



Care for Caregivers. Hungarian experiences with the caregivers of refugees

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In the summer of 2006, I was invited to Toronto by York University's Department of Refugee Studies to share my experiences in Hungary with supervision of caregivers for refugees.. As the result of eight years work I presented some photos depicting the atmosphere of the workplaces where supervision regularly took place. Thanks to my Canadian colleague, Kyle Killian, we found the proper name for the presentation: „Workplace Wellness”.

THE FIRST STEPS

In 1998, The CORDELIA Foundation recognized the need to address the issue of care and empathy on the part of staff and administrators working in the refugee camps. As an NGO providing psychological support for these refugees, we realised that the staff had not received even the minimum training teaching them how to cope with the psychosocial problems facing the asylum seekers, how to handle the so-called „difficult cases” and conflicts. Our positive psychological attitude toward the asylum seekers met a hostile response from some of the shelter's staff. One refugee shelter director, for example, referred to the refugee as „monkeys”. Several NGOs began to advocate before the Immigration Office for better care of the refugees. Our strategy was to slowly convince the refugee camp staff that without refugees, they would be unlikely to find other job opportunities, and that it was therefore in their interest to work together with us and learn to find meaning and pleasure in their work rather than to disparage it.

The great fluctuation of the staff members at the reception centres also drew the attention the Immigration Office, who „ordered” the employees to participate in our sessions. Two of us – one of whom is the medical director and a psychiatrist, and one a nonverbal therapist - began to support the social workers and the nurses.

With the help of the Hungarian UNHCR Office, we began providing regular psychologically oriented training sessions to the staff.

The word „supervision” carried with it a suspicious resonance for the eligibility officers, who came from the ranks of the police or security service of the past socialist regime. One of these officers „confessed” several years later that, being



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a” good guy,” he even wrote reports to his chief after every session about our discussions „at the secret supervision.” Afterward, we declared the „rule of the three N-s”: „never, nowhere and nobody”. (Never, nowhere, and to nobody do we speak about the material of the supervision.

Step-by-step we moved forward, and some years later, the staff realised that the work with refugees could be seriously traumatic. At the same time, they recognized the need for regular psychological support and self care strategies to protect them from vicarious traumatization and from burnout.

PSYCHOLOGICAL MINDEDNESS - *The reasons of the missing empathy*

Being a member of a hierarchy causes fears, false expectations and images. The staff members of the refugee shelters had been deprived of proper insight into the refugee experience. Some of the personal were very vulnerable, others were very suspicious, and some of them even paranoid. We began with special trainings that addressed the interview techniques appropriate for traumatized patients. The staff understood, gradually, what trauma meant, and the sorts of defences the clients used. They learned about Posttraumatic Stress Disorder, and how to recognize it among the asylum seekers. Twenty to twenty-five percent of the asylum seekers were not „only” traumatized, but they were also suffering from PTSD, complex PTSD or DESNOS (Disorder of Extreme Stress not Otherwise Specified). A great many claimants are survivors of torture with special psychological needs. The greater depth of psychological insight deepened the staff’s repressed empathy , and the appreciation of the need for self-care and preventive methods against burnout evoked by their work. Our slogan was: „The more you understand your client, the more you understand yourself. The more you understand yourself, the better you can protect you”.

The participants of these trainings gained the insight that, initially, their seeming lack of empathy might stem in large part from self care strategies that were either misused or never used at all.

BASIC CONCEPTS

Trauma is a ancient Greek word meaning wound. Traumatization might cause

Posttraumatic Stress Disorder (PTSD)

When an individual who has been exposed to a traumatic event develops anxiety symptoms, reexperiencing of the event, and avoidance of stimuli related to the event lasting more than four weeks, they may be suffering from this Anxiety Disorder.



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DIAGNOSTIC CRITERIA FOR 309.81 POSTTRAUMATIC STRESS DISORDER (PTSD)

A. The person has been exposed to a traumatic event in which both of the following were present:

1. the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others
2. the person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior

B. The traumatic event is persistently reexperienced in one (or more) of the following ways:

1. recurrent and intrusive distressing recollections of the event, including images, thoughts, or perceptions. Note: In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
2. recurrent distressing dreams of the event. Note: In children, there may be frightening dreams without recognizable content.
3. acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific reenactment may occur.
4. intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.
5. physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event.

