Psychotherapy and psychosocial care of torture survivor refugees in Hungary

"*A never-ending journey*"

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"Wild animals never kill for sport. Man is the only one to whom the torture and death of his fellow creatures is amusing in itself."

J. A. Froude

The therapists of Cordelia Foundation have been assisting torture survivor refugees since 1996. The therapeutic activity of the Foundation includes verbal and non-verbal, individual, family and group therapies, and psychological and social counselling.

Our therapists are partly members of a mobile team and partly local therapists in the refugee shelters of Hungary.

Due to the multicultural composition of our clients, the therapists of the Cordelia Foundation continuously innovate, transform and adapt their therapeutic methods by taking into account the ethnic background and special cultural characteristics and issues of the clients.

Thanks to the therapeutic treatment our patients receive, they are able to address the traumas of uprooting and torture. Their improved adaptive and coping capacities are the most important resources in the integration process.

We offer regular training and supervision to the staff of the refugee shelters in charge of our potential clients in order to increase the level of psychological mindedness and to prevent vicarious traumatization and burnout.

Keywords: PTSD – torture, refugee, psychotherapeutic methods, psychosocial care, training, supervision

Introduction

There are more than 140 active rehabilitation centers in the IRCT network located all over the world which deal with the psychosocial rehabilitation of torture survivors. The Cordelia Foundation belongs to this network, and is in charge of the rehabilitation of refugees who have survived torture, fled their homes, and are currently residing in Hungary. The present article introduces the most relevant issues of torture, as well as the theoretical background of the rehabilitation of clients suffering from Post-traumatic Stress Disorder (PTSD) or other forms of psychological syndromes due to torture. The second part of this article describes the special rehabilitation methods adapted and implemented by the therapists of the Cordelia Foundation in order to achieve optimal results in a multicultural context.

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Torture and its sequaelae

"No one should be subjected to torture or to cruel, inhuman or degrading treatment or punishment."[1]

The chronicle of torture can be traced back to the history of human beings. It is worth comparing the meaning of torture in the past and in the present. However, the *direct aim* of torture is universal, that is to intentionally inflict and sustain intensive suffering. The *indirect aims*, forms and the legitimacy of torture have gone through great changes throughout the recent past and present.

Until the middle of the eighteenth century, torture had a dual role:

a) to force the victim to confess;
b) to punish criminal acts.

The main goal of torture was to demonstrate the power of the ruling government and to threaten the population in order to avoid being overruled or attacked. Presently, the aim of torture may vary; torture is still inflicted to oppress political opponents or to provoke a confession, but torture has also become a form a degrading, humiliating, or exterminating the unwanted, as is the case in the most severe form of this inhuman phenomenon, ethnic cleansing/genocide (e.g. in Armenia, Rwanda, Bosnia, Sudan etc.). Most societies accept the use of violence by law enforcement on behalf of the society in order to control antisocial behavior; democratic societies have laws to regulate the use of these methods.[2] As of May 2010, 146 nations have ratified The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT),[3] the international treaty that mandates an absolute prohibition of torture worldwide. Nevertheless, we have recently experienced the controversial implementation of torture techniques even within the most democratic governments. Oppressive regimes might also condemn torture in their constitution, but apply torture illegally and with illegal methods in non official torture chambers. These governments legitimize their controlling and repressive function through a discourse of state protection, by declaring their oppressive acts as shield against rebellious initiatives and organizations, which pose a threat to the state. In these cases torturers are public officials or other individuals acting in an official capacity. There are a number of states however (e.g. Afghanistan, Somalia, Sudan, Kenya etc.), where the actual power is exercised by various non-governmental parties, gangs, armed groups, militias etc., who hold the population in terror, and commit a number of crimes against the unprotected and powerless civilians. The government, if there exists one, is most often incapable and helpless when it comes to protecting its citizens. According to the 2007 report of Amnesty International, the use of torture and other inhuman treatment was documented in at least 81 countries worldwide.[4]

