – human behaviour, and the specific or concrete culture in which a person is socialized. Supervision works always within a certain common framework of culture and it assumes the existence of common structures, categories and mechanisms. In this article we address however the specific problems related to the different concrete cultures in which the individual patients or supervisors are socialized. We may compare this with language. Languages have a certain grammar in common and

when people do not know each other's language, this does not mean that it is totally impossible to communicate. As there are individuals who have a gift to pick up a completely foreign language, so it is expected from a supervisor to be open to the world of a patient or supervisee of another culture and to understand what at first sight seems not understandable. Apart from this, openness and reflection are general characteristics of all clinical supervision; they are also required when working in the own culture.

How clinical supervision can work in a non-western environment will be elaborated in this article. We will do this by describing and commenting on a number of selected cases. These cases reflect two quite different situations. The first situation occurs when supervision is given to a therapist who is in charge of treating a patient from abroad, for instance a refugee from Afghanistan living in Holland. The therapist can be a professional who is new in the treatment of refugees, or he can be an experienced therapist who has run into some difficulties with this particular case. In these cases the supervisor is mostly a Dutchman. Within this supervision system, the main cultural split is between the Dutch therapist and his patient, although there also may exist some minor 'sub-cultural' differences between supervisor and supervisee.

The second situation occurs when a supervisor goes abroad as a team member of a training project. This can happen at several places in the world where the violence of civil wars and tribal conflicts has made many victims. Often elementary help is given by the Red Cross or other charity organizations. When they have left, people may need other help, including psychological assistance. Western organizations may assist in the form of training projects, which can include a training of trauma counsellors. Here the major cultural split in the training system is between a western trainer and his trainees. The trainees are confronted with a new, western method of helping patients, while they are familiar with their patient's culture and often belong to it. When the trainees are medical doctors, teachers or social workers who are trained in western concepts, the cultural difference with the trainer will be smaller, but there might be some cultural split between them and their patients. In most cases however they know their patient's culture and have working experience within their culture. They have thus learned how to handle new input from the West.[1]

[1] This situation can be even more complex if supervision is a part of the training method. In most cases an expat staff member of the international NGO will supervise the local workers. He (or she) introduces supervision as a western concept like we described above. But his long stay in the region may lead to a fruitful interchange of cultural elements in the supervision. It also happens that local, senior counselors are appointed as supervisor of junior colleagues. The seniors are often trained by a western trainer-supervisor. He comes for a restricted period of some weeks to give some form of supervision training. In these fleeting encounters the intercultural components are even more difficult to handle, even if the same trainer-supervisor returns at regular intervals when the supervision trainings are continued during a certain period of time.

Western Therapists and Foreign Refugees

Let us start with an example of the first situation, supervision of therapists who are treating patients from abroad, thus also a case of group supervision.[2]

Case I

Supervised is the therapeutic work done by Peter, a 70-year old retired psychotherapist, who is giving support to a refugee family of the Middle East. The central person in this family is a refugee woman of 41 years old. Her name is Aisha. Peter started his work with Aisha by doing supportive sessions. She has recently been admitted to the psychiatry department of a general hospital, as she was considered suicidal. Doctors at the hospital have treated her well, to his opinion. After two weeks she has been discharged and now she is at home again.

Peter, who knows this family for several years now, has changed his approach in the course of time from supportive sessions with the mother to 'accompanying the family', as he calls his work now. The family has taken refuge from a country in the Middle East, where they as members of an ethnic minority people were subject to severe restrictions, and even threatened to be persecuted on a local level. The husband, whom we shall call the father, was a member of a forbidden political organization that sought independence from their country. Police raids resulted in arrests of family members (father and his two eldest sons), who after some routine ill-treatment at the police station were interrogated and kept in prison for some days. A few days later and after some further ill-treatment they were released with a serious warning. They had to refrain from any political activity. But they did not; they went on with secret meetings with political friends. The result was another police raid, ill-treatment, arrest and release after a few days, and another grave warning. They went on, however, meeting political friends in secret. Apparently police was able to trace their activities and a third police raid followed, accompanied by a military squad. The soldiers have beaten the family members up and took the four-year old youngest boy in a separate room, battered him too and flung him against the wall. The boy cried terribly but suddenly it became quiet. In the meantime the handcuffed father and his sons were carried off to the police station. Later it came out that the boy was heavily injured, and after a short period in hospital the child died from his injuries. Furthermore the soldiers troubled the mother and the eldest daughter in a way that could not be spoken of until today.

The prisoners, the father and his two eldest sons, were told that they would be transferred to a faraway prison under a strict regime. During their absence Aisha and her eldest daughter had to report to the police station every day. It was obvious what threats were imminent for them. If they wanted to prevent this,

[2] Names and locations in this article have been changed in so far as they can give any information about the identity of patients or therapists.

they had to be law-abiding and loyal to the authorities. This implied that they had to report about all activities of persons from their political party. Only on this condition they would be released instead of being transferred. The father, seeing no other way out, decided to accept these conditions, and after that they were soon discharged. The father had no intention to obey the authorities and on the first occasion the family fled the country. They applied for asylum in a German speaking country where they arrived in 1999 (father's brother was living there). At that time the family consisted of father (then 37), mother (35), a son of 17 years, a son of 16 years and three daughters of 12, 9 and 6 years old. They were six years older now.

In the story that follows the matter of obtaining a permission to stay in the country of asylum plays a very important role. As regulations became more and more strict appeals for a residence permit were rejected time and again. A local committee of church members took care over the family. Procedures were protracted when they moved to other districts; and psychological support was organized. When the mother got into problems, the psychologist Peter, member of this committee, offered to help. He had regular talks of a supportive nature with her. As no official interpreter was available the eldest daughter, who had acquired a reasonable knowledge of the language, acted as interpreter.

Peter's Efforts

The continuous insecurity about a residence permit made the mother desperate. Authorities considered the situation in the home country as much improved and saw no reason to let them stay. For this family going back was however unacceptable. Neither the father could cope with the situation. He let off steam against wife and children. Outwardly things went better for the children: they learned the local version of German, they did odd jobs, and they managed to go to school. There was some contact with other refugee families from their country. But Aisha became more and more unbalanced. She did not sleep well and she often cried. She felt neglected by her husband and she thought that he was deficient in caring for his family. Her eldest daughter supported her by doing household chores. But Aisha's situation worsened. She collapsed at times, she had fits of screaming, and she got anxious and threatened with suicide.

Then Peter decided to help the family. He had talks with the father, he spoke with the children separately, he learned to know all of them and he even held a few family sessions. As no regular social worker could be obtained – again, this country leaves the case of not yet recognized refugees to charity, which means that regular services are not available in most parts of the country – Peter acted as such, assisted at times by other citizen volunteers. The family held Peter in high esteem. He carefully kept some distance when they tried to become closer to him.

About one year and a half ago (early 2005) a turn for the better seemed to come for this family. New rules determined that refugees had the right to stay for treatment reasons in the country where they had applied for asylum, as long as

the same treatment was not available in the country of origin. Mother's mental condition was recognized for treatment. The need to be treated gave her and her family the right to stay temporarily, as long as the treatment required, and as long as treatment would not be available in the country of origin. Together with a psychiatrist Peter had written a medical report for this purpose, which was recognized by the court. His conclusion: Aisha was suffering from chronic PTSD with depression as co-morbidity.