C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:

1. efforts to avoid thoughts, feelings, or conversations associated with the trauma
2. efforts to avoid activities, places, or people that arouse recollections of the trauma
3. inability to recall an important aspect of the trauma
4. markedly diminished interest or participation in significant activities
5. feeling of detachment or estrangement from others
6. restricted range of affect (e.g., unable to have loving feelings)
7. sense of a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span)



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D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:

1. difficulty falling or staying asleep
2. irritability or outbursts of anger
3. difficulty concentrating
4. hypervigilance
5. exaggerated startle response

E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.

F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: if duration of symptoms is less than 3 months

Chronic: if duration of symptoms is 3 months or more

Specify if:

With Delayed Onset: if onset of symptoms is at least 6 months after the stressor

The traumatization can be primary for the victim and secondary for her/his relatives or for a caregiver who witnessed the trauma, as well. Compassion fatigue is a term for caregivers suffering of the stresses of the helping profession.

Vicarious trauma arises from the „intrusive nature of trauma” invading the listener as well. Judith Herman said that „the trauma is contagious,” and the contagious factor is embedded in the therapeutic relationship itself. Active listening is the most important characteristic of empathy, and through the thread of this empathy, the trauma intrudes into the caregiver’s unconscious. Thus, we survive the trauma „instead of the client”. We can often detect the milder symptoms of the Posttraumatic Stress Disorder in ourselves:

- Anxiety
- Depression
- Helplessness
- Flashbacks
- Alienation from „normal” life
- Dissociative episodes
- Paranoid thoughts
- Cynicism, pessimism



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- Extended helper's role
- Overidentification with the victim's rage/mourning
- Identification with the aggressor
- Feeling of guilt
- Hypervigilance
- Social dysfunction
- Mistrust
- Existential panic

Facing and listening to cruel, inhuman and degrading human relationships might break the image of humanity and increase the woundedness of the caregiver. Facing traumatic experiences might evoke the caregiver's own traumatic experiences, as well.

The rate of recognised refugees used to be very low in Hungary in the past. It was 1 percent per year. Later it increased to 9 percent as the result of our trainings, our supervision and our medico-legal reports on victims- survivors of torture. Recently 20 Somalian claimants have arrived to our country. After the first hearing the eligibility officers were threatened by the „torture stories” recounted by all of the applicants. The officers asked for extra supervision sessions to discuss the trauma narratives they had heard during the hearings. The whole Immigration Office was moved. They arranged special care for this group of torture survivors with the help of Cordelia Foundation.

The **burnout syndrome** is a psychological phenomenon which involves caregivers/helpers who change their relationships towards clients, colleagues and family. A person can burn out if s/he had previously „burned out” before! According to New York psychologist Herbert J. Freudenberger, who coined the term, burnout is a state of fatigue or frustration brought about by a devotion to a cause, a way of life, or a relationship that failed to produce the expected reward. Burnout is a problem born of good intentions, because it happens when people try to reach unrealistic goals and end up depleting their energy and losing touch with themselves and others.



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Three things are associated with burnout:

- role conflict: A person who has conflicting responsibilities will begin to feel pulled in many directions and will try to do everything equally well without setting priorities. The result will be the feelings of fatigue or exhaustion associated with burnout. („Superhousewives” might perform extremely well in their workplaces offering good career opportunities.)
- role ambiguity: The individual does not know what is expected of her. S/he knows s/he is expected to be a good career person but is not quite sure how to accomplish this because s/he has no role model or guidelines to follow. The result is that s/he never feels that she has accomplished anything worthwhile.
- role overload: The individual can't say no and keeps on taking on more responsibility than s/he can handle until s/he finally burns out.

Symptoms:

- The onset is slow. The early symptoms include a feeling of emotional and physical exhaustion; a sense of alienation, cynicism, impatience, negativism and feelings of detachment to the point that the individual begins to resent the work involved and the people who are a part of that work. In extreme cases, the individual who once cared very deeply about a project or a group will insulate himself to the point that he no longer cares at all.
 - Emotional, mental, somatic exhaustion
 - Feeling of helplessness and hopelessness
 - Feeling of emptiness
 - Somatic symptoms: headache, weakness, overstretching, pain in the neck and shoulders, gastric pain, increase of weight, decrease of immunity towards infections, sleep disorders
 - Emotional symptoms: dysthymia, helplessness, hopelessness. („my soul died”)
 - Mental symptoms: negative attitude, rigidity and distance in human relationships, cynicism instead of empathy
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SOLUTION STRATEGIES