Torture trauma, PTSD and alternative diagnoses

The literature of trauma and torture dates back to ancient times. As a result of the horrific events of the twentieth century, numerous writers, philosophers, social scientists, psychologists and psychoanalysts turned their attention to the phenomenon of massive, chronic traumatization and its consequences. The Holocaust, which aimed at the destruction of a great part of the civil population, became a model for extreme traumas. Nevertheless, it took some time for it to become part of the psychotherapeutic discourse, which was especially the case in Eastern and Central European countries,

due to the political, historical and societal context.[5] In the sixties, psychoanalysts treating survivors of the Holocaust made a common discovery: the classical concepts of psychoanalysis applied in cases of depression, mourning and trauma, did lead to successful results in the treatment of these survivors.[6] Based on interviews conducted with these patients, the "survival syndrome" was developed.[7-10] This category became one of the first approaches to the current understanding of (Complex) PTSD. The most pertinent symptoms described by the authors were sleep disorders, nightmares, affective symptoms (chronic anxiety, depression etc.), cognitive damages (memory deficits, concentration problems) and personality change.[8, 11] One important distinction between the survival syndrome and the official diagnosis of PTSD is the phenomenon of identity distortion. This conceptual absence is discussed in length by Judith Herman[12] who suggested an alternative diagnoses (Complex PTSD) which is a result of prolonged exposure to (interpersonal) trauma in the context of captivity or entrapment where there is a violation of boundaries and lack of control. Herman[12] points out that as a result of this extreme type of traumatization, damaged self-perception must also be included into the diagnostic category. Another term for the concept, 'Disorders of Extreme Stress Not Otherwise Specified' (DESNOS), was recognized by the American Psychiatric Association (APA).

Torture survivors often suffer from Complex PTSD or DESNOS, which commonly indicates special treatment needs. The therapists of the rehabilitation centers must pay particular attention to these cases. In recent years, there has been extensive discussion concerning diagnostic differences between the consequences of torture and other forms of extreme psychotrauma. Some researchers[13-15] made efforts to distinguish a separate "torture syndrome". However, it proved problematic to order the diverse symptoms into meaningful and valid symptoms clusters, and to provide evidence for the causal relationship between torture and its consequences. Due to these obstacles, the approval of a separate diagnostic category for torture did not succeed.[15, 16] Based on controlled studies with torture victims, Basoglu[17] demonstrated that there is no real scientific proof for the necessity of a diagnosis distinct from PTSD. Other researchers and practitioners[18] point out that while there are a number of common symptoms between PTSD and the psychological consequences of torture, an essential distinction is the highly relevant phenomenon of altered identity and personality, already discussed above. According to Somnier et al[18] the most common psychological symptoms among torture survivors are sleeping disorders (often paired with nightmares), affective symptoms (chronic anxiety, depression), cognitive impairment (memory-deficit, attention disorder) and changed identity.[19]

An additional shortcoming of the diagnostical category of PTSD is that it does not take the political and historical context into consideration, which is highly relevant in the case of torture and other forms of inhuman treatment.[16, 20] Turner and Gorst-Unsworth[21] divided the consequences of torture into four categories, and argue that since the Freudian concept of war neurosis, numerous psychoanalysts[10, 22-24] have acknowledged that the premorbid personality and ego-vulnerability constitute only one part of the multifactorial causal model of post-trauma reactions. Turner and Gorst-Unsworth[21] point out that the political meaning also plays an essential role beyond psychological analysis, in theory and therapeutic practice alike, since torture, as already

described above, serves various and distinct functions.

Torture intrudes into the most private and intimate parts of a human being;[25] under torture the victim is forced into the position of an object, which leads to a loss of sense of interiority, intimacy, and privacy.[26] These experiences result in a psychic metamorphosis and collapse, paired with a sense of identity disorientation and depersonalization, and a fear of losing one's very essence, the soul, or spirit.[25] In the end scene of the Roman Polanski film 'The Pianist',[27] a newly freed concentration camp prisoner confronts a German prisoner of war and discloses: "You stole my violin, you stole my soul".