The family got a house. The father as well as one of the sons found a simple job. Peter kept in touch with the family. Mother made regular visits to the local psychiatric clinic on an outpatient basis. With the help of medication she found some rest. Her condition improved for some time. The girls went to school. But after half a year the mother's condition started to decline again. When she complained of suicidal thoughts, she was admitted to the psychiatric department of the local hospital, as mentioned before. After her discharge her condition went up and down without showing real progress for the better. The hospital's outpatient department followed her with supportive contacts and anti-depressive medication.

As Aisha had psychiatric treatment now, Peter could give his attention again to the family. He had the impression that mother was the carrier of the stress of the whole family. Every once a while he had a session with the father, and he had also sessions with the eldest daughter. At times he had a session with the whole family about their stressful situation. This situation can be summarized as follows. The mother cannot become better; her disorder allows the whole family to stay. This also means that domestic care for the family, and care for mother, is in the hands of the eldest daughter, now 18 years old. She does her best to keep the family going. She has almost no contact with peers from outside the family. But she got an eating disorder (frequent vomiting) which makes Peter think of anorexia nervosa. Father is worried about his wife and daughter, who are very ill he thinks. He insists on a thorough physical examination, but no physical disease was found after it took place.

'Accompanying' this family became a bit too heavy for Peter. He saw the family sliding down, since now also the 15-year-old daughter showed up with symptoms. She had complaints of anxiety when walking in the streets and started to stay at home from school. A school social worker showed up, who worried about the girl. He tried to help her overcome her anxiety, and when this did not succeed, he wanted her to see a psychiatrist.

The Supervision

Peter brings this case in the supervision group. All members of this small group of seven people are therapists of traumatized refugees. The group meets on a regular basis every month and they have agreed to follow a certain sequence in their sessions for group supervision as proposed by their supervisor.

After Peter has finished his story about the family, there is room for some clarifying questions. Then Peter states his question for supervision: "What more could be done for this mother, as she seems to be the center of the problem?" He has an

additional question: "Could something else be done for the eldest daughter?" Before starting the supervision *with* the group, two special rounds are made according to the 'structured group supervision': one from the perspective of identification with the *patient* and one from the perspective of identification with the *position of the therapist*.[3] After a minute of silence in order to concentrate on the reality and life of the patient everybody, except the supervisee and supervisor, is asked to tell how he or she feels as the patient (Aisha). This round of identification allows the supervisees to come closer to the difficult and sometimes impossible and stressful situations a refugee family is living in.

All participants reveal how they feel in the role of Aisha, the mother of this refugee family. They worry about the children, since they do not receive support from the husband. They feel the oppression through the traditional role of men and women in the family and have no idea what more misery the future may bring. Furthermore they feel alone, because now Peter, the psychologist with whom Aisha could talk so well is letting her down. He is a nice man and she sees him as a sort of grandfather for the family, but evidently he does not know anymore what to do. And neither she nor her daughters are able to speak about what happened when the soldiers had carried off her husband and sons. One of the group members feels as if she ought to have been killed. As a mother she was absent when her child was so badly beaten up and smashed against the wall so that it died shortly after.

Peter is asked to give feedback now. He has recognized everything that has been said. Aisha had expressed herself in fact like this: "I have earned death, but I can't leave my children now alone". Peter does indeed not know what to do with this family and he thinks that the family needs psychological assistance. The best thing to do now is to find another social worker who works intensively with the whole family, besides the psychiatrist for the mother, a psychiatrist for the eldest daughter and the social worker for the younger daughter. Where however to find another expert to work with refugees from another culture?

The supervisor asks the participants now to make a round of identification, in which they identify with the task and position of the psychologist (not with the psychologist Peter himself, as a person). They have to imagine that they really work with the family in Peter's place. After a minute of identification the supervisor asks again how they feel – and not what they should do now. This should avoid that they

[3] It is important to emphasize that the supervisor works *with* the group of supervisees (Proctor (2000:38). He follows the lines of a 'structured group supervision' (Lansen & Haans 2004:340–3), where the group executes several rounds during the supervision process: (1) presentation of the case; (2) questions for clarification; (3) identification with the patient; (4) identification with the task and position of the therapist; (5) supervision *with* the group; and (6) a final round. After the case has been presented (1 and 2) and before the discussion with the group starts (5), two rounds of identification are held in which explicitly the feelings of the participants are discussed. The purpose of these rounds is to attune the participants to a climate of reflection instead of giving comments and advice from a distant observer position.

speak from the perspective of an audience in an easy advice-giving position. Participants express now feelings like: "I feel insecure, confused, helpless and desperate; I cannot work with my regular 'instruments' and that makes me feel miserable; I feel the desire to offer 'holding' to the family; I feel that I have to work very carefully". But also: "I feel irritated, furious with those soldiers, shocked by the ill-treatments".

Peter is asked to give his reaction. He says that he feels helpless himself. As a man he cannot imagine, he says, the things that happened to the women. It must have been awful. He himself is furious with the father, who is relatively indifferent to the difficulties and sufferings of his wife. Peter tells now how furious he becomes any time he thinks about the helplessness of these women when their little son and brother was so deadly ill-treated. His words are followed by an impressive silence.

The supervisor then proposes to make a normal round of supervision *with* the group. He opens the joint reflection with the question "What more could one do here with this family?" and "What suggestions are living in this group?" A profound exchange of ideas takes place, out of which several are taken to the foreground here. It is clear that individual therapy for the mother may be indicated, but at the same time it is impossible that she will heal completely. She cannot, as long as she has the unpronounced duty to remain ill. The secondary gain for the family is huge, as family members can stay in this country as long as treatment is necessary. Going back is impossible for the time being, even if the political situation and the behavior of police and military would improve. The members of this family have not yet come to terms with their traumatization and for several reasons it does not look like this will soon be possible in their place of origin. Politically they still run the risk of persecution by local authorities; psychologically they fear to be seen as cowards by their former comrades for their flight to the West; and also culturally because everybody in their village will have a misgiving about what happened to the women by the police (which means that the girls cannot marry in their region of origin).

A treatment concept for this woman should imply a compromise: she may get a supportive therapy, which would enable her to cope with mourning and also would make her 'self' grow. As for symptoms, medication could take care of that. If the psychiatrist is satisfied with a limited objective, the mother will be able to function much better, while a number of complaints will remain.

Peter's role is also discussed. He has a role as a sort of 'adopted grandfather' (as he calls it himself), a wise old man, who gives advice and help and who is seen as a personal helper. This role is very important for this family, but also for himself. Instead of loosing courage and leaving things completely to others, he should reflect about his role and accept this role in a sensible way. Peter has a role in reality for this family. He is respected and all are very grateful for what he has done so far. He has the uneasy feeling that this family puts him too high on a platform, whilst he should like to be on more familiar and equal terms with them. They decline to call him by his first name and to consider his rather egalitarian wish (during this supervision we might have explored the issue whether this wish is coming forth from his training as a western therapist or from a

personal need of Peter). They call him 'Herr Peter' which sounds a bit absurd but evidently they do not feel the freedom to call him by his first name, as they see their contact more in terms of doctor and patient in their own culture, notwithstanding all sympathy and even friendship. In fact Peter would like to be one of their people or tribe. But on the other hand, is it wise to be in the 'grandfather' position? Why not take some distance while going on being sympathetic to them and declaring his solidarity by his deeds? He might have a role as adviser but also as somebody who confronts them with unwise behavior. He is a sort of 'elder', but a bit different from elders in their Muslim village community; he is allowed to be different, because he has his own identity as a citizen of his own country. Why isn't he satisfied with this role? Why does he want to be part of them? In fact, as an outside 'elder' he can do a lot. He can take the father apart and show him in a quiet, respectful conversation that he has some shortcomings and might be more considerate to his wife. He may tell the sons that they may help a bit in the household. He can also support the children. He may watch the treatment of mother and eldest daughter from a distance and if necessary act as a consultant to the psychiatrists. Maybe he can do something for the girl with the school phobia. If mother and eldest daughter will experience less stress, the overall level of stress in the family might decrease. Most probably it will not be necessary at all to add a new caregiver, a social worker, to this family as he has proposed. That would make things more confusing.