Active	Direct
changing stress situation	speak about the stress!
influencing certain stressors	insight, understanding
positive attitude	other activities

Passive	Indirect
denial of certain elements of the stress	drinking (alcohol abuse)
bagatellisation of the elements of the stress	escape into disease
leaving the stressful situation	breakdown



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Some advice for prevention

- Make your reactions conscious in the stressful situation!
- Examine your ability to adapt and your coping mechanisms!
- Prioritize your aims!
- Divide your energies!
- Separate your private life and work!
- Evaluate the situation and your ego-forces!
- Positive attitude: humor and delight.

In the Hungarian practice, we use regular debriefing with our interpreters, as well as regular supervision after every case or working day. Trainings and conferences are very good occasions to raise the level of the psychological mindedness and share the load of special problems with colleagues. We try to locate these trainings at nice place far from the workplace so as to enjoy free time, e.g. at spas or at different wellness programs. Trainings and seminars are also more valuable if the organisers add some creative activity and humor into the training material, in order to learn how to „switch off”, how to „close and open the door”. In the worst case, if someone recognises the previously mentioned symptoms of vicarious traumatization, two weeks or one month holiday are advisable.

Who chooses the role of the caregiver? Those persons who have enough empathy and understanding of others' suffering.

Empathy is a very important tool to understand our clients, to know what s/he thinks and feel what s/he feels. There is a great danger in empathy, as well: the identification with the client. This feeling might intrude upon one's own private life and destroy healthy relationships, invading the helper with the feeling of helplessness or hopelessness and leading her/him to burnout.

To understand **projective identification** we have to look at the literature of psychoanalysis. Sigmund Freud described projection, and his daughter, Anna Freud, dealt with the subject as a defence mechanism. Melanie Klein described projective identification. In the supportive therapy of the traumatized refugee clients, we apply Kohut's theory about the „calming mother”: Kohut thought that the client projects missing functions of the self onto the therapist, and the therapist performs those functions until the client can integrate them in her/his own personality.

Countertransference is originally coming from the psychoanalytic literature, meaning the caregiver's reactions in a therapeutic relationship evoked by the client's transference and the caregiver's own past experiences. Some authors consider it as an interpersonal and intrapsychic experience, as well.

What is traumatic countertransference?

Patients suffering of PTSD have a special form of transference in which the destructive phenomenon is attributed to the aggressor's (therapist's/caregiver's) destructive force in the therapeutic process. It includes the caregiver's emotions towards the client and the



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traumatic experience. In the therapy of seriously traumatized or tortured refugee patients the transference-countertransference phenomenon is not diadic but triadic relationship encompassing the aggressor-victim-helper. This projection might be supported by the triadic setting of the therapy: victim – interpreter – therapist. Evoking the original traumatizing situation, the therapist might be identified with the aggressor and the interpreter with the helper as the result of projective identification.

The therapeutic relationship might be destroyed or the therapeutic process might get stuck if **countertransference fixation** occurs. The therapist feels helpless and s/he loses the control of the situation.

According to Wilson and Lindy (1994) the empathy is overwhelmed by the feelings of helplessness and hopelessness. The therapist might overreact her/his helper's role and overprotect the patient. This might result in dependent behavior by the patient and in the patient's questioning the competence of the therapist upon whom s/he depends, destroying the therapeutic boundaries.

To avoid countertransference fixation we have to recognise its signs:

- lack of empathy as a way of avoiding traumatizing situations in the therapy,
- skepticism towards the patient, fear of his rage,
- alienation,
- hate – identification with the aggressor, guilt, feeling of shame,
- wish to get rid of the patient.

To avoid the traps of overprotecting the patient we have to speak about **the boundary problems**.

In the process of helping our client the caregiver is traumatised, resulting in care giver and patient regression. Omnipotent feelings might impel us to act more and more for our patient. We don't realise that we've arrived at a level of incompetence where serious conflicts might occur, conflicts which we are unable to solve, and thus we become frustrated. This can also result in burnout.