One of the main paradoxes of torture is that while the physical distance between the torturer and the victim is minimal or nonexistent, the moral-, existential-, and psychic gap is the largest imaginable between two human beings. This experience has important implications concerning the psychic reparation of the survivor. The aim of torture is the destruction of one's identity, the core of the personality, making the victim, and then his/her children, and the children of the children incapable of leading a "normal" daily life.[28] Torture does not only damage the survivor, but by diffusing deeper it wounds the next generations in the form of transgenerational trauma. The works of psychotherapist and child analyst Teréz Virág,[29, 30] founder of the Hungarian 'KÚT' center for the rehabilitation of Holocaust survivors, describe how traumatic experiences find shelter in the unconscious, and act as 'phantoms'[31] by effecting the next generations of survivors through silence, family secrets, 'unfinished tasks' and transmitted psychological symptoms (anxiety, aggression, guilt, shame etc.).

Torture, due to its intentional nature, destroys the fundamental trust of the survivor, and distances the person greatly from other human beings. The internalization of the torturer's attitude, whose aim is to disgrace or even eradicate the victim and to prove that she/he is not a worthy human being, has severe consequences concerning the survivor's self image, self-esteem, and identity. It is also extremely difficult for the survivor to process how she/he reacted to the torture sequaelae, in particular if the person experienced apsychic breakdown. Restoring the broken trust in others and oneself is a primary objective in the therapeutic process.

During the sequaelae of torture, the victim falls into a severely regressive position, and reaches for immature defense mechanisms (splitting, primitive idealization, projective identification, denial), but these reactions can serve an adaptive function during the torture episode. According to Papadopoulos[32] the psychological frozenness (temporary withdrawal) of refugees can limit damage and activate self-healing mechanisms. This is to ensure temporary survival, and it requires an appropriate attitude of the therapist. However, reactions given to the traumatic situation become maladaptive following escape. The defense mechanisms applied among the walls of the isolation cell can result in pathological reactions (aggression, inadequate rage, depression and suicidal ideation) within the walls of the home of the torture survivor, and can also lead to transgenerational trauma.

Psychological reports on the consequences of the Holocaust trauma[5] describe how the victim of severe persecution regresses back to the earliest forms of traumatization (the initial trauma of birth), which destroys the pre-oedipal structures of the mother-child relationship. Again, this leads to a damaged and constantly threatened identity structure.

Based on these accounts, it is clear that

the functioning of torture survivors is disturbed on various and multiple levels, which must be taken into consideration in the rehabilitation process. Therapists of the Danish rehabilitation center RCT[33] distinguish five levels of damage: somatic, psychological, social, legal and spiritual. Derrick Silove[34] from an Australian rehabilitation center points out that torture challenges five core adaptive systems: ensuring safety, attachment, justice, identity role, and existential meaning. Yael Danieli[35] focused on how becoming a victim destroys the continuity of the complex identity system, which may be effected on various layers (biological, intrapsychic, interpersonal, social-cultural), depending on the strategies of survival, the extent of losses, and secondary traumatization.

Some centers treat the traumatized population of their own country; others are challenged by the problems of multicultural issues having a pool of refugee patients or asylum seekers. The trauma of uprooting, which is the case of the traumatized refugee load of the Cordelia Foundation, means there is a fundamental damage to the human psychological structure. This object loss and the trauma of torture are multilevel difficulties facing the clients and the therapists. Akthar[36] describes how complex the identity change is as a result of immigration. The author, himself a practicing immigrant psychoanalyst, emphasizes the difficulties in psychological advancement (the development of a new and hybrid identity) if migration was forced, if return or visiting the home country is problematic, and if the host environment demonstrates a hostile attitude toward the migrant. Akthar[36] argues that the main intrapsychic conflicts of immigration is the splitting of self (home land) and object (host land). The resolution of this conflict is the key to psychic rebirth. Culture shock is a widely-used term for the experience of encountering a new environment, and is defined as a stressful, anxiety-provoking situation which encompasses a serious threat to the newcomer's identity. It is accompanied by a process of mourning as a result of the individual's enormous loss of a variety of love objects.[37] The Mexican psychoanalyst Cesar Garza-Guerrero[37] emphasizes that one must distinguish "uncomplicated culture shock" from "complicated culture shock", which is suffered by refugees who fled from sociopolitical disruption in their homeland and thus are confronted with additional crises concerning the mourning and identity rebuilding process. Another approach to this primary object loss can be found in Papadopoulos's[32] description of the meaning of home and identity. According to the psychoanalyst professor, the fundamental sense of home and belonging somewhere is part of the core 'substratum of identity', which is mostly unnoticeable, but provides us with an essential feeling of humanity and a sense of predictability. However, when this substratum is disturbed, which is the case among refugees, then great confusion arises, paired with a sense of unreality and an "inexplicable gap". Furthermore, refugee torture survivors loose not only their sense of belonging to a home, people, and culture, but in a way, also to their own bodies. Papadopoulos names this state of bewilderment "nostalgic disorientation", which is not a conscious loss, but much rather a state of 'existential anxiety'.[38] This disturbance can cause many kinds of reactions (e.g. panic, depression, apathy, suspiciousness, splitting, etc.), and must be dealt with in therapy accordingly, bearing in mind the context which resembles an existential gap rather than a pathological state.