Peter reacts to this with a broad smile. He feels that he can do something with this. It is as if he has got something like a permission to do what he wanted himself but did not dare to accept. The role as 'elder' is a nice compromise between his wish to be close with the family but to take some distance too.

What about the other participants? For some of them, what happened in this supervision is an eye-opener. Others have to get used to the idea that a psychologist leaves his usual position in treatment (that had happened already a long time ago in this case) and gets a supportive role for this family. For one member it is unsatisfactory that the mother will not get a thorough, effective treatment. This member sympathizes very much with the mother; she fears that her suffering will not be adequately tackled. Another member points out that a social group has just been established for adolescent refugee-girls from the same minority in their country. It might be good to invite the eldest daughter to this group. Finally it is agreed that Peter will bring in this case for some follow-up in future sessions of this group again. It might be useful to give him more support in his role.

Evidently Peter has a role problem that is often seen in therapists working on a voluntary basis with refugees from other cultures. He is part of a group of volunteer citizens. For volunteers it can be difficult to draw a line to their assistance. Peter acts as a volunteer but on the other hand he also tries to act as a professional, because he continues to give psychological assistance. No doubt, it is tempting and laudable to help people in distress when there is no regular assistance available from the mental health system during the crucial time of entry in the country of asylum. It is also tempting to underestimate the problems that may arise. From his wish to assist he was a bit blind for the complications that might arise. Gradually

these complications became too heavy. He liked to withdraw by calling in more professional help, but he did not really believe that this family would make any progress this way. He has a sense of reality, but also feelings of guilt. At one hand he liked to withdraw, at the other hand this was not acceptable to him.

Saving this refugee family by trying to arrange a provisional residence permit and hoping that in some magical way a definite permit would be given has been an important motive for his actions. Did it give him a feeling of power to fight against authorities without knowing what the outcome of the war would be? Was it naivety? Was it the battle against injustice? Has he unconsciously been motivated by unfinished conflicts with his parents or teachers? He has saved the family for the time being, but things are not going well. He is committed to the family and feels stuck. He is looking for supervision in order to prevent worse.

Looking Back at Supervision

Peter hardly expresses himself on his motives in supervision. Yet the supervision group knows what is going on. Problems like these often arise, maybe not as hectic, in working with traumatized refugees who fight for a residence permit. Almost all members of the supervision group have experienced how their role as a therapist can interfere in their work. They don't have to explain this to Peter. He knows that he has rushed into helping this family with the best of intentions. He is familiar with the pattern of a passionate caregiver, who is hampered by the impossible context of the people he tries to assist and by the disappointing outcomes. He knows how often a man or woman resigns from this work in frustration or ends up with forms of burnout or 'traumatoid states' (Wilson & Thomas, 2004). He also knows the temptation of a savior's role.

These topics were hardly discussed in this supervision; they were seen as a matter of course and as a well-known theme. The supervisees, amongst whom some experienced therapists, shed some light on other possibilities. Peter does not have to withdraw, but he can better style his role than he has done up till now. This family is open to his role as 'elder'. He has to give up his role as a 'beloved grandfather' belonging to this family, and he should rather accept the role of respected wise man from this European country. An 'elder' at some distance can have more influence than a close pseudo-family member. Why not being a wise and humane western psychologist with empathy, but also distance? Wherefrom this tendency to over-identification? Why such a need to be recognized by the family as 'one of them?'

Looking back at this question an answer might be found in the special situation of giving care and assistance to refugees in Peter's country. At first sight there are a lot of differences between those refugees and their helpers. The people being assisted come from another culture, the culture of a minority people within their home country, whose culture is rather different from the culture in this German speaking country where they have sought asylum. They come from a technically primitive, rural area, whereas their assistants in the new country do often belong to an academic or semi-academic milieu. But there is an important matter that

these groups have in common: both groups, these refugees as well as their assistants, are in a certain sense people living in the margin of the society in which they live now.

The group of refugees is not welcomed and the other group's work for refugees is hardly well received. Assistants can seldom show off with their efforts as their neighbors and friends are scarcely interested in this kind of work, or worse even, have a negative opinion about it. Working for traumatized refugees has got a negative note in their country. It is not recognized as a regular part of the work in the mental health system. This means that in practice idealists are engaged in doing this work. Politically they are rather actively engaged against the prevailing opinions in their country about refugees. When refugees do not get a residence permit, lawyers ask them to write a report about the traumatization of their clients. That means another source of unpaid or badly paid work, a source that often takes more than one half of their time. This situation brings along a whole series of particularities in the psychological sense. We see them in this case especially in Peter, the therapist, who asks for supervision in the first case. He is over-involved with this family and finally he phantasizes to be part of it.

Such identification with the victim role can lead to errors and mistakes. It can make an assistant blind to important elements in a case or in a patient system. In this case Peter lost his distance. The case of this family had a strong emotional impact on him. He is in trouble with his role – is he a volunteer like any citizen, a professional or some sort of family member? – and he has problems with the case concept.[4] He has also made an error in assessing the role of men and women in this family. He seems to consider the fact that it is self-evident in this family, that women are more burdened with tasks of internal family life than men, as a personal deficit of the father. He has not seen that this might be a structural given in their culture. Probably it did not occur to him how in countries in the Middle East women behave in regard to emotions.

Females are encouraged to express emotions that elicit support and reflect weakness, such as fear, unhappiness and helplessness. Men are encouraged to express emotions and encourage actions, such as anger, anxiety and revenge. Second, emotional distress is caused by conflicting value demands on women in a society that is both collectivist and paternalistic. The general feeling is that society is a threatening entity that pursues women and prevents them from fulfilling themselves. Very often men are not conscious of the intrapsychic and social pressures on their wives and are not aware of their distress. Third, the notion of suffering in silence is glorified. There is a term for a woman who suffers in silence without complaining: the 'Mastoura' woman. Abu-Baker (2005) describes this as the wife and mother who is to the outside world the sick woman, pleading for help. To the inner family she has to be strong. Se has to fulfill her domestic duty. The husband and father does not know better, to him it is self-evident. He thinks that she does not need support; she is a strong woman, even if she is sick. Anyway she should

[4] For a more detailed explanation of 'case concept' see the next section.

be. Two of the daughters are on the way to fulfill the same role. The psychologist Peter in his role as 'elder' has to give a nice package of psycho-education in order to clarify that father has to adjust his expectations and behavior, also in his own interest.

Preliminary Remarks

In this case we have shown that clinical supervision can play an important role in the support of traumatized refugees by western therapists. The open and free-floating reflection of the group helped to find new ways in dealing with a difficult case. The reflection on the role of the supervisee Peter exemplifies the main reasons why supervisors ask for supervision that we have distinguished elsewhere[5].

The first reason why Peter asked for supervision was the emotionally overwhelming impact of his involvement with the family. In a more generalizing manner, we distinguished such reasons as *problems of personal impact*. We can specify them as problems in counter-transference reactions and emerging problems of burnout, heavy emotional impact or even 'traumatoid states' (Wilson & Thomas, 2005).

