GESELLSCHAFT ZUR UNTERSTÜTZUNG VON GEFOLTERTEN UND VERFOLGTEN E.V.
(Association for the Support of Torture Victims and Persecuted Refugees)

What you should know about trauma

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This guide gives a brief overview of what you should know about trauma and traumatised persons. It is issued by the Association for the Support of Torture Victims and Persecuted Refugees (Gesellschaft zur Unterstützung von Gefolterten und Verfolgten e.V.). Its purpose is to help improve understanding of traumatised people. It addresses professionals in a wide range of activities and everyone working with refugees and asylum seekers.

The main focus of this guide is to communicate fundamental knowledge about traumatisation, to provide information and raise awareness. At the same time, we want to satisfy the frequently expressed need for clear directions and instructions for action, for sensitive handling of refugees and asylum seekers. That need is, however, very hard to meet because of the wide range of different human reactions to traumatisation and the differences in professional context. That is why we encourage everyone working with traumatised refugees and asylum seekers to make use of further education, professional advice and supervision when confronted with concrete situations.

However useful this "What you should know" guide may be, it is no substitute for expert consultation and supervision in specific cases.

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We talk about 'trauma' (derived from the Greek word for 'wound') when people are confronted with threatening experiences such as accidents or disasters, which leave traces as long-lasting mental and physical consequences.

In general the term 'trauma' is used to describe a whole range of different 'extreme experiences' such as traffic accidents, natural disasters, violent crime, imprisonment, torture, persecution, war experiences, rape, sexual abuse of children, and it is also used for experiences resulting from subjection to mobbing, unemployment, etc. Thus the word 'trauma' is very widely used in everyday language, and risks being used in an inflationary way. Its definition has therefore been systematised in clinical language, with specification of criteria to define when an event is to be regarded as 'traumatic'.

We can talk about traumatisation in the 'clinical sense' if a person and/or persons close to them are exposed to situations that are exceptionally threatening or have catastrophic dimensions, to an extent outside of normal human experience. What is "outside of normal human experience" is dependent among other things on the development stage of the person concerned. Thus threatening experiences have a different impact on children than on adults. A situation is potentially traumatic if it would cause far-reaching disturbance in practically any person that is at the same stage of development.

Threats are regarded as 'catastrophic' and 'existentially threatening' in this sense if the traumatic situation involves a threat either

- to the victim's own life and/or physical safety *(existential threat to life)*; or
- to the relationship with a significant reference person. That is the case, for example, for a witness to a situation that is life-threatening for a person or persons with whom there is a very close relationship *(existential threat to bond)*; or
- to the perception of being an autonomously thinking and acting human being *(existential threat to autonomy).*

In a 'traumatic' situation it is not possible to escape or to defend oneself, or else flight or defence would not reduce the threat; i.e. the situation can only be undergone in a state of intense fear, helplessness, a sense of being exposed to external forces, and of horror.

Trauma is a normal physical and mental response to an abnormal event, or to sustained experience of an abnormal situation outside of everyday experience.

Based on the traumatic event, there are different types of traumatisation, which may be described as being of different severity.

A distinction is made first of all depending on the duration of the traumatic experience:

- Non-recurring, or short-term traumatisation traumatic events (*Type I traumata*); and
- Recurrent and/or long-lasting traumatisation (*Type II traumata*).

A further distinction is made depending on the cause of the trauma, between

- Traumata caused by human beings (*'man-made disasters'*, such as war, torture, rape, etc.); and
- Natural disasters, that is traumata not directly caused by human beings.

Type II traumata and injuries caused by human beings are regarded as more serious, because they cause a fundamental disruption of trust in human relations.

1.1 The trauma as a process

Isolated consideration of 'trauma as an event' quickly proves to be inadequate in work with refugees and the victims of societal and political violence. This perspective fails to explain, for example, why some people develop traumatic physical and mental difficulties after extremely threatening experiences, while others do not. In addition, isolated consideration of the event as a single occurrence fails to take account of further potentially 'pathogenic' factors such as conditions during flight, loss of home and social identity, and the conditions of life in the host country. Refugees and asylum seekers are not only subject to a biographic background of extreme stress before their flight (e.g. torture, detention, rape); after a flight, which may involve equally serious problems/deprivations, they are subject to extremely destabilising conditions of life once they arrive in the receiving country (e.g. Germany).