Through these examples and descriptions we can comprehend the magnitude of

traumas that refugee torture survivors must deal with in processing the experience. However, throughout the history of mankind, we have experienced the great potential that human nature has for survival despite adversities. This is especially true for those who have suffered and survived torture, the shame of humanity and civilization. The next section demonstrates how these courageous survivors can be supported through therapeutic interventions and psychosocial rehabilitation.

The rehabilitation model of the Cordelia Foundation

The working methods of the Cordelia Foundation differ in many ways from the therapeutic models and techniques of the clinical practice applied in the outpatient centres/hospitals of general health care. Although our therapeutic services are difficult to model due to a series of specific local and cultural challenges, we have succeeded in creating a theoretical framework for our therapeutic approaches. This section of the article first provides a general overlook of the refugee situation in Hungary, and then continues on to describe the therapeutic models of the Foundation.

Refugees in Hungary

Following the political and social regime change in 1989, Hungary joined the 1951 Convention relating to the Status of Refugees[39] and started accepting refugees and granting asylum based on the Convention, but with geographical restrictions. Since the enforcement of the Asylum Law of 1998, asylum seekers from non-European countries may also apply for asylum in Hungary. Between 1998 and 2002, an average of 8,000 to 9,000 refugees sought asylum annually in Hungary.[40] Following the year 2003, there was a significant decrease in this trend with 2,000 to 4,500 refugees applying for asylum annually. The most recent statistics[41] for the year 2009 reflect a small increase in asylum application (4,670), though this comprises less than 2% of all applications filed in the European Union (246,200). In 2009, the number of applicants receiving some form of protection (humanitarian-, subsidiary-, or refugee status) was 390, but the number of those who received refugee status (170) was lower than all other forms of protection, which ensure less rights and support than asylum. The most common countries of origins are Serbia (including Kosovo), Afghanistan, Somalia, and Georgia. The number of unaccompanied minors seeking asylum in Hungary (170 in 2009) is higher than in any other Central European country.

In 2009, the number of refugees treated by the Cordelia Foundation was 850, out of this 288 clients were survivors of torture, and 92 were secondary torture victims. All together torture victims and secondary torture victims constitutes 44.7% of our clientele. The rest of our clients are refugees who suffered other forms of inhuman treatment and severe traumas.

Refugees who are permitted to apply for asylum first reside in the reception center in the outskirts of the city of Debrecen, where approximately 600 to 800 asylum seekers reside at once.[a] Here the applicants are interviewed by an official who is in charge of their asylum application. Asylum seekers generally spend three months to two years in this center depending on the progress

a) Permission to apply for asylum was previously granted in the reception center of Békéscsaba, where refugees spend 15 days for medical and legal screening. This system is now under reorganization since the change of government in April 2010.

of their asylum case. If granted asylum or subsidiary status, the refugees move on to the reception center in Bicske, which functions as a "pre-integration unit". In Bicske refugees receive language courses daily, and often start searching for accommodation and jobs outside of the refugee center. This center is smaller in size and inhabitants, as only the "lucky" ones make it to this station. Recently, the screening center of Békéscsaba has been restructured to host families who are waiting for permission to apply for asylum. The therapists of the Cordelia Foundation visit all three centers regularly.

