Trauma therapy with adolescent refugees

A CONVERSATION WITH PETER KLENTZAN*

During the last 6 years before your retirement you were the director of the TraumaHilfe-Zentrum in Ruhpolding/Germany for the foundation* Wings of Hope*.* Wings of Hope *is an institution that cares for unaccompanied minor refugees in a trauma-therapeutic intensive living community. How did you first have contact with this topic?

Klentzan: Unrelated to my work as a deacon, in 1992 I started to help refugees in the war zone of the former Yugoslavia – in the so-called protection zones that were set up by the United Nations. That was the first time I was in contact with people who had had war experiences, especially with children and adolescents. Starting in 1997, in an introductory seminar I looked more closely at psychotraumatology. At some point my work as a trauma therapist, teaching therapist, and supervisor became my life's vocation.

What topics were the children and adolescents concerned with back then in Sarajevo?

Klentzan: Organising how they were going to stay alive was the primary concern for those children and adolescents. They were experts at survival and had learned to make do with very little and make the best out of almost nothing. But of course they were also experts at dissociation and repression; emotionally they were usually disconnected as a survival mechanism to deal with the death that was all around them. Children have unbelievable abilities when it comes to survival because they can make something out of everything: They even get ideas for how to play in the stairwell of a high-rise – usually the stairwells in the high-rises were the safest places during grenade attacks.

What is the work at the TraumaHilfeZentrum like?

Klentzan: Most of my work was helping people to stabilise themselves. In *Wings of Hope*, our help is supposed to enable people to help themselves, re-organise themselves, and take control of their lives again. No matter where we are, whether in Germany or abroad, we try to activate those affected – social workers, teachers, psychologists, the professions that are already active in these areas. I see our primary task as that of enabling helpers to help themselves and thus others

Intrusive symptoms (flashbacks, nightmares, etc.) Ways to handle them: understanding memories as part of the past	**Constrictive symptoms** (fearful avoidance strategies, e.g. not wanting to go out the door) Ways to handle them: respect, but also to point out the inappropriateness in this situation
Hyperarousal (constant restlessness) Ways to handle them: create safe structures; daily life at school that allows for experiences of being self-effective	**Psychosomatic symptoms** (e.g. stomach pains, headaches) Ways to handle them: make clear how this is connected; create safe structures

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Ill. 2: Overview of symptoms from which traumatised refugees often suffer

because that is what I have found to be the most effective way over the course of the last 30 years (Ill. 1). Of course I could become a little hero and do good all over the world, but the efficiency I would have is minimal because I'm only one person. But when I can manage to get people to help me, especially locals who can work with the people in their own language, then I can do more than one single helper.

What are the greatest challenges for people who work with traumatised refugees?

Klentzan: We try to categorise the symptoms into 4 groups because it is easier to recognise things when we have an internal structure (Ill. 2). The group of intrusive symptoms is a group in which those affected are repeatedly confronted with the traumatic event: with flashbacks or nightmares, that is, unsuccessful attempts by the brain to work through these events during the night. The second group is that of the so-called constrictive symptoms. People who are affected have fearful avoidance behaviours and try to avoid anything that could bring them into contact with what traumatised them. This is not a conscious avoidance behaviour but a phobic one that usually leads to the people withdrawing and becoming lonely and isolated. The third group of sypmtoms is so-called hyperarousal. These people do not act on a normal level of arousal, they are always above it. And the fourth group of symptoms are the somatic or psychosomatic symptoms. The people affected have unexplainable pain that is checked out medically. In the end, the doctors say: "Really there's nothing wrong with you; you're healthy." This pain is of course not made up but held as a kind of "pain memory". The pain belongs to a specific event and can be repeatedly re-activated. People who have survived serious trauma and suffer from this kind of pain would be in the classic symptom group 4.

How do intrusive symptoms present in children?

