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Foreword

These *Good Practice Guidelines* originated from a project on *Refugee Reception and Integration* as part of the work of the *European Council on Refugees and Exiles* (ECRE), made possible by the financial support from the European Refugee Fund. The entire project ran from May 2001 in two phases of differing importance: network activities and analysis of the current practice of *Reception and Integration* in Europe¹. In both phases of the project the work was based on setting standards, and developing *Good Practice Guidelines*. The entire project contains various topics, which concern refugees in a significant way. They were delegated to ECRE's chosen organisations to be further elaborated on by:

- Employment - British Refugee Council, UK
- Education - World University Service, UK
- Older Refugees - Asylum Coordination, Austria
- Local Authorities - Italian Refugee council, Italy
- Traumatized Refugees - Caritas Germany, Therapy Centre for Torture Victims- Caritas Cologne Refugee Counselling Association, Germany
- Community Centres -Greek Refugee Council, Greece

The Therapy Centre for Torture Victims- Caritas Cologne Refugee Counselling Association - led four workshops entitled "*Versions and Visions*" in connection with its theme "*Protection and Rehabilitation for Traumatized Refugees and Victims of Torture in Exile*" drawing on expertise from a total of ten countries from the European Union. The work on standards for traumatized refugees focussed on children and adolescents. In this way, the practical experience of the Therapy Centre² could be linked with the research- and treatment experience in the university setting of the University of Hamburg. The Department for Psychiatry and Psychotherapy for Children and Adolescents in the University-Hospital in Hamburg-Eppendorf holds a pioneering role in the residential treatment of traumatized child refugees in Germany and beyond.

In the European and international context, written principles exist which concerned themselves in diverse ways with refugees, including child refugees and/or traumatization, e.g., the *Istanbul Protocol* of 2001³ of the United Nations, the "*Guidelines for the examination of survivors of torture*" of the Medical Foundation, London⁴, the German regulations, which were published under the auspices of the Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften (AWMF)⁵; the AWMF rules for the German Society for Children and Adolescent psychiatry and psychotherapy on the reactions to severe stress and

¹ Phase I: Networking in Europe; Phase II: Analysing New Approaches in Policy and Practice

² Since 1985, the Therapy Centre for Victims of Torture - Caritas Flüchtlingsberatung Köln, e.V., (formerly: Psycho-social Centre for foreign refugees, Caritas Asylberatung Köln, e.V.) has specialised on the treatment and advice of severely traumatized refugees.

³ Office of the High Commissioner for Human Rights (ed.) (2001), *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. Professional Training Series No. 8, United Nations. New York and Geneva, 2001

⁴ Medical Foundation for the Care of Victims of torture (ed.) (2000): *Guidelines for the examination of survivors of torture*. London

⁵ Flatten, G., A. Hofmann et al. (Hrsg.) (2001): *Posttraumatische Belastungsstörung. Leitlinie und Quellentext*. Stuttgart.

adaptation disorders⁶. ECRE has published important position papers on the reception and integration of refugees in Europe, as well as a position paper on refugee children.

The positions presented in these papers are in agreement with the positions and necessities that are discussed in this Good Practice Guidelines, therefore the ECRE statements are not specifically referred to in the paragraphs of the following text. Up to the present time, however, there have been no concise *Good Practice Guidelines* for traumatised child- and adolescent-refugees. From a professional point of view, it is necessary to discuss three aspects - the needs of the psychosocial context, assessment and diagnosis, and intervention. This takes place for the first time in the guiding principles compiled here and edited by the Cologne Therapy Centre for Torture Victims and the Hamburg Department for Child-psychiatry and -psychotherapy in the University-Clinic in cooperation with ECRE. They are based on the discussions held by the experts from ten European countries and are to be equally addressed to politicians, professionals and non-professionals.

Brigitte Brand-Wilhelmy
Dorothea Irmeler

The Therapy Centre for Torture Victims –
Caritas Cologne Refugee Counselling Association

Cologne, November 2002

⁶ Deutsche Gesellschaft für Kinder- und Jugendpsychiatrie und Psychotherapie u.a. (Hrsg.) (2000): Leitlinien zur Diagnostik und Therapie von psychischen Störungen im Säuglings-, Kindes- und Jugendalter. Köln

Acknowledgements

The *European Council on Refugees and Exiles* (ECRE) has not only made the realisation of the entire project *Good Practice in the Reception and Integration of Refugees: Analysing New Approaches in Practice and Policy* possible, but with its vision and commitment, has raised the topic of traumatised refugees to a clearly visible position within the whole project and, thereby, gained the financial support of the *European Refugee Fund*. Throughout the project, ECRE has continually expressed, in many ways, its readiness to assist in overcoming the problems of planning and accomplishing the project with new ideas and practical suggestions - communication was eased by their conviction about the project itself and the general light-heartedness of human encounter. These two poles radiated through the cooperation of the European colleagues with the project and enabled it to become a valuable and enriching professional and human experience. The German Foundation for UNO - Refugee Aid generously supported the project financially. Caritas Germany upheld its commitment to the questions posed by refugees within this project financially and personally, as did Caritas for the City of Cologne and the Diözesan-Caritasverband für das Erzbistum Köln e.V., with generous financial help. Dr. Arne Hofmann, the scientific advisor for the project, through his professional knowledge and vitality, gave his unflagging support in all phases of the project, and also through his unshakeable conviction, that now is the time to activate all society's resources for traumatised refugees.

All colleagues of the Therapy Centre for Torture Victims supported the project in diverse situations, even those colleagues not actively involved with its organisation and execution: this was achieved through the exchange of ideas, discussions, participation in workshops, through the steadfast concern in times of doubt, in overcoming obstacles and in especially intensive phases of work, through their interest and the shared satisfaction in the creation and achievement of the project's goals. We thank all those involved and the institutions that helped us in the participation and execution of this important project. We give special thanks to our colleagues in the Department of Child- and Adolescent-psychiatry and -psychotherapy of the University-Hospital in Hamburg-Eppendorf, who showed their motivation, their purposefulness and their commitment, to invest their knowledge, ensuring the accomplishment of the *Good Practice Guidelines*. We express our thanks also to all the experts actively engaged in the workshops (see list of institutions and individuals involved), without which there could not have been such a broad based and impressive European exchange and consensus on so many important questions. Our thanks also go to the many child- and adolescent-refugees, who, despite their many terrible experiences in and from the world, offer us their trust that we might improve their situation. In remembrance of German history of the 20th Century and, confronted by the current abuse of human rights, we take thought and reflect on our role in this European project on the topic of *Refugee Reception and Integration* with a feeling of responsibility. We hope that our contribution not only helps the traumatised child- and adolescent-refugees to experience a more peaceful future, but also those responsible to create it.

“There are no great discoveries
and there is no progress,
as long as there is an unhappy
child on earth.”
Albert Einstein

1. Introduction

Dorothea Irmeler

Of the 22 million refugees worldwide, about half of them are children, i.e., minors under the age of 18 years. These numbers comprise only the refugees who fall under the mandate of the UN Convention on the Status of Refugees; but one has to assume that there is in actual fact an even greater number of refugees and therefore a respectively greater number of child refugees (von Barrata 2000).⁷ The reasons why parents flee with their children, or children and adolescents flee alone, are many and varied and can be the results of, among other things, political persecution, imprisonment, torture, war, civil war, compulsory recruitment into armed services, female genital mutilation, poverty, child labour, slavery, sexual and other forms of abuse, and violence (Racketseder 2002). The reasons for flight and the number of countries of origin involved are numerous because the civilian population is being affected to a greater extent. Besides individual persecution for political reasons, civilians are also increasingly used as deliberate targets in warlike conflicts. The destruction of civil communities is often a weapon in the course of civil war.

Child- and adolescent-refugees are differentiated into accompanied and unaccompanied.⁸ Accompanied are those who flee with their parents and siblings, part of the family or other important bonding figures / care takers from the extended family. It is assumed that currently about 100,000 unaccompanied minors exist as refugees⁹ in Europe (Ayotte 2000). Children and adolescents, especially unaccompanied, belong to the refugees most in need of protection. In the international context there are different agreements, for example, the 1984 UN Convention Against Torture and the leading 1989 UN Convention on the Rights of the Child, which specify and demand children's rights, including those of child refugees. Here it is important to note that a changing understanding of childhood is beginning to prevail. In these agreements, children are no longer seen - as in the western countries at the beginning of the 20th century - as the possession of their parents, in particular the father, or as incomplete adults, but as people in their own right in a special phase of life who are valuable in themselves and worthy of protection, albeit needing assistance and instruction. This view caused a change regarding rights and duties as well. Governments and other institutions are now obliged to provide decent living conditions for children, which encourage their development. This is seen as a duty and not as a moral gift of sympathy (Unicef 2001). In Europe, the laws and regulations concerning asylum and immigration are currently being “harmonised”. In the Treaty of Amsterdam, an agreement was made among the EU Member

⁷ All literature of the Introduction is to be found under Literature of the chapter “Psycho-social context”

⁸ “Unaccompanied children and adolescents are children and adolescents, who have not yet reached 18 years-old, who live outside their native country, and who are separated from both their parents, and are not looked after by an adult, who is obliged, by law or by custom, to look after them“ Separated Children in Europe Programme – SCEP, Statement of Good Practice, <http://www.sce.gla.ac.uk>, in: Racketseder (2000)

⁹ Save the Children works from a figure of 200.000 (Gittrich, T. 2002). These different figures make the problematical situation regarding this group of children and adolescents evident. One can assume that a large number of them live illegally in Europe.

States to create an “area of freedom, security and justice” (Gittrich 2002). In Article 63 of this Treaty, the areas in need of harmonisation were agreed on. They are:

- “Criteria and methods for a member-state to determine and deal with the question of asylum;
- Minimum standards for the admission of an asylum-seeker in the member-states;
- Minimum norms for the procedure of recognition or judging the recognition as a refugee;
- Minimum standards for allowing temporary protection for asylum seekers from another country, who cannot return to their native country or who seek international protection for another reason.“

(Gittrich 2002, p. 76)

This document and its proposals is a contribution towards strengthening the obligations that arise from international conventions, in shaping higher standards in the European Union. It is currently observed that tendencies exist to move towards “minimum standards”, although it is expressly left open to the individual countries to achieve and realise higher standards. The recommendations and text sources are to be understood as guidelines for competent and dignified action towards the protection and the encouragement of development of traumatised children and adolescent-refugees. In making these recommendations organisations and experts from ten European countries, specialised in the treatment and caring of these children and adolescents, were involved. Discussions were solely orientated on the welfare¹⁰ and the dignity of these children and not on financial and / or political issues. These children have special needs because of their experiences of being uprooted and of violence and/or separation from their parents. This *Good Practice Guide* is composed of:

- The psychosocial context (chapter 2)
- Theoretical and practical aspects of the assessment and intervention (chapter 3)
- Presentation of the consensus that was achieved by the European workshops, concerning the treatment phases of traumatised refugees generally - not specifically concerning children (chapter 4)
- Case studies on different treatment - and context - ideas, based on lectures from the European workshops (chapter 5)

¹⁰ The “welfare“ of the child is guaranteed, when “the minor’s physical existence and adequate intellectual and emotional development is ensured to form a worthwhile character and to be a capable member of the society“. (Happe 1992 in: Jordan 2000)

2. The psychosocial context

The arrangement of details for the psychosocial context for traumatised child- and adolescent-refugees in European countries must be orientated on:

- International Agreements for the protection and development of children
- Development tasks, that children and adolescents should achieve in a normal development
- Knowledge of risk- and protection factors, vulnerability and resilience in the development of children
- Knowledge of the consequences of traumatisation of children and adolescents, especially child- and adolescent-refugees.

These points of orientation are introduced in this text through following paragraphs:

- Legal conditions (2.1)
 - UN-Convention about Child Rights (2.1.1)
 - Asylum procedures (2.1.2)
 - Residency status (2.1.3)
 - Age (2.1.4)
 - Determination of age (2.1.5)
 - Deportation / detention (2.1.6)
- Bonding figures (2.2)
 - Families (2.2.1)
 - External bonding figures (2.2.2)
 - Guardians (2.2.3)
- Accommodation (2.3)
 - Families (2.3.1)
 - Unaccompanied minors (2.3.2)
- Education (2.4)
- Training (2.5)
- Cultural aspects - loss and integration (2.6)
- Medical, psychosocial, and therapeutic care (2.7)
- Literature (2.8)

Traumatisation must be understood as a process (Fischer & Riedesser that is divided into three main phases, whereby the post-traumatisation phase is of special significance. This is recognised by the high degree of vulnerability experienced by the person involved. Re-traumatisation, which could take place in this phase, can cause long-term, in some cases, permanent damage (Keilson 1979). The psycho-social context, therefore, must be devised with special attention to the great need for the protection of traumatised children and adolescents with a view to healing and prevention; for most child- and adolescent-refugees the post-traumatisation phase begins when they reach their country of exile. Once there, they have to tackle and overcome the tasks of their further psychic development from the background of traumatic experiences and the necessity, to come to terms with the foreign culture and society.

Psychological development tasks are described by Erikson (1950) referring to multi-cultural settings and classified under age groups. They are listed in the following table, as they should always be considered when the psychosocial context is being devised.

<i>Age</i>	<i>Psycho-social stage</i>	<i>Psychopathology (Remschmidt, 2000)</i>
0-1	Basic trust & mistrust	Autism, analytic depression eating and sleep disorders
1-3	Autonomy v. shame, doubt	Symbiotic behaviour, negativism, obstipation, shyness, withdrawal, pavor nocturnus
3-5	Initiative v. guilt	Phobia, nightmares, speech disorders, enuresis, encopresis, anxiety states
6-11	Industry v. inferiority	School problems, school anxiety, school phobia, obsessions, conversion symptoms, tics
12-17	Identity and role confusion	Identity diffusion, anorexia nervosa
Young Adults	Intimacy v. isolation	delinquency, schizophrenia

(According to Erikson 1969 & Remschmidt 2000)

The following exposition concerns itself with accompanied and unaccompanied child- and adolescent-refugees. Differences are mentioned specifically.¹¹

2.1 The Legal Context

The psychosocial context for child- and adolescent-refugees refer to international agreements on the rights and the protection of children. These are called:

- UN General Declaration on Human Rights (1948)
- The Geneva Convention & Protocol Relating to the Status of Refugees (1951, 1967)
- The Hague Agreement for the Protection of Minors (1961)
- The International Covenant on Civil and Political Rights (1966)
- European Social Charter (1961)
- UN Convention on the Rights of the Child (1989)

The UN Convention on the Rights of the Child, also called the Children's Constitution, from which the different aspects of arranging the details of the psychosocial context can be justified, will be described in more detail below.

2.1.1 The UN Convention on the Rights of the Child

The UN Convention on the Rights of the Child, initiated by the General Declaration on Human Rights from 1948 and the UN Declaration on Child Rights from 1959, is based on four main principles:

- The right to equal treatment - no child should be disadvantaged through gender, nationality, ethnic or social origin or descent, citizenship, language or religion, colour, because of a handicap, because of political beliefs or other views, estate, birth or other status of the child, his/her parents or guardian.
(Article 2, Paragraph 1, in Unicef 2001)
- The principle of the best interests for the child - the State must be concerned with the welfare of the child above all else in its dealings. States are obliged to protect children and to promote / benefit child developments.
- The right to life and personal development - not only the right to survival is secured, which should particularly protect young girls against disadvantages, but also the

¹¹ This document will only deal with the most important aspects of gender-specific differences in development processes and in ways of coping with trauma.

obligation of States to ensure the “biggest possible range” of development for children.

(Article 6, in Unicef 2001).

- Respect for the opinion and the will of the child - it is emphasised that children have the right to influence their conditions of life; they should be taken seriously, listened to and included, according to their age and maturity, in the decisions made. Children are not only to be seen as an investment for the future, but they already possess rights now.

(Article 12, in Unicef 2001).

In an additional report in 2000, it was agreed that children under the age of 18 years should not be compelled to do military service (Unicef 2001). Child- and adolescent-refugees, accompanied and unaccompanied, should be afforded special legal and beneficial protection (Holz-Dahrenstaedt 2002). Meanwhile, 191 countries have signed the UN Convention on the Rights of the Child, with only USA and Somalia not yet signatories. Some countries, among them Germany (compare chap 2.1.4), have only ratified the Convention with reservations although in Article 51 it states that reservations are not permissible if they do not conform to the goals and meaning of the agreements (Unicef 2001).

2.1.2 Asylum procedures

The policies concerning asylum procedure are particularly significant for unaccompanied minors, as these children and adolescents are often overwhelmed by the complexities in the asylum procedures, this being often recommended to them by their carers as being the “smallest evil” compared with deportation. They are structurally disadvantaged against because they mostly cannot fulfil the requirements of:

- Personal credibility
- Plausible and definitive descriptions of the grounds for fear of individual persecution
- Credible proof of their own identity (Schuster 2002).

These requirements are in accord with those for adult asylum-seekers. However, there should be specific child orientated asylum procedures which make sure that the child can freely and without fear explain his case according to his age and maturity. Children and adolescents often do not make the decision to flee themselves, this being made by their relatives (Save the Children & UNHCR 2000). This does not mean that their reasons are not relevant for the welfare and future of these children. Children and adolescents should not be punished for the decisions that others have made over their lives. Such discriminations are opposed to the obligations that are to be found in the UN-Convention for Child Rights. Accompanied children should also have the right to apply for asylum, independently from the adult who accompanies them, if this would be the best way to protect them. Child-orientated reasons for flight and the abuse of human rights have to be included in the reasons for granting asylum:

- Compulsory recruitment or the danger of it
- Child-trade for prostitution
- Female genital mutilation
- Compulsory labour (UNHCR in Schuster 2002).