The second reason for supervision was Peter's lack of a proper assessment of the case and therefore his error of judgment in understanding the case. We took these reasons together under the heading of *problems with the case concept*. They can consist in using unproductive working models, a lack of knowledge about trauma and culture and as a result application of inappropriate therapeutic methods; a concept of the case exclusively formulated in clinical terms, discounting the social, economic and political processes. In the case of Peter the personal impact and the problems with the case concept have led to an unclear conception of his role. Role confusion is often seen; we have put it in a rest group of dissimilar problems, together with problems like aggression in patients, treatment of perpetrators, conflicts with interpreters, unstable work situations or lack of experience in certain therapies.

What clarifies this case however in terms of culture? We like to spell out three points:

(1) The most outspoken cultural difference we noticed were related to the characteristics of gender in the Middle East. The notions about the tasks of men and women held by this Middle Eastern refugee family were initially hard to understand for the psychologist Peter. Instead of acknowledging its cultural meaning, father's dominance made him angry. The case shows how a lack of familiarity with a patient's culture can disturb an adequate perception of the family relations of the patient. Cultural difference was outspoken here, but in principle not dissimilar to

[5] The authors have elsewhere made an inventory from their own work in supervising therapists treating traumatized patients, amongst whom the majority consisted of refugees; they selected notes from 100 cases (Lansen & Haans 2004).

what is encountered in the treatment of more common patients. In practice, however, it can be much more difficult to get sufficient cultural knowledge. Sometimes interpreters can give it or there are staff members from other cultures, colleagues with a long experience or a supervisor's expertise.

(2) Cultural differences are not only more outspoken but also more intense. The story is dramatic; it involves persecution and homicide in the country of origin, and the threat of deportation to their asylum country. At the same time we are forced to look beyond culture and to take into account the political context, not only the story behind their flight but also the refugee situation in the asylum country, as no regular psychotherapeutic help exists for refugees who have not yet got a residence permit. All psychological and most social support has to be organized in an impromptu manner and a regular and solid financial base and organizational structure are lacking. An appeal is done on the therapist for more than therapeutical activities (help with money, transportation, making a phone call to authorities about non-therapeutical affairs, involving friends or the church community for accommodation or other support). In such cases supervision is essential.[6]

(3) Of particular interest is the intense cooperation between persons from two different cultures, here the psychologist Peter and the Middle Eastern family. For such interactions no clear-cut models are available and it is more difficult to develop professional neutrality than in common treatments. There are risks like victimization, exotization or identification. Peter's over-identification, which became clear to him in the supervision session, is perhaps understandable given the massive indifference and political harshness towards refugees in his country. This cultural interaction, which is a cooperation and confrontation at the same time, is an eminent theme to be subjected to clinical supervision.

Expatriate Experts

In this part we will discuss several cases that represent what we have called 'the second situation', when western supervisors go abroad and present their method to therapists, professionals, and social workers from non-western cultures. What are the effects, possibilities and limitations when the 'western-bound' method of clinical supervision is applied to counseling and clinical work in, for example, Cambodia, Uganda or Sri Lanka? We limit our description to supervision in areas that have been hit by natural disaster or organized violence. Here we may be confronted with huge numbers of survivors who have lost almost everything: family members, limbs, house and dwelling-place, facilities for practicing their

[6] Practical experience has learned that supervision can also be important in countries where care for refugees is part of the regular health care. In such cases the main issue is not the definition of the professional role, but dealing with the emotional impact the agonizing lot of these people can have even on experienced team members.

profession, and so on. They are forced to live in bad conditions, are poor, often hungry and sad, and suffer from disease or mental health problems.

After the first emergency help, a process of rehabilitation starts. When the first-aid NGO's, often helped by the Red Cross, have dealt with the most urgent problems, new NGO's enter the field, by their own initiative or invited by governments or local organizations. These "second wave helpers" often focus on mental health conditions and psychosocial interventions of a more permanent kind. During this period local counselors have to be trained in helping methods, they can use as community worker or mental health counselor. Students in these trainings are often local volunteers, grass root workers with little education or other professionals like nurses, teachers, clergy, leaders etc. The methods taught are often forms of fundamental counseling based on their local helping practices (Van der Veer, 2003).

To support them in their work *clinical* supervision is provided. Most ideal will be to have this supervision applied by supervisors from the local helping organizations and to give more experienced senior team members the formal role and position of supervisor. In reality this option is not always possible. Often outsider experts from the West will be brought in, to provide the capacity and expertise for adequate supervision. If local senior counselors are available to execute clinical supervision, the western expert can limit his task to provide more or less regular trainings as a trainer-supervisor.[7]

In this section we will look at the interaction of cultural differences in a setting where western expatriate experts cooperate with local counselors as long term supervisor or brief trainer-supervisor. The expat supervisor has a western background, but acts within a local – and for him 'strange' – environment. The following examples, where supervisor and supervisees are Tamil, and the trainer-supervisor is Dutch and male, illustrate situations which are quite usual.[8] Most of the following examples occurred in 'structured group supervision' sessions, as described above.

---

[7] We are using the following terms: 'supervisees' are counselors and local staff members from non western helping organizations, and the 'supervisor' is also a person with the same cultural back ground. The 'expat supervisor' or 'western supervisor' is a non local expat who works for a longer period with the local staff. The 'trainer-supervisor' refers to the western trainer who provides the supervision training, often in short blocks of one or two weeks.

[8] During the years 2004 and 2006 one of the authors (Haans) executed a supervision training as a trainer-supervisor with local NGO's in the Tamil region in Sri Lanka and the southern part of India. These organisations had started as a branch of Doctors without Borders and had become independent institutions in due course. The trainer-supervisor offered trainings in individual, group and team supervision. The intended local supervisors were senior counsellors and community workers. They executed supervision within their own organisation and for external organisations like secondary schools and local staff from other NGO's.

Case II

In case II we describe a phenomenon that often occurs when a western supervisor tries to attune to local circumstances.

The local supervisor asked one supervisee to describe her problems. The supervisor listened attentively and empathically, and so did the other group members. There was a warm, supportive climate and at a certain point the supervisor and group members interfered by asking questions. These questions clarified the actual situation and the client's problems. And then, quite unexpected for the western trainer-supervisor, the group members started to give advice and to advance solutions in a quite directive manner. The supervisee who contributed the case listened attentively, nodded and after a few minutes she expressed her acceptance of the solution.

The trainer-supervisor had the feeling that the case presented was a complicated one that, according to his experience, requested a meticulous elaboration of the motivations behind the supervisee's helping strategies. The solution was – to his view only – a variation of other solutions that had failed, but everybody was happy with this outcome and this result of the discussion. "This is like we always do, so what is your problem Mr. Trainer-supervisor?"

Emergency work is often done within the framework of a kind of casualty department. This case is a clear illustration of such an attitude. Significant is that the urgency of the immediate problem, the need to find concrete solutions, convinces all participants of the adequacy of quick answers. For the trainer-supervisor it was like watching the American television series "ER", an emergency ward where problem presentation and solution agreement are reached in a very high speed and within a subordinate frame of relationships. One could wonder if in distress all humans act like this, or whether this American export product had such a strong impact on the local community. The latter is quite implausible and a tendency towards hierarchic quick solutions in catastrophic circumstances seems a likely general human response. Such a response can be consolidated by the influence of expats in the emergency aid and supervision of the local staff. Often supervision is provided by one of the expats in the organization, mostly a doctor or skilled nurse, who is familiar with a medical emergency way of supervision and induces this in the local staff with good results; the effectiveness of the emergency and rehabilitation work often improves considerably.