The Stay Model and the Go Model

There are *two main models* for the care of torture survivors in Hungary, developed by the therapists of the Cordelia Foundation: the *Stay Model*- and the *Go Model*.

A) The *Go Model* is the earlier of the two and was implemented by the mobile team of the Cordelia Foundation. The psychiatrists, psychologists, social counselor and the interpreters visit the three refugee shelters described above and conduct therapies in the rooms of the clients. Until recently, the Foundation did not have a permanent location at the reception centers, so this revolutionary idea (therapies in the rooms of the clients) stemmed from the practical situation. However, it has therapeutic consequences, as well. In this model the client invites the therapist into their living space and acts as a host instead of as the guest, which is the common perception and even self-perception of refugees. This provides the client with a sense of mastery and control and lets trust be built in a special form. It symbolizes the first step, the first link, the first secure place in the host country. The security this setting offers is especially important in those cases where the patient is suffering from extreme anxiety, or is severely distrustful of all shelter facilities (such as the social or medical unit). The "go" model also proved very efficient and successful in the treatment of families, as all family members would be present, even the youngest or most resistant ones. The situation and its meaning can furthermore be used as therapeutic material during the interpretation of uprooting and the processing of object losses.

If for some reason the client does not wish to conduct the therapy in their room, or if their room is not suitable at the time given (e.g. roommates present), we were usually permitted to use a room at the medical unit of the center.

We also have one local psychiatrist in each refugee shelter in order to have a permanent contact person with our Foundation.

Due to legal regulations, as described above, the refugees are transferred from one refugee shelter to another. It offers great relief and trust for our clients that we ensure that they will not lose contact with us despite the move; we do not cease to fulfill our role as transitional objects 42 throughout their plight for recognition as refugees. One of the first pieces of information we share with our patients is that wherever they are sent in the country they can turn to our therapists in every Hungarian refugee shelter. This approach is in accordance with theories of Bowlby[43-45] and the Hungarian psychoanalyst Imre Hermann,[46] who demonstrated that object attachment is a basic need, especially for those who have lost their relatives, their beloved persons and their home.

Most of our therapists were fed on the works of the Hungarian Budapest Psychoanalytic School, having a personal psychoanalytic or psychotherapeutic training. It is essential in our daily practice to be able to respect therapeutic boundaries and at the same time to be sufficiently flexible and tolerant when required.

We work with interpreters to ensure that all clients have a possibility to express their innermost feelings and thoughts in their mother-tongue. Our interpreters take part in a complex selection process and professional training. The applicant is initially invited to a first interview, conducted by the medical director of the Foundation. At this stage, the suitability and fit of the applicant is assessed, and the mission and activities of the Foundation is presented. Afterwards, the applicant takes part in a two-day intensive interpreter-training conducted by the Cordelia Foundation in partnership with two other refugee NGOs, the Hungarian Helsinki Committee (legal work) and the Menedék Association (social work). This training offers complex psychoeducation on the topic of refugees, trauma, torture, rehabilitation, human rights, and social and cultural integration, with case studies and discussion. Afterwards, the interpreter-to-be joins the mobile team of the Foundation and participates in a work day as an observer next to the trained interpreters. A debriefing and case discussion follows with the therapist at the end of the day. If the candidate withstands this test (which takes several rounds) well, the trial period continues with the applicant actually interpreting therapies. The interpreters are never selected from former patients even if they had recovered from PTSD. However, they often originate from the same country and/or culture as the clients, which often helps deepen therapeutic understanding as the interpreters act as cultural mediators as well. Thanks to their complex training, the interpreters are prepared for transference and contertransference situations, and often act as a pulling force and a source of hope for our clients. Our interpreters also take part in the regular supervisions of our staff, which prevents vicarious traumatization, especially challenging in seriously traumatizing tranference-contertransference situations, and is also an essential tool in preventing professionals from burnout.

Previously our patients did not apply for therapy; they were referred to us by the medical or social staff, or by other refugees. General criteria for selection is being a torture victim, or suffering from the psychological consequences of other severe trauma. Generally we do not reject any person in need, but refer those who require non-psychological and psychiatric support to the appropriate professionals and organizations.