The members of Cordelia Foundation realised after several years of practice that sometimes a new member enters our Foundation and s/he begins to behave in a hostile manner with the staff of the refugee shelters, becoming upset about the „not good enough protection” of the asylum seekers. The newcomer takes over the role of the social workers of the refugee shelter: s/he gives the client a lift to the somatic outpatient clinic or looks for employment or even offers to rent her/his home to the client, etc. It is our duty to explain that s/he has to keep in mind her/his boundaries and focus on the supervision.

Everybody has to recognise her/his own trauma filter, its own characteristics, with her/his background of personal woundedness or vulnerability, as we know that trauma has an intrusive nature. Vicarious traumatization depends on this the filter function, as



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well. Becoming traumatized by the client's trauma history, the caregiver mobilises her/his primitive or immature defence mechanisms as the result of regression. Denial results in mistrust, projection might result in the distorted image of „the government as the enemy”. If the caregiver over-identifies either with the victim or with the aggressor, s/he might split the surrounding world into „helpers” and „enemies”. Recognising and elaborating our regressive behavior with mature defences are the best „psychological tools” to handle the process in a healthy manner, sublimation (productive or creative activity) and humor being the best boundary or border guards in such a situation.

We must always take into account the reality frames: depending upon how much time and energy we have, we must respect the personal, the professional and the environmental boundaries! Adequate self esteem and use of our psychological resources, sufficiently strong and flexible boundaries at the professional empathic levels are needed to avoid serious problems or conflicts. Belonging to a team is a great help, with its' support and criticism. It has a container function, sharing the load of traumata. Colleagues are the best „boundary/border guards” in the prevention of incompetent acts. Learning and elaborating new methods together increase group cohesion significantly. The group is the best circle in which to laugh together at our mistakes – as we know the humour is one of the best mature defence mechanism!

Returning from the refugee shelters located more than 200 kilometers from the capital, the ticket controllers of the train often ask us: „Are the ladies coming from a theatre?” After discussing the daily experiences we begin to laugh so loudly that sometimes other passengers want to join our „lively company”.

And last but not least is the ability of „closing the door,” taking enough leisure time after the hard working hours, might help maintain a healthy distance from the problem.



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PREVENTION

We distinguish three levels of prevention (Caplan, 1964.):

Primary prevention is the identification of the damage in order to decrease its persistence on a psychological, environmental, somatic, social and cultural level. In our profession this means an appropriate knowledge of self care strategies and proper self esteem. Teamwork can support the professionals by using the colleagues as a „safe background” or as containers. They are the best „boundary/border guards” in the prevention of incompetent acts and they can mirror our psychological status, as well.

Secondary prevention means decreasing the time and effect of the damage, the treatment of the psychological problems in the early phase, crisis intervention – if necessary – and exploring the hidden damages.

Tertiary prevention is the treatment of the psychological problems/ the symptoms of vicarious traumatization.

We have to speak about the „healthy psychological management” of trauma issues and take into account the **resilience** of the caregivers. Since human beings have existed, trauma has existed, as well. Since trauma has existed, resilience has made human beings more mature and more stable. Confucius described it, like this: ” Our greatest glory is not in never falling, but in rising every time we fall”. Citing Nietzsche: ”That which does not kill us can only make us stronger” means that resilience is something like the capacity of resistance and rapid recovery after traumatization. It includes that the person is enough flexible to survive and then reintegrate the trauma in a healthy way with active problem solving behavior, responsibility, while using creativity and humor.

SUPERVISION

According to Morris Cogan, supervision increases professional socialisation, personality and competence. Bernard and Goodyear (1992) considered it as a tool in collegial socialisation, increasing professional life in the team. Dye and Borders (1990) wrote that supervision

- facilitates the learning process in supportive relationships,
- stimulates the maturation of the team,
- makes the adaptation to the team possible and
- facilitates the effectiveness of the client service.

It is not „super” and not a „vision”! The expression can be misinterpreted. It has nothing to do with „looking down” on a problem and it has nothing to do with visions or illusions! The word means to study a problem of an interpersonal relationship in another interpersonal context with the help of a professional who doesn’t belong to the therapeutic relationship - the supervisor must be an independent person.



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„Supervision is the therapy of the therapy” stated Abrams (1977).

It is a triangular situation - the participants are the supervisor, the supervisee and the client.

Its aim is:

- to elaborate a self image through introspection,
- to analyse the work in a self-reflective way,
- to discuss work and self-image in a group situation taking in account the group dynamics and reflectivity.