Minor unaccompanied refugees should be allowed free legal aid, specialised in the specific questions involved. The legal representative should explain all legal questions and support the child until he achieves a secure, long-term right to residence.

2.1.3 Status of residency

Minor unaccompanied refugees need secure residency up to at least the age of 18 years, in order to deal adequately with the emotional development tasks, to develop goals and perspectives, to have the chance to be integrated and to cope with their traumatising. Achievable goals and perspectives are vital for a healthy development; they give meaning and significance to the individual. Should such perspectives be lacking then it can lead to self-alienation, loss of orientation, and loss of meaning, and even to mental illnesses (Oerter & von Hagen 1999), which is particularly serious for traumatised children and adolescents. Children and adolescents who have no long-term secure state of residence also suffer from the fear of sudden decisions from the authorities, which they are unable to influence and which could lead to their deportation. One of the consequences of traumatising in children is that they have lost faith in the predictability of the world, so to speak. This means that they need careful and trustworthy explanations about processes and procedures that are of concern to them.

A case example may illustrate this: A young adult who originally came as an unaccompanied minor from a war torn African country to Germany and has stayed there for six years was finally granted a permanent stay. He was supposed to go to the Immigration board to get the document. There he was asked to hand over his previous document plus two photos. While waiting, he was suddenly asked to come to a different room. The Immigration officer did not explain why, but left him alone. He was suddenly convinced that he was brought into a trap and that he was about to be deported. He was stiff out of anxiety, convinced that the doors were locked. It seemed to him that he had to wait for a very long time until the officer came back, gave him his new document without saying a word to him and left the room. The young adult fled the room, but broke down on the stairs of that building. This episode could have been easily avoided if the Immigration officer would have offered a few words of explanation to the young adult.

(21 year-old refugee from Angola, living in Germany)

Children and adolescents should be informed about the decisions concerning long-term, secure residency as soon as possible after their arrival, without their having to be subjected to an interview- procedure by the authorities, this being unsuitable for children. Insecurity and the persistent anxiety of deportation result in re-traumatising, with all its consequences for further development (Preitler 2002).

2.1.4 Age

The fact that minor, unaccompanied refugees over the age of 16 years are treated as adults in the asylum procedure in Germany contradicts the UN Convention on the Rights of the Child. It contradicts the fundamental right to equality, non-discrimination and protection. Should the suggestion of one German member of the European Parliament to lower the age of majority for the right to asylum to 16 years¹² in all European countries become legislation, then the non- discrimination clause in Europe would be disregarded in all respective countries (Gittrich 2002). In some European legal systems – for example in Germany-, adolescents under the age of 18 years are allowed an interim period (Remschmidt & Martin 2000).

¹² See the reservation to the ratification of the UN-Convention of Child Rights. According to the UN-Convention, a child under the age of 18 years should not be treated as an adult. Germany, for example, also abuses the fundamental principle of equality, because it superimposes the asylum rules and regulations over and above those of the Children and Young Persons Act. According to this Act, it is not allowed to treat a child under the age of 18 years as an adult.

According to these legal systems, the following classification applies:

Under 14 years	Children
Over 14 years, but not yet 18 years	Adolescents
18-21 years	Late adolescents
18 years, but not yet 27 years	Young adults

By the consideration of age in the penal law of some countries, the question arises as to whether the psychic development has taken place within the expected norms and time-span; or, whether, under developmental-psychological viewpoints, the development of the personality is not yet completed and this must then be taken into account (Remschmidt & Martin 2000). In the case of traumatised child- and adolescent-refugees, this question can most probably be answered in that their psychic development has suffered gaps or breakdowns. This has to be considered when addressing the child's welfare regarding the coming of age of the child, i.e., the right to residency must be assured until over the age of 18 years.

In many European countries – for example in Sweden, UK, Austria - it is practice that adolescents are allowed to stay in children's homes or similar places until the age of 18. After that age they have to leave these places or are threatened by the fact that they have to move to asylum homes for adults. This practice is not adequate considering the fact that many of the traumatised refugees under age not to be considered as mature adults after their 18th birthday. In addition, the threat of being in danger to lose the right to stay in the host country becomes very real for many adolescents in European countries. Maybe they have managed to start a school career or an apprenticeship, all of that is in danger when they have to face the fact that they will be 18 and considered as adults in a legal sense.

2.1.5 Age determination

It is especially degrading – and in some cases re-traumatising - for the adolescents to have their age determined (as part of the asylum procedure) because of methods – as it is practised in some European countries; these include questionable X-ray investigations of the bones of the hand and even the “viewing“ of their body's hair-growth and other gender-specific signs of maturity (Kaufman 2002). Compulsory investigations like these are an abuse of human rights. X-rays can, in some cases, be seen as physical abuse. All these methods are scientifically doubtful and do not ensure certainty in determining age (Kleffer 1999, Heiber 1999). Such age-determinations do not serve the welfare and the need for protection of traumatised adolescent-refugees and should not be practised, nor should other investigations be substituted in their place. Also, one has to keep in mind that traumatised adolescents often have been subjected to physical abuse - rape, forced labour, beatings, etc. – which means that their body boundaries have been forcefully, without their consent been violated, therefore their physical integrity should be treated with great respect. Instead, efforts should be made and resources mobilised to encourage the development of adolescents, late adolescents and young adults- see the age classifications listed above.

2.1.6 Deportation and detention

Deportation and detention¹³ should be forbidden out of principle for minors and adolescent-refugees in European countries. Currently, deportation-detention for minors is only practised in two European countries: Germany and Austria. The “airport-procedure“ as practised in Frankfurt/Main (Germany) is similar to deportation-detention (Kaufman 2002). In this

¹³ Deportation-detention is called “push-detention“ (“*Schubhaft*”) in Austria.

“airport-procedure“ minor-refugees, who enter Germany without valid documents, are not allowed to leave the rooms allocated to them at the airport. This procedure should be abolished, as demanded for a long time by human rights organisations and from the *Good Practice Guidelines*. It entirely contradicts the principles of the special need for protection and non-discrimination of minors.

In most cases, minors cannot fully and systematically understand the reasons why they are brought into detention, why they should be deported because their reasons of why they are in a foreign country are mostly not determined by themselves but by either other adults or by war or other circumstances out of their control. In any case they had to obey those circumstances and decisions. If they are forcefully brought into detention, they think that the adults of the foreign host-country decide against them, or decide on grounds of arbitrariness against them personally. In addition, they experience that they have no influence on their lives because they are (in almost all cases) detained by force against their will. The feeling of being helpless and psychologically disorientated is enforced by this measure. Furthermore, in detention minors are surrounded by hopeless, depressed and often suicidal adults, confronting them with life histories which are often far beyond their emotional and intellectual capacities to come to terms with. Their own special needs of protection and care are not met at all.

2.2 Bonding figures

Child- and adolescent-refugees are always to be seen in the centre of a network of family and other ties, even when they enter the country of exile unaccompanied. From the systemic point of view, this should not only apply to therapeutic interventions, but also to devising the psycho-social context; the resources and the sources of endangering factors can also be clarified through the systemic point of view.

2.2.1 Families

The clarification of the psychosocial situation in which parent-refugees and their children are to be found, their past, wishes for the future, the risk-factors for their psychic- and physical health, and their need for support, should take place as soon as possible after their arrival. Talks should be offered with specially trained professionals - independent of the status of residency, which is valid at that point of time. Clearing - and other offers of counselling - is important, in order that the parents, or other familiar bonding figures who are acting in the parental role, can maintain their role of responsibility towards their children even in the country of exile, i.e., can resume this role after their own traumatisation. Parents (and other main important bonding figures) serve as a “protective wall against external irritations“ (Schepker 1997) in that they have influence on the extent of the suffered traumatisation. The cooperation of trained translators on a long-term basis is of great importance in order to prevent a situation arising whereby the children function as translators for the family, which often leads to parentification, i.e., the children take over the parent-function for the parent. Research into risk- and protection factors for the development of the personality and experience with these factors by refugee families and their children (Bala 2000) and, likewise, research on Salutogenese¹⁴ showed that unfavourable psycho-social factors contribute to the development of vulnerability in children and adolescents. These factors include, specifically:

¹⁴ The concept of Salutogenese was developed by Antonovsky (1987) and assumes that a person can, under certain circumstances, develop an internal resistance, which serves the need for avoidance and consistent coping with demands and stress-factors. This resistance is not temporary, but permanent. The feeling of a meaningful, internal coherence is important for Salutogenese, likewise for the possibility to participate in decision-making, to set own goals, to influence results and for the suitable employment of own resources.

- Membership of sub-groups
- Poverty
- Living in unfavourable areas
- Relationships and characteristics of bonding figures (Fiedler 1999)

Favourable factors, which also have effect in a high-risk environment as seen in the growth of defence resources, include:

- Grandparents
- Older siblings
- Caring adults outside the family
- Popular and trust worthy teachers
- Priests and social workers
- Close friends
- Spirituality (Oerter 2002)

Resulting from this knowledge, it is clear that parents and similar bonding figures who fulfil the parental and/or protective role for the traumatised children and adolescents, must be supported and strengthened by:

- Measures for the clarification of the results of traumatising (psycho-education)
- Offers of therapy to deal with their own traumatising
- Offers of support for bringing up the children in a foreign culture and society
- Help in dealing with everyday life
- Strengthening of existing resources
- Adequate financial security
- Support for the realisation of plans for the future (measures of integration); including help by wishes to return to native country.

Trauma that parents have experienced is often not spoken about out of a wish to protect the children. Many traumatised parent- refugees or single parents have so much to do with coping with everyday life in the country of exile, their worries for the future, feelings of alienation and internal discord, the loss of their native country, planning for the future and their social status, that they think it is necessary to split off from their past and everything that they once were. A trauma that is not dealt with and thus becomes taboo can often break through in the form of violence - violence in the family, the reasons for which are not comprehensible for the other family members involved. This is, for example, often witnessed in families who are under additional cultural pressure not to show any signs of “weakness”, for example families from Iraq.

Case study: The father of a family from Iraq has been persecuted, imprisoned and tortured. After his release, he flees the country leaving his wife and two children – boy and girl – behind. In his country of exile, the Netherlands, he is granted asylum for political reasons. He therefore has the right to family reunification. After a long and extremely frustrating process, his family finally arrives in the place where he lives. His family does not know about his past experiences in prison nor in the country of exile. Out of their own frustrations and anxieties, they blame him for the fate of the family, and for the long process of reunification. In addition, the father is now expected to earn an income, provide housing and ease away any difficulty that stems from the new cultural and societal surroundings. The father expects these tasks from himself because of the role expectations, which he has internalised, yet he is haunted by the anxiety of failure, by nightmares from his traumatising experiences and the pressure of his family. He cannot talk to anybody about this, and his

reactions end up in domestic violence, especially towards his wife and his son. The son then shows symptoms of withdrawal, school failure and aggressive behaviour. It is therefore necessary to offer specific, culture sensitive, family and child orientated interventions in order to prevent long lasting disturbances in children of traumatised parents. Specific interventions like that are now offered by a number of Trauma Therapy Centres in Europe.
(Iraqi refugee in the Netherlands)

Untreated trauma in the parent's generation is unconsciously and involuntarily passed on to the next generation (Bar-On 1992). Because of this, traumatised parent-refugees must be supported as a prophylactic measure as much and as intensively as possible through all the above-mentioned measures for the health of their children, and independent of their status of asylum/residency and as soon as possible after arrival in the country of exile.

As an example for how refugee families can be supported even in a Reception Centre, the Oulu Reception Centre in Oulu, Finland, should be named. Each refugee family who arrives there is offered a family interview in which the history but mainly the needs of each family member are assessed. The Centre offers social work, day care, help with household work, family work, health care (including mental health provisions), basic work by instructors, interpreter service and a community model for living. Children are offered structured play activities in groups. Certainly this is a model, which is suitable to help to prevent the development of long-term dysfunctions in traumatised refugee families and their children.

2.2.2 Bonding figures outside the family

Bonding figures outside the family, among others, teachers, play-school teachers, youth workers, 'god-parents', members of the community in which the refugees live, play an important role for the protection and development of resilience of children and adolescents. They should have the possibility for further training in:

- Trauma-orientated themes and topics
- Topics from the range of normal development of children and adolescents
- "Life Development Skills" (Danish et al. In Oerter et al. 1999)
- Ethnic topics
- Cultural topics
- Topics concerning the causes of flight/asylum
- Topics concerning personal reflection

In addition, supervision should be offered and/or the possibility to take part in a Balint-group¹⁵. The concept of sponsorships / 'god-parents', as built up in some centres in Europe¹⁶ has proved itself to be worthwhile, especially for unaccompanied minor refugees. The sponsors, after they have been through selection- and training procedures and agree to have supervision, accept long-term guidance of and responsibility for their 'god-child'. Traumatized child- and adolescent refugees need a feeling of belonging (Melzak 1995), only a minority of them need actual therapy. This is under the condition that there is a possibility, which allows other people being available to care for the unaccompanied child refugees, who have time for them and give emotional support. Sponsorships are one of these possibilities. They can contribute to a feeling of security for the children and adolescents, to build up self-

¹⁵ A concept developed by the English psychiatrist, Michael Balint, whereby colleagues work in groups to discuss cases from their practice; the resulting dynamics of the discussion mirror the problematical characteristics of the case and become, therefore, a key to understanding it.

¹⁶ Among others, the Medical Foundation, London; the Asylum Coordination of Austria, Vienna; the Therapy Centre for Torture Victims, Cologne.

acceptance and self-esteem. Not only will help be offered in dealing with the many difficult daily tasks, but also an environment created for good, stabilising experiences (Krainz 2002).

A sense of belonging to a group of fellow nationals and existing refugee-communities should - according to the wish of those involved - be supported and, according to need, aided financially¹⁷. Refugee communities, as well as other nationals, who already live in the country of exile, can have the function of protective networks. As shown in 2.2.1, the lack of social support has an adverse effect on the development of psychic- and personality disorders (Fiedler 1999). As in all children, and especially adolescents, the possibility to make friends plays an important function in the development and forming of the personality. It enhances self-esteem, the understanding of justice and morality, the experience of symmetrical relationships and the ability to understand others (Oerter & Noam 1999).

2.2.3 Guardians

Unaccompanied minors up to the age of at least 18 years, preferably up to the age of 21 years, should have a guardian. A guardian should, with regard to the special needs of traumatised child- and adolescent- refugees, be as well-trained and capable to build up a trusting relationship as in 2.2.2 for bonding figures outside the family. Over-worked guardians from the authorities are not suitable for the special situation of unaccompanied minors. From a cultural point of view, the concept of a guardian, as well as the concept of a sponsor / ‘god-parent’, is used widely in many cultures (although maybe with a slightly differing focus) and therefore understandable for people from many cultural backgrounds. Refugee children and adolescents who come from societies with a more role and group based understanding of the personality (rather than the more individual understanding of the personality as in Western societies) expect that there are adults who have the authority to guide them, who give them advice and whom they have to respect. As one adolescent from Eritrea put it: “I need guidance and advice. My tutors in my children’s home always tell me that I have to define what I want, I should tell them if I dislike anything. But it is them who should tell me what to do. I cannot just say, no I do not like that. I want to have somebody who cares, who knows me and guides me.” (16 year-old girl from Eritrea, living in Germany)

As shown in 2.1.4, adolescents, who have suffered traumatising, up-rooting and the learning of a new culture and society, are not so stable once they reach the age of 18 years that they experience themselves as being adult in every aspect, or are seen by other to be so¹⁸.

2.3 Accommodation

Favourable conditions for growth can be greatly influenced by the standard of living. As stated earlier, poverty and unfavourable accommodation increases the risk factors to the development (Oerter 2002). One can assume, that most of the community homes for refugees are not appropriate for the special needs of children and adolescents. Also, there are often risk factors in that single adult refugees live together under very crowded circumstances with families and children – these unfavourable circumstances may lead to sexual harassment, especially for single mothers and young girls.

2.3.1 Families

¹⁷ e.g., through paying travel costs, when refugee-communities live outside the town

¹⁸ It is vitally important to conduct research and also start new projects concerning the interim-period between the ages of 18-21 years; this should be specifically devised for this phase of life. A model-project is currently being developed, e.g., from the Red Cross Trauma Centre in Sweden.

Families with children need adequate space for living, which, according to the age and gender of the children and their cultural needs, enables them to differentiate their relationships with the family and to respect generation boundaries. In practice, this means that adolescents should not be expected to live in the same room as their parents, especially adolescent boys should not sleep in the same room as the mother. It is still happening in asylum hostels that, for example, Muslim single mothers from Kosova are expected to live and sleep – for years - in the same room as their adolescent sons. This is unacceptable from a cultural and psychological point of view under normal circumstances, and in cases with traumatised refugees additionally so from the point of view of prevailing sleep disturbances, nightmares, screaming and enactments at nights.

The accommodation must be so devised as to guarantee the protection of women and children in particular and, above all, young girls. Institutions should take care that the room capacity allows for self-sufficient cooking facilities, whereby self-determination, independence and control over individual living conditions is preserved, at least with regard to nutritional values. Nourishment has an important function for the maintenance of health and is strongly determined by cultural norms. The control over their own accommodation, or the possibility to re-gain this, is especially important for traumatised people. The living quarters should include adequate possibilities for occupation and for children to play. Play is an important prerequisite for children to achieve a healthy, individual development. Through play, they express in their own way their experiences, feelings, and desires and needs, they engage in trial behaviour relating to their fantasies and solutions to problems, they develop meaning and creativity (Schmidtchen 1999).