We make contact with potential clients by first introducing ourselves as therapists, and providing information about our mission and the services we offer. Some of our patients have never even heard about psychotherapy, so we generally begin with a short session of psychoeducation to achieve maximal transparency, understanding, and compliance. We try to give a realistic picture of what the clients can expect from therapy, what their role comprises, and we make it clear what our professional boundaries are. This provides a base for an egalitarian relationship, and prevents misunderstandings and disappointment. We often conduct an initial informal group meeting with a homogenous population of potential clients to establish a first link.

B) Thanks to new developments at the refugee centers, the Foundation established a permanent therapeutic unit in each of the two main refugee centers, Debrecen and Bicske. The *Stay Model* has been establishd by our therapeutic team. Due to this new situation, potential clients (residents of the centers) have started to find us on their own. They visit us in our unit, schedule an appointment for therapy, and/or use the community room of the facility to wait for their turn. This new model has therapeutic signifi-

cance as well, as it provides the clients with a sense of independence and empowerment. Nevertheless, we still pay special attention to those clients who, due to intense and severe post-trauma symptoms, are not yet capable of making these first steps on their own and require individual care. In their cases, the "Go-model" is still in use; their rooms function as therapeutic space. Often, after the decrease of stress symptoms, they start visiting our therapeutic unit.

At the Bicske refugee shelter, the Cordelia Foundation has its own complex outpatient center, with rooms for individual and group therapy, as well as a community space where patients can borrow books and art supplies, read magazines, make their own arts and crafts, have a cup of tea, and chat with staff or other clients. This is the last stop of the clients in the refugee shelter. Here their main task is to prepare for the great challenge of integration into the Hungarian society. The model applies a multi-disciplinary approach, and offers an eight-week intensive therapeutic program, which is conducted three days a week by two psychiatrists, three psychologists, one non-verbal therapist, one social counselor and two interpreters. There are two different and homogenous groups of clients (e.g. men from Afghanistan and women from Somalia) who take part in individual, group, and art and non-verbal therapies, as well as cultural-orientation workshops.

The aim of this rehabilitation program is to offer psychological support in the process of reintegration. However, this task involves new challenges, difficulties, and disappointments that may open up old wounds, enhance stress symptoms, and cause re-traumatization. Trauma processing is a continuous eternal procedure and must be appropriately handled in each phase of healing.[12] Thanks to the complex approach of the program, clients can discover and develop their coping resources, strengthen their self-esteem, find new missions and paths in life, and ease their old sores. This enables them to get settled on their own outside of the shelter and determine their place in their new home. The therapeutic activity models the closing phase of their stay in the refugee shelter. The methods are more direct, and focus on creativity, inner strength, and empowerment to enhance the supportive network of the clients for their independent life.

Therapeutic methods

The therapies we offer include individual, family and group therapies with verbal or/and non-verbal elements.

1) The *individual verbal* method is a short therapy (eight to ten sessions) focusing on the trauma of torture, uprooting, mourning, personal losses. It aims at easing post-trauma symptoms, acquiring insight, and regaining trust. However, depending on the case we conduct longer therapies (15 to 20 sessions), as well. This therapy also serves the development of coping strategies and discovering inner resources, which are vital in the future life of the refugees, who reside in a country completely different from his/her land of origin.

2) In the early stages we did not have much experience with *family therapies* with torture survivors. This treatment developed as a spontaneous therapeutic initiative as the family members were present at the first session(s) of the therapy of the patient, which took place in the living room of the refugee. In family therapies we must on one hand deal with the torture survivor's individual trauma and on the other hand with the traumatization of the family members as well, who are secondary victims (eyewit-

nesses of the traumatic event) or vicariously traumatized victims (traumatized by the torture survivor). Torture fragments the ego of the survivor, and at the same time the family also becomes disorganized by the trauma. The surrealistic world of the torture chamber is often unconsciously reconstructed in the chaotic human relationships of the family, through the mechanisms of repetition compulsion[47] or identification with the aggressor.[48] The tortured head of the family, the raped mother, the child being a survivor of violence, restructure the relationships of the traditional family in a pathological manner. The defense mechanisms appear on the family level like secret collaborators oppressing or silencing the trauma. Torture may also be experienced as a castration equivalent for the head of the family forcing the wife to take over the position of managing the family. Nevertheless, the husband may pathologically insist on securing his position by all means and despite circumstances. This can damage the children by causing serious disorientation and identity confusion. The new roles in the family are normally not acceptable for the community, which further increases the disorientation of the child.