Klentzan: Especially smaller children try to work through traumatic experiences during play. For example when children have lost someone through violence, often they saw it happen, when their relatives were murdered, then we can see that in the way they play: They role play with dolls or even with stones and act out the situation they experienced over and over again. We notice, though, that it doesn't help them, and instead their depression, auto-aggression, or aggression toward others is the same at the end of the game. Sometimes we even see that these behaviours get worse because the child despairs that they won't find a solution.

What kinds of help are available then?

Klentzan: In this case I would work with a method called EMDR (Eye Movement Desensitisation and Reprocessing). That is a method we can use to help a child's brain reprocess things it hasn't been able to process yet.

We know that every trauma is linked to a problem in processing information. That is true for every age group. Usually our brain is able to perceive, recognise, and classify information from daily life and then either make it into a memory that we can continue to use or place it under the heading "don't need it". With trauma we experience the opposite: The information is not processed well. In some cases, it is only processed in part. And these fragments can be triggered again and again. To make this fragmented memory into a coherent and complete memory, I would use the EMDR method, that means reprocessing the emotions, physical reactions, and images that belong to the un-processed event with the child so that the event can be put together as a whole. That usually helps a lot and is very efficient for processing it retroactively. If a child has lost their mother and maybe also had to watch how the mother died, then we can't undo that. What we can do, though, is help the child to make it into a memory that will always be a sad memory, but the child can remember it in an appropriate way because it has been processed.

Can you give a typical example for when children and adolescents show fearful avoidance behaviours?

Klentzan: We often see children who have difficulties opening a door normally, going in or out of the door, who always have to reassure themselves and hesitate for a long time before they open the door in the refugee home or classroom and go out into the hallway. That is a typical avoidance behaviour. This fear is a very sensible fear; at a certain time in these children's lives it was very important. What they need now is a good explanation. We have to explain to them what is going on inside of them. We tell them: "You know, I'm happy that you're so careful. If you hadn't been so careful, then you might not have made it here. There was a time in your life when going out the door was very dangerous, and you didn't know what might be waiting for you around the next corner. Your brain learned to be very careful. Today you're in a safe place and now you could practice slowly setting aside the fears from back then so you can feel more confident again. But we are happy that you were so careful then. I'm sure that saved your life."

What symptoms do children and adolescents have when they suffer from hyperarousal?

Klentzan: Hyperarousal occurs when the brain is swamped too early with images linked to emotions and feelings that we have, and these are then connected to physical reactions because all emotions are reflected in our bodies. This leads to us being in a state of constant restlessness. Many minor refugees are hyperaroused by everything they have experienced: at home, while fleeing, in their new country. And then in the refugee home the television is turned on 24/7, news programmes from home show war and terror attacks.

How can you support hyperaroused children and adolescents with refugee backgrounds?

Klentzan: What is important is to create an external environment that is as safe as possible with very few stimuli. A serious obstacle to the recovery of these children is frequently the fact that in the mass home where they live with their parents they often do not have this kind of environment – because too many people from different countries with different languages, sometimes also with different cultural and religious backgrounds, have to live together in very close quarters. You should also make sure that their day is well-structured. For children it is very important that you make the day back into the day and the night is the night. During the night we sleep and during the day we get up and go to school. For most refugee children, schools are the safe external places. They love leaving the refugee accommodation and being at school. The more self-effective experiences they have in the framework of a structured school day – that means experiencing that they can do something, achieve something, make progress, that they are capable of learning German and finding new friends – the faster these children will recover and overcome the hyperarousal.

What are typical phenomena for children in the psychosomatic area?

Klentzan: For adults, more often the head is affected and they very frequently have headaches. For children, typical pain is often in the abdominal area. This is stress-related pain, that means first the stress has to be reduced, and then the stomach pain also gets better. When they're smaller, we look for age-appropriate ways to reduce their stress and then the pain usually also goes away. If the children are old enough, then we explain to them that this is how their body is reacting to the many exciting new things. It is important to always take children and adolescents seriously, take time to listen to them, and support them in managing the many demands they face.

