Aus der Abteilung für psychosomatische Medizin
der Fakultät für Medizin der Universität Regensburg
Betreut durch Prof. Dr. Thomas Loew
Leiter der Abteilung für psychosomatische Medizin des
Universitätsklinikums Regensburg

Development of a curriculum for the education of certified "Traumahelper Supervisors" as part of the Traumahelper Project and verification of the curriculum's efficiency during practical use

Dissertation
zur Erlangung des akademischen Grades
Doktor der Medizin (Dr. med.) der Universitätsmedizin
der Universität Regensburg

Eingereicht von
_____Annika Katharina Biederbeck_____

2024

From the department of psychosomatic medicine
of the medical faculty of University Regensburg
Supervised by Prof. Dr. Thomas Loew
Head of department of psychosomatic medicine at
University Hospital Regensburg

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Dissertation
for acquisition of the PhD in human medicine
at the medical faculty of
University Regensburg

submitted by
_____Annika Katharina Biederbeck_____

2024

Dekan:	Prof. Dr. Dirk Hellwig
1. Berichterstatter:	Prof. Dr. Thomas Loew
2. Berichterstatter:	Prof. Dr. Karin Tritt
Tag der mündlichen Prüfung:	03.08.2026

The scariest monsters are the ones that lurk within our souls.

-Edgar Allan Poe

Preamble

The human psyche has always been a topic of interest for me. Unconscious processes and the experiences we have made during our lives influence our behaviour and perception of the world every day. It is therefore easy to understand that mental health is an important field of modern medicine. But regardless of its importance psychotherapy is still not available for everyone who is in need. Because of this I am grateful that I was offered the opportunity to participate in this project and to help change the circumstances regarding this issue for the better. I want to thank Prof. Thomas Loew and Dr. Beate Leinberger as well as “Gewiss e.V.” for involving me in their work and offering this great chance to me. The intercultural teamwork during this study has not only led to a successful performance and representative results, it also changed my personal view of the world. Special thanks therefore go to Dr. Frank Viswanath and the members of CARDS. I further want to thank Ulrike Paeper and the “Partnerschaft In Einer Welt e.V.” for their support both financial and personal. I also have to mention all Trauma Helpers and Supervisors in this context whose hard work and dedication has made this research possible as well as I want to thank the children who participated in all therapy sessions with joy and who it was inspiring to work with. Apart from those involved directly in the project I would like to thank my family for their emotional support and expertise that allowed me to successfully finish my university-studies as well as this research work.

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All photography included in this work has been taken during a visit at the CARDS-organization in India 2018.

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Zusammenfassung

Im Rahmen der Flüchtlingskriese von 2015 wurde auch in Deutschland deutlich, dass die vorhandene Zahl professioneller Psychotherapeuten den bestehenden Therapiebedarf in Krisensituationen kaum decken kann. Häufig entstehen für die Betroffenen lange Wartezeiten auf einen Therapieplatz, ohne dass bis dahin irgendeine psychotherapeutische Unterstützung angeboten werden kann. Eine frühe therapeutische Intervention kann jedoch insbesondere bei Traumafolgestörungen eine Chronifizierung der Symptome verhindern. In Ländern mit einer generell schlechteren medizinischen Versorgung erhalten Betroffene nicht selten aus finanziellen oder aus Gründen der Verfügbarkeit nie eine angemessene Therapie und leiden langfristig unter schwerwiegenden Symptomen der Traumatisierung. Das Konzept der Traumahelfer, bei dem Laien als Multiplikatoren in den therapeutischen Prozess miteinbezogen werden, ermöglichte es die Kapazitäten eines einzigen professionellen Psychotherapeuten zu verzehnfachen. Trotz geringer personeller und finanzieller Ressourcen kann so eine Therapie für viele Menschen ermöglicht werden. In einem zweitägigen Lehrgang werden Laien geschult und auf ihre spätere Tätigkeit als Traumahelfer vorbereitet. Der Lehrgang zum zertifizierten Traumahelfer umfasst dabei auch einen Einblick in die theoretischen Hintergründe von Traumatisierung und Therapie, sowie das Erlernen von Stabilisierungstechniken, wie dem entschleunigten Atmen, Somatic Universal Regulative Exercise (SURE) oder der bilateralen Stimulation. Die Wirksamkeit dieses laienassistierten Therapieverfahrens konnte bereits in vorangegangenen Studien zum Thema im In- und Ausland nachgewiesen werden. (1)