It is unusual for a single event to be responsible for the traumatisation response. Traumatisation is a process, and arises or develops on an individual basis, resulting from the sequence of potentially disrupting events.

The concept of sequential traumatisation

The damaging combination of past and present stress experience is described by the term 'sequential traumatisation' coined by Keilson in 1979. Keilson distinguishes between three phases of traumatisation and thus possibilities of worsening of the trauma or coping with it –primary, secondary and tertiary traumatisation.

Apart from individual differences and resources for coping with the ongoing trauma and the period shortly afterwards (primary and secondary phase), Keilson attaches particular importance to the third phase, that is tertiary traumatisation, for the establishment of a traumatisation reaction or chronification of mental and physical impairments. The third 'phase'

refers to the possibility and necessity to build up a new life with social assurance and stability following experience of the trauma. If there is a lack of social integration and support, that not only means that new wounds will be added to the old ones, but that the traumatic experiences and life phases will take on a new quality due to the duration of the stress, and will harden into a consistent traumatic process.

The trauma as a complex interaction between person and environment

Another model for description and explanation of complex traumatic reactions is the *development model of mental traumatisation* developed by Fischer and Riedesser. This not only considers the potentially traumatic event, but also attaches key importance to the available individual and social resources of the individual.

Fischer & Riedesser define extreme mental trauma as follows:

"A trauma is experience of vital discrepancy between threatening situation factors and individual coping resources, combined with feelings of helplessness and unprotected exposure, thus causing a long-term disturbance of self-perception and perception of the world" (Fisher et al., 1996).

This definition indicates that a potentially traumatising situation is one where there is a dichotomy between the event itself and its impact on the individual. On the one hand there is the extremely threatening event, and on the other hand there are the resources for coping with it as perceived subjectively by the individual in this situation. The individual response of a person to a long-lasting traumatic situation is to be understood as the attempt to balance out the traumatic situation (process of traumatic compensation).

One of the decisive factors in whether an individual can cope with a trauma or whether the traumatisation will continue is thus how the social environment responds to the traumatic suffering (e.g. recognition of the injustice suffered) and the nature of the social environment after the end of the traumatic experience (social perspective vs. exacerbation of the situation).

The 'pathogenic' impact of the environment

The life situation and the framework conditions for refugees and asylum seekers looking for protection and security in Germany as the receiving country, e.g. enforced inactivity, are specified in such a way that they can easily reinforce and fix the individual conviction of victims that they 'can exercise no influence on their own life'.

The psychological concept of 'learned helplessness' (Seligman, 1975) says that if an individual meets with uncontrollable situations and events, and repeatedly has the experience that he/she cannot make any change in it or that his/her actions do not have the desired effect, he/she will generalise this experience.

The helplessness experienced in the situation (e.g. repeated or fruitless application for permits) will increasingly generate a generalised conviction and expectation of helplessness. There will be a reduction in willingness and effort to exert any influence. Even events which are partly controllable will be perceived as uncontrollable, and the emotional world will increasingly reflect a hopeless, resigned, depressive mood lacking perspective.

There is a decrease in self-determination, that is the element in the concept of self which says "I am someone that can master situations", and thus in an important element in mental health, and the motivational basis for action.

Refugees in Germany repeatedly have the experience that they cannot influence their own lives by means of their own efforts, and they transfer this experience as a generalised formula into all areas of their lives.

The life situation of traumatised refugees and asylum seekers is characterised by at least a **double stress background** – the biographical experience of extreme stress before or during flight, and the considerable restriction in their conditions of life where there is insufficient life perspective or no life perspective at all in Germany as the receiving country (particularly for those with unsecured status of residence/toleration). The tightly stipulated legal framework and the social exclusion due to official regulations often lead to the maintenance of past traumata and increase the risk of chronification and re-traumatisation.