Let's follow the therapeutic process of a hurt family:

A female patient from Iraq was struggling with dissociative symptoms as the leading problem which brought her to therapy.

Her husband was kidnapped and she received only his tortured corpse.

The young client escaped with her three children to Hungary.

She was unable to adapt to the challenges of the refugee shelter neglecting her children and herself, as well.

She got lost during shopping, and she generally began to cry instead of managing their family life.

Her 10-year-old daughter took over the role of the lost father and the sick mother and became the head of the family.

We began non-verbal group therapies together with other women of single parent and complete families. The patient's daughter participated parallel in creative therapy with our child psychologist.

Later family therapy was introduced beginning with the mourning the lost father/husband together. The therapist and the family members discussed the challenges of the distorted roles in the present family comparing them to the pre-trauma situation. Mapping the pathological family structure and working through the traumas from uprooting to other object losses helped to address these challenges.

After seven therapeutic sessions the female inhabitants of the refugee shelter opened the door to our therapists with shining faces and beautiful hair. Our client had taken over the role of the hairdresser of the refugee shelter. She found herself in her previous female role again. She went shopping together with other women of the shelter and began to cook and take care of her children again.

The ninth session was the last one in the therapeutic process, as the family was planning their move out of the shelter. The mother got engaged to a fellow Iraqi refugee, and the family was now ready for the challenging process of integration into Hungarian society.

3) The verbal therapies are often prepared for with *non-verbal group therapies*, by helping the client who is suffering from shame and the feeling of humiliation become accessible for the verbal process.

The group situation facilitates group cohesion and simulates a situation of trust. It offers a safe relationship for the patients

who are mistrustful or have a paranoid attitude.

The Hungarian non-verbal method has a dual role:

a) it prepares the clients for verbal therapy
b) it facilitates the decrease of PTSD symptoms with special therapeutic (art, relaxation, movement) techniques

The non-verbal methods are:

3/a) *communicative movement group therapies* – developed for refugees from Bosnia, based on the experiences at psychiatric departments, followed by

3/b) *animation group therapy* – This method is based on the animation of inanimated objects focusing on reconstructing the relationship of the torture survivor with their own body and with social contacts. Today we use this method as a link to verbal methods. The nonverbal therapist is the leader of the group session and the verbal therapist is the co-therapist. The verbal co-therapist takes the role of the individual psychotherapist later.

3/c) We established the *station group therapy* with refugees from the war in Kosovo, referring to Jesus Christ's stations at Mount Golgotha.
In their case, the trauma was very near to or at the conscious level, and the experience was still actively present. Due to this special situation, it proved nearly impossible to create an intimate group situation, so sometimes there were 30 participants at a group session. This type of group therapy focuses on the reconstruction of the lost basic trust. We applied psychodrama elements as well as movement exercises.

3/d) We established *symbol group therapy* for Arabic speaking clients.
Its theoretical background originates in the Jungian symbols. We offer a symbolic object of the lost past to the clients in order to facilitate the mourning process and to decrease extreme anxiety. We evoke the object verbally and symbolically, e.g. with the smell of the Arabic coffee or with a handmade Afghan tissue. If the group offers a symbolic object it can be interpreted as a sign of the increased trust.

3/e) Other new initiatives are in preparation (e.g. for unaccompanied minors from Afghanistan, for Somali women etc.), which still require time to document the experiences and to standardize the methods in order to achieve maximal efficiency and validity.