Da in Regionen mit schlechter medizinischer Versorgung und geringen finanziellen Mitteln nicht immer die Möglichkeit besteht professionelle Trauma-Therapeuten für die Leitung der Therapiegruppen einzustellen, wurde die Fortbildung zum Traumahelper Supervisor erstellt. In einem zweiwöchigen Kurs haben pädagogische Fachkräfte und Studierende mit naturwissenschaftlich-medizinischem Schwerpunkt, die Möglichkeit die Zusatzqualifikation „zertifizierter Traumahelper Supervisor“ zu erhalten. Diese Zusatzqualifikation ermöglicht es dem Traumahelper Supervisor, Traumahelfer-

Gruppen zu leiten, und Traumahelfer auszubilden. Um einen internationalen Standard und eine konstante Qualität der Ausbildung zu ermöglichen, erfolgt diese nach einem zu diesem Zweck erstellten Curriculum, das die zeitlichen Rahmenbedingungen, sowie die notwendigen Lerninhalte festlegt.

Methode:

Die Verifizierung der Effizienz des Curriculums erfolgte anhand von Daten, welche in der Region Guntur in Andhra Pradesh erhoben wurden. Durch die Zusammenarbeit mit der dort ansässigen CARDS-Organisation, welche auf die Arbeit mit Kindern aus sozial schwachen Verhältnissen, sowie auf die Förderung der Rechte der sogenannten Dalits spezialisiert ist, konnten bereits seit einiger Zeit erfolgreiche Traumahelfer-Gruppen stattfinden. Zum Zeitpunkt der Datenerhebung wurden dort erstmals fünf Trauma Supervisors nach dem hier vorgestellten Curriculum ausgebildet und übernahmen dann im Anschluss die Ausbildung der Trauma Helfer, sowie die Leitung der Therapiegruppen. Um den therapeutischen Erfolg der Maßnahme zu objektivieren, erfolgte sowohl ein Screening mithilfe von etablierten Fragebögen vor Therapiebeginn als auch eine entsprechende Nachbefragung bei der die Bögen erneut ausgefüllt wurden. Da dieselben Fragebögen in der vorangegangenen Forschung, zur Therapie mithilfe von Traumahelfern, eingesetzt wurden, erlaubt die Auswertung der Bögen auch eine Vergleichbarkeit der Ergebnisse.

Die Daten aus der Region Guntur in Andhra Pradesh wurden als Grundlage für diese Arbeit gewählt, da die Zusammensetzung des Patientenkollektivs, dem aus vorangegangen Studien gleicht. Ein großer Teil der dort lebenden Bevölkerung lebt unter der Armutsgrenze. Das Resultat daraus ist eine insgesamt schlechtere medizinische Versorgung. Krankheiten werden nicht selten mit schmerzhaften Hausmitteln behandelt, was insbesondere für Kinder ein potenziell traumatisches Erlebnis darstellt. Viele Kinder sind zudem gezwungen bereits früh zur finanziellen Unterstützung ihrer Familien beizutragen. Obwohl Kinderarbeit auch in Indien per Gesetz untersagt ist, arbeiten weiterhin Kinder unter schlechten Sicherheitsbedingungen in Fabriken und Steinbrüchen. Eine professionelle Psychotherapie um die Folgen von Armut, Kinderarbeit, Krankheit und sozialer Isolation zu verarbeiten ist für den Großteil der Betroffenen außer Reichweite.

Die Therapien mit Hilfe der Traumahelfer Supervisors erfolgten in einer Schule für Kinder mit Behinderung, einem Waisenhaus für Mädchen und einer Schule für

Kinderarbeiter im Indischen Staat Andhra Pradesh. Alle Einrichtungen waren Teil der CARDS-Organisation.