The above concepts of 'vital discrepancy experience', 'traumatic process' and 'sequential traumatisation' point to further protection and risk factors, which are important for the deepening and thus for the course of a traumatic reaction. The risk factors include not only lack of security, stability and social integration, insufficient possibility of 'recovery', lack of capability for the creation of meaning with respect to present and future, lack of creation of perspectives, and lack of experience of competence and self-effectiveness. Every new experience of helplessness, incapacity and exclusion can thus break open old wounds again, and is subjectively experienced as a continuation of never-ending persecution.

The physical and mental traces of traumatic events are often maintained in Germany, and harden to form a range of physical and mental disorder complexes.

2. Psychological consequences of traumatisation

The possible physical and mental consequences of traumatisation vary widely, and may be as different as people themselves are different. There is also a difference in the capability of the individuals exposed to such violence to cope with the mental and physical consequences of these injuries alone, with the help of their families, and with the support of others. But there are various efforts being undertaken by experts to systematise the frequently occurring phenomena and structural elements of mental traumatisation.

2.1 Complaints and symptoms that may indicate underlying traumatisation

The following complaints and symptoms occur frequently as a consequence of traumatisation, and may be indicators of potential underlying traumatisation:

- ***Intrusions*** – that is flashbacks and similar intrusions, i.e. suddenly 'being overwhelmed' by traumatic memories, or having a feeling or constant sensation that the trauma is just happening.
- ***Nightmares*** – i.e. the recurrence of the traumatic event or of scenes of the traumatic event in dreams; waking up in the night in a state of fear, trembling and sweating.
- ***Extreme sleep disturbance*** – i.e. being unable to go to sleep, not sleeping through the night, waking up early, insomnia, fear of the night, and inability to sleep in the dark.
- ***States of absent-mindedness*** – known as dissociative states, e.g. "crossing the street although the traffic lights are red", "missing the bus stop", mental absence during conversations, and "not following a conversation".
- ***Concentration disturbances*** – in reading, learning, working, in the course of daily activities, e.g. "forgetting how the sentence started by the time you reach the end of it."
- ***Memory and recall disturbances*** – i.e. no longer remembering, or "forgetting" a complete period of time, often the time of the traumatic experience; complete avoidance of any contact with the past.
- **Hyper-arousal, being in a state of inner pressure and restlessness** – i.e. continually in a state of alert or being 'on guard'.
- ***Extreme liability to exaggerated startle response*** – e.g. nervous reactions at the slightest noise or sudden movement.
- ***Extreme mood fluctuations*** – i.e. becoming depressed or angry due to trivial occurrences, sudden crying fits or spasms, irritability and fits of rage.
- ***Fear of 'no longer being normal'*** – of losing control or going mad, because the disorders are perceived but cannot be assigned to a cause or understood; the person affected suddenly behaves differently from the way he/she knows him/herself.
- ***Extreme mistrustfulness and a sense of isolation*** – the feeling that there is no-one who can understand or help.
- ***Brooding*** – about the past, about what has been lost, and also about the present, in the sense of 'Why me?"

- ***Lethargy and apathy*** – i.e. a low level of activity.
- ***Vegetative symptoms*** – such as trembling, respiratory complaints, heart palpitations, heart pains.
- ***Various physical pains*** – such as long-lasting headache, migraine, pains in body and limbs, circulation problems, gynaecological complaints.

2.2 Narrow clinical definition of traumatic complaints

Apart from the acute stress response (shock, paralysis, horror and withdrawal for a period of hours or weeks after the trauma), a number of long-lasting mental and physical disorders induced by traumatisation are recognised internationally by the two authoritative institutions – the World Health Organisation (WHO) and the American Psychiatric Association (APA) – under the terms **Post-Traumatic Stress Disorder (PTSD)** and **long-term personality change following extreme traumatisation** as disorders having the status of illness where health professionals have a mandate to intervene.

Thus the criteria set out below are binding for physicians and psychologists working with refugees and asylum seekers and in the elaboration of expert reports.