Apart from the urgency of a problem, this local culture (like most Asian cultures) may support such an attitude when a strong tendency exists to await and to follow the advice of authorities, an attitude that hinders reflection and which is also a pattern that is particularly common in the medical profession. In our case it seems that the local supervisors and supervisees responded from this mixture of general and cultural common behavior.

When the trainer-supervisor questioned this response, the local supervisors and supervisees were quite astonished about the nature of this question, they did not see a problem. The trainer-supervisor explained that this emergency attitude

is less required during the rehabilitation and even less during the following reconstruction period, in which the team was now. It can be effectively replaced by a more clinical way of supervision. The supervisees agreed to give a try to this joint reflection. Despite the common occurrence of this submissive supervision attitude, it has struck the trainer-supervisor again and again how easily it is abandoned by both supervisees and supervisors and replaced by a more mutual cooperative attitude in later phases.

Case III

The next example shows the contrary. Here we have a group of counselors who are well-trained during four years of counseling; they have much experience and knowledge regarding the psychological consequences of man made disaster for refugees and displaced persons. They are well-equipped to deal with complex psychological and relational problems. This was a dynamic, non-structured supervision group.

A supervisee presented a case of a woman who had to take care of her mentally disabled son in a refugee camp. She explained to the supervisor and the group how she became more and more demoralized by the incapacity of the mother to care for her son. There was no housing equipment, no food, and the neighbors were mocking her son and herself. The supervisor interrogated especially on these feelings of helplessness of the supervisee. The group members revealed that they had the same experiences in the shelters. They shared their feelings and after a supervision session of 45 minutes all ended in despair.

The trainer-supervisor expressed his concern about the emotional morass they were all in. They confirmed his observations and got stuck again! No alternatives came to their mind, no allies turned up and the local supervisor and the supervisees took the same emotional and professional positions.

This case illustrates the effects of the shared blind-alley job experiences many counselors find themselves in. Shared feelings of powerlessness and despair are quite common among supervisees and supervisors working in the same area and having the same background as their clients. Here the work of the local supervisor becomes very complex. Not only must she (or he) release herself from these feelings of misery and hopelessness, she has also to stimulate the group to a constructive and professional attitude and at the same time she has to do justice to this emotional layer. Irrespective of their cultural background, trauma relief workers and counselors all over the world tend to respond with these feelings of futility and humbleness. Of course, these feelings are colored by the cultural environment, but they reflect shared worldwide experiences. Being a western supervisor can bring an advantage here. He (or she) is more distant, can easily take a ‘helicopter view’. Supervisor and supervisee can engage in a dialogue about more unusual local resources, and about the strength and coping capacities of clients, counselors and supervisors. This can help to get out of the blind alley. We will elaborate this in more general terms in a later section.

Case IV

Male-female relationships are a common feature of all supervision relationships, but often they play a more outspoken role in non-western countries.

This group started to work along our structured group supervision framework. From the preceding dynamic supervisions the members were accustomed to the supervisor's question: "Who encounters what problems in his work?" Mostly all supervisees presented a case and the supervisor quite naturally selected the case the supervision group would deal with, irrespective of the supervisor being male or female. The following pattern emerged when within the structured framework, the trainer-supervisor asked the supervisor to encourage the group to decide themselves to select one of these cases for supervision. In this group (and many other supervision groups) the females form the majority; the males are always counselors, the females are either counselors or less-trained community workers. When the group engages into a selection process, nearly always the problems of the male members are chosen. Women's topics only are dealt with if a male group member has the same supervision question.When the trainer-supervisor noticed this pattern, the group and the supervisor responded with surprise, as if they were made aware of something obvious that did not require special attention. When this was brought to their notice by a stranger, they were able to question this automatic pattern and change it. Male group members normally show no discomfort in restraining themselves, female group members have however much more difficulty to convince the others that their problem is an important one. Here the intervention of the trainer-supervisor made them aware of a questionable relation pattern in their cooperation.

Culturally internalized relation patterns are present in the group sessions as well. It takes the 'eye of a stranger' to question this 'natural' daily routine. Case IV points to a common feature in both western and non-western supervisions, the inferior position of women in society. In western societies the supervisees themselves take the initiative to balance male-female relations, but it is also a point of continuous concern for the supervisor. In non-western countries this balancing is less self-evident. The 'natural' characteristics of these relationships are used as a rationalization of the maintenance of existing power structures. When an expat trainer-supervisor mentions this uneven balance within the supervision training, it is often recognized as something that can be changed. Most counselors working in mixed teams, are willing to cooperate on an even gender balance.

Case V

Within supervision the realities of the outside world can not be excluded from the sessions. The social relations and power structures within a community are often mirrored in the supervision session. This happens in this example, where a supervisee, a young female counselor in a secondary school, discussed the difficulties she had with a pupil.

The pupil had lived for a long time in a shelter nearby the school town in the Tamil region of Sri Lanka and had moved with her family to a new house in a new neighborhood. The girl (14–15 years old) caused great problems at school. She often skipped school, was irregular in performing her duties and misbehaved in various ways. She had been expelled from school for some weeks and returned much later than was arranged. The counselor was ordered by the principal to discuss this case with him, and he summoned her more or less to make sure that this girl would stop her deviant behavior. The normal procedure of returning was that the girl talked to her mentor and the school principal and that engagements were made to control and reduce the disturbing behavior. Neither of these happened. The girl was attending school, but officially she was not there, nobody knew about the guidelines she had to keep; she just roamed around and her behavior was even worse than before.

In the supervision the female local supervisor was talking to the supervisee only in terms of her relationship with the girl: "How could the supervisee-counselor improve her working alliance with this unstable young woman?" In the following training exercise, the Dutch trainer-supervisor stimulated the supervisor however to inquire about the mentor and the principal. After some reluctance of the supervisee, it turned out that they had not properly fulfilled their duties and had seriously dropped a clanger by not inviting the girl into their offices. Both were men, the mentor was of the same, the principal of a higher caste than the counselor. This caste issue became only addressed when the trainer-supervisor explicitly asked about it. Both women (supervisor and supervisee) avoided the power relationships involved in it. In their social perception men were naturally more dominant; and at an informal level, the caste shudder towards the principal was still very powerful in these lower caste women. During this supervision they agreed that the counselor should have confronted these men with their negligence, although both were men and one was of a higher caste, which made it very difficult to call them to account. There were two hurdles to be cleared, which proved to be too heavy for the supervisee and the supervisor. Therefore they avoided the issue and concentrated on the client-counselor relationship.

In the outside world there are many socially constructed gender hindrances. The female supervisee, the group members and supervisor were all dissatisfied with the treatment by both male officials, but their behavior was considered proper and natural to a certain extent. Women had to subordinate and show respect, so was the general, culturally accepted agreement. The interventions of the "stranger", the expat trainer-supervisor, brought their neglected feelings of personal and professional injustice to light, made them aware of their avoidance and opened new tracks to grasp the situation. In this way the counselor-supervisee could protect her client, continue the counseling in a responsible way, as well towards her client as to her superior.

In Case V we could observe the basic ingredients of the supervisor's fecundity as an outsider. Often the difficulties that result from the cultural differences between supervisor and (western) trainer-supervisor are stressed, but the position of a stranger can also be very helpful. If the supervisor and supervisee have the

same cultural background, many contextual and social boundaries are taken for granted. This also happened in this situation. Both supervisor and supervisee got together in an unconscious collusion and avoided the influence of the misbehavior of both men towards the girl, and towards the supervisee-counselor. They took these socially prescribed male–female power relations for granted and thus avoided a clear analysis of the professional role.