Supervision is not always a volunteer process but in several situations it is needed if, for example, belonging to the team solves the separation anxiety. The experiences of the personal past are emphasized only to a certain extent in understanding the relevant parts of the situation.



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Supervision has three aspects:

- educative or formative,
- supportive or restorative,
- managerial or normative.

What does psychological work mean in the supervision?

- The participant/s is/are the professional/s.
- Time is „here and now”.
- The orientation is focused on the future.
- It focuses on professional problems.
- The operation level is mostly that of the adult self-level, dealing with the profession, the professional role, the institution, the supervisee’s position in the hierarchy, personal conflicts, problems etc.

Individual or group/ team supervision?

Complementary approach

- First of all the supervisor must have capacity and sensitivity to
- know the special field of activity of the supervisee,
- help through empathy, self knowledge and self analysis,
- understand resistance, transference, countertransference, acting out and regressive behaviour,
- have a grip on theory.

What is the case supervision for the whole team?

It is not an individual supervision in the context of the whole team. The team as a group shares opinions. Team members also react with their associations of a personal nature. This supervision has many aspects of group supervision, but it is influenced by events, existing team culture and the level of psychological mindedness of the team. All members should bring in their cases – one new case in a meeting – followed by one/two shorter reports about patients discussed in previous sessions. This way three members can bring their case to the current session, followed by three other papers in the next session.



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What is team supervision?

It is about *cooperation in the team* and team functioning. It can replace regular team meetings.

The need for an outside supervisor occurs when the team is in a beginning phase, when the distress is a serious burden for all members, or when there is a serious team conflict and the leader is not considered neutral. It may occur when something new must be learned, or when the team is in transition.

Sometimes *combined* - concurrent or conjoint - supervision is needed, meaning two parallel therapeutic modalities: individual and group supervision.

Concurrent supervision flows from the idea of concurrent therapy. The two – group and individual supervision modalities - have a synergic effect and offer a complementary approach to the supervisee's needs. Sometimes concurrent therapeutic support is needed as well if the supervisee is suffering of a psychological problem disturbing the group process.

The goal of group supervision is to gain insight into interpersonal processes of the team

Individual supervision allows the exploration and working through of intrapsychic issues and their relationship with group processes

Concurrent supervision is offered by the same supervisor, and *conjoint supervision* is offered by another supervisor without any relationship to the group. One supervisor (group and individual) can more easily observe the supervisee in two different modalities. No important material is lost. Sometimes conjoint therapeutic support is also needed with the same indication as mentioned above.

Concurrent individual supervision may prevent drop out from group supervision. It must be identified early and worked through to prevent subgrouping and splitting of the group as the result of sibling rivalry.

Confidentiality has to be clarified at the group session but important information must be shared with the group. (The rule of the three N-s!)

Combined supervision is needed if interpersonal issues occur in the process of the individual supervision, if the supervisee's dynamics evoke particularly different countertransference feelings in the supervisor(s), or if group supervision evokes „special/intimate intrapsychic problems” influencing group-dynamics.

Supervision with caregivers and the cotherapy model

According to our experiences, the cotherapy model is a practical one in the elaboration of the psychological processes of refugee professionals.

First of all the therapist/supervisor1 and cotherapist/supervisor2 share the load of extreme trauma narratives to which they are listening at the sessions.



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The supervisor partners are equal: no rivalry occurs, they cooperate with mutual respect, they can work out their discrepancies in a constructive manner.

If the supervisors are coming from different disciplines, this may provide added insights

Some authors recommend debriefing after each session (Williams, 1976).

Having two different supervisors (group and individual) offers the advantage of having multiple transference objects and multiple observers to interpret the transferences.

Some practical advice

- Agree previously about length of sessions, the frequency and the duration of the supervision period!
- Decide about priorities: what sort of supervision is required most urgently and for whom?
- Evaluate supervision after a set amount of time, by supervisor and supervisees!
- Discriminate „caring” and „curing” issues, keep in your mind that supervision is not individual/group therapy!

The *Hungarian practice* is based on more than seven years of experiences with „refugee professionals” - eligibility officers, border guards, nurses of the health units, social workers, interpreters - of the Ministry of Internal Affairs.

The supervisors are a psychotherapist and the non-verbal therapist working together as therapist and co-therapist of the session.