Posttraumatic stress disorder (PTSD)

PTSD is characterised as follows (summary in accordance with WHO and APA criteria):

- ***A repeated sensory reliving of the trauma***, in the form of
  (a) intrusive images and memories (intrusions, flashbacks);
  (b) recurrent, severely distressing dreams (nightmares);
  (c) suddenly feeling and acting as if the trauma had returned (e.g. the feeling of living through the event again); and
  (d) intense mental distress at confrontation with events which symbolise the traumatic event or are in some way similar to it.
- ***Ongoing of situations or 'trigger stimuli'***, which are similar to the original traumatic experience or which could awaken memories of the trauma.
  Those include
  (a) activities and situations which call up memories of it;
  (b) thoughts and feelings which recall the memories; or
  (c) inability to remember important elements of the trauma – that is a typical disturbance of memory (psychogenic amnesia).
- ***Long-lasting symptoms of increased arousal***, i.e. continuous over-stimulation, which may be expressed in sleep disturbance, irritability or outbreaks of anger, concentration disturbance, exaggerated startle response.
- ***Restriction of general responsiveness,*** i.e. limitation of emotional response in the form of a constant feeling of numbness and emotional bluntness, equanimity towards other people in the form of isolation and alienation, indifference to the environment in the form of lack of interest in meaningful activities and the feeling that the future is overshadowed.

The above symptoms and complaints are not present to an equal degree in all traumatised people, but occur in different patterns in different individuals. The symptoms and complaint complexes may also change in the course of time, i.e. this is not a static clinical picture, but rather symptoms of an intrapsychic traumatic process. A diagnosis of PTSD is made if several symptoms of the above groups occur together with a relationship to a traumatic event (see 1.1). The complaints should have occurred within a maximum of six months from the traumatic event, and should have been present for not more than two years.

In many cases the concept of PTSD is not sufficient to capture the consequences for people who were exposed to chronic trauma, and where the traumatisation was caused by human beings ('man-made disasters'). To refer to this condition, the term 'Complex Stress Disorder' was defined by Herman (1992) and submitted to the WHO and the APA for recognition.

This clinical picture, which has not so far been taken up in the diagnosis manuals of these two authoritative institutions, was the basis for characterisation of enduring personality change after extreme stress. The concept of complex PTSD includes not only the relationship to the traumatic event, but also attaches more importance to the far-reaching loss of self-perception and perception of the world, with a simultaneous sense of being completely vulnerable, with feelings of powerlessness and helplessness.

Complex Posttraumatic Stress Disorder

Complex PTSD is characterised by the following additional symptoms, alongside the symptoms previously listed:

- ***Disturbance in the 'emotional world'***, such as depression, hopelessness, persistent preoccupation with suicide, self-aggression and self-harmful behaviour.
- ***Changes in self-concept***, that is perception of ones own person, such as intense feelings of shame and guilt, feelings of alienation from oneself, other people and the world, feelings of worthlessness and stigmatisation.
- ***Changes in social relations***, i.e. extreme distrust, social withdrawal, isolation, loss of social abilities, reduced self-protection capability

This concept characterises very severe and chronic traumatic consequences, i.e. they last for many years and in some cases cause irreversible mental trauma consequences, as set out in the WHO diagnosis manual under the heading of permanent personality changes after extreme stress situations.

Permanent personality change after extreme stress

Permanent personality change following extreme stress is considered to have taken place if an individual changes his or her attitude to their internal and external world for a period of more than two years, in a wide range of situations and without exception, in the following ways:

- Taking a hostile, mistrustful attitude to the world.
- Social withdrawal, isolation, going as far as loss of the most basic social skills.
- Feeling of emptiness and hopelessness.
- Chronic feeling of hyper-arousal with a sense of being constantly threatened.
- Alienation (from self, from the world, and from other people).

As indicated above, not all individuals that have suffered traumatic events exhibit mental symptoms and complaints. Apart from the relationship between the traumatic experience and individual resources and coping capabilities, there are different protection and risk factors that have an impact on the traumatic response, promoting or inhibiting the development of a traumatic process.

In addition, posttraumatic stress syndrome is only one of many response possibilities, i.e. exposure to traumatic events increases the overall probability of suffering from mental disorders.

Other disorders that occur more frequently in 'traumatised' individuals:

- Adaptation disorders
- Depressions
- Anxieties
- Somatisation disorders

3. A range of support capabilities

The possibilities and necessities of support are just as varied as the responses that people show to traumatic events, and in some cases the course of such traumatic responses. What traumatised people need above all is reassurance and stability. Capabilities of support include support for their accommodation and clarification of their situation (secured status of right to remain in the country, as a basic security), and other areas and means of increasing stability.