Traumatised children often develop anxious, repetitive play- behaviour patterns; on the other hand, play is a possibility for them to express what they have experienced (Weinberg 2000; Fischer; G. & P. Riedesser 1998). In addition, traumatised children often, as a result of hyper arousal symptoms, which are part of possible symptoms developed as a result of traumatisation, display a hyperactive behaviour they need a stimulating and secure environment for playing. For these children it is especially important to have enough but also safe places where they can play. Places like asylum ships in harbours, for example, are completely unsuitable because of the imminent danger that a child will fall into the water – as happened in a city in Germany. Equally, in houses with many floors, the windows of the rooms have to be equipped with mechanisms that can be closed safely by the parents so that children do not fall out of the window – a real danger because of the hyperactivity of traumatised young children. Again, in a German asylum home, there were two instances in which two children fell out of a window and died because the windows could not be closed at all.

2.3.2 Unaccompanied minors

Unaccompanied minor-refugees have special needs for social- instructive care and support. They live under high pressure to conform and adapt to a new culture with other “unwritten“ laws and to come to terms with school and language requirements. Their accommodation must, therefore, be carefully selected to suit their needs. Large youth hostels with insufficient offers of care and support are totally inappropriate. Another question that must always be considered is whether it is suitable to offer accommodation together with children and adults from their respective exile country. They are often living together in institutions with children and adolescents from problem- families with difficult behaviour, which might place too high a demand on those involved (Jordan 2000). With regard to the importance of peers for the development of adolescents (Oerter & Noam 1999), it is essential to group children and adolescents together in homes and community groups according to their age and maturity,

their social and cultural background and their specific psychological needs. In all types of accommodation there must be, on the one hand, adequate care and support, and, in addition, help to further age- and development-related independence and assistance with integration in the country of exile.

As one girl from Ethiopia put it: “The children’s home is like being at home for me, my care takers are like my aunts, they know my problems and help me. They have told me that, when I’m 17 years old, I must start to live more independently, I’m afraid because where I come from, nobody lives alone, but they will help me.” (15 year-old girl from Ethiopia, living in Germany). The care takers in children’s homes, in which traumatised refugee children are living, must have the possibility for adequate training and supervision on a continuous basis.

2.4 School education

School education is an extremely important stepping-stone for social-educational development and the possibility to integrate in country of exile. Language-learning and school education are closely linked, as most child refugees have to first learn a new language. As shown by the development tasks (s. chap. 2), success at school, especially for children between the ages of 6 - 12 years, and the possibility to be “industrious“ is of central importance - in keeping with the motto “I am what I can“. Failures, setbacks, and the inability to build on previous school achievements, can cause serious self-esteem-complexes and crises. This applies in the same degree to traumatised child refugees, for whom school itself, as well as the opportunity to learn, reflect the desired island of normality. In addition to acquiring knowledge, learning includes the developmental possibilities of motivation, thought and task-consciousness in a group (Mewe 2000). Parents and families often delegate commissions to their children to achieve a good education, which can be experienced by unaccompanied children and adolescents as a bequest. They feel obliged to fulfil these. As it was said by an adolescent boy from Angola whose family was killed during a raid on his village: “I believe that my father wanted me to learn, I do believe it, I must learn a lot.”

Accompanied and unaccompanied child- and adolescent-refugees often encounter huge difficulties connected with their wish for success at school; mostly, difficulties in learning the new language and problems related to the results of their traumatisation, e.g., concentration problems, tiredness due to insomnia, or frequent headaches. It is crucial that teachers are familiar with the consequences of traumatisation and flight¹⁹, to enable them to recognise the obvious as well as the unnoticeable problem children; they can support them emotionally and educationally and, when necessary, refer them to suitable therapists. Schools have an important preventive function; on the one hand, because of the content of its syllabus and, on the other hand, because of the possibility to get to know the children and adolescents in a setting outside the family (or children’ home) and thus become aware of their possible problems (Tuk 2000). Children and adolescents should be enabled to visit normal state schools according to their abilities (Jordan 2000). The type of school should, in the first place, suit their abilities and not their age, or the school form visited in their native land, or their status of residency. A qualified school-psychological assessment and counselling with professionally trained educational-psychologists is essential here. Language learning should include the language of the respective native country as well as the language of the country of exile.

¹⁹ e.g., a relevant training for teachers of all school forms is offered by the Pharos Foundation in the Netherlands (Patricia Schell, unpublished lecture, Nov. 2001, Cologne).

2.5 Training

In some European countries, for example in Germany, adolescent refugees do not have free access to the training possibilities such as apprenticeships. The access to apprenticeships is dependent on their status of residency and in some cases excludes the access to training, which is especially favoured by local adolescents / young people. This, in practice, could mean that a severely traumatised adolescent, whose family was murdered during the genocide in Rwanda, is only allowed to train as a butcher. This actually happened in one German town and was a really gruesome experience for that person.

Under psychosocial aspects, training or further education offers the adolescent or the young adult:

- Further development of independence
- Training of skills
- Pursuit of long-term life-planning
- Perspective of financial independence
- Community participation in the form of learning a role which makes a contribution to society
- External acceptance and self-esteem

Each of these aspects enhances the strengthening of a coherent identity and is effective as a protection factor (Fiedler 1999, Jordan 2000, Irmeler 2002). Erdheim (1982) describes the phase in which adolescents learn a trade or profession²⁰, in accord with Eißler, as the phase of the “second chance“, in which the effects of previous trauma can be counteracted. Employment is a central element of this possible process. Illusions of greatness or omnipotence, that often plays a role as a compensation mechanism against suffered trauma, can be counteracted, in that the adolescents are confronted with the associated requirements and social process of employment. Without employment, these unrealistic self-images remain intact and unquestioned; the consequences can be physical neglect, delinquency and psychosis. Erdheim assumes by “broken adolescence“, that the wish for self-fulfilment through a suitable, skill-enhancing employment has been discarded (as in the example of the boy from Rwanda, see above); a forced, unrealistic role is then lived.

A further unfavourable development is seen by Erdheim in the “burnt-out adolescence“, in which it comes to a coexistence between further maturity and the continued operation of harmful influences from the time before adolescence; a “second chance“ does not take place, all skills are imbued with negative, destructive omens; social ties are, on the other hand, weakly represented, rationalisations predominate (Erdheim 1982). The course of adolescence decides which solutions are decisive in later adult life. Society takes a more important role here as in early childhood, i.e., which training - or employment – possibility it provides. This is particularly important for adolescents and those shortly to reach the age of maturity, who have had to deal with traumatic events out of their past biography.

For unaccompanied adolescents, who cannot rely on a family network, learning a trade or profession is existentially important. The eventuality is also increased of a possible desire to return to their native land. Traumatized adolescent-refugees should have the opportunity to complete training, either practical or theoretical, according to their skills or inclinations, and to get an appropriate status of residency to enable them to pursue this purpose. This potential

²⁰ This is the phase of late-adolescence.

of unlimited residency, which concurs with the non-discrimination stipulations of the UN Convention on the Rights of the Child, should be made known to them as soon as possible after their arrival in the country of exile or at least long before they reach the age for commencing a training. In this way, their psychological well-being is promoted, motivation is strengthened to learn the new language and achieve the school certificates.

In practice up to date, children and adolescents often hear right after their arrival in the country of exile that they are not allowed to access the same education as local children and that they are not allowed to learn a profession. This is conveyed to them by some care takers who are maybe not informed enough about the possibilities to fight against restrictive regulations, by teachers at schools or even by people from the employment boards. It is extremely discouraging, often children and adolescents say: “Why should I learn, why should I bother, there is no future for me, I’m not allowed to learn the profession which I would like to anyway, I’m not allowed to learn anything.” (17 year-old boy from Sierra Leone, living in Germany)

2.6 Cultural aspects - loss and integration

Eisenbruch (1990) described the many-sided experience of the loss of one’s native country, social community and the related cultural meaning patterns, as “*cultural bereavement*”. He refers to the experience of loss and the grieving process. According to Winnicott (1971), cultural experience begins in the earliest relationships between the infant and his bonding figure. In this context, it is understandable that the process of cultural *bereavement* lasts a long time, if not life long. Adolescents have a much longer inner-experience of their native culture as is superficially apparent (Eisenbruch 1990). Culture gives people a sign and mode as to how they themselves can understand their values for their family, their society, how they can interpret sickness, healing, health, the changeability of life, spirituality and life itself, and also how to deal with it. Geertz (1987) described culture as a “richly woven fabric”; every individual is part of a specific fabric. Anthropologists’ and psychologists’ studies confirm that people invest a great deal in order to maintain their cultural patterns (Richman 2000, Fabian 1983). This makes problems for refugee children who live in exile with their parents: the children want and must “learn“ the new culture; on the one hand, their parents may want this; on the other hand, they experience anxiety about loss. Therefore, culturally tied patterns for raising their children are often all the more restrictively applied.

Young girls suffer mostly from this fact. The conflicts assume greater proportions; the more the goals of the native culture differ from those of the culture in exile. Such conflicts lead to insecurity of identity and sometimes to mental illness (Richman 2000). It may happen that the boys in a refugee family are “allowed” to adapt much more into the culture of the host society than the girls of that same family. Depending on the abilities, the energy and the loyalty towards the more or less conscious wishes of their parents, these girls might succeed to make steps towards the new culture or they withdraw into the parents’ home and expectations or they might develop signs of more severe symptoms.

Unaccompanied minors - and also the accompanied - are confronted with the task to learn to live in two cultures and, in the most favourable case, to develop a “third“, their own (Irmeler 2001). This is a life-long process, accompanied by feelings of winning or/and losing; this process takes place in phases and on different psychological levels within the person. It is certainly not a process that has a definite end at one single point in time. Bonding figures are helpful in overcoming the associate problems as they function as “bridges“ between both

cultures. They can be especially helpful in supporting unaccompanied child- and adolescent-refugees to retain realistic pictures of their native culture, because these also serve as an orientation regarding what is expected of them. Expectations are important as a guiding factor for the development. The more or less conscious attitudes of the bonding figures and carers to the native culture of their refugee figures encourages or impedes a healthy grieving process as in “cultural bereavement“ (Eisenbruch 1990). As shown in chap. 2.2.2, training possibilities for external bonding figures regarding culture-orientated topics is of great importance. Richman(2000) suggests the following measures to support not only child- and adolescent refugees, but also their parents:

- Encouraging the continued use of the mother tongue, either at school or in the supplementary lessons;
- Local projects, in which, on the one hand, the resources of the refugee-community are strengthened through *oral* history and cultural activities, and on the other hand, the opportunity given for children and adolescents to learn something about their native country.
- Instruction and training (for those involved, including the bonding figures) about how children learn about life in two cultures and how parents can deal with it;
- Contact with people from the country of exile;
- Activities to encourage tolerance and discourage racism.

The model-institutions for adolescent-refugees, in which the young people can live for a defined limited time and in which integration is one of the main topics dealt with, is a further possible measure²¹.

2.7 Medical, psychosocial and therapeutic care

The aspects of the therapeutic care will be extensively dealt with in the next chapter (chapter 3) and the source texts; the psychosocial care was discussed in this chapter. At this point it should simply be summarised, that traumatised child- and adolescent-refugees must be allowed unlimited access to medical and therapeutic care - to the same extent as the indigenous population. Access and care should not be impeded by asylum legislation or regulations and/or should not be limited. This would not conform to the UN Convention on the Rights of the Child.

Nevertheless, it is happening in European countries such as, for example Germany and Austria, that medical care is restricted to just the basic emergency care for those refugees, including children and adolescents, who have not yet been granted a permanent residence status. In other countries, such as, for example, the Netherlands, Sweden and Denmark, refugees are entitled to the same medical provisions as the local population. The individual elements of the medical, therapeutic and psycho- social care should be synchronised to cooperate with one another. This is especially important in cases of unaccompanied minors because normally the parents hold that “coordinating” role. Those employed in the health system - doctors, nurses, psychologists, midwives, physiotherapists, etc. - should be informed in their basic training about the consequences of traumatisation, flight, and life in exile, i.e., have the possibilities for relevant training at a later date.

2.8 Literature

²¹ The “Project-Integration-House“ in Vienna is named as an example in which different areas are worked on individually and in groups: language-learning, investigating possibilities for employment, inter-cultural topics.

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3. Recommendations for the treatment of child refugees and migrants – theoretical and practical aspects

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Definition

Migration and flight as a significant cause of psychic stress are no new phenomena. In the period following the 2nd World War alone, for example, 10 Million exiles, refugees and voluntary returnees came to Germany in 1950, comprising 20% of the population (Hettlage 1988). Their individual fates relating to their migration, as well as their specific coping-mechanisms, were the focus of interest in psychiatry and psychotherapy. Grinberg and Grinberg (1990 s. 14) attempted the following definition of migration based on sociological knowledge: “Migration is the act and the consequence of the transfer from one country to another in order to settle there“. Flight, being one aspect of migration*, is furthermore defined as the degrading necessity to change places of dwelling accompanied by the involuntary breaking-up of relationships (Brucks, 2001). From the point of view of child- and adolescent-psychiatry there are developmental-psychological aspects to consider, giving the following definition: “A child-migrant is a child up to the age of 18 years, whose biography is marked by a sometimes life-long process, which can swing between the poles of voluntary travels, on the one hand, and compulsory flight on the other. If the child, i.e., his parents, have also experienced war, civil war, or another form of “organised violence“ (Geuns 1987) and, as a result of this, the child has had to leave his country of origin, then it concerns a child-refugee.”

Child-migrants and -refugees are often exposed to psychic stress over and above that of the “normally to be expected“ stress, they can consequently develop a large number of the well-known child and adolescent psychiatric disorders. Psychological assessment, treatment and rehabilitation appropriate to their problems are necessary according to child and adolescent psychiatry. The influence of the “quality“ or form of migration on the patient’s disorder must be considered in all these steps. Social medicine and social psychiatry have often recognised premature physical “worn-out“ symptoms, psychosomatic and mental illness as well as familiar crises following the psychosocial stresses induced by migration (s. Leyer 1996; von Klitzing 1982; Real 1995; Valiente et al. 1996). The psychopathology of extreme stress situations, particularly those following persecution and imprisonment in concentration camps has been investigated for the first time in Germany from Baeyer, Häfner & Kisker 1964. They discovered that the loss of the familiar environment could result in long-term mental disorders, this also applying to “not quite such radical turning-points in social existence“. It is furthermore known, that the culture in which a person grows up has a great influence on his thought, feelings and behaviour and the “cultural filter“ through which the world is perceived (McGoldrick 1982) plays an important role (Leyer 1996). The significance for the development of psychiatric symptoms in children and adolescents of the traditional values and norms and the experience in the surrounding “mainstream society“ following migration is referred to in various studies (s. David 1998; Greenberg et al 1997; Hovey et al 1996; Sack 1998; Steinhausen 1983).

* In the following text, the reader has to keep in mind that the term “migration“ is used here as the umbrella term – accordingly “flight“, under the definition in use, is one specific form of migration and can inclusively be meant even if not stated specifically.

3.1 Main symptoms

Specific main symptoms do not exist in migrant children, rather it would be more important to gather information in general appertaining to the previous history of all children who do not conform to the norm to ascertain whether migration is significant. Migrant children are often, but not always, exposed to psychic stresses before, during and after migration. They develop specific adapting- and coping strategies, that can temporarily function in the sense of encouraging development but can also lead to a masking of symptoms i.e., chronic development of a deeper-lying disorder. One should also be aware that in children and families who are less psychologically troubled, coping strategies might not deteriorate until after migration, only then making symptoms evident. Frequent symptoms of psychologically troubled child-migrants are:

- Social withdrawal,
- Anxiousness,
- Sleep disorders,
- Indefinite pain,
- Dissociation,
- Enuresis,
- Encores (Poustka 1984),
- Learning problems,
- The danger of suicide (Storch & Poustka 2000; Steinhausen & Remschmidt 1982).

Observations of psychic traumatisation of children through war, flight and persecution had already been in the 1940's (Solomon, 1942; A. Freud, 1949). A growing number of publications followed, which were concerned with the diverse consequences for children and adolescents of different forms of catastrophes ("man-made disaster" and "natural disaster") (Bloch, Silber and Perry, 1956; Eth and Pynoos, 1985; Garmezy and Rutter, 1985; Jensen and Shaw, 1993; Keilson, 1979; Kuterovac, Dyregrov and Stuvland, 1994; Terr, 1979; Terr, 1991). In the "International Classification of Diseases" (ICD-10) (World Health Organisation, 1991) there is no difference in the diagnostic formula "Post Traumatic Stress Disorder" (PTSD) made between the symptoms of children and adults. A special pattern of symptoms, however, is described in the "Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)" (American Psychiatric Association, 1994).

In addition to the three main groups of symptoms observed in adults (hyper- arousal, intrusions, extrusions) this includes the following ((Saß, Wittchen and Zaudig, 2000):

- Agitated behaviour
- Play, in which themes and aspects of the experienced trauma are repeatedly expressed.
- Intensive anxiety-inducing dreams without recognisable content
- Trauma-specific scenic repetition of actions and feelings.

Furthermore, after the experience of "man-made disaster" through forced migration i.e., flight, disorders must be considered that originate from the disturbance of trust in the "world" and the "self".