Ergebnisse: Nach Abschluss der therapeutischen Intervention zeigte sich bei allen Kindern eine deutliche Verbesserung der Belastungswerte verglichen mit den Ausgangswerten während des Screenings. In einer vorangegangenen Studie konnte bereits die Wirksamkeit der klassischen Trauma Helfer Gruppen demonstriert werden. Basierend auf diesen Ergebnissen wurden die Post-Therapie Scores des CRIES und DSRS Fragenbogens traditioneller Trauma Helfer Gruppen mit denen der von Trauma Supervisors geleiteten Gruppen verglichen. Es konnten in den Gruppen, welche von Trauma Supervisors geleitet wurden, für beide Fragebögen ähnliche Resultate wie in den traditionellen Trauma Helfer Gruppen erzielt werden. Die Leitung einer Trauma Helfer Gruppe durch einen Trauma Supervisor kann daher schnelle und niedrigschwellige, jedoch trotzdem durchaus effiziente Hilfe für traumatisierte Menschen bieten. Für die Ausbildung der Trauma Helfer wurden darüber hinaus keine Dolmetscher benötigt, da es sich bei den Trauma Supervisors um Muttersprachler handelte. Die Ausbildung der Trauma Helfer erfolgte dabei nach dem bereits bewährten Prinzip der an mehreren Standorten in und außerhalb Deutschlands angebotenen Fortbildung.

Da alle Therapien innerhalb der Schule oder Unterkunft der Kinder stattfanden, erleichterte das die Teilnahme und verringerte das Risiko eines vorzeitigen Therapieabbruchs oder versäumter Stunden.

Summary

During the refugee crisis of 2015 it became apparent that even in Germany the number of professional psychotherapists, especially during situation of crisis and disasters, is not sufficient and that in many cases therapy cannot be provided when it is needed. This in turn results in long waiting periods and increased suffering for the affected individuals. Yet an early therapeutic intervention is known to prevent the chronification of trauma symptoms and may also improve people's everyday performance. While in Germany there are long waiting lists for therapy-places, in countries with a less developed medical system due to financial and personnel reasons, people suffering from trauma related disorders may never receive any psychotherapy and therefore sometimes must deal with severe symptoms.

The concept of Traumahelpers, uses lay-helpers as multipliers during therapy. The efficiency of a single professional therapist by that can be increased up to ten times. Using this concept therapy can be provided to a high number of people even when there are low financial and personnel resources. During a two days course lay-helpers are educated and prepared to work as Traumahelpers. The education of certified Traumahelpers includes basic background knowledge about trauma related disorders and trauma-therapy as well as practical techniques, such as the slow-paced breathing, somatic universal exercise (SURE) and bilateral stimulation. The effectiveness of Traumahelper–assisted therapy has been proved during previous studies in Germany and abroad. (1,2,3)

As especially in regions with low financial and personnel resources it is not always possible to hire professional trauma therapists, the curriculum for the education of so-called Traumahelper Supervisors has been developed. In a two-week course counsellors, pedagogues and students with a scientific or medical major subject have the chance to acquire the title "Certified Trauma Supervisor". This additional education enables the Traumahelper Supervisors to lead Traumahelper Groups and to educate Traumahelpers. To maintain the educations quality the course is structured according to the curriculum presented in this work. The efficiency of the mentioned curriculum and the education based on it have been tested in practice.

Method:

The efficiency of the curriculum has been proved based on data from the region of Guntur in Andhra Pradesh. In cooperation with the Indian CARDS-organization, which is focused on the work with children from low socioeconomic backgrounds as well as the so-called Dalits, Traumahelper-groups have already successfully taken place. The data used here has been collected during the first therapies lead by Traumahelper Supervisors.