Stabilisation in this context means the establishment and promotion of external and internal structures that promote a sense of reassurance, of orientation, of ability to exert an influence, of skills and self-esteem, and a dependable and closely linked social network, and which promote meaningfulness, continuity and perspectives in their own existence.

In these sense, stabilisation always relates to various external areas, and also to promotion and support of positive inner attitudes. Externally, it includes support in such areas as education, occupation, training and qualification, and also building and supporting social integration and involvement, and promotion of self-organisation. Internally, it includes all kinds of support and promotion to help people get a sense of their own initiative, with positive experience. Stabilisation in this sense involves a range of different vocational groups, addresses a number of different areas, and covers a wide range of possibilities to help mitigate the traumatic process or at least avoid making it any worse. Support in this sense is a 'modular system' covering areas such as right of residence, vocational and social inclusion, and psycho-social well-being.

What do traumatised people need?

Stabilising elements in this 'modular system' are all measures, activities and contacts which open up scope for decision and action for traumatised persons, and thus enable them at least to some degree to have the following experiences:

Getting away from…	***Moving towards…***
'Learned helplessness' as an everyday experience of helplessness and powerlessness	*Experience of own effective activity, i.e. the experience of being 'competent and useful'*
Experience of loss of control due to prescribed passivity and inactivity	*Experience of control due to own activity and initiative*
Fixation to apathy with identification as a victim, and from being forced into rigid remaining in this attitude	*Possibility of (renewed) establishment of a positive identity by creating access to skills and resources*
Experience of exclusion	*Experience of socially belonging, with participation and recognition*
Experience of lack of perspective and meaning	*Possibility of creating meaningfulness for the present and the future*

3.1 What can 'helpers' do?

The need for detailed guidelines for sensitive treatment of refugees and asylum seekers, avoiding retraumatisation, is easy to understand; but it cannot be totally satisfied due to the wide range of human reactions following traumatisation and due to the differences in professional contexts.

However, it is possible to specify a number of attitudes, forms of communication and forms of behaviour which are helpful in dealings with potentially traumatised people. Apart from these general 'guidelines', specific situations and questions, and concrete problems in dealings with traumatised people are a subject for expert advice and supervision.

Attitudes

- ***Sensitivity*** to possible background traumatisation. The same applies to sensitive and careful handling of statements such as 'You are traumatised', because being traumatised means stigmatisation for many, i.e. it is understood as meaning 'sick' or 'deranged'.
- ***Partiality and acceptance*** – not suggesting that the 'person' is to blame for his or her condition.
- ***'Collecting people where they are at'***, as a general principle of all psycho-social counselling. That means it is necessary to allow and accept avoidance reactions on the part of refugees with respect to what they have undergone.
- ***Do not see traumatised people as victims, but as 'survivors'***, i.e. people who have succeeded in surviving a catastrophic threat, in escaping, and who have undertaken the attempt to find safety.
- ***Be prepared for a long-period of establishment of a relationship, and for repeated tests of this relationship***, because any person who has suffered very severe upheaval in his or her trust in the human environment will (rightly) tend to mistrust this environment again and again, and to have the feeling of being isolated, misunderstood and exposed to a helpless situation. That means it is essential not to take personally any mistrust and reproachfulness towards oneself. And if the advice offered is not taken and/or put into practice, not to think 'all this is no use' and to stop giving support. What is useful in such situations is, for example 'to take a look at it together', to see what is preventing acceptance of help which seems useful from the professional viewpoint.