This often results in an

- Inability to make relationships,
- General distrust,
- The inhibition of fantasy and play,
- Regressive behaviour and/or
- Over-adaptation to the new environment.

Behaviour models from parents are often accepted unthinkingly in times of external change and psychic symptoms “copied“. Development tasks far in advance of their achieved stage of development are forced on the children by their parents (parentification); on the other hand, parents feel themselves to be weak and helpless, cannot comfort their children (infantilisation). The children often suffer the loss of the seeming omnipotence of the parents.

While concepts of self are mainly influenced through gender, age and the immediate environment, the “familiar self“ is, according to Steinhausen (1983), mostly more lastingly influenced by cultural factors. Particularly migrant families of the first generation, shortly after their arrival in their new country but still under the influence of the socialisation factors of their native country, often show an understanding of the family typical of that experienced in their past.

According to clinical experience, migrant children often find themselves in an “intrapsychic interim-world“. They want to settle in Germany and have invested hopes in their migration, i.e., flight. They are, however, often not able to make use of the context they encounter, and are unable to discern a perspective for themselves. A voluntary return to their native country is mostly impossible, as the governing social-economic context there is worse than that in the country of exile. An intrapsychic interim-world is created for migrants and refugees. They are open to ambivalent feelings, on the one hand, wanting to return to their country of origin but, due to the obstacles found there, are not able to realise this plan. On the other hand, they want to be in the country of exile but cannot find an opening for themselves. These opposing wishes and feelings, which are difficult to integrate psychologically, can pose an additional burden to the individual in the context of the migration process (Adam 1999).

3.2 Sub-groups

Migrant- i.e., refugee-children:

- Children born in families, before/during migration/flight
- Region of origin with high “pressure of migration“, no violence
- Region of origin with similar violence potential as in West Europe
- Region of origin with shorter experience of violence
- Region of origin with chronic experience of violence enduring war, civil war)
- Families with high/low reflexive functions
- Children born in families after migration/flight
- Children with interim stay without their parents during migration, flight over a period of more than three months
- Children with/without staying in country of origin for a period of more than three months a year (temporary re-migration)
- Children who became “perpetrators“ (e.g. in war) during the migration/flight
- Unaccompanied minor migrants/refugees
- Biographical details hard to validate as no relatives to be found, degree of actual stress in exile to be categorised:
 - Length of right to residence
 - Frequency of liability to punishment
 - Participation in the social environment

3.3 Assessment

Problem-orientated:

The following aspects are to be noted in the assessment of children:

- The type and degree of experience of stressful situations before, during and after flight.
- Compiling of protective and helpful factors from the point of view of the child.
- Compiling cultural- and family-orientated coping strategies regarding the flight, but also regarding other stress factors.
- Subjective, possibly culturally orientated experience of sickness.
- How have the primary bonding figures reacted before, during or after the migration/flight?
- Was there a manifestation of new or previously existent symptoms, or a change of symptoms?
- Which memories are helpful, and which are stressful?
- Are there specific, recurrent play-scenes, children's drawings, and dreams?
- What does the subjective balance of migration/flight look like?
- What are the statements of the child/adolescent regarding native region and age?
- Have there been verbalised wishes to return, is ambivalence about this evident?
- Are there signs of guilt in dealing with the past life, or even a perpetrator-identity (child-soldier)?

The following aspects are to be regarded in the inclusion of the bonding figure of the therapeutic process:

- When this is not the parent: how long has there been contact with the child, to the unaccompanied minor migrant/refugee?
- What is known about the circumstances before, during and after the migration/flight, how and where do other relatives, family members live?
- Were parents or bonding figures physically present during migration/flight, i.e., accessible emotionally?
- Who belongs to the family, what is the culturally specific definition of the family?
- Were psychic or psychosomatic symptoms related to migration/ flight, i.e., with stress?
- What is the actual legal status of residence?
- Was there a change of town in the country of exile or a special school for refugee children?
- Which notable changes in the development of the child were apparent to the bonding figure before and during migration/flight?
- What is their subjective balance of the migration/flight, which differences are there between this and that of the child?
- Which unspoken, possibly culturally orientated delegations to the child exist?
- Which statements do the bonding figures make about the region of origin and age?
- Is ambivalence about returning able to be spoken about, or not?
- Do the bonding figures have secrets, possibly about their own perpetrator-identity?
- Was it possible for the migration/flight to be prepared?
- Which family members took flight?
- Who was left behind?

- What was a possibly traumatic situation for each member of the family like? Which significance does violence, persecution and flight have?
- Are there psychological reasons (traumatic processes, grieving processes) to impede the development of speech?

Scenic information is particularly significant in discussions with the parents and family in order to come into contact with them about difficulties of access as well as about the hopes and wishes for the therapeutic contact. Parents often do not want to burden the children with the background details and facts of war, persecution and flight, the children do not want to ask in order not to expose the parents, thus a “pact of silence“ can be created, that should be worked on. Professional therapists, and, in particular, institutions are attributed a tempting omnipotence to be able to change the external world, in the sense of psychic defence mechanisms against individual helplessness. This can lead therapists to overlook serious problems and conflicts and to give the families “short measure“ with a social-psychiatric quick-intervention. Particularly in dealing with severely traumatised refugee-families adequate supervision is required, in order to deal correctly with the feelings of anxiety, anger, shame and guilt in the therapeutic team.

Development-orientated:

We know from modern research into infancy and bonding, that the infant’s experience of relationships in early childhood from the first weeks and months of life is imminently important for the development of a trusting relationship between the parent and the child; and also the assurance needed to find one’s way in the environment and encounter difficulties is strengthened. In the development of every child there evolves, before and after the birth, independent of the culture in which he lives, an extremely complex network of relationships between the child, his primary bonding figure and his environment. From the psychological point of view of the child, the developmental lines of the child must be focussed on, the developing infant being confronted with various development tasks on his way to becoming an adult, autonomous person; which lines, particularly in childhood and adolescence, follow each other in a relatively rapid sequence.

This extremely complex network of relationships is influenced externally, by crisis, war and exile. A symptom can only be understood in the context with the various development tasks and -stages. An infant will, therefore, react differently as a toddler, a schoolchild and an adolescent. If the child’s abilities to signal anxiety and to cope are overwhelmed by a traumatic event and the child is confronted with an extremely threatening sense of helplessness, alarm reactions are produced that are partially described in the symptoms of post-traumatic coping strategies. These symptoms are not to be viewed as primarily pathological, but firstly as psycho-biologically meaningful alarm reactions and as attempts at coping. They are, partially, complex preventive-measures that the child develops in order to cope with the traumatic experience and to prevent a re-occurrence of it.

Whether an event is traumatic or not depends, therefore, besides the type and length of the “traumatic situation“ (Fischer & Riedesser 1999), entirely on the child’s cognitive, emotional and social stage of development. The whole constellation, in which external factors confront a child in a certain stage of development are of central significance, and, from this point on, is invested with a very specific meaning dependent on the development. Real or distorted perceptions are combined to shape the fantasy and mobilise the whole spectrum of functional and dysfunctional defence- and coping strategies, which can lead to specific symptom patterns, e.g., in the form of PTSD, but also to other symptoms (e.g., severe regression, feelings of guilt, etc.)

Through the course of time, post-traumatic constellations, e.g., the family situation and the social environment, are of considerable significance for the possibilities of dealing with the traumatic processes. Schools and play-schools are an important starting-point for therapeutic help. Additional developmental stresses, particularly the relationship to the primary bonding figure, influence the diagnosis and needs for treatment. Disturbing psychosocial conditions, such as the separation of the parents, mental or physical illness of one or both of the parents, or the loss of near relatives, should be investigated.

This is, however, often difficult to do. Especially with unaccompanied minors, the need to live with a legend plays a big role - whether it serves as a defence against stressful and conflicting memories, or as a "recommendation" from the transit-organisation involved. This applies as much to children and adolescents, who have been actually affected by organised violence, as to those affected by flight, from poverty or the family. Everyone who tells his story chooses, consciously or sub-consciously, a possibly glorified or selected part to relate.

Making a diagnosis, one has to be aware that there is no such thing as an "objective biography", rather that the way in which this is told and interpreted depends on many factors:

- From the ability and the wish to make order out of often chaotic and therefore traumatic experiences.
- From the previous history of bonding- and separation experiences and the wishes and needs of adults regarding war, which are mostly marked by unreliability, threat and disappointment.
- From the age-related ability of the adolescent to perceive external events, to reflect and develop adequate possibilities to act.
- From the ability to connect with the past, despite stressful experiences and to use it as a resource.

It is important in contact with unaccompanied child- and adolescent refugees to discover something about their history, and to understand their strengths and their life-experiences, onto which they can positively build. Indeed, one cannot, as with some refugee families, count on the parental statements and biographical descriptions, but must concentrate on those experienced and interpreted by the adolescents and individual family members. Even when the story told is, in the first instance, not correct, the way it is told, with embellishments and in discrepancies, can mirror the individual situation. The chance must then be utilised, not to rely so much on the "objective reality", but more on the subjective world and story as it represents itself in the interaction with the therapist and the institution.

Context-orientated:

An offer of assessment and treatment is to be made when necessary, independent of either the situation regarding health insurance or the right to residence. The granting of a "therapeutic right of residence" should be made. Furthermore, there should be an initial clarification of the treatment contract. Here it is necessary to differentiate between the agreement to a diagnostic procedure, or whether it is in order to achieve an evaluation or written expert opinion. This differentiation must be cleared with the parents, on the one hand, and with the relevant social- and educational professional workers on the other hand.

In the first contact, it is indispensable to engage an independent translator and to make a clear reference to confidentiality, as well as explaining about the possibility of refusing the translator without stating reasons.

A frequent problem is the integration of migrant children in the appropriate school classes, as there often is a language problem, which does not allow the child's actual cognitive stage of development to be recognised, resulting in the under-stimulation of the child. They are often much older than the rest of the class. On the other hand, specific development disorders remain unrecognised due to the language problems and adequate learning is impeded by the lack of help with homework (the parent's insufficient knowledge of the language of the country of exile). Parents fear a "negative cultural influence" of the school on the children, but do not work together with the school or with the other institutions.

It is recommended to confer with the translators during the assessment phase, because there can often be difficulties in keeping appointments in the day-patient setting. The frequent long journeys to the remote social catchments-areas lead to cancellations, thus making assessment difficult. Families and/or social workers often see psychological or psychosomatic disorders as being solely affected by specific circumstances in the individual's life-context. The "socio-legal" topics that are introduced (residency, accommodation, work, request for a doctor's certificate) are, thus, often a "presenting-problem". A state of tension occurs between the individual concerned, the social workers and the doctors/therapists. A position of power can be created on the therapeutic side, so that, ensuing from the background of psychiatric history, hope germinates that migrants and refugees can be "saved" from further persecution by certificates/expert opinions.

It is not uncommon that crises of suicide occur in particular social circumstances, especially when residency expires. In this atmosphere of political tension, the introduction of other treatment- and diagnostic centres can often not be avoided, which influences the decision about further day-patient/residential treatment. Child refugees in particular can be abused through third persons wanting to achieve political goals; on the other hand they often are marginalised because of racially motivated reasons.

3.4 Special aspects of assessment / diagnosis

Cooperation with the family is often difficult because of language problems and sporadic contact. Better opportunities for assessment of problems exist in a partially-residential setting, such as the assessment of school problems, delayed development, or possible intelligence disorders, as it is possible to observe the children over a long period of time and to also experience them in other social contexts. During an admission to a hospital or clinic for the purpose of diagnosis, the intensive effort of social workers and also translators is necessary. The introduction, or changing, of a therapeutic procedure to further the child's welfare, is more likely in a residential than a non-residential setting. The wish and need for protection, for "therapeutic asylum", must be focussed on and dealt with, with the resulting effect on the dynamics of the team.

3.5 Literature

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4. Consensus on treatment phases for traumatised refugees

This consensus on treatment phases for traumatised refugees was achieved during two workshops held during the project in 2001. These treatment phases were also being discussed during the two workshops in 2002, which focused more on traumatised children and adolescents. It became apparent that there is wide agreement that these phases are relevant in all different therapeutic approaches and for all ages.

1. Stabilisation – social, psychological (can be very time consuming, dependant on a stabilising environment)

Traumatised refugees in particular have experienced severe ruptures in their lives. These ruptures include geographical, cultural, social, professional, family, spiritual and other aspects of their lives. Most of them have undergone processes, which they were never able to imagine before these experiences occurred to themselves. In many cases, they had no opportunity to prepare themselves emotionally, intellectually and/or practically or their children. To the opposite, in re to children, very often, parents try to hide – if they possibly can – the fact that they may have to flee and leave it to the last minute to inform them vaguely. In most cases children are not told the whole truth because the parents themselves don't know what the future holds for them. Unaccompanied minors rarely ever know what is ahead of them when they have to leave their home.

Therefore, after traumatised refugees arrive in the country of exile, where difficult asylum procedures are awaiting them in addition to an uncertain future, stabilisation of the person concerned is of vital importance. Mostly, newly arriving traumatised refugees are torn between relief, exhaustion, hope and despair – this is so for children, adolescents and adults. By stabilisation is meant that all aspects of the person's life should be discussed, assessed where help and realistic perspectives for the future are needed, the person should get a sense of "being grounded" again, emotionally and socially. Emotional stabilisation may be a very complex process for traumatised refugees because their trust in the world, in human beings as such and in themselves may be completely shattered. Emotional stabilisation means mending the identity of the traumatised person. This process may also be very time consuming and difficult because of the often very destabilising and unpredictable asylum procedures.

2. Trauma metabolisation (e.g. testimony, art therapy methods)

Therapeutic work on the traumatic experiences can only be done when a certain degree of stabilisation is achieved. The aim of this phase is that traumatic experiences loose their pathologic power over the development and well-being of the person. It is hoped that traumatic experience, in the end, will be integrated into the person's biographical and psychological self-awareness in such a way that they do not have a sustained overwhelming, dominating, destructive influence. Some therapists hold the position that this should only be done after refugees have been granted a permanent status of residency. In practice this is difficult because of the sometimes very long asylum procedures, which can take several years (in the case of traumatised refugees from Bosnia it took up to seven years before they were granted permanent residency in Germany).

In addition, some traumatised people – adolescents as well as adult do want to talk about what happened to them in detail. However, there always needs to be a careful monitoring and steering of this process from the therapist. Also, work on trauma metabolisation and stabilising are not clear-cut, separate phases. Often they are mingled. It has been widely acknowledged that non-verbal therapeutic methods such as forms of art therapy, imaginary techniques and EMDR (Eye Movement, Desensitisation and Reprocessing) may be of great help during the process of trauma metabolisation.

3. Integration and rehabilitation

Responding to complexity of life

Traumatised children, adolescents and adults have to and often want to go on living a “normal” life. However, very often they find themselves not being able to do so because of their traumatising experiences, up-rooting processes and the complexity of having to live in a new country. Adolescents and adults very often have suicidal tendencies. Traumatised children and adolescents characteristically have an uneven development often with set-backs during transitional or difficult phases (being introduced to school, exams, having to move from one place to another, changes of care takers, teachers etc.). Often, their tolerance for frustrating experiences is very low. Children, adolescents and adults alike need help and assistance to face and respond to the “normal” complexity of life.

Growth

Traumatised children and adolescents are in the midst of their psychological and physical development. They have to tackle all tasks going along with their development in addition to coming to terms with traumatising experiences. Those are the background of their developmental processes. It is the task of their care takers, parents and/or therapists to help them to grow without the traces and symptoms of their experiences becoming a negative sustaining element in their lives.

Hope for future

The symptoms of depression are very prevalent after traumatising experiences. Underlying depressions can be shown in various different ways according to age. Younger children tend to regress - they do not practice things they were able to do before (speech, being able to go to the toilet, playing with other children, being able to concentrate etc.). Adolescents often show no interest in normal activities including learning, develop no plans for their future, have open or hidden suicidal thoughts, engage in risk behaviour such as alcohol or drugs etc.

Yet, realistic hopes for the future is the most important ingredient to feel able to tackle all the difficulties of a “normal” life and in addition all the difficulties which arise out of their traumatising experiences and the complexity of their asylum processes. Therefore, to build on hope for the future is one of the major tasks to work on for any care taker and therapist. This is so for traumatised minors and adults alike.

Being able to mourn

All traumatised children, adolescents and adults have had losses of many kinds. Without looking back, future is not possible. It is vital that good memories are kept and not split off; bad memories should be understood, not generalised or split off. Processes of psychic defence mechanisms like splitting off absorb energy, which they need for their normal growing up processes.

Traumatized children and adolescents have a life history before the traumatizing events, before the up-rooting process took place. They need to understand where they come from and be able to mourn about the losses they had in order to gain energy for their developmental processes and their future.

Being able to work on cultural identity

The process of up-rooting and having to live a new life in a new country means that the cultural identity which children, adolescents and adults bring with them doesn't "fit" any more into the cultural web of the new society. They have the task to work out in what ways they have to learn new ways, in which sense they can/want to adapt, what they want to keep and nourish from their culture of origin. This is a complicated, often life long process which takes place in phases according to age and normal life phases. It requires a lot of emotional awareness, flexibility and courage, and it is a reflexive process which is also influenced by factors from the exile community.