Five Traumahelper Supervisors were educated according to the presented curriculum. Afterwards they were asked to educate Trauma Helpers as well as leading Trauma Helper Groups. The education of Trauma Helpers was done according to the already established concept. To quantify the results of the therapeutic intervention the participants who suffered from symptoms of trauma and who took part in the Traumahelper groups were asked to fill out questionnaires. During a first screening the questionnaires got answered by all children living in the different charity Institutions in the Indian state of Andhra Pradesh. All institutions were part of the CARDS-organization. Those children, who reached the highest scores in the questionnaires, received an offer to participate in the Trauma Helper assisted therapy-groups. The questionnaires, which have been used in this case, are already established and well tested tools for the screening and diagnosing of trauma-associated disorders. In a second survey after finishing the therapy, the children and their caretakers were asked to answer the questionnaires again. The scores and the pre- and post-therapy evaluation were then compared. As the same questionnaires have been used during a previous study, which has shown the efficiency of the Traumahelper project, the post testing results of these two questionnaires got compared to the results of the former study. This has been done to evaluate the efficiency of Trauma Supervisor assisted Trauma Helper groups in comparison to those groups that are led by a professional trauma-therapist. All sessions took place in the institutions functional rooms to make it easier for the children to participate regularly and to prevent unnecessary dropouts. Moreover, the well-known environment was supposed to make the children feel more comfortable.

The Region of Guntur has been chosen for this project as the group of participants resembles the ones of previous studies. Many people in that area live in poverty and therefore do not receive professional medical treatments if needed. Instead, often

painful house remedies are used, which in turn can lead to potentially traumatic experiences for the patient. Child labor is not legal in India but due to the lack of money, many children are still forced to work in factories with very low safety standards. Poverty, child labor as well as social marginalization may lead to trauma associated disorders while there is no possibility for the affected ones to ever receive any form of psychotherapy.

Results: After finishing the therapeutic intervention all children showed a reduction in trauma related symptoms and emotional burden. The comparison with the post-therapy scores in the other mentioned study about Traumahelper therapy has also shown that there is almost no difference regarding the efficiency of Traumahelper Supervisor led and traditional Traumahelper groups. Therefore, educating Traumahelper Supervisors can be a way to offer fast and accessible therapy to those in need. As Traumahelper Supervisors belong to the local communities it is also not necessary to recruit translators for therapy and the education of Traumahelpers.

1 Introduction

Since early human history there have always been potentially traumatizing events people had to deal with. Those kinds of events can be war, torture, and violence as well as natural disasters and the loss of home. But what has changed over the last decades is our understanding on how these events may affect the human mind and eventually lead to psychiatric illness. Especially an early therapy after potentially traumatizing experiences showed to be very important in the prevention of psychiatric illness. It also can reduce symptoms for those who are already affected and therefore may improve people's ability to manage their everyday life as well as preventing psychiatric illnesses from becoming worse over time.

Even though we now know about the importance of early adequate Psychotherapy, it is still not available for a huge number of people in need. Especially in those areas of the world where natural disasters or war have taken place, the need for therapy is very high while the availability of professional psychotherapists is rather low. This leads to a lack of much needed therapy especially for those who may lack big financial resources.

But even industrialized nations like Germany must face a lack of professionals when it comes to psychotherapy. This lack gets worse whenever there is a situation that leads to a sudden rise in the need of therapy. The most recent example for such a situation is the refugee crisis. People who survived many traumatizing experiences while leaving behind their home and families often must wait for a very long time to get therapy because there are simply not enough professionals and waiting lists are long. These long periods of waiting for therapy can lead to posttraumatic stress disorders which otherwise could have been prevented as well as causing an unnecessary amount of suffering for those who are affected.

Due to the just mentioned importance of early therapy as well as the difficulties in its provision in many cases it becomes clear that new concepts for treatment are needed. As we may not be able to increase the number of professionals very soon, especially in those areas where medical help is not easy to access in general, there must be

found other ways to provide early psychotherapeutic help to those who are in need. Furthermore, this kind of therapy needs to be affordable even for those people with low income who are affected the most by the lack of psychotherapists.

One concept to address all these problems is the inclusion of lay helpers in the therapeutic process. Working with lay helpers has been successfully carried out in the past and has shown good results. *(3)* So called Traumahelpers who undergo a two-day course in advance can support the psychotherapist during therapy leading to a decreased number of needed professionals as more people can receive therapy at the same time. This concept already offers a chance to improve the situation for many people but still in some cases and areas there are not even enough psychotherapists to provide a professional supervisor for each trauma-group. Therefore, in these cases it is necessary to also include non-professionals in supervising trauma therapy groups. To maintain the quality and efficiency of the provided therapy, these Traumahelper Supervisors need to receive an adequate training in advance to be able to perform the required task.