Each session is divided into a verbal and a non-verbal part: the first one is focusing on psychological processes like negative and positive transferences, special situations (e.g. interviewing torture victims might remind the client of interrogation, s/he might behave in „provocative way” or say nothing about her/his torture etc.), denial („there is no problem”, no problematic case occurring at the session, „everything is in order”, the group stays silent etc.). The participants are the members of a hierarchy, so it is always quite a long process to elaborate the paranoid attitude of the group or some of the group members. This might also be the result of vicarious traumatization. We try to set up the likely lost „trust” with the introduction of the „rule of the 3 N-s” (never, nowhere, nobody), handling the psychological material as a group secret. This is obligatory and mandatory for every participant.

It is interesting to follow up how the process proceeds from the „obligatory” participation in the supervision to the „volunteer” participation, how needs are raised for the next sessions. As the result of the process the team members become more and more interested in their own work. They want to learn more information and begin to organise trainings and seminars. Psychoeducative elements always occur. One of the goals of the supervision is the sensitisation of the participants to the other’s and to their own problems, „to open up ears, eyes and minds” in order to recognise the Posttraumatic



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Stress symptoms, or the vicarious traumatic symptoms resulting from professional casework. Such sensitisation serves as a tool of the prevention of burnout. Concurrent (individual) psychotherapeutic help is often needed at the beginning of the process, so that later the attitude of group can grow into so supportive one, fulfilling its „holding” function, in which the participants can find solutions to their individual problems, as well.

The non-verbal aspect means relaxation and contact exercises in the last thirty minutes of the supervision session. It is important as another tool to drain the tension of the group session if the members have to continue their daily work. These non-verbal methods give relief and the possibility of managing the rest of the day in a relaxed way. It can facilitate group cohesion, as well.

We cannot close this material without speaking about the problems of the keypersons of the therapeutic processes, the *interpreters* belonging to the team, or coming from outside the team.

When dealing with torture survivors or seriously traumatized clients, the traumatization of the interpreters is unavoidable. S/he has to be the bridge over two different cultures, over the therapist and the client/s. S/he is the channel of transference and countertransference, the filter of all the narratives, of the emotions and psychological interpretations and the channel of traumatization and vicarious traumatization, as well. S/he has to be accurate and neutral, and it is an extremely great task for someone who has never learned psychology or, moreover, who is a survivor of trauma/torture her/himself. The triangular situation (interviewer/therapist – interpreter – client) might evoke her/his own memories, diving the interpreter into a regressive psychological state in which s/he is (re)traumatized..

We train our interpreters in a minimum of psychology, psychotherapy, work in multicultural settings, issues surrounding trauma etc. before employment. They are treated as a member of the team, participating in our daily life, belonging to us. Working as an interpreter for other organizations might be accepted only in exceptional cases, as s/he knows and keeps (!) medical secrets of the client, as well.

What can we do in order to avoid her/his vicarious traumatization?

First of all we trust her/him and accord her/him exceptional honour, as without her/him the therapeutic process is impossible. The therapist with whom s/he works together debriefs her/him, and the medical director being a psychotherapist herself does a short individual supervision at the end of every working day. S/he participates in our supervision sessions every month as a member of our team.

The author asked some eligibility officers to write down their experiences with the supervision. What follows supports the theories we have discussed.



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What is supervision to me?

One of the most important things is the spontaneous and informal talk with my colleagues. The other important thing is the help of the „two colleagues from outside” (the therapist and the non-verbal therapist! We are not „colleagues” but the supervisee accepts us!) I can get acquainted with some of our clients in a different aspect.

I often feel it helps to find the optimal attitude towards the claimants and get rid of my „official customs” in the human relationships.

Supervision made my working relationship with my official colleagues deeper when sharing my „stories” with them as well as getting information about their ones. We have no other place to communicate this way. I can get acquainted with the humanistic side of my colleagues listening and intervening in their case histories. Sometimes I wonder if I get to know a new profile of my mates.”

I tried to give some snapshots about special psychological issues arising from the care of caregivers based on our daily experiences in Hungary.

It is not the „only tool” with which to protect ourselves from vicarious traumatization and burnout.

There are several methods based on different psychological schools and attitudes.

I gave you our knowledge and way of thinking about the problem. Perhaps I succeeded to give you an „appetizer” to this important issue in caring with traumatised refugees.



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