Finding a meaningful (post-traumatic) role in life

During the normal process of growing up, children are aware that one day when they are adults, they will have a certain role in their respective society and for their families. This knowledge is a "given" that goes without saying, yet it is one of the underlying motivating factors. Children, adolescents (and adults) who had to leave their countries and seek exile in a foreign society have lost this obvious and natural role. The role they will have in life – in many ways – will never be the one that they would have anticipated, been delegated or worked for before the traumatizing events and the uprooting took place. The process of working out a meaningful, authentic and not hate- or revenge-dominated role in life is far more complex for traumatized refugee-children and adolescents than for children without these experiences. Again, it requires emotional awareness, flexibility and courage to achieve it in a satisfactory way. It is necessary to help and assist in these processes.

Being able to seek advice and assistance in social support systems (e.g. friends, self help groups) if needed.

Traumatized children and adolescents do need a lot of support from suitable adults, not necessarily from therapists. Especially unaccompanied minors need a sense of belonging to someone or at least to a place of importance to them like a school. The aim, however, is to enable them to lead their adult lives in a constructive, autonomous way without being solely dependent on a therapeutic or care takers' system. To be able to create a suitable social network - friends, neighbours, work mates, church or cultural communities etc. - for oneself is one of the means by which the social systems in European societies function. These networks function as social support systems in the sense that they prevent isolation, provide for leisure time, assist in normal life crisis situations etc. Therefore, it is vital that traumatized refugee children and adolescents (and their parents) learn to build up these networks in the new country, trust, use and contribute to them.

5. Case Studies

A. The tasks and endangering factors of the therapeutic process of severely-traumatised, unaccompanied child- and adolescent-refugees.²

Dorothea Irmeler

The treatment process of severely traumatised, unaccompanied child- and adolescent-refugees is discussed in the context of the model of the therapeutic intersubjective room or transitional room, which is at the centre of Winnicott's (1971) theory (ch.1). The tasks and the endangering factors of the treatment process as regards the psychosocial context (ch.2), the therapist (ch.3) and the children/adolescents (ch.4), will be discussed. In chapter 5, the balance between the tasks and the endangering will be illustrated.

1. Trauma and the symbolic room of the therapeutic processes

The first steps of the psychic development take place in the intersubjective room between the mother³ (or the surrogate mother-figure) and the infant. The mother, who appropriately tunes in and adapts to the respective inner needs of the child, makes it possible for the child to adjust its fantasies of omnipotence within the experienced relationship, i.e., to socialise, but also to experience that it can effect reactions in the exchange with the mother (Winnicott 1971). Existentially important social qualities of life and skills are experienced and developed in this intersubjective room or transitional room (Winnicott 1958): respect for the boundaries of its own personality and those of the mother, i.e., the bonding figure, and also trust, symbolism, speech and communication. Trauma harm or destroy the transitional room. Winnicott calls the anxiety that is then created "unthinkable anxiety" (Winnicott 1971). Damages to these boundaries are to be found at the core of traumatic experiences - the margins of the intersubjective room between the child or adolescent and his person of reference, between himself and his cultural-social environment with its orderly system of values and norms; damages to his psychic and/or physical boundaries.

The earlier trauma are experienced in childhood development, the more serious is the loss of trust (Streek-Fischer 1998), but also the harm done to the developing skills with the intersubjective room. The same applies to the intensity and duration of the traumatic events - the more intense and lasting they are; the more harmful are their effect. The consequences are to be seen, in speechlessness in connection with the traumatic event; in limited skills of symbolism and play, and creativity; and often hard, emotionally dispassionate or apathetic use of speech, i.e., in general communication (Möller & Lucas 2002). Thought and feelings can be damaged in a general sense.

The child- or adolescent refugees that have suffered acute violation of human rights, aggression and flight, have often experienced that reality can be more destructive than their fantasies (Möller & Lucas 2002). They have experienced the negation of their own reality with regard to their needs for coherence between their inner and external world (Amery 1977). Therapeutic processes with severely-traumatised child- and adolescent-refugees must enable development - lasting, continuous development - to take place, and allow the prospect of coping with traumatic events and their consequences and integrating them in their individual biographies. Without the latter, a stable and healthy psychic further development is not possible. The symbolic-therapeutic place, in which this can

² This manuscript is based on a lecture, given at the workshop "Versions & Visions: "Protection and Rehabilitation for Traumatised Refugees and Victims of Torture in Exile", "European Conference on Refugee Reception and Integration: Analysing New Approaches in Policy and Practice" 11-13 October 2002, Vienna.

³ When the role of the mother is referred to, it is also implicit that a surrogate mother is possible, even when not mentioned specifically.

take place is the intersubjective room between the child or adolescent and the therapist, it is here that a trusting relationship can be experienced - without this trustful, inner transitional room, the therapy cannot encourage psychic development or healing (Winnicott 1971).

It is in particular the therapeutic processes with severely-traumatised, unaccompanied child- and adolescent refugees that are exposed to diverse stresses, which means that the margins of the fragile transitional room are endangered: through the psychosocial circumstances in which these children and adolescents live; through various demands on the therapist; through the children/adolescents themselves (s. diagram). The endangering factors are often further aggravated in the adolescent group, which applies to almost all traumatised adolescents (Streek-Fischer 1998), but additional sources of endangering are to be found by severely traumatised, unaccompanied adolescents.

Before the tasks and the endangering factors of the therapeutic processes are dealt with in the following list, the therapeutic goals should once again be brought to mind:

- To build up and experience a trusting relationship
- To make stability possible
- To make self-protection against traumatic memories and *re-enactments* possible⁴
- To dismantle strategies for coping with the trauma, such as those which include dissociation and splitting
- To build up psychological coping strategies and emotionally “practice” those which lead to a satisfying inner experience and make social participation possible; suitably correlating to the age, psychic development level and to cultural aspects, as well as making chances for further development possible and for planning for the future
- To develop thought, symbolism and feelings
- To make remembering and grieving possible
- To understand the individual past and present situation

2. Psychosocial context

Keilson (1979) demonstrated in his long-term investigation of the fate of Jewish war-orphan in the Netherlands after the 2nd World War, that the psychological consequences of acute trauma caused by violation of human rights have to be understood as a life-long process. In particular, he emphasised that the phase following the traumatisation is determined by a high degree of vulnerability, when serious and long-term damage could be initiated by re-traumatisation. The post-traumatic period, therefore, requires special and careful attention. This is the phase, in which most of the traumatised child- and adolescent refugees are when they enter the respective host countries. Therefore the psychosocial circumstances are not only significant as the setting for the therapeutic processes, but also, independent of this, for the avoidance of re-traumatisation of these children and adolescents.

2.1 Tasks of the psychosocial context

- The protection of the welfare of the child and the establishment of legal equality with minors possessing German citizenship
- The provision of specialised psychosocial, psychological and medical resources that are suitable to support seriously traumatised child- and adolescent-refugees, in that they act prophylactically through the early recognition of the endangering factors and their elimination.
- By devising appropriate legislation that meets the needs of the traumatised child- and adolescent-refugees for enduring protection and the right to residence; to clarify the legal conditions necessary for adequate education and vocational training or university studies.
- The provision of resources that enable learning about the new culture of the country of exile.

⁴ van Trommel (2001) draws attention in his work to the meaning of creating self-protection, incl. self-protection against re-enactments.

- To negotiate and secure a social climate of protection, tolerance and acceptance of minorities.

2.2 The endangering factors of the therapeutic process, which could result from the psychosocial context

- Uncertain status regarding the right of residence, up to the point of the threat of deportation
- Lack of transparency regarding further permission for residence and insufficient instruction from the competent authority for aliens
- No legal equality with German citizens⁵ e.g. concerning possibilities for training
- Inadequate living and welfare conditions for youngsters, as in a residential unit for adult refugees
- High pressure of expectation from the caring person e.g., in residential units and community groups
- Racial, anti-refugee climate on social and political levels

3. The therapist in the therapeutic process

Aspects of the social-political and individual systems, differing from one another and yet inter-related to each other, affect the therapy of severely traumatised child- and adolescent-refugees. This means that the therapist must also always be aware of tasks concerning human rights issues during the course of her customary therapeutic work (Irmler 2001): these tasks sometimes tend to predominate due to the restrictive psychosocial circumstances which could initiate a re-traumatisation (Möller & Lucas 2002). This causes a high degree of stress for the therapist. It is therefore important to focus on the tasks and also the endangering of the therapeutic process from the therapist's point of view.

3.1 Tasks of the therapist in the therapeutic process

- The tasks of the therapist are orientated towards the goals of the therapy.
- First and foremost, the therapist is responsible for creating the conditions for a secure intersubjective room - the room for the therapeutic processes: she is closely bound to observe confidentiality
- To engage a translator when required
- To be a safe *containment* - also for aggressive feelings and fantasies
- To help the child/adolescent
 - To develop symbolic play and thought
 - To establish contexts, to develop *narratives*
 - To differentiate between fantasy and reality
 - To develop meanings
- To help the child/adolescent to deal with the process of grieving
- To help the child/adolescent to develop realistic and appropriate plans for the future and to act on them
- To help the child/adolescent to relate - where necessary - the internalised values and norms of their country of origin with those of the host country and thereby to understand the latter⁶
- To help the child/adolescent to develop autonomy

⁵ (Heiber 1999)

⁶ According to Winnicott, cultural experience begins in infancy in the intersubjective room between the mother and child (Winnicott 1971). This sustains Eisenbruch's research, which shows that adolescents suffer much longer from the loss of their country of origin (*cultural bereavement*) than their superficially blatant or cool attitude often suggests.

3.2 The endangering of the therapeutic processes that could emanate from the therapist

- Violation of confidentiality through demands for assessment from the authorities
- Role-confusion, e.g. the therapist/rescuer securing the right to residence and/or threat of deportation; surrogate parent-role
- Conflicts between the translator and the therapist (e.g. rivalry)
- Intensive counter-transference feelings, possibly unnoticed and therefore not dealt with in supervision, such as over-protective or rejecting feelings, feelings of doubt as to the patient's credibility, feelings of shame or guilt (e.g. because of German history⁷)
- Latent or acute social and/or political endangering of the therapist⁸ through repressive political systems
- Restricted conditions of work for the therapist, possibly leading to the premature ending of the therapy
- Burn-out syndrome of the therapist

4. The child/adolescent in the therapeutic process

Unaccompanied, traumatised child- and adolescent-refugees need in the first instance, a sense of belonging - this can be, e.g. a reliable group in a children's residential home, sometimes a suitable school class, a refugee-community. Only a minority of the children and adolescents develop such severe and lasting symptoms that require a therapy. It is, at all events, a very sensitive process to ascertain what is to be attributed to the traumatising and what to the current aspect of biography, i.e., the stage of development already achieved. This is often hardly possibly to achieve, especially when the children and adolescents are unaccompanied and there is no adult person of reference who knew the child before it entered the host country. The child and/or adolescent and the therapist is solely dependent on the therapeutic process, to adapt to the trusting relationship, and to understand the signs, scenes and words that occur in the intersubjective room of the therapeutic process: on the one hand, to support the child or adolescent's normal psychic development tasks and, on the other hand, to make the integration of the traumatic event possible.

4.1 Tasks of the child/adolescent in the therapeutic process⁹

- The child/adolescent must be prepared to accept the challenge of the therapeutic process. This can present problems from different perspectives¹⁰:
 - Because of the damaged skill to conceive trust

⁷ Example: an adolescent patient from an African country, who suffered from severe anxiety due to her insecure status regarding the right to residence, felt degraded by an appointment at the department responsible for aliens. When there, she remained silent and cried. In the following therapy session, she doubted whether the expert evaluation about her traumatic past would really be accorded adequate consideration. Her depressive mood suddenly switched to deep anger when she spoke about German history: she knew everything that had happened in Germany, what had been done to the people, she had learned all about that at school in her own country. The therapist reacted inwardly with feelings of shame about German history and with guilt, that the evaluation had possibly not been done well enough (the discussion regarding evaluations and by whom they should be made should not be focussed on here, s. BAFF 2000).

⁸ At this point a current example should be mentioned of the endangering of human rights activists and therapists in Turkey, how it presented itself in, e.g., the court cases and accusations against Dr. Alp Ayan (Izmir) (The News from IRCT, Issue 15, October 2002).

⁹ The following presentation simply illustrates some aspects, they are obviously linked up with the tasks of the therapist concerning the content of the therapeutic processes.

¹⁰ Difficulties of this nature often require a long period of explanations, trial sessions and also flexible settings, in which, e.g., the person of trust who the child sometimes has, can also attend the therapy session, before a therapeutic contract can be made.

- Because of the cultural alienation
- Out of fear of becoming insane, or to be seen as insane
- Because of previous experience with indigenous healing methods
- The child/adolescent must be prepared to go to the therapy regularly¹¹
- Difficult phases of the therapy have to be endured
- A “contract renouncing violence” must possibly be made, which can be particularly important with male, severely-traumatised adolescents
- The child/adolescent must agree not to break off the therapy before this wish has been discussed¹²

4.2 The endangering factors for the therapeutic process, which could emanate from the child/adolescent¹³

- Reactions of behaviour detrimental to the therapeutic process¹⁴
- Acting illegally¹⁵
- Use of violence
- “Disappearing” in illegality or another host country¹⁶

5. The balance between the tasks and the endangering of the therapeutic processes

The symbolic room of the therapeutic processes, the transitional room of the therapy is, as shown above, open to many dangers. Nevertheless, in creating these intersubjective rooms, the chance exists to give severely traumatised child- and adolescent-refugees the possibility to develop authentic personalities despite incurred psychological damage. According to Winnicott, trauma exists mainly through the interruption of the experience of continuity of an individual (Winnicott 1971). Reliable and predictable bonding in the therapeutic process and the renewed experience of trust is a chance that severely-traumatised children and adolescents have to overcome defensive reactions, serving in the first instance the purpose of psychic survival, then in limiting harm (Bürgin 1998). Thus they gain the expectation, not only that previous trauma do not repeat themselves in their future life, but also that they can lead an autonomous life. To be aware of the endangering aspects of the therapeutic processes strengthens the forces that must continually ensure a balance between the endangering factors and the tasks of the therapeutic process.

¹¹ It is sometimes the case here, that newly arrived child- and adolescent-refugees feel overwhelmed by a variety of obligations, like, e.g., additional hours to learn the language, medical examinations, etc.

¹² This is of fundamental importance, in connection with the rifts and ruptures in the past, that all these children and adolescents have experienced (Melzak 1995).

¹³ Similar as presented in footnote 6, it applies to some extent here as well. Furthermore, the endangering presented here is concerned more with adolescents than with children.

¹⁴ In this context, internalised perpetrator (Reddemann 2001) and the tendency to revictimisation (Herman 1993, Fischer & Riedesser 1998) of severely-traumatised children, and especially adolescents, must be referred to.

¹⁵ In some cases adolescent refugees in Europe are forced by those who have organised or even paid for their flight, to pay for the “flight costs” and thus get involved in criminal activities.

¹⁶ The fantasy to go to another host country plays a special role with male adolescents, who are not prepared to accept the degradation of insecure right of residency. These fantasies are sometimes accompanied by narcissistic illusions of greatness as a defence against re-traumatisation (Streek-Fischer 1998).

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B. Traumatised children and adolescents - How to learn to live with the inconceivable?

Brigitte Lueger-Schuster

The submitted manuscript concerns itself with experiences in connection with the project “Bosnien Guests” at the University of Vienna, which took place from 1992 -1994. Many of the examples have actually occurred to children from Bosnia and later to those from the Kosovo. Some of these children I got to know as an examiner in my practice, teachers presented some to me during workshops, and some children live in Vienna and were cared for by workers to whom I offer supervision. In common to all children is that they have experienced war, that they show obvious psychic injuries, and that for many, it was unsure initially how long they would be living in Austria. Their experiences and reactions to their trauma are described without identifying individuals as they represent whole groups of other children and adolescents.

There are some studies that confirm the psychological consequences of trauma for children, albeit only in connection with the diagnosis “post-traumatic stress disorder“ (PTSD) and without referring to the corresponding phase of development (compare Awadh, Vance, El-Beblawi & Pumariaga, 1999). The prevalence count from Essau et al 1999 can be understood in this context. They found an age tendency of 1,6% in German adolescents between the ages of 12 -17 years old (percentage of the population that ever suffered an illness). Children and adolescents are regarded as the group with the highest risk of developing PTSD as all epidemiological studies show that the risk of developing PTSD reduces with age (compare Ellis, Stores, Mayou, 1998, Essau et al., 1999, Kessler, Sonnega, Bromet, Huges Nelson, 1995). Generally speaking, it can be concluded that the reactions of children and adolescents differ enormously and cannot be classified by DSM and ICD, i.e., many traumatic reactions that manifest themselves as an illness remain unrecognised as a trauma-reaction.

What leads to a traumatic experience?

- If a child's life is directly endangered
- If a child is seriously injured or disabled (e.g., actual war injuries, prisoner of war)
- If it has experienced another person being injured or crippled.
- If it has learned of the unexpected or violent death or lethal danger of a familiar person (e.g. loss of own parents, relations or friends).

How do children react?

In common with all experiences, such events incur deep shock and are therefore a severe crisis or landmark in life. From one moment to the next, the world becomes insecure and incalculable, life is thrown completely out of joint, familiar and trusted patterns change radically or cease to exist. Everything that was reliable is put in question. The symptoms are many and varied: suddenly recurring images of the experience continually trigger the memory, there can be anxiety states, depression and insomnia, and somatic complaints also substantially reduce the quality of life.

A traumatic experience can be much more serious for young people than for adults. Children are neither able to comprehend nor understand the meaning of a traumatic event or its consequences. They often invent magical explanations for the event or they experience guilt in connection with it e.g., “the soldiers came because I was bad“. Children often believe that they could have prevented the event, or, if other people were involved, that they could have rescued or have helped them.