Communication forums

- ***Ability to listen*** – i.e. to respond appropriately when the person affected wants to talk about what he or she has experienced. Talking *can* help to understand and cope with the situation better.
- ***Make an offer for discussion: 'do not avoid discussion, but do not force discussion either'*** – it is not advisable to say either 'You don't have to think about it now; you are safe now' or 'You simply have to talk about it now', because it is up to the person affected to decide when, where, about what and to whom he or she wants to talk.
- ***Be patient – be relaxed in your responses*** *– and give yourself time!*

Behaviour patterns

- ***Give information and explanations***: If someone perceives mental symptoms, it is important to address possible connections with biographical experience, and to show how the symptoms and complaints may be **normal** physical and mental responses to an abnormal situation (principle of psychological education). The same applies to outbreaks of emotion, and the occurrence of thoughts that cause fears, such as the idea of 'going crazy'. It is particularly important in such situations to keep calm, to allow such thoughts and not to evaluate them, and to identify them as a normal reaction to the specific mental situation, to relieve the worries of the individual concerned.
- ***Promote opportunities for relaxation*** – e.g. discuss the possibilities for relaxation that a person had before the stress experience, so that these can perhaps be taken up again.
- ***Establish and restore normality*** – i.e. support the person affected in planning 'normal' daily activities, such as shopping, leisure activities and social contacts, possibly also encouraging participation in ceremonies/festivities that are important in the culture in question.
- ***Strengthening self-esteem*** – e.g. by expressing recognition of what a person has achieved in the past, by directing attention to what a person can do/achieve, and by pointing out small steps of progress and successes, i.e. also giving positive feedback, emphasising strengths, and by sharing humorous ideas, helping one another, etc.
- ***Strengthening own initiative*** – that is helping someone, but not taking over too much from that person; always working towards opening up a certain scope for action for the person affected, so that he/she can perceive himself/herself as acting successfully in his/her everyday activities, e.g. in social relations.
- ***Work against generalisations*** – e.g. take up extreme references such as 'everything', 'nothing', 'always' or 'never' and put them into perspective by pointing out alternative examples.

3.2 When does psychotherapy make sense?

A further module in the range of support capabilities is expert psychotherapeutic support by a physician or psychologist/psychotherapist. But there are a number of obstacles here – apart from the shortcomings in the health care sector, and difficulties in securing funding, another obstacle is often that the person affected does not want treatment, because he or she believes in self-help or another form of help, or as a survival strategy wishes to have nothing more to do with his or her own past.

Calling in a health professional such as a psychiatrist or a medical or psychological psychotherapist, is meaningful and necessary particularly in cases where:

- ***Distress*** is present, i.e. the person affected himself/herself wishes to enter treatment, because he or she is tormented by the traumatic symptoms.
- ***Severe, persistent depression is present***, i.e. there is major lack of motivation, or apathy, lack of interest, loss of appetite or weight, physical weakness, increasing withdrawal from contact, no longer leaving the house, tearfulness.
- ***Other severe mental disorders such as psychoses or anxieties*** are present.
- ***Danger to self or other people***, i.e. suicidal thoughts and impulses are expressed, or self-harm in the form of cutting, beating, scratching, or by increasing aggressive outbreaks directed against objects and/or against other people.
- ***Physical complaints, or the occurrence of pain or paralysis*** and fainting attacks should also be examined by healthcare professionals (physical and/or psychosomatic).

3.3 Own 'mental hygiene' – means of self-protection

The most important form of protection against potential overburdening in dealings with traumatised persons is exchange within a team, as suggested above – and that is also advisable in order to provide expert advice, supervision and coaching. The more personal involvement is felt, the more important it is to talk to an expert about ones own emotional feelings, helplessness, wishes, etc. – partly for joint planning of further procedure, and partly in order to regain the necessary professional distance. Other points important for own 'mental hygiene' are:

- To have a good, clear, transparent time structure – that is clarity and transparency in terms of the beginning, end, place and time for discussions can help to avoid creating excessive expectations and can prevent exaggerated demands being made of oneself and the individuals concerned.
- To have the confidence to set limits, i.e. not to be afraid to 'stop' someone in an appropriate manner if one notices that one cannot listen any longer.
- Assessing the limits of ones own resilience, and knowing where the limits are. Talking about such limits (with the team and with the management).
- Activating natural and institutional support ('I'm not the last straw').
- Responsibility for the fate and for the suffering of the people one is counselling, helping, etc. must <u>always</u> remain with the institutions which in fact have responsibility for it.