Case VI

Counseling in the area of natural and man-made disaster is often very complex. Decisive cultural influences emerge not only in the assessment of symptoms of distress, they also show up in the counseling relationship and the evaluation of human relationships between family members, community members and counselors, as this case shows.

In a structured supervision session, the supervisee presented a case that was going on for more than half a year now. The father of a family had been very demoralized by the tsunami disaster. His boat was destroyed; he had lost his reason of existence and had become mentally ill. He withdrew himself more and more from friends and family members, he roamed the other villages, slept in the woods and became more and more dependent on charity by the church. He had no longer contact with the other family members. Both his wife and the two adult daughters also drifted apart. One daughter got married to a fisherman and moved to his nearby village; the other one went to the neighboring city, leaving her mother alone with the counselor. The mother became more and more dependent on the counselor, who together with the son-in-law tried to find the father and to reunify the family. The supervisee told about his feelings of exhaustion, entanglement and confusion. These feelings reached a climax after a rare meeting with the father, who mistrusted him, yelled and called him all sorts of names. He was so shaken up that, after this session, he escaped to a Hindu temple, although he was a Christian. In this quiet atmosphere he was able to calm himself down and resume work. The supervisee also reported that there were few team members available to support him.

In this organization the "doll method", described by Diekmann-Schoemaker and Van der Veer (2003) was frequently used by counselors and clients. It is a visualization method in which the counselor uses small dolls, puppets and other objects to visualize the inner and outer world of the client. Together they signify on the table all the relevant relationships. They can "represent the whole family, their neighbors, or anybody else who plays an important part in the client's life. Even a dead person may be depicted: by laying a doll on its back". It makes the problem of a client visual and "helps both the counselor and the client to get an accurate overview; not only of the people involved, but also of the way the client feels that they interact." (Diekmann-Schoemaker & Van der Veer, 2003, p. 38).

The local supervisor and supervisees also used this method in the group supervision. During the exposition round the dolls were frequently used as a tool to visualize the problems of the supervisee.

In this case the supervisee depicted the father fifty centimeters away from the rest of the family, behind a barrier. The mother and the two daughters were close to each other, the married daughter was close to her husband. This son-in-law was replacing the husband for his mother-in-law, he visited her often, took care of her misery during long talks and supported her financially. He became closer to his mother-in-law than to his own wife. The counselor put himself nearly in the centre of this family. He was close to all the remaining family members and much closer to the mother than the youngest daughter, a rebellious teenager, who lived in a sheltered house because of psychological and behavioral problems. He vividly described his warm relations to the mother, the oldest daughter, his compassion for the youngest and his feelings of despair and anger towards the father who had left them all alone.

The supervisees responded empathically to him, and had great difficulties in making critical remarks about his emotional over-involvement. This had to be done by the supervisor who did so in an indirect way by questioning the position of these dolls. The father was put accurately in a very remote position, but the supervisee put the other dolls much too close to the mother. The youngest daughter saw her mother only at rare occasions; the elder one visited her one or two times a month. The only regular visitors of the mother were the son-in-law and the counselor, who were in a kind of rivalry. Both neglected the father and were rejected by him. The supervisor discussed the more appropriate distances of the dolls towards the mother, they were rearranged much more remote from each other. So it became clear that the supervisee idealized the interconnectedness of the family members.

To the trainer-supervisor it was clear that this was a very unproductive family situation. The group agreed, it also considered this family structure as very unacceptable, but the rejection of the father and the stepfather position of the-son-in law were not questioned, neither by the other supervisees nor by the supervisor. The supervisor also questioned the unproductive counseling position of the counselor. Not only was he very alone within the family system, also his rivalry with the son-in-law hampered his helping capacities towards the mother. When the supervisee told more about the recent history of this helping relationship, it became clear that his original client was the father. He was referred to him by a community worker because of his increasing signs of distress. The father had lost his boat and his dignity as a fisherman; and he was afraid of going to the sea again. He was unable to support his wife anymore. He also was a bad father to his younger daughter.

The counselor was supportive to him, gave educational and practical advice, which the father half-heartedly tried to put in practice. The counselor got dissatisfied with it; the client became angry and came no longer to the meetings. He then increased his wandering life style. Then the mother showed up as a client, she could no longer cope with the youngest daughter; her son-in-law was a great help, but he could not deal with the increasing problems. Therefore the counselor supported the mother, found a temporary shelter for the daughter and became a

"second son-in-law". This seemed quite acceptable for the supervisor and the group members.

Here the trainer-supervisor intervened, questioning this shift in clients, the professional isolation of the supervisee-counselor and his inability to get in contact with the father. How could he find allies to make contact with this man, who was his original client? It seemed that a catholic priest still had irregular charity contacts wit this man. So the trainer-supervisor asked if he could approach this priest for help. This suggestion was met with great reluctance. Feelings of animosity dominated the discussion and the trainer-supervisor did not understand from where they originated. At a certain point the local supervisor insisted on the autonomy of the counselor and warned him that his role could not to be taken over by the priest. "Counselors work along their own methods and within their own dignity". On this condition the supervisee could approach the clergyman and ask him to help in establishing contact.

In this example several important elements come together; it is a quite thorough description of the post-traumatic cases counselors have to deal with. It is a complex case where the traumatic events have severely affected the client-fisherman and his family. The supervision group members, inclusive the supervisor, look at this family as a pitiable group of people. The behavior of this family is not considered as extraordinary in comparison to other severely affected members.

The description of the family relations is idealized by the counselor and the other supervisees. The position of the counselor as a second son-in-law neither causes much amazement in the group. On the contrary, when the supervisor asks how adequate the distance in his interventions was, he is at first met by suspicious disbelief. If he interrogates further on the actual signs of this strong relationship, it gradually becomes clear that the family members are much more distanced from each other than he originally presented. The dolls' positions are adjusted to this new awareness and then the loneliness and despair of the counselor fully come to the surface.

The complexity of the family and the emotional distress of the counselor is increased by the delicate issues that are mentioned when the seeking of allies becomes a subject of supervision. These issues are dealt with in a nearly secret language. It becomes clear to the trainer-supervisor that there are a lot of religious differences in the area that are not openly discussed. The translator has a lot of problems in finding the correct English words for the phrases that are used. She tries to avoid the joking and sometimes bitching expressions of the counselors.

At first this priest is unacceptable as an ally in supporting the fishermen. The priests are seen as competitors, who do not accept the counselors from the outside, although they are from the same region. If the counselors are accepted in their village, the priests will try to dominate and modify the counseling relationships into a Christian direction.

When discussing other opportunities to establish contact with the father the result is nil, so the counselor has to fall back on this clergyman. Reluctantly he admits he has no choice, but then the supervisor warns him and nearly prescribes him strong boundaries he has to take into account between himself as a counselor

and the priesthood. During this part of the supervision the trainer-supervisor estimates that many cultural and possibly even ethnic issues are touched upon, but not openly. It apparently has to do with religious differences, with authority and power struggles in the villages, with generation conflicts between the elder clergy and younger counselors. But it becomes not clear to the trainer-supervisor, the conversation takes place in a scornful atmosphere. It is as if a taboo field is explored in a mystifying way, where the trainer-supervisor is a real outsider and is effectively kept outside. And he simply has to accept these boundaries.