A short-term regression often follows a trauma in childhood, represented by an increased need for support and a higher degree of anxiety. Some children lose skills they had already achieved. Others develop fears that a similar event could reoccur and prophesy the next catastrophe. The process is similar with adolescents, and must also be viewed in relation to their actual stage of development (compare Lueger-Schuster, 1998).

The role of the family and environment

Psychological reactions in children and adolescents relate to the patterns of bonding in the family i.e., children tend to adopt their parents' interpretation of the trauma or vice versa: the parents act as a filter, through which the children perceive the meaning of the threat. The parents are models for coping with the trauma: they can intensify or reinforce strategies that either alleviate or exacerbate the symptoms. An example of the reinforcing of the symptom-group intrusions (very strong graphic memories of the traumatic event) is the caring for of the children by their parent. Parents want to protect their children from terrible memories, they want to help their children to forget, i.e., whenever possible, they do not mention the event, thus intensifying the symptom and resulting in the opposite of what they really want. The tendency of children not to talk about their suffering in order to protect their parents is a complementary process: the children are aware of how difficult it is for their parents to speak about the traumatic event, above all when parents and children became trauma- victims in a shared experience or when children witness the traumatising of their parents. The vicious circle between protection and caring increases the symptoms. The last straw is often the fact that children relate everything to themselves, e.g., because they were not well behaved. They are not able - either cognitively or emotionally - to comprehend that, for example, being driven out of their house by soldiers has nothing whatsoever to do with their behaviour: they then try to be particularly well-behaved in order to restore the previous state of affairs.

Bonding

If traumatic events take place and children are influenced by them or involved in them, parents try to protect them by talking with them, through a shared meal, and by holding and caressing them. They do what all parents do, they care for the children and in so doing reinforce the developmental processes of bonding and differentiation. It is especially important during and after a stressful situation to stabilise these processes in order to modify and regulate the agitation invoked by every traumatic situation. Speaking about it requires thought and thought modifies feelings and increases the level of flexibility to deal with the situation: i.e., the strategies for coping become more varied and 'colourful' (compare Van der Kolk, 1998). Traumatized parents find it difficult to regulate their child's agitation and in this way chronic over-reaction and trauma-symptoms occur. The children automatically develop anxiety states, but also anger and the desire for competent parents. As there is no external possibility to modify these experiences and feelings, the children develop inner mechanisms such as avoidance, ambivalence and chaotic reactions.

Avoidance, or denial, means the evasion of their own feelings, not noticing inner discomfort and wishes and the display of a positive facade. It means that after a time, the children do not know what would help them. Outwardly, they seem self-sufficient, more so than they are. They are emotionally distant, avoid nearness and friendship but are all the more willing to achieve. However, their bodies take another course: they sicken, often have pain such as headaches or stomach-aches, are tired, lacking in energy and despite all this doctors fail to recognise the relevant diagnosis. The somatic symptoms express the constant over stimulation or disquiet following the traumatic event.

Ambivalent children mostly develop into people who rely on their feelings but who ignore their thoughts. The perception of reality confuses them; they rely on their feelings and do not consider the meaning of the experience. They adapt themselves to their inner reality and distance themselves from the social reality. Thus they fall into social isolation. Despite this, they know that they need social support and therefore look for it, while at the same time they feel misunderstood and badly treated in the relationship. Logical arguments in such relationships cannot be understood by ambivalent people because their ability to adjust their expectations to reality is limited. They need psychological support, i.e., above all qualified psychotherapy and less medication.

Immediate age-related reactions of children to a trauma

Immediately after traumatising, children react with separation anxiety, self-imposed starvation, frequent crying and the need for bodily comfort; furthermore, there can be signs of general disquiet and over stimulation (ranging from fidgeting about to sleeplessness) as well as reactions of denial, as though nothing untoward had taken place. This applies mostly to children while adolescents tend more

to aggressive and questioning behaviour in order to assimilate the event into their perception of the world. Common to all age groups is non-reacting, as seen in the above-mentioned denial.

Longer-term age-related consequences of trauma and their development. (Kocijan-Hercigonija, 1997)

- Children up to the age of 3 years old can react with changes in previously achieved habits and patterns of behaviour; they can also regress into earlier stages of development, they cry more often, with no apparent cause and their sleep patterns and eating habits can be disturbed. Some children stop communicating or 'lose' the ability to speak.
- Children between the ages of 3 to 8 years old can be generally extremely anxious or develop specific anxieties; they can also develop the fear that the event could reoccur. They don't understand why people have to die, they speak less and suffer from insomnia and nightmares, regress in their development and have problems relating with their environment.
- Children between the ages of 9 to 14 years old show cognitive difficulties, such as concentration- or learning problems, develop anxiety about stimuli that remind them about the trauma; some re-live the event through compulsive role-play (e.g. they 'kill' each other while acting as soldiers); they can suffer from acute graphic memories, develop exaggerated fears about others; they take excessive care of their parents (by being models of behaviour themselves) and they can incline to repeated stomach- and headaches and heart problems. Others can become very aggressive.
- Adolescents between the ages of 14 to 18 years old can react with severe behaviour problems such as irritability, depression, social withdrawal, the loss of their power of imagination concerning the future, suicidal tendencies, fluctuating values and increased addiction. The adolescent is aware of how vulnerable they are, is easily hurt and can therefore experience helplessness.

Possibilities for support

Adults are especially in demand to fulfil this function. Support, stability, safety, security and protection, as well as a normal daily routine, can be helpful here to overcome the trauma and cope with the regression. Generally speaking, the adults' helpful and suitable support in the form of continuous caring through the traumatic crisis can be successful in increasing the ability to cope with a trauma. Post-traumatic growth can be the result of the therapeutic process.

The first step towards the support for children and adolescents should always comprise clarifying whether the behaviour patterns show a normal reaction to an unusual event, or whether it has to do with a post-traumatic symptom. It is recommended here to ask expertly trained psychologists to undertake a professional psycho-traumatological diagnostic. This can result in a series of support-measures being developed to closely respond to the particular situation of the child and parents.

In the first instance, the symptoms should be explained to the parents and they should be informed about how to deal with them: this conveys a sense of security to the parents which is necessary as they can then understand their child's behaviour and develop the appropriate responses. They can then, for example, encourage a discussion about the traumatic event, rather than avoid it, thus making coping strategies more possible; or they can offer their child a reliable setting, which still includes familiar aspects of the daily routine, to give their child security and stability.

Parents should be informed about the necessity to speak with their child about death and to specifically mention its finality, even if this is stressful to them. It promotes the child's strategies for coping with the trauma. Further possibilities to increase a sense of security are: to directly involve the child in the 'reconstruction' of the daily routine by allowing it to make its own decisions like, e.g., what it wants to wear or eat, to give a feeling of being able to control its own life; parents should also be encouraged in the first phase of grieving to make it possible for the child to play, which is vital for recuperation. It is also important to give children the opportunity to share the grief about the traumatic event as well as the attendant fears with their parents: thus the children experience that their own anxieties are normal

and acceptable. Children can only endure a certain amount of anxiety, i.e., parents should be made aware of their tolerance level. Talking about these fears can be accompanied by closeness and bodily comfort.

Possible measures in the field

- Play: this is suitable for children of pre-school age and helps to re-establish communication with their surroundings. The form of play (role-play) closely adheres to the needs of the child, making use of the medium of either animals or dolls and it serves the purpose of helping the child express its feelings (grief and/or fear). Play, as a medium for coping with trauma, needs its own framework and should be guided by professional workers. It is of foremost importance that the child has its own special place.
- Drawing: this is a good introductory way of making contact to therapists and also enables the child to express feelings and thoughts. When a child speaks about its drawings it is referring to itself. Drawing is also a way of documenting the treatment process. It is also important here to make sure that the tempo corresponds to the needs of the child.
- Telling stories: this method has to be very well prepared, the story has to be thought out in advance and appropriate to the particular child. It should also offer the child a suitable figure of identification to make it easier for the child to develop the story in its own way, thus expressing and dealing with its feelings and thoughts. It is important that it is the therapist and not the child who tells the story, the child adding to it and supplementing it whenever it wants to.

Further possibilities for children following a traumatic event could be:

- Special support in a respective setting (e.g., school or hospital): establishing an atmosphere of trust in the class/group through the preparation of the colleagues for the return or arrival of the children concerned. Care should be taken to ensure that the children develop as few anxiety fantasies as possible, receiving instead clear information about the event and how they can deal with it.
- Dealing with the trauma within the respective environmental setting (school, play-school) through, for example, joint discussion about what has happened to all the children in a class or group and the development of collective rituals, e.g., preparing a burial.
- Clarity about the limitations of support in the respective setting, e.g., when the child needs psychotherapeutic treatment. If the symptoms do not decrease after 4 - 6 weeks, it is advisable to seek the advice of a professional therapist in the field of trauma (clinical psychologist or psychotherapist).
- Interdisciplinary cooperation: the importance of case-conferences for traumatised children is to be emphasised here - the participating institutions judge the needs and reactions differently and subsequently deal with them differently, which can adversely affect the success of the treatment.

In all aspects of the care and support of traumatised children it is imperative to keep the factors of insecurity and instability to a minimum: traumatised children have suffered a massive loss of trust that they have to cope with. The more stable and reliable a relationship is for the child, the higher the chances are of overcoming this. Should the rebuilding of trust be obstructed by issues such as the legal right of residence or human rights, then it can become the task of the helper to act on a political or legal level. This conforms neither to the usual psychotherapeutic or psychological attitudes towards clients, nor with the transference processes; an insecure existential basis, however, contradicts with psychic stability, making it essential to work initially to establish existential security. This requires legal knowledge but it can be supported by helpers, either through collecting evidence or simply through emotional support that says nothing more than "I am here for you, I am available for you at this particular time of your life". This task can be fulfilled by anyone in the near environment of a traumatised child.

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C. The psychosocial context for traumatised unaccompanied minors.¹⁷

Barbara Preitler

Talking about the psychosocial framework for young refugees in Europe, I want to start with two case stories of my young clients. I work as a psychotherapist in “HEMAYAT -Organisation for torture and war victims” in Vienna, and during the last eight years we have seen many unaccompanied minors who also need psychological support. In this work we learned about the importance of their life “after the trauma”. This means that the welcome in the country of exile will be an important factor for the psychological status of these children.

Case history 1

This case history concerns H. a 13-year-old boy from Afghanistan to you. In our context we will concentrate on the specific situation after arriving in Austria.

Trauma history: - father “disappeared”
 - in policy custody for 10 days and tortured during this period several times

Flight history: - together with his younger brother
 - organised by family members
 - no further traumatic situation

Arriving in Austria: - immediate contact with a relative living in Vienna
 - social service was given to the boys
 - medical check up / health insurance
 - school entrance after few days
 - “family counselling“ with the relatives and the boys
 - waiting list “priority” for a big flat
 - support from the relative employer (extra free days, collection for the boys)

Contact with HEMAYAT:
 - through school teacher 10 days after arriving
 - three days afterwards first meeting with both boys and the relatives
 - psychotherapy starts for H. three weeks after arriving in Austria

H. had a very good supportive system soon after arriving Austria, and was able to develop the feeling to be safe and to have a future in the new country.

Case history 2

The second case history concerns L. a 16-year-old girl from Congo/Zaire. Her arrival and reception in Austria was very different from H., so the start of psychotherapeutic intervention was much more dramatic. Even the long lasting symptoms L. developed are more serious.

Trauma history - at 14 years: mother died, she has to take care of the younger siblings
 - at 16 years: she became eyewitness to the murder of her father by the police
 - has received death threats since

Flight history - alone
 - organised by father’s friends (to other friends living in the UK)
 - several further traumatising events during the flight

Arriving in Austria: - “Schubhaft”, brought to prison for deportation
 - nearly three months in prison, no communication with other inmates possible

¹⁷ This manuscript is based on a lecture, given at the workshop “Versions & Visions: “Protection and Rehabilitation for Traumatised Refugees and Victims of Torture in Exile”, 11-13 October 2002, Vienna.

- fear of being deported back to Congo
- hunger strike for 17 days – wish to commit suicide

Contact with HEMAYAT:

- through social worker one week after she was released from prison
- first contact: next day
- Intervention: crisis intervention – suicide prevention (took several months)
- Chronic PTSD
- persistent symptom: eating disorder

With these two case histories I wanted to show you how different the conditions for young minors can be in a European country like Austria. For the psychological health of these young refugees a safe welcome is a **must** to overcome the nightmare of (political) violence and the trauma of separation and the very often again traumatic flight from their home countries to Europe.

The different form of trauma children suffer from

1. Children as eyewitnesses of atrocities: they become witness of bombing, shooting, the forceful occupation or/and arrest of people. They have to see the torture, rape killing of their parent(s) or other close relatives and friends.
2. Loss of parents and other close relatives and friends
3. “Disappearance” of parents or/and close relatives and friends
Not to know where father/mother or another close person are can become an even more traumatic situation for the whole family and special for the children. No mourning process is possible as long as a person is “disappeared” – so families stay in a “frozen” stage where they cannot really cope with the loss of a loved one.
4. Forced to take the role of an adult
5. Torture and other forms of physical violence
6. Separated from the family – left alone
Separated children are most vulnerable. To survive they have to behave like adult people. They even don’t get any support in their mourning process about the loss of their whole family, social environment etc. and no help to cope with the totally new and stressful situation in the country of exile.
7. Re-traumatisation in the country of exile
As shown in case history 2 the situation after arriving in a country of exile will be very important for the psychological status of every refugee – special for children. A safe place where they can rest and where they can mourn is needed. And also a chance for their future can be possible. So possibilities for education, vocational training etc are also prevention of psychological illness.
8. Traumatised parents
Traumatized parents are often not able to give their children a safe childhood. Children can become the caretakers of their fathers and mothers.
Normal problems children have will be seen always in the frame of war/torture/killing.
9. Child soldiers
Children have been not only victims – as victims they were made to perpetrators also. To deal with these life histories needs a very specific and sensitive understanding.
10. Adults, who have been traumatized in their childhood
Here we have to learn how badly traumatisation in childhood can handicap people for their whole life.

As basic for the request to give young refugees a safe exile, I refer to two international documents: the UN Convention on the Rights of the Child and, more practically, the suggestions of the Separated Children In Europe Programme.

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989. Article 37 c states that: “every child deprived of liberty shall be treated with humanity and respect of the inherent dignity of the human person, and in a manner which takes into account the needs of persons of his or her age. In particular, every child deprived of liberty shall be separated from adults unless it is considered in the child’s best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.” Article 37d continues: “every child deprived of his or her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.”

“The Separated Children In Europe Programme” suggest:

- Protection against forced return (refoulement)
- Access to the asylum procedure
- The right to be appointed a guardian to represent the child’s best interests
- The right to have a legal representative to assist with the asylum claim
- Separated children seeking asylum should never be detained
- The need to commence family tracing and reunification as soon as possible if this is in the best interest of the child
- Forms of human rights violations that specifically affect children need to be taken into account in determining their protection needs. E.g. recruitment of child soldiers, trafficking for prostitution, female genital mutilation and forced labour
- The need to involve child experts and people who have been sufficiently trained in all decisions regarding interim care and long term solutions
- The need for appropriate interim assistance and care
- The need for programmes to assist return to country of origin when it is in the best interests of the child” (For further details see www.sce.gla.ac.uk/Global/English/home_en.htm)

From the background of our therapeutic work and the already existing international documents we have to ask for a healthy psychosocial framework for young refugees. Good standards should include:

Medical examination:

- Only through medical doctors who have special knowledge about traumatising
- Following international standards
- Stopping inhuman and ineffective methods to determine the age of adolescents
- Stopping methods which can produce re-traumatisation
- Careful use of methods like EEG etc, – allow sufficient time for explanations
- Accompanying during examination

Psychological examination:

- Only through psychologists who have special knowledge about traumatising
- Enough time
- Understandable communication (with translator if needed)
- Follow up counselling if needed or access to psychotherapy

Psychotherapeutic context:

- Psychotherapists need a special training in working with psycho-traumatisation
- Safe place for psychotherapy
- Translator (with special training) should be available
- Long-term therapy
- Further training, intervision and supervision for the therapists

D. Treatment of Traumatized Refugees¹⁸

Luise Reddemann

I feel very honored by being invited to this conference. The question is if my experience is interesting enough for you. I think that you are much more experienced in the treatment of traumatized refugees. We have been treating traumatized patients for about 15 years and have developed a method that we call psychodynamic imaginative trauma therapy that I will present you later on. This way of treatment has proved to be helpful to patients with complex PTSD. Most of our patients were traumatized during childhood, and by their families. But sometimes we are treating patients who have been traumatized through war, torture and being refugees. In Germany the fact that after World War II many, many people had become refugees and traumatized through this was for a long time completely repressed or denied. It's only in recent days that these facts are faced. But, of course, we see patients with PTSD caused by expulsion after World War II. We also meet patients who have become victims of recent wars and their sequels. What might be different to most of your clients is that our patients have the right to live in Germany. Many of them even have a German national status. So this makes our work much easier than yours.

I want to present to you now our procedure. When working with severely disturbed traumatized people who suffer from complex PTSD, we had to pay attention to find treatment models that really fitted to the special needs of this clientele. It seems that Janet's model of phase-oriented trauma therapy is a helpful one to deal with the challenge of treating this patients properly. With these clients or patients we had first to find out ways to help them to feel as secure as possible. This is, of course, an extreme task while helping refugees and torture victims. We try to help these patients to feel safe within them selves. And this can only be managed when the therapeutic alliance gives the patient a feeling of safety and acceptance.