4. ‘Emergency tips’ for crisis situations

How to handle crises and panic reactions

- Ensure clear division of responsibilities with the other colleagues present (who is to do what in this situation?)
- Set priorities (What has to be done straight away? What can wait?)
- Find out exactly the course of events (facts of the situation).
- Deliberately act slowly (no blind action just for the sake of action).
- ‘Reality interventions’ – seeking eye contact, offering water, etc.
- Formulate contents in the ‘here and now’, use unequivocal wording and simple words and sentences.
- Do not make any promises that cannot be kept.
- Assess rare deviant behaviour as ‘coping attempt’.
- Establish predictability, express intentions.

Handling irritable/aggressive outbreaks

- Keep uninvolved persons out of the situation.
- Eliminate superfluous background stimuli (extraneous noises, music, etc.).
- Keep physical distance and communicate in short sentences and with de-escalation gestures.
- Further de-escalation behaviour alternatives are to talk to the person calmly, to re-establish relation to reality, ignoring provocations, to use humour, to use surprising (paradoxical) interventions.
- Make suggestions, while leaving freedom of decision – demands and orders are more likely to increase aggression!
- If escalation has already taken its course and use of force is coming into play, minimise the risk of injury to those affected and those present by danger-reducing behaviour. That can be done by evasion, non-violent defence, and if necessary by constraint.
- The dialogue with the person concerned should also be maintained even after escalation phases, to prevent impairment of the relationship.

How to handle 'dissociative states'

To help someone to return from a 'dissociative state', it is advisable to apply any strategy that can restore a relationship to the present reality of the 'here and now':

- Always start by introducing yourself, saying who you are and what you are going to do next (e.g. "It's me, XY, your teacher, and I'm going to have a talk with you").
- It is helpful to use 'reality interventions', e.g. seeking eye contact, offering a glass of water, and thereby use simple sentences and words, etc.
- A vital point is to restore contact with external reality, e.g. by describing where you are and asking the 'dissociated' person to look around and describe precisely the surroundings, until that person is 'centred' again. M. Huber (2003) suggests the "5-4-3-2-1 reorientation exercise" – that is asking the person who looks like drifting away first to describe five objects in the room, and five sounds and five physical sensations, and then four, then three, then two, then one of each (page 116).
- Once a good relationship has been established with someone who is dissociated, a good way of establishing contact with the here and now is to touch them (e.g. on the hand or arm). That must always be announced in advance! But mostly it is better to ask a person to embrace him/herself, to establish contact with their own person.

5. Contact points and persons

Institutions for psychosocial care of refugees in Hamburg

Accept (unfortunately closed)

Psychosocial care and treatment centre for refugees
(Gesellschaft zur Unterstützung von Gefolterten und Verfolgten e.V.)

Grindelberg 7
20144 Hamburg
Tel.: 040 / 411723 – 6
Fax.: 040 / 411723 -70
e-mail: accept@gesellschaft-hamburg.de

Basics

Coordination and mediation unit for employment and qualification and for psychosocial rehabilitation of refugees
(Gesellschaft zur Unterstützung von Gefolterten und Verfolgten e.V. & Beschäftigung und Bildung e.V.)

Nagelsweg 10
20097 Hamburg
Tel.: 040 / 731130 – 41
Fax: 040 / 731130 – 50
e-mail: **Demirbilek@accept-hamburg.de**
elke.daempfling@bb-ev.de

Beratungsstelle für MigrantInnen Wilhemsburg
Vogelhüttendeich 81
21107 Hamburg
Tel.: 040 / 7533106
Fax: 040 / 42873291
e-mail: **migrantenberatung@psk-Hamburg.de**

FLuchtpunkt

(Counselling in asylum applications and advocacy for obstacles to deportation)
Eifflerstr. 3
22767 Hamburg
Tel.: 040 / 43250080
Fax: 040 / 43250075
e-mail: **info@fluchtpunkt-hamburg.de**

Haveno (Julia Fischer Orthmann, Michael Brune)