What the trainer-supervisor did not mention, since he had too little evidence, is the problematic psychological situation of the father. Although the whole population had suffered enormously from this flood, the material losses of this actual family were relative petty. It looked like a strong post trauma psychological reaction and according to western nosology one could suspect a psychotic decompensation or a schizoid regression of this man. Neither the counselor nor the supervisor mentioned any clear-cut symptoms pointing in this direction. On the contrary, they considered these reactions as an appropriate, though vehement response to the tsunami. And maybe they were just simply right in their cultural context.

Reflection on the Cases

All the preceding five cases (II–VI) have in common that there is a search for a productive relationship between local counselors and supervisees at one hand and a western trainer-supervisor at the other hand. The difficulties in the development of these interactions were clarified in close connection with the examples. We will now deal with some more general characteristics of this cultural interaction. There are three important strategies that an expat supervisor or trainer-supervisor can use to realize an intercultural dialogue in his or her work in non western countries. The first strategy is an attitude of benign contest, an empathic approach to the people he or she encounters in the other culture. The second strategy is the installment of adequate reference power; and a third strategy is the use of a specific methodology. The combination of these three approaches enables the supervisor to vouch for the viability of exchange in a meaningful social context. In the following paragraphs we will work out these strategies.

Supervision as a Benign Contest

A supervisor must create a climate in which a supervisee feels himself safe; a supportive atmosphere that allows to make mistakes regarding the technique, as long as they are no mistakes of the heart. Especially community workers and counselors feel often vulnerable and doubt about their own possibilities. A good atmosphere should make them receptive for positive feedback. (Van der Veer, De Jong & Lansen, 2004).

Here we approach the middle of cultural tension. Supervision is in non-western countries usually seen as a strict control of work. It mostly takes local supervisors and even more the supervisees a long time and a great effort to find autonomous ways of interaction and reflection. In the follow-up of a humanitarian crisis the help questions become more complicated, and so become the answers. Although there are in the aftermath of a disaster problems that still need such a practical approach through e.g. psycho-educational advice and guidance, in this phase more serious cases of suffering from complex psychological consequences become immanent. Then more community work and trauma counseling is needed.

Many community members cannot cope with their losses and mourning, notwithstanding good advice and good practical support from their environment. The relationship between client and helper will become more intensive, with a deeper emotional impact. She or he must learn to recognize the emotional interaction between clients and herself. Clinical supervision helps the counselor-trainee to become aware of this emotional interaction and stimulates her to evaluate her own feelings and behavior.

One may question whether the original orientation towards effective solutions is not been replaced by the strong emotional tendencies of western counseling methods. Trauma counseling is in western societies very much associated with and even identified with “emotional discharge” or “catharsis”. Also the more behaviorist trauma methods concentrate on a “central or core trauma” that has to be dealt with (Foa, Keane, & Friedman, 2000). It is our impression that many untrained counselors focus on immediate solutions for practical problems, but that the more classically trained counselors are more directed at emotional expression. Western trauma counseling methods are therefore pretty culturally insensitive and it requires a lot of reframing to adapt western counseling trainers to local perspectives (Kos, 2005). The same applies to western trainer-supervisors. They tend to follow the “emotional discharge” approach and should take more care of the other supervision tasks. In this complex dialogue the expat-supervisor or trainer-supervisor does not have to give up his own cultural notions and orientations, but he has to be prepared to put them into a benign battle field, where they will enter into a confrontation and conflict with those of the local supervisees and supervisors.

Expat Power in Supervision

We like to present a wider perspective on intercultural supervision by expat or trainer-supervisors. We remind, that they are both outsiders and experts and this capacity gives them a certain amount of power and prestige. Often the interests of international NGO’s differ from those of the local people. Although their aim is to give help, they are also committed to their donors, who expect results according to their western criteria. Not always can results be achieved within these terms of reference. Many NGO’s have short-term interests; once the emergency phase is over, they leave the country and abandon their local staff. Sometimes their interests may even be selfish, the writing of a PhD thesis or

the opportunity to publish articles (Sri Lankan psychologist, 2006). It needs no further comment that when interests are so different, clinical supervision is inapplicable. The basic condition of clinical supervision is a shared mutual understanding of expat and local staff, a strong cognitive and emotional congruence between both parties. Even in that case the expat trainer-supervisor is seen as an expert. He has great guiding power in the selection of the topics that will be reflected upon and he can be quite manipulative. In order to control this selective power as much as possible, the selections and interpretations of the external expert are only "viable if [they are] granted coherence within a significant interactive context". (Krause, 1998, p. 148).

In the supervision process itself expert power is only one of the powers that are influential. Holloway gives a description of several power relations affecting supervision. "Types of power inherent to the role of the supervisor are evaluative (i.e., reward and coercive), expert and legitimate power." These powers are more or less socially given. Referent power on the contrary is immanent to the supervision process itself. It "results from the personal and interpersonal attributes of the supervisor. Referent power can emerge only as a relationship develops" (Holloway, 1995, p. 32).

The notion of referent power is a kind of safety valve in the actual intercultural dialogue. Expats are from the very beginning invested with expert power. Often, especially when they have academic qualifications or are high ranking officials of an internationally respected NGO, also a lot of legitimate power is attributed to them in the host country. In supervision they therefore can wield many 'reward' and 'coercive' power. These powers are easily asserted, all the more by a short term visit of a trainer-supervisor who comes only for some weeks.

The building of adequate reference power requires more personal investment from all parties involved. Supervisors and supervisees together "come to know each other's values, attitudes, beliefs and actions". Although both participants share their commitment to the development of the supervision relationship, it is the supervisor who is responsible to "create an effective learning environment for the trainee". (Holloway, 1995, p. 32) Especially the trainer-supervisor must be aware that he has to build a significant interactive context, in which he has to bring about reference power and promote its constructive effects. In that sense he has to accept the supervisees as equal contributors in this intercultural dialogue and to stimulate their independent thinking and acting.

The Limits of the Outsider

In the preceding examples we mentioned several times that the expat supervisor or trainer-supervisor can have an inducing effect on questioning the casualness of the professional and personal experiences of the local supervisees and supervisor. In an empathic exchange he (or she) might question the naturalness of professional and social relations. These behaviors are often pre- or unconscious, they are "written into behavior, practices and interactions without the participants

being immediately aware of this or aware of it at all" (Krause, 1998, p. 144). Often we can observe that these relations are performed as an unconscious, second nature. Although learned in preceding developmental stages (childhood, youth or professional training) they became part of the immediate psychological make-up, they are internalized in the common behavior of people within their cultural environment. Krause, inspired by Bourdieu (1990), refers to this as a "doxic experience"[9].

Such doxic experiences can be exemplified by what occurred in many supervision groups. The participants sat, for instance, on the floor and the supervisor and the supervisees at the same level, but mostly the men and women sat in subgroups next to each other, leaving an open place between them for the local supervisor. Whenever a dispute arose, it often took the form of a "battle" between men and women, the supervisor sitting in-between as a mediator. When the western trainer-supervisor asked not to sit in separate subgroups but to mix in a one-woman-next-to-one-man shape, they immediately found this quite awkward. They could not explain why, but in the arguments that followed, it was much more difficult to distinguish the two "battle camps". The group members were more talking for themselves and from their own opinion. But in the first exercises most group members showed some discomfort, which later was explained as "being alone". Later on they appreciated the more personal exchanges that were made possible by simply changing the sitting order.

These are doxic experiences; people perform this sitting "rules" without noticing them and without even being aware of these rules. They are natural and provide "the illusion of immediate understanding". Its naturalness has two major consequences. It is unquestioned; it is a "characteristic of practical experience of the familiar universe". And "at the same time excludes from that experience any inquiry as to its own conditions of possibility". (Krause, 1988, p. 144).