The history should be taken with utmost caution and a stable working-alliance should be installed. Let me say that - with complex PTSD - it is not enough to install a safe place. These patients need much more than an inner safe place. Following Debbie Korn (2001) patients with limited capacity of stabilisation may confront us with:

1. increased looping
2. increased dysphoria and suicidality
3. increased trauma-related symptoms
4. increased sense of failure and hopelessness, i.e. "I'll never get well. This won't work for me.
5. Increased dissociation and avoidance behaviors, i.e. canceling sessions, decreased compliance."

We mainly concentrate on imaginative work that we combine with EMDR for resource-installation. We emphasise on keeping the working alliance always intact. This has not been - and is still not - common in Germany at all. Many therapists accompany their traumatized patients into deep regression and this is normally combined by a loss of a functioning working alliance and - even worse - stable ego functioning in normal life. Today we understand that the traumatized ego is not a well functioning one in the sense of Freud. Working with a concept called "the inner stage" the patient can regress deeply within herself but does not regress in the therapeutic alliance and in daily life. The inner stage seems an important tool to avoid problematic regression.

In our understanding it is important to work on

- Self-soothing
- Affect control and
- The capacity of the patient to distance her- or himself and to be able to observe rather than to identify with disturbing material

¹⁸ This manuscript is based on a lecture, given at the workshop "Versions & Visions: "Protection and Rehabilitation for Traumatized Refugees and Victims of Torture in Exile", 1-2.7.2002, Cologne

- And as already mentioned to keep a working-alliance intact.

What I want to do now is to present you some of the imaginative work that we are using in order to help the patient to develop more ego-strength and explain our procedure. What is important to us is the using of as many "normal" self-healing procedures as possible. What does that mean? I think that mankind as a whole has in possession all that is needed for healing and people has this in their (collective) unconscious mind. We can also call these general coping-strategies. The good news therefore is that we, the therapists too, can make use of imaginative exercises in order to prevent burnout. We learnt that each person possesses power to heal themselves, and that our most important task was to support them in this. Findings about the powers of self-healing have, in the mean time, found their way into the world of science through research on salutogenesis and resilience. If we support our patients in listening to the voice of their inner wisdom, we support powers of self-healing, and free flowing of these often-submerged powers. The problem is that patients with complex PTSD need much more support to get – again - in contact with their healing resources than people with monotrauma.

Many of our patients had already found creative escape routes for themselves in situations of dire distress. They had made both internal and external places/spaces or rooms, in which they felt well and secure. Furthermore they had “invented“ inner companions, fairies, guardian angels, animal forms and others, in order of not having to feel alone any more, and being comforted. But in general they did not learn to esteem their capacities. I learnt that the imagination of a safe place and inner helpers essentially corresponded to very old shaman proceedings. Today I hypothesise that there is something like a shaman, or an inner wisdom, in everybody. I have often observed that people, and especially those (, too), who were very disturbed, very often have knowledge and wisdom at their disposal from within themselves, that goes far beyond that which the conscious self is aware of. Most have however forgotten how to listen to this inner wisdom, because one needs silence to be able to hear the inner wisdom. It also requires that reasoning and the mind be given a proper place, rather than being applied everywhere. Let me now talk about special ways to make use of imagination:

1. Finding pictures and ideas opposite to those of the horror visions

Many of our patients feel as though they are helplessly controlled by horror thoughts, "I can't do anything against such thoughts“. We therefore recommend consciously finding an opposing vision to the horror vision, or opposing thought to the horrific thought. We suggest alternating back and forth between these two pictures. In this way it is not necessary to suppress the disturbing thoughts. If a positive alternative picture is there, I can choose. I can occupy myself with one picture, or with the other. I may consider staying a little bit longer with the positive picture. I can also ask myself whether it makes a difference for my body or not if I think about one picture or the other. Most people will discover that the body certainly reacts differently to these different pictures. Normally patients say how good it is to be able to do something. It can be a very satisfying experience for people when they start experimenting with how they can control their own thoughts and images. So this is an important lesson for patients with complex PTSD. It is a very simple and effective exercise that can be done simply and at any time. During the exercise it is important not to suppress anything, rather one should look for an inner alternative, to make choice possible. By the way there are even some similarities with EMDR: The idea of relying more and more on inner choice should play an important role in whatever therapy of complex PTSD. We suggest opposing the world of horror step by step by an opposite world.

Of course there are patients who say that everything in their lives was terrible, and they do not know how to imagine anything good. We then ask: "Assuming you were able to think of something good for a moment, what would you think of?“ there are very few people who are unable to imagine something good regarding the future. Many are able to begin by asking them selves what they would have wished for if the good fairy from the fairy tales had really existed. What would a good safe place have looked like? Some could ask themselves the question what they think this good fairy would have been for others, for example for their own children, or other people close to them. It seems to me that people who are able to find their way to psychotherapy already have a grain of hope, otherwise they would not have come. This grain of hope is our point of access. One can also ask under the motto: "There are

60 times 24 minutes, your week 7 times 24 times 60 minutes. How many minutes would you say there are when you feel a little bit better?" As far as I have experienced there has been no one who has claimed there is no minute or no second of respite. As you can see we are doing a lot of cognitive therapy, too.

When we are working with severely disturbed patients we cannot rely on their spontaneous going to the positive during an EMDR session but we have to prepare them thoroughly before going into disturbing material so that they are enabled to go to the positive. It was Verena Kast who brought our attention to the question of whether our patients ever experienced joy, inspiration and hope. In her book with this title she advised doing what the title suggests writing a biography of all joyful events in ones life. I would strongly recommend this to you. It will help you to believe in your patients' ability to do this. For patients it may be a new important experience to concentrate their attention on the pleasant things they have experienced in life. So I would propose:" Think about the child you were, about the things that made a child happy: that sunbeams form rings on the wall, dust particles dance in the sunlight, that it is fun to jump around in puddles, to give a few simple examples. Children express their joy – as well as other feelings - through their bodies. Do you remember the feeling you had when you were swinging, or skipping, or playing with a ball? It is very unlikely that feelings of joy and happiness were not for one second present. Let these feelings spread through your body, as though every cell of your body were filled by these feelings. Then search for other moments. Once you have come into contact with these feelings again it becomes easier to find more feelings of joy. Even when you have had only a few joyful experiences in comparison to those of other people, you will discover that it is worth not only concentrating on all the pain in your life." When positive thinking, feelings and images are emerging, we install them with EMDR. We focus on the following: The power to heal from pain comes from positive feelings, not through the singular concentration on pain.

2. Practicing awareness

A precondition to being conscious of how we are is awareness. Awareness is not something we can take for granted. On the contrary we tend to learn unawareness from a very early age onwards. We should “not notice“ as Alice Miller termed it. Therefore we have to learn awareness anew. Although this is about small exercises I recommend that patients integrate awareness into their daily lives. For example one can eat something attentively. Being conscious of every bite, and after a while one can become aware of what is happening to the body with each bite you take. Jon Kabat Zinn suggests eating three raisins with awareness, a very simple and impressive exercise. Or we empty our dishwasher with all the concentration we can muster. There are no bounds to the imagination. Being aware means to be present. When we are in the present fears from the past or about the future cannot plague us. We can be conscious of the exclusivity of the moment, we can be aware of ourselves more consciously, and as a result also of others. Awareness is also one of Marsha Linehan's principles in her phase I.

Jon Kabat Zinn lets his patients work with this exercise for eight weeks. In addition he offers yoga exercises and the “loving kindness” meditation exercise. Kabat Zinn has had much success with seriously ill people, for example with pain conditions, with this program alone. Many of our patients - but not only them - are treating their bodies worse than their cars and simply expect that it keeps on working. The exercises of awareness or mindfulness are also suitable to ground one self and therefore are of utmost importance for dissociative patients. And, as you know, patients with complex PTSD are all dissociative from time to time. Short awareness exercises have the effect of letting the body relax as much as it needs to without having to consciously command the body with the order ‘relax, relax’. Patients can do this whenever they feel tense or nervous, the concentration on the movement of the body whilst breathing can help. Through experience we have noticed that it makes a difference whether patients concentrate on their breathing or on the movement of their body whilst breathing. The latter appears to be more suitable for traumatised people.

A further important point is the awareness of the bodies' boundaries, and contact with the body. As many traumatised people are not ‘properly’ in their bodies but distant and dissociated, we very strongly recommend such body awareness exercises. The exercise makes one of our principles clear:

Simplicity

The simpler something is the more chance it has of being used. Although for many of us simple things can also be difficult because they do not appear to reconcile with what our mind is telling us. Our intellect prefers complicated things and does not want to believe that something can be so simple. Critical reasoning is certainly important, it has often taken on the role of a protective function, and therefore it does not make sense to ignore it, but one can ask it to remain quiet for a while. It is also worth thanking your mind for everything it has done for you, remaining true to you over many years'.

Self-healing, Physical Memory, and the Principle of Awareness

In our work it has proved valuable to look at the ideas of Peter Levine (1998), who was the first person to point to the connection between trauma healing and the reptilian brain activity. Levine recommends paying attention to the necessity of an activation of the reptilian brain when treating people who have undergone an extremely stressful experience, which caused them to go into shock, or “freezing”. The body normally carries out this activation automatically but much of what we do hinders this *self-healing mechanism*. I have also found his suggestion of keeping to physical experiences very useful. Fear, according to him, is only a “concept”. When one concentrates on this “concept”, the fear increases and its physical equivalent likewise. If you guide the patients towards concentrating on their bodies this often calms them down very quickly. However this does not always work; sometimes it can have the opposite effect on people who tend to hypochondria. Levine’s processes refer to Gendlin’s “focusing” (Gendlin & Wiltschko 1999). Basically both use the very old Buddhist exercise of mindfulness. In Buddhist psychology, awareness is seen as a way towards healing. Not being judgmental also belongs to the principal of awareness. It is plausible that our customary judgment of, for example, fear, can increase this. In contrast a non-judgmental, attentive way of dealing with changes that are happening anyway in the organism can be brought more easily into the conscious mind. Without having to be said, awareness strengthens trust in one’s body and its ability to change or transform. In EMDR and other confrontation techniques patients need to be able to follow the processing with the knowledge that this is “old stuff”, mindfulness meditation or any other way to learn awareness helps to develop this ability.

We think that attentive work with the body, especially when it is about being aware of sensations, provides the best form of bodywork with traumatised people. The body is the place of the trauma; therefore it has to be included. Every successful trauma therapy should find a way to incorporate the body. Unfortunately there are still physical therapies that are very painful for the patient, because they are once more intensively taken into the pain. According to our experience and research from Levine, this is not necessary. One can gently work towards the stress in the body, which also leads to dissolution of the trauma effects. It is a fallacy to believe that violent abreaction decides the value of a trauma therapy. Instead, the softer it is, the better. Traumatized people should also have the possibility to find out that despite all the terrible experiences that their body is a place of joy and full of energy. We have discovered the Breema bodywork, Qui Gong and July Henderson's work. Breema and July Henderson's work are about treating your body in a playful manner. With the help of Breema people can learn to touch themselves - something that is often unpleasant for traumatised people, but very important to learn. Because the exercises have a clear structure, a beginning and an end, it is often easier for patients to start to touch themselves.

3. Finding a counterbalance to the horror visions

Seeing clearly means perceiving that there are both the terrible and the beautiful, the difficult and the easy, the light and the dark in life. Healthy or neurotic people know this. Patients with complex PTSD often are stuck in an inner world of horror visions. Therefore we recommend imaginative exercises to counterbalance this inner world of horror. Working with exercises helps the clients to learn to counterbalance. Not every patient likes every exercise. The best thing is to become familiar with all of them: First to read through them all and then to see which ones one personally finds the best. Then people can try these exercises out. If they find that they enjoy a certain exercise then it is good to practice this regularly for a while. We advise people who want to deal with their traumatic experiences to try the exercise with the inner safe place and the inner helper. The helper in particular can stand by them when meeting horror. They can of course also return again and again to their safe place to regain energy. Apart from this these exercises are closely related to the practices of Shamans

all over the world. In their imagination they go to a place at the center of the earth, and meet their spiritual guides there, who support them with advice and help. As Shaman healing is a healing method that uses the imagination, and is the oldest form to the practice of healing, I thought that in our collective consciousness, as termed by Jung, there is knowledge of these two images in particular, and therefore many people are quickly able to summon them up. But whoever finds these images completely foreign, should not force themselves to work with them, rather they should look for their own images. We all use linguistic images more or less frequently. Some people use a language full of images, others a rather dry language. But no one uses absolutely any pictures at all. One can become consciously aware of these linguistic images; during therapy the therapist can make a note of these and can develop healing images from them together with the patient. Or one remembers a situation in which one felt happy and one develops from this an image of a safe place as in a dream, where one can put many different images together, or places or times. One can use a similar process to create a helper too. Patients can take the characteristics of people who are dear to them or important for them and create a helper. Some people believe that this process is too conscious and does not come enough from the unconscious. Our unconscious learns from our conscious mind and the other way round. In the end it is not important where the comforting images come from, the main thing is that people make a start. In general patients with complex PTSD have to "instruct" their unconscious mind through their conscious mind.

I remember a patient being a torture victim who had lost his whole family. He came from a country in the Middle East. He loved to combine several imagination exercises and thus made them more powerful. And he would smile when he had found his way of dealing with the exercises. Let me give another example: Let us take "It's like a ton weight on my shoulders". To this you can find an opposing image. The image of a skipping child comes spontaneously to my mind. Then you can move from one image to the other "to and fro" With this picture of the light-footed, skipping child it is easier for me to enter other pictures that make me happy. In this way there could be created a series of images that could be of help. If people take to imagination exercises, they can also become a very good and friendly guiding companion.

I would like to say something in general about the side effects of these exercises. An important side effect of every form of relaxation is that one is open to more burdensome things. It can also happen that painful thoughts, images and feeling come to the surface when one becomes calmer than one simply does not notice when one is too busy. This can be frightening. Patients with complex PTSD tend then to dissociate. A good way of keeping the side effects at a minimum is to do the exercises in the form of thoughts rather than pictures. We have found through experience that that thinking the exercise through has the same end result, but the patients feel more secure because they have control. They can think about the imagination exercises, as I have already mentioned, like a story that they tell themselves.

Let me come back to some concrete examples: The safe place can be on earth, but it does not have to be. It can also be outside the earth. This place needs to have a boundary of the patients' own choice that is so created that they can choose which beings should be, or are allowed to be in this place, their place. Helpful beings can be invited to this place. If possible, I advise not to invite any human being but perhaps dear companions or helpers, beings that give love and support. The inner safe place is an ideal place and therefore real beings do not fit in. Patients should check if they feel good there with all their senses.

The exercises only work in tense situations if they are internalised. We do not consider the exercises at the beginning of the treatment in the stabilising phase as a source of material for deep psychological interpretation. Later, for example after the trauma confrontation phase, people can look into the meaning behind their images. In the first place it is about making these images readily available when one is in a difficult situation.

The exercise of the inner helper is a very comforting exercise that is useful for bringing patients into contact with their helpers whenever they are feeling lonely or helpless. In my opinion it's also an excellent prevention for burnout problems. Other supporters and helpers closer to the ego are members of the "inner team". We think of an inner team as former/younger and future selves or egos that we

can ask for opinions and advice. Each member of this team is invited to contribute their opinion on the topic. It is important that each member has the possibility to say what they think even when the other members have a completely different opinion.

On this inner stage there are as many figures as patients would like to have: they are the authors of their inner drama or comedy, they are also the director, the stage manager and they are also a member of the audience. The helpful beings and the inner team represent, to a certain extent, inner wisdom.

If the present is difficult and stressful it can be of help to consider how to imagine the future. A way of doing this is to look for a symbol, and with the help of this symbol to shape the future. The exercise of the inner garden has proved very useful to us in our work. This exercise has the advantage that it offers a solution at the same time, as well as to what one can do with things that one does not want. This means in a way it offers an alternative to the treasury exercise, if patients are not completely satisfied with it. The solution shown here consists of putting everything they do not need in the garden onto the compost heap from which new earth is made.

Patients should find out what is most suitable for them. The most important thing is that they like the exercises, and that they get the most out of them when they use them. There are of course many more imagination exercises. One will find many things in endless books on relaxation. I advise not to do things because other people find them good. It is important that the patient finds out for herself what she likes. She will practice the exercises she enjoys. If people have been traumatised they have reason enough of deciding to do something for their well being, and that means they do not need to put themselves under pressure and do things because 'one' should, or because they are supposed to do good. They should learn to trust in their inner wisdom. There is nothing that is suitable for everyone, but everyone can find something that is good for him or her.

4. Learning to distance oneself from horror visions

Sometimes one notices that it just does not work; it's not the right time, as many people say to only find counter-images. The old wise saying from the Bible that everything has its season, and that there is the time for every activity, is also valid for working in a therapy. Sometimes it is not possible with opposing images. Another quite different possibility, done by everyone, is to distance oneself from something. If we stand with our nose in front of a picture we do not see much of it, but when we move away from it we can then see the whole picture. Seeing the whole picture means being aware of much more and thereby also being able to put things into relation. Torture victims often have resources within the time before the trauma. Here I would like to turn to a few ways of distancing.