Seewartenstr. 10
21107 Hamburg
Tel.: 040 / 31793535

Lotse

Psychosocial contact point in Wilhelmsburg

Fährstr. 70
21107 Hamburg
Tel.: 040 / 75660175
Fax: 040 / 75660176

Opferhilfe Beratungsstelle

Counselling unit for victims

Paul-Nevermann-Platz 2-4
22765 Hamburg
Tel.: 040 / 381993
Fax: 040 / 3895786

Psychiatrisches Krankenhaus Ochsenzoll

Langenhorner Chaussee 560
22419 Hamburg
Tel.: 040 / 5271 – 0 (telephone reception)
040 / 5271 – 2143 (psychiatric acceptance 24 hours a day)

Sozialpsychiatrisches Zentrum Altona

Grosse Bergstraße 231
22767 Hamburg
Tel.: 040 / 38907800

Suchttherapiezentrum Hamburg

(Counselling in alcohol and medical substance abuse)

Am Hehsel 40
22339 Hamburg
Tel.: 040 / 5381038

Universitätsklinikum Hamburg-Eppendorf

Out-patient reception for refugee children and their families

Martinistr. 52
20246 Hamburg
Tel.: 040 / 428032633

Useful websites:

To help find specialist physicians and psychologists/psychotherapists with knowledge of foreign languages:

www.kvhh.de: Website of the Kassenärztliche Vereinigung (Association of Physicians recognised by health insurance companies) – includes all formally recognised physicians/psychologists/psychotherapists.

(On home page, click on section 'Arztsuche' ('find physician'), then in the section 'Fachgebiet' ('specialist area') select 'Psychiatrie/Psychotherapie' and in the 'Fremdsprache' ('foreign language') window select the desired language. Enter return to see the hit list ('Treffer').

To find a therapist specialised in working with traumata:

www.emdria.de : Website of the EMDR-Instituts Deutschland (**E**ye **M**ovement **D**esensitization and **R**eprocessing, a method used in trauma therapy)

(Search for EMDR therapists possible by postcode, by clicking 'Verzeichnis' ('Directory') and entering postcode.

www.traumatherapie.de : Website of the Institut für Traumatherapie Berlin

(To search for therapist by postcode, enter your postcode in the 'Postleitzahl' window)

General therapy guide for Hamburg in the Internet:

www.hamburg.de : Enter 'Therapieführer' in the 'Schnellsuche' ('Quick search') window.

The Therapy Guide (Therapieführer) gives information on diagnostic, therapeutic and rehabilitation offerings in psychiatry and psychotherapy in the administrative area of the city of Hamburg. A few entries have also been included for offerings outside of Hamburg, for therapy of dependent drug users, addicts, and some hospitals.

Literature

American Psychiatric Association (Publ.): Diagnostisches und statistisches Manual psychischer Störungen, DSM-IV, (deutsche Bearbeitung Sass, H., Wittchen, H.-U. & Zaudig, M.), Hogrefe, 1996

Dilling, H., Mombour, W. & Schmidt, M.H. (Publ.): Internationale Klassifikation psychischer Störungen, ICD 10, Kapitel V (F), klinisch-diagnostische Leitlinien / Weltgesundheitsorganisation, 4. korrigierte und ergänzte Auflage, Huber, 2000

Fischer, G. & Riedesser, P.: Lehrbuch der Psychotraumatologie, 2.Auflage, Reinhardt, 1999

Graessner, S. & Wenk-Ansohn, M.: Die Spuren von Folter, Eine Handreichung, Schriftenreihe Behandlungszentrum für Folteropfer Berlin, 2000

Huber, M.: Trauma und die Folgen, Trauma und Traumabehandlung, Teil 1, Junfermann, 2003

Huber, M.: Wege der Traumabehandlung, Trauma und Traumabehandlung, Teil 2, Junfermann, 2003

Materials and counselling organisations

Deutsches Rotes Kreuz (Publ.): Materialien zur Traumaarbeit mit Flüchtlingen, Ariadne Buchdienst, von Loeper Literaturverlag, 2003

Therapiezentrum für Folteropfer, Caritas-Asylberatung Köln, e.V.: Zuhören hilft... Ratgeber für ehrenamtliche HelferInnen im Umgang mit Betroffenen von Krieg und Menschenrechtsverletzungen (order by postcard to: Therapiezentrum für Folteropfer Köln, Spiesergasse 12, 50670 Köln).