The expat as an outsider, within the framework of his (or her) benign questioning, has the opportunity to enable this enquiry and stimulate new perspectives. He (or she) must connect to the feelings of doubt that exist in the supervision group and help people to develop new strategies and insights. It is not needless to say however that in these cases his own social concepts are subjected to discussion too. But this procedure, in which multiple and often contradictory meanings are questioned, is not an endless procedure. Cultural relativism has its boundaries. The doxic experiences seem natural and to a certain extent they are perceived as unchangeable. Especially in power relationships this unchangeable naturalness is used as a powerful tool to maintain the power position. This means that the external supervisor or trainer-supervisor must not only search for alternative strategies together with the supervisees, she or he must do so in a way that the "attacked" party can change without losing face. And she or he must realize that some doxic

[9] 'Doxic' can be recognized in the words 'heterodox' and 'orthodox' that refer to manifold or single meanings. Doxic experience can be understood as 'meaningful experience'.

experiences cannot be changed, cannot be questioned in the actual cultural circumstances, neither by the local supervisor, nor by the local supervisee.

The long stay western expat working as a supervisor or the passing western trainer-supervisor working in non western countries also has his or her own doxic experiences. From his own original culture he also embodies subconsciously "natural" ways of behaving professionally, socially and culturally. The joint reflection of supervisor and supervisee under guidance of the external supervisor is therefore always a mix of complex doxic experiences, cultural and quasi-natural values. In case IV, for example, the trainer-supervisor could easily connect to the hidden expressions of polite discomfort of the women supervisees in the group. When he raised the issue of the gender steered decision making his remarks fell in a fertile ground, both with the women and men of the group.

In the preceding example (Case III) the participants could rearrange their behavior in the group according to a new value system they were already familiar with from their training. During these trainings they had appreciated and internalized the equality of men and women, but they had difficulties to put it into practice. With the help of the trainer-supervisor this was a relatively easy job.

In case V the resistance of the female supervisor and supervisees was much greater and the social structures were much more robust. To appeal to these high official men, did not only require a sense of self-esteem from the counselors and supervisors, who were "just learning" their job; it also called for a strategy to approach these men about their "mistakes" without "losing face". Here the social and cultural constraints were much more powerful and limited the modes of action substantially. For the trainer-supervisor it was quite a thrill to observe and participate in this strategic thinking within the boundaries of the Sri Lankan culture; it taught him a great deal of the ways in which in western and in particularly Dutch society status constraints are immanent in these kind of conflicts.

Formal Structure as a Warranty

In the third strategy the methodological framework that is used, is closely connected to Holloway's system of supervisory tasks and functions. It is a formal scheme which she developed by investigating what clinical supervisors actually do and how they do this (Holloway, 1995; Lansen & Haans, 2004). It serves as a general, maybe universal, frame of reference of the themes a supervisor has to address and how he has to go about with the supervisee or supervision group. This formal framework offers a maximum opportunity to be filled by all parties involved. It is a kind of umbrella for the cross cultural dialogue.

According to Holloway (1995), the supervisor performs several tasks during a supervision session. She/he observes the skills of the supervisee, her (or his) case concept, the professional role, emotional awareness and the capacities of self evaluation. If the supervisee has a supervision question, this question can be categorized under one of these tasks. The supervisor monitors to which tasks the supervision question applies, and also searches for the more complicated

interconnectedness of these tasks and a, sometimes hidden, theme that the supervisee in unaware of. (Hawkins & Shohet, 2000)

What the supervisor is actually doing during supervision, his actions, are called the functions of supervision by Holloway (1995). The supervisor monitors and evaluates the professional activities of the supervisee; and he can provide instruction and advice if required. The supervisor is also a model, both explicitly and implicitly. He can give advice to the supervisee, support him and share his own professional or, if necessary, personal experiences with him.

A similar formal procedure for warranting an optimal socially valid and viable exchange in group supervision is the one developed by Lansen and Haans (2004), briefly described above (note 3). Here several supervision rounds are used: case presentation and questions, identification with the patient as a person, identification with the position of the therapist and supervision with the group. We see these rounds as a formal structure that allows an optimal exchange of meaning, viewpoints and perspectives. During this exchange a vast complexity of multiple meanings (heterodoxy) can emerge. Local culturally accepted and non-accepted behaviors and attitudes can become more conscious. But it brings also a great benefit to move and mix cultures. When people from the same cultural or ethnic background meet, it becomes obvious to them that their culture is not a static, monolithic entity. Within such a formal structure, group members become aware of the individual ways the group members construct and build, internalize and externalize the culture they share. At the same time they produce their culture and are a product of their culture.

Concluding Remarks

Although clinical supervision can be seen as a "western" expression of professionalism it is more than that. We consider it as a general human and professional tool that is effective in helping people to increase their professional skills. Clinical supervision as we describe it offers a formal structure that is evocative and inviting all participants to engage in a joint reflection on the helping activities within the actual social and cultural environment.

In a situation in western countries, where intercultural supervision is exceptional, the supervisor should be aware of his tasks and study, together with the supervisee, the failings and potencies of the supervisee. He must do so with respect to the professional standards of supervision and execute his work within the boundaries of the supervisory functions. Within this framework he must be able to promote a good cooperative relationship based on growing reference power. In these situations the culturally mixed supervision group offers good opportunities to become aware of the cultural and ethnic opportunities and constraints.

In non-western countries another requirement emerges next to the preceding ones. In this intercultural setting clinical supervision offers an effective tool for

increasing awareness of cultural and ethnic influences on the helping relationships. In this way, well applied clinical supervision offers many opportunities for indigenous helpers to increase their professional expertise within the framework of their current local, cultural and societal circumstances.

References

Abu-Baker, K. (2005). The impact of social values on the psychology of gender among Arab Couples: A view from psychotherapy. *Israel journal of Psychiatry and Related Sciences, 2*,106–15.

Bourdieu, P. (1990). *The Logic of Practice*. Cambridge: Polity

Diekmann-Schoemaker, M., & van der Veer, G. (2003). An extra language in counselling and training, *Intervention, 2*, 36–9.

Foa, E., Keane, T., & Friedman, M. (Eds.). (2000). *Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford Press.

Hawkins, P, & Shohet, R, (2000). *Supervision in the helping professions*. Buckingham – Philadelphia: Open University Press.

Holloway, E.L. (1995). *Clinical supervision. A systems approach*. Thousand Oaks, CA: Sage.

Kos, A. M. (2005). Training teachers in areas of armed conflict. *Intervention supplement, 2*, 1–64.

Krause, I. B. (1998). *Therapy Across Culture*. London: Sage

Lansen, J., & Haans, A. H. M. (2004). Clinical Supervision. In J. P. Wilson & B. Drožđek (Eds.), *Broken Spirits* (pp. 317–353). New York: Bruner/Mazel.

Proctor, B. (2000). *Group Supervision. A Guide to Creative Practice*. London: Sage.

Sri Lankan psychologist (2006). INGO's and international trainers in Sri Lanka, *Intervention, 2*, 169–170.

Veer van der, G. (2003). *Training Counselors in areas of armed conflict within a community approach*. Utrecht: Pharos.

Veer van der, G., de Jong, K., & Lansen, J. (2004). Clinical supervision for counsellors in areas of armed conflict. *Intervention, 2*, 118–28.

Wilson, J. P., & Thomas, R. B. (2004). *Empathy in the Treatment of Trauma and PTSD*. New York: Brunner-Routledge.