4.) The *culture-orientation workshop*, developed for the new outpatient unit at the Bicske center, aims at facilitating integration skills and competence as well providing specific culture and integration related knowledge, information, and experience. These workshops were established with special care to address intercultural differences and always take the original culture of the participants into consideration. The culture-orientation workshops thus serve as a bridge between experiences, knowledge, and customs of the land of origin and those of the host country. The activities facilitate a common understanding, as well as the attainment of new experiences through exchange and participation. These sessions include role-play of everyday interpersonal and official interactions, discussions on cultural differences and similarities, and visiting various institutions to offer a possibility of practicing recently acquired skills on safe ground. Group discussion and the non-verbal processing of the experiences always follow the activities. The non-verbal therapist and the social counsellor of the Foundation

conduct the workshops, keeping in mind the special needs and sensitivity of torture survivors and other traumatized refugees. This is a strength-based practice and enhances the capacities of the individuals and groups.

Other activities

One of the most important activities of our therapists is to make medico-legal reports to assist the legal process of asylum attainment. These reports are based on the principles of the Istanbul Protocol, and document the physical and psychological consequences of torture. Generally, either an official of the asylum procedure (officer, judge) or the defending lawyer requests this report, so there is no secondary gain for our clients in undergoing therapy. Through the report, the therapist can present a proper picture based on a recent and a present longitudinal relationship. The independent expert focuses on a cross-section picture, so we make efforts to collaborate with our forensic colleagues in order to provide a detailed and realistic picture for the legal process.

Our Foundation also offers support in the rehabilitation of torture-related somatic symptoms, as much as our budget allows. This comprises various medical treatment procedures (gynecological, urological, physiotherapy etc.), which are an essential part of the physical-psychological healing of the torture survivor.

Our therapists offer regular trainings and case discussions in the context of supervision sessions focusing on the sensitization of the staff of refugee shelters to assist their daily work. This supervision serves a double function: increasing psychological awareness and the prevention of burnout. Care for caregivers is vital in the prevention of vicarious traumatization of the helpers in charge of our clients. Furthermore, it strengthens the network of governmental and civil organizations dealing with torture survivors and other seriously traumatized refugees.

Results

The effects of the previously mentioned methods can be detected after the first three to four sessions. The agitated emotions sooth, an important phase in the mourning process comes to an end, and the symptoms of PTSD decrease. The clients begin the long and challenging process of integration from a more healthy position. Follow-up methods are under development. We currently apply a psychological questionnaire created by our psychotherapists based on validated PTSD surveys. Assessment includes two to three follow-up rounds (depending on the availability of the client) with the help of the questionnaire. Recording changes can be problematic however, since our clients move to locations throughout Hungary after leaving the shelters, and many even continue migration into other EU countries or sometimes overseas.

From time to time phone calls, letters and e-mails inform the therapeutic staff of the Cordelia Foundation that our clients are doing well and that they have found their place in society. Keeping in mind that they always have access to our assistance, some of them come back saying that Hungary is the best place to build their new life.

Conclusion

”Panta rhei” – ’Everything is continuously in motion’, according to Greek philosopher Heracleitos. The process of history, the process of a life, all around the world from the deepest point of the sea high into the sky …

But for survivors of torture, their suffering seems constant. For these individuals, feeling of continuity does not exist. There appears to be a great division between life before and life after. Therapy for torture sur-

vivors challenges these ideas and helps with the development of a narrative and psychological reintegration.

The experiences of life-threats and other countless horrors, as well as the presence of the trauma of torture and uprooting are extremely different in each victims' psychological development.

Our strength is the ability to accommodate the challenging circumstances and facilitate the innovation of therapeutic methods and techniques.

The clinical best practices are the columns of a therapeutic building where we can engrave new lines of new methods in order to exhibit the importance and the success of the rehabilitation of torture survivors. The more ornaments we carve into these columns, the more decorative these buildings become, demonstrating the necessity of the progress of the psychotherapeutic methods. These symbolic buildings can serve as memories of people around the world investing great energies into the eradication of torture.

The aim of this article was to present the complexity of the rehabilitation issues of torture victims and to provide ideas on how to develop and expand treatment approaches that adapt to the continuously altering multitude of challenges. As we can see, the task of self-development and transformation must be undertaken by caregivers and survivors alike.

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