That sounds like a serious challenge for integration, both for teachers and fellow pupils. Are there also opportunities and not just problems?

Klentzan: In recent months, I was asked to speak at a lot of schools in Bavaria/Germany. I found that it helped a lot of teachers to tell them how extremely important and good their work is and how much the children experience the schools in particular as safe places, how good that is for the children, and how much it has led to a reduction in their stress levels. But of course these people also have a serious challenge when working with the children and adolescents with the symptoms I described. That is why it is important for us to have seminars on this topic and that we as experts make ourselves available in the areas in which teachers are working so that they can see not only the challenges but also the opportunities. That is an additional burden, it demands something from the teachers. They not only have to work on inclusion, they now also have to see how they can manage with the refugee children and their symptoms. But the opportunity is that they can accomplish an extraordinary amount with the children.

How can children without a refugee background profit and learn from this situation, too?

Klentzan: 4 years ago, my wife and I took in 4 adolescents from Afghanistan and, since our own children are now grown and don't need our undivided attention any longer, we took them in as foster children, so to speak. First we put them in private schools. What was interesting was the schools' reactions. 4 years ago, the number of refugees coming in wasn't yet so high as it was last year. And now these schools have said: "Oh, that would be interesting for our pupils if we accepted these adolescent refugees because it will be good for our pupils' social learning. They can benefit from

this." I used these thoughts when I held my speeches in the governmental or municipal schools and asked the question: "Let's think: How could our children and adolescents benefit from this?" Many of our children suffer from luxury, the conditions of our prosperity. And for them, it can sometimes be a big help – if it is done in the right way – to get to know what life is like for children their age in other countries. Then they can all benefit from one another. And that is what I would try to convey. Educators should try to take advantage of this opportunity. ■

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WHAT IS TRAUMA?

According to the World Health Organization's scientific classification (ICD 10), trauma is exposure to "a stressful event or situation [...] of an exceptionally threatening or catastrophic nature" (ICD 19, F 43.1). The people affected were confronted with actual or threatened death, serious injury, or sexual violence. Type I trauma refers to sudden, unpredictable and unintentional events such as accidents or natural catastrophes. Type II arises from events in which people purposely do something to other people ("man-made disaster").

In a traumatic situation, the body reacts with an extreme burst of energy that arms the person for running away or attacking ("fight or flight"). With traumatic stress, this can also lead to dissociation, which is a neurobiological protection mechanism: Numbness and an inner distancing from an unbearable reality with simultaneous, extreme psychological and physical tension.

The events are always saved deep within the person's memory. The amygdala, the "control centre for emotions" is over-activated. It is responsible for things such as assessing the threat posed by perceptual stimuli, and during the situation it records many details and notes them as being "life-threatening". At the same time, the hippocampus, the area of the brain that classifies events according to their location, time, and content within an autobiographical context, shuts down. The information from the situation therefore remains saved in the hippocampus but has not been processed.

The most common consequence of trauma is "post-traumatic stress disorder" (PTSD). Common symptoms are hyperarousal, re-living the situation (intrusion), avoidance (constriction), or internally retreating (dissociation). Traumatisation during childhood is particularly serious. Traumatised children often regress to an earlier stage of development, and their further cognitive, emotional, motor, and social development can only continue in a fragmented manner.

Protective factors such as safety, stable structures, access to education, and leisure activities can help. But often these are not sufficient for processing the trauma and traumatic experiences. In these cases the children need professional therapeutic assistance (trauma therapy).

Summarised from the following: Zito, Dima & Martin, Ernest (2016). *Umgang mit traumatisierten Flüchtlingen. Ein Leitfaden für Fachkräfte und Ehrenamtliche (Dealing with traumatised refugees. A guideline for professionals and volunteers).* Weinheim & Basel: Beltz Juventa.

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