Namely the observer exercise is a helpful way to distance oneself. One can become aware that one can observe the body, the thoughts, the feelings and the moods. Most of us have already done this many times, but maybe they have not given it this name. Every time we notice what we are thinking, or feeling, or what is going on with our body, we have observed it beforehand. The fact that we can observe something tells us too that we are more than that which we are observing. And this is a useful realisation especially when we are so involved in our thoughts, feelings or pain that we often associate it with the sensation or thought "We are only....". It is as if we identify completely with what is happening at that particular moment. When we are calmer we know of course that we are much more than a feeling or a thought. But when we are agitated it is as if we had forgotten all about this. This way of dealing with themselves has a soothing effect on many people, at least taking on the position of observer stops us from getting more and more agitated and we can thereby 'de-dramatise' the situation. Torture victims use this technique spontaneously and to use it intentionally is very useful.

If patients are wrestling with something stressful that they could not, or did not want to pack into their safes, then they can try looking at this memory with the help of their observer. Perhaps it is possible after this to pack it into the safe. If they want to talk about it they could try talking about it in the third person, that is not from himself or herself but from "the child" or "her", etc. Philip Reemtsma talks about himself in this way in his book called "The Cellar", whenever he describes his traumatic experiences. This is also a way of distancing. All possibilities that are available to the therapist or patient to distance themselves from their problems should be used in the stabilising phase. We advise

to avoid going too deeply into stressful material during the stabilising phase. Only when the patients feel they are in contact with all of their abilities and they have enough control over their inner burdensome condition, one can go into this area in more depth.

5. Getting to know ones feelings and learning how to control and how to deal with difficult feelings

I would like to mention here a few ways of dealing with burdensome feelings during the stabilisation phase so that patients can learn to deal within a more competent way: Feelings as: fear, panic, fear of death, helplessness, powerlessness, the feeling of being completely at the mercy of society, and being overwhelmed with horror, then secondly shame and feelings of guilt that have proved valuable. Here again it is about using images and figurative speech. We also work with cognitive restructuring.

Giving an Unpleasant Image a Form

If patients notice anger or fear – or other feelings too - they can try and give them a form. They can then talk to this form or figure by asking it what it wants to teach them. It is amazing how feelings that have been experienced as unpleasant can all at once become a useful resource. This technique is used in many humanistic schools of therapy.

Only someone who is to some degree able to control and endure his or her feelings should risk a trauma confrontation. Many of our patients - and also many of their therapists - think they would like to confront their trauma as soon as possible. They think that they will feel better as soon as they have got it over with, but this is a misconception. One has to be in the position to stand the strong feelings that come up in the reliving of the traumatic experience. Otherwise patients may traumatise themselves yet again. Therefore I say to both the patient and the therapists that they should take their time in developing a stable way of dealing with feelings. They reap the harvest of this work manifold in the trauma confrontation phase.

The regulator exercise can be used when feelings are too strong or too suffocating, in the same way too for feelings that are not strong enough, that one would like to feel. Thereby it is always important to consider that people who have suffered a trauma are dead or almost dead to their feelings for a good reason. Therefore it is also important to use this exercise carefully. One can really regulate the stages in tenths. With some patients I have worked on certain feelings stage by stage, and therefore this exercise can take up quite a bit of time. But it is especially important for people who have little feeling for themselves to take things slowly because they always know that they are in control.

In cases where feelings seem to be overflowing it is advisable to first of all turn the regulator down drastically. The regulator can then be supported by the observer exercise because it creates distance immediately. Also changes in the perspective of time help to distance. I have already mentioned the exercise of the inner teams. That is the round table meeting with the younger and older selves. Contact with the much older self, is especially useful, when patients ask them what they think about this problem, this thing, these feelings or this agitation, to see things from a different perspective.

The medium of the imagination "*Meeting Younger Selves within Oneself*" plays a central role in our work in dealing with traumatised younger selves. This work seems to us to be a very effective instrument to strengthen the adult of today in their ability to function, *but at the same time allowing an inner regression that avoids however spreading out into the therapeutic relationship*. The working relationship between the patient and the therapist remains intact. The person who comes for therapy is treated as fully capable, the problems are attributed to the younger self and the person of today is invited to look after the younger self. In this way the patient who is searching help is immediately addressed as someone who is competent and resourceful. In the case of people traumatised as adults it can also be very helpful to invite the self before the traumatising to help the traumatised self or ego. Today I am convinced that only when a patient with complex PTSD is fully able to sooth his or her younger selves *before* trauma confrontation and when the younger selves already feel save in therapy trauma work can go on without dissociation. Together with the images of the safe place and inner helpers the work with the younger selves is *the* means of self-soothing.

The Inner Stage

The inner stage has already been mentioned at various points. The imagination of a good and safe place, inner helpers, younger selves are all figures on the inner stage. I want to concentrate now above all on the “villains and rogues”, because we have already become acquainted with the good figures. I would like to remind you that we are all the directors of our inner stages, and also the actors.

Therefore basically it is all myself that takes place on my inner stage. The concept of an “inner stage” helps to recognise and play with our inner being. At the same time it helps to distance things. I can bring the individual figures nearer to me or keep them at a distance according to my will. And it is as though this stage was outside of me that also allow one to distance oneself.

If patients have good contact with good inner beings it is easier to get in touch with the not so friendly figures. Very often the evil figures are representing the introjected perpetrator. Today I recommend “rendering the evil figures or the introjected perpetrator harmless”, which leaves room to different ways of dealing with these figures. Sometimes this can mean killing as shown in the fairy tale of “Bluebird”. Sometimes it means a gentle transformation. In the meantime I have worked with many people on the theme of the evil inner object and the introjected perpetrator, and have found out that there is no solution that covers them all. The introjected perpetrator had had a very important protective function as he was created. I have learnt over the years how important it is to pay respect to this protective function. Richard Schwartz terms these introjections as “managers“, and from this term it is clear to see what an important role they play. Even so these figures on the inner stage are often very destructive and therefore it is important to take their destructiveness away, and that is what I meant when I said to “render them harmless”. When the introjected perpetrator is a torturer it can be helpful to imagine that he apologises. Or to imagine a helpful human being who explains that he was wrong. When we are severely hurt we become in some ways like children. How children’s games deal with evil, threatening figures they stimulate us in the same way as fairytales and myths. So it can be even helpful for patients traumatised as adults to remember the playful children within themselves. An important element when dealing with the villain is what I call “the treasure upon which the villain is sitting or guarding”. That means that if we consider something to be very frightening or threatening, and therefore want to get rid of it as quickly as possible, we should not forget that hidden behind this threatening being is something valuable to us that should be saved and that the perpetrator has stolen. But it was always ours! I hope that I could have given you some ideas how our precious collective gift, the capacity to imagine or to dream can be helpful to stabilise patients, as Hölderlin said: “When thinking man is a beggar, when dreaming he is a god.” (Ein Gott ist der Mensch, wenn er träumt, ein Bettler, wenn er nachdenkt).

It was Jorge Semprun, a victim of the Nazis who was at the concentration camp at Buchenwald who has reflected the question if to remember can kill. He called his book “Schreiben oder Leben” (to write or to live). Therefore I think it is before all-important to help people before they remember to install inner strength and hope.

E. Unaccompanied Minors - Some Crucial Points to Take into Account.¹⁹

Harry van Tienhoven

In the following synopsis, I shall comment on my presentation at the ECRE-organised conference on reception and integration of refugees in Vienna, 11-13 October 2002. Unaccompanied minors (UM) come alone or in the company of brothers or sisters to Europe. They vary in age from 8 to 18 years and it is sometimes difficult to make an exact determination of their age. Special procedures for this forced age determination are devised which are criticised by medical professionals in several countries. In the ECRE conference professionals asked for a procedure in which the minor is free to choose whether to cooperate or not and they were strongly opposed to forced procedures.

In some European countries, unaccompanied minors quickly come under legal guardianship and are offered special housing facilities separate from the adults with trained personal who can give pedagogical assistance. However, in some countries the asylum procedures for children differ from those of adult refugees. This makes permission to stay in the host country until the age of 18 years a possibility. This is, however, certainly not the daily practice in all countries. The policy towards UM is rapidly changing. More restrictive measures are also applied to this age group and it is no longer an advantage to be an UM when it comes to legal procedures.

Unaccompanied minors need special attention because, in addition to their traumatisation and uprooting, they lack the necessary family support in a crucial phase of their life. The period of adolescence is one in which important developmental tasks have to be fulfilled. One of these tasks is to become an independent individual person. To achieve this, a youngster needs to experiment with situations of attachment, on the one side, and freedom and independence on the other. In normal situations, youngsters can in this crucial period of their life rely on their parents. The acute and sudden rupture of family and friends and country of origin is in itself traumatic, and creates additional difficulties for the UM to grow and find a balance between experiment and safety, because they lack the protection, support and safe place which parents can guarantee. In an investigation in the Netherlands, these extra difficulties were confirmed when Dutch school children, migrant children and unaccompanied minors were compared. Among these three different groups, UM showed statistically more problems.

The following survey can be given of the characteristics in the lives of unaccompanied minors.

- They have to deal with the difficulties of being an adolescent. All the feelings, tensions and problems belonging to this age-period they encounter as well.
- They have had traumatic experiences in the early period of their life, such as organised violence, hiding, forced flight, loss of relatives and family, sometimes being victims of human rights violations and experiencing child-soldier memories.
- They experience loneliness as they miss their family. Sometimes the bereavement of important family-members, the lack of the structure of the family, the care and the advice, rules and norms a family gives causes additional problems.
- They cannot rely on a support system as they arrive alone, not embedded in a family structure, without a social network. Long-lasting friendships have been broken up and they do not know the prevailing values in the country of exile. Especially in the beginning they have no friends, clubs and no agenda for recreation.
- Finally, UM have to deal with at times two contradicting cultural systems which creates identity problems (where do I belong to) and problems of loyalty towards their former culture. What they share with other refugees are the experiences with discrimination and xenophobia.

¹⁹ This manuscript is based on a lecture, given at the workshop “Versions & Visions: “Protection and Rehabilitation for Traumatised Refugees and Victims of Torture in Exile”, “European Conference on Refugee Reception and Integration: Analysing New Approaches in Policy and Practice” 11-13 October 2002, Vienna.

Because a normal family life is lacking, a lot of minors seek their necessary support in their peer group and, if they are available, in boys or girls from the same country and background. School and education are important places to prevent isolation and the lack of structure in the lives of these youngsters. Not attending school can be considered a risk factor. For tutors and guardians, it is important to have an idea of how the UM are growing up and overcoming the difficulties of the missing family and parents. To have a checklist of the tasks special for this age-period helps to keep in mind the normal developmental stages youngsters need to complete.

General developmental tasks:

- They need to show more self-care instead of care by an adult person, which helps them to move around more independent in society.
- They should learn to shape their own life. Also establishing friendships with peers takes place independent of the control of adults. It is also the life period in which sexual impulses are strongly felt and they should learn to integrate them.
- They learn more and more to form relationships with parents and other adults in a new mature and equal way. Because education is so important for their careers, they should learn to make plans for the future. This is sometimes more important for boys than for girls, as is the need to manage or handle aggressive inner impulses in their direct environment.

But UM have extra tasks caused by their special situation. It is important to show them as well because it makes their special situation clearer. These extra tasks are directly connected to their situation, as UM they should try to overcome the social isolation in which they find themselves. Because of their experiences in their country of origin they have to learn to deal with post-traumatic problems and symptoms like difficulties with concentration in school, sleep disturbances, etc.

When they have left important family members behind, they should deal with family back home. More often than not this is a burden for them. In the strange and sometimes hostile new society they should acquire a place often for a long time not knowing if this place is safe and secure. While obtaining this place they have to deal with the values of two cultures. All these tasks are in the short-term period. In the long-term they face the problem of every migrant and refugee, i.e. 'is this the country where I will stay for the rest of my life'?

Tutors, teachers, and guardians, but also mental health personnel, can through contact with the UM open the discussion about these tasks and can try to support the UM in the process of achieving them. Likewise, with these tasks in mind, they can judge better where and how impediments exist and help to overcome them. In housing facilities meant for UM people who give guidance to these youngsters use the above-mentioned tasks as a checklist. It makes them better equipped to fulfil the special needs of unaccompanied minors.

When UM are referred to special institutions like youth guidance clinics or mental care institutions, mostly there are multiple problems. Behaviour problems like aggressive behaviour and self-destructive or anti-social behaviour show the more extrovert type of reaction while isolation, loneliness, absence from school and withdrawn behaviour, are signs of a more depressive and introvert reaction. Especially important for this life period are the motivational problems to attend school and the learning problems youngsters have. Apart of these reactions, other psychopathology and main psychiatric diagnoses specific in this age group can be seen.

All of them can interfere with their development because the family as a target for intervention is lacking. All professionals who have contact with the UM like personnel in the housing facilities, schoolteachers and professionals like psychologist and psychiatrist should cooperate.

Ambivalence is a characteristic of the period of life of adolescents, thus making the referral to and the treatment in mental health institutions more complicated. UM have mostly no experience with professional help and are afraid of becoming insane. Sometimes they do not want to tell anyone about their experiences, afraid as they are for re-traumatisation. This creates the wish to forget and the fear to have to talk. If the ambivalence is not taken seriously, it can lead to failure in the treatment and

frustration on the part of the professional worker. A flexible attitude is needed especially in situations of not showing up on appointments. Not too quickly giving up, a lenient attitude and showing concern and interest, and the giving the UM control over the situation are crucial factors for success.

A risk factor for the professional is the tendency to compensate for all the losses an UM have had. Sometimes professionals see their own possibilities as meagre and conclude that the adolescent needs a family and not therapy. Sometimes the life conditions or the lacking of a residence permit form a reason for not offering help. However, when the attitude of UM is seen as a normal aspect of their age and the situation of UM as complicated but not impossible, the professional can deal with it in a more satisfactory way.

F. TREATMENT ISSUES PTSD²⁰

Max J. van Trommel

1. *Create Safety*

- Refugees and PTSD is a doubly complex situation.
- Perpetrators and victims of violence are anxious and need a lot of trust before they are able to develop a working alliance.
- Be prepared that they will regress, when you have developed a working alliance, and they will start to mistrust you again.

2. *Make a contract*

- What can be done
- What cannot be done
- Realistic goals
- Beware of giving too great expectations.
- Be aware that, in comparison with the country of origin, Germany is a country of milk and honey.
- In their country of origin, refugees had different methods to try to obtain privileges, or even food.
- Be clear that threat or violence towards you is not permitted.

3. *Co-operation*

- Develop rules together with your colleagues, how to react in case of threat or violence.
- Be clear about working tasks for every colleague, in order to prevent overruling your colleague.
- Keep your colleagues informed.
- Working with traumatised refugees can be demanding, difficult, and emotional.
- Therefore you need to develop regular peer group supervision meetings.
- You need to have a group leader who is responsible for a trustworthy environment in the group.
- Give each other emotional support.

4. *Non-violence contract*

- Violence will not be accepted
- If there is a secondary advantage through violence: no other help other than stopping the violence
- Accept the perpetrator as a human being but don't accept his violent behaviour
- Break the vicious circle of using violence as a reaction to others' violent behaviour
- Teach perpetrators to refrain from violence
- Help to overcome loneliness in developing a network with relatives, neighbours, colleagues, helpers etc.
- Teach victims how to develop self-protection e.g. with relatives or neighbours
- Help victims to develop security areas in case of renewal of violence.
- Help victims to overcome learned helplessness
- The perpetrator has to accept the safety rules of the victim

5. *Careful examination of case history*

- Ask concrete and simple questions
- Ask detailed questions of what has happened

²⁰ This manuscript is based on a lecture, given at the workshop "Versions & Visions: "Protection and Rehabilitation for Traumatised Refugees and Victims of Torture in Exile", 12-13.11.2001, Cologne

- Be careful with male/female role in case of sexual violence or abuse
- Ask about
 - Sleeping patterns
 - Anxiety
 - Memories
 - Nightmares
 - Revival of memories and flash-backs
 - Re-enactment or repetition
 - Obsessive thoughts
 - Depression
 - Suicidal
 - Self-destruction
 - Hallucinations
 - Guilt feelings
 - Self-esteem

6. Examination of social support groups

How can social support groups e.g. families, neighbourhoods, other organisations help in reducing traumatic stress.

7. Therapeutic strategies

Several strategies are developed, such as psychodynamic or explorative therapy, cognitive behaviour therapy, desensitisation, supportive strategies, non-verbal therapy, combination with medicaments etc. It is clear that this will only be possible with a therapeutic team. There must be a team leader who has responsibility for the whole therapeutic process. It is not necessary for a team leader to be a psychiatrist. The team leader should have good managing qualities and have sufficient knowledge in order to have a good overview about the different therapeutic activities.

The first therapeutic strategy should be creating an atmosphere of trust. The revival and renewal of traumatic memories may interfere with explorative therapy. It is therefore a therapeutic goal to help patients to tell about their traumatic experiences and memories, to go back to the frightfulness of the traumatic experience in order to diminish the destructive power of those memories. However a different strategy should be made in case of re-enactment of traumatic experiences. In case of re-enactment the situation of the patient is disturbing and alarming so that explorative therapy is not indicated. In that case desensitisation and pharmaceutical therapy is recommended. Mostly a combination of therapeutic strategies is more helpful. Therefore a multi-oriented team needs a team leader who has the responsibility for the whole therapeutic process. Take the family or the network of the patient into account. Give psycho-education to patients and his/her relatives.

8. Therapeutic goals

- Relief of traumatic stress
- Diminish destructive power of trauma memories (be careful with traumatic re-enactments).

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