The curriculum for the training of Traumahelper Supervisors presented in this work is designed to offer a well-founded and standardized education, so that a good quality of therapy can be provided to those in need, even with limited resources. After successfully participating in the course the Traumahelper Supervisor should be able to educate Traumahelpers as well as to lead the therapy-group. Due to the standardized curriculum the quality of Traumahelper Supervisors is intended to not vary much so their efficiency becomes comparable across different locations.

1.1 The concept of the Traumahelpers

1.1.1 History of the Traumahelper project

The concept of psychotherapy that includes so called Traumahelpers in the therapeutic process has been developed by Prof. Thomas Loew and Dr. Beate Leinberger at the University of Regensburg during the refugee crisis of 2015. At this time many children and adolescents who had experienced violence, abuse or many other traumatic events arrived in Europe. Even though Germany in comparison to a lot of other regions of the world has a rather good health care system the amount of professional psychotherapist has not been sufficient to offer the much-needed treatment for those high numbers of traumatized young people. Before taking part in the therapy-groups Traumahelpers will undergo a two-day training to provide the necessary basic knowledge as well as practical skills to them.

Nowadays there are about 1.8 million officially registered refugees only in Germany according to the central foreigners register *(4).* 54% of them are below the age of 18. Most of these minors faced terrible experiences during their escape and still suffer from the psychological consequences. According to a survey of the scientific Institute of AOK, at least 75% of refugees suffer from psychiatric symptoms while 58% of the asked people said that they have faced not only one but several potentially traumatic events during their journey. *(5)* As multiple exposures to traumatizing experiences further increase the chance of developing post-traumatic stress disorder it is crucial to be able to offer early psychotherapy.

As mentioned above the sudden rise in the demand of psychotherapy during the refugee crisis caused an even worse lack of professionals in this field. Right now, the estimated waiting time for therapy, which is approximately seven months, is leading to the development of psychiatric illnesses and even suicide in many cases that could have been prevented with early therapy *(6)*

1.1.2 The education of certified Traumahelpers

The basic idea of the Traumahelper can be compared to a person performing first aid in an emergency situation. Even though there might be no doctor available the lay helper is able to provide basic life support until professional help arrives. But to be able to do so, the lay helper needs some training in advance. The same accounts for Traumahelpers which is why a standardized curriculum for their education has been created. After taking part in a course the Traumahelper will be able to use the learned techniques and offer some basic help. By this early basic support, the concept of Traumahelpers can help to prevent the development of psychiatric illness after traumatic events. Also, teachers, parents and social workers can benefit from the Traumahelper education as children might as well show symptoms during class or at home and may need support by their caretakers. *(2,3)* Peers from a similar socio-cultural environment can be included in the therapeutic process and therefore also help to overcome language and cultural borders. A relationship of trust is supposed to develop between the client and the Traumahelper and will lead to a good therapy-outcome, even if there is no professional available, as similar projects in Rwanda have shown. *(7)* The early intervention reduces the consequences of the traumatic experience compared to long waiting times or only pharmaceutical treatment. (*8,9)*

Right now, courses to educate certified Traumahelpers take place in many different cities in Germany like Regensburg, Lindau or Wittenberg but also in Austria, Mongolia, Afghanistan, Syria, Nepal and India the project is active and Traumahelpers are trained.

The training basically consists of two parts: a theoretical part and a practical part. In 16 hours of training the participants get prepared for their work as Traumahelpers. Basic knowledge about trauma and post-traumatic psychological reactions is transferred including the neuroscientific, social, and psychopathologic background. In addition, the Traumahelpers get to know stabilizing techniques that can be used during therapy to support their client. While taking part in the training the participants get the chance to experience the effect of those techniques themselves during several practical training rounds. Traumahelpers shall also get a basic understanding of the methods and concepts which are used in the different therapy-groups. There are two

main concepts used that will be presented in detail later. One of them is the Lifeline as a part of PARTNERS (Painting and Rewriting as Traumafocused Neurophysiological Enhancement and Regulation of the Self) which is used for adolescents between 12 and 21 years of age. The other one is SPRINT (Sandplay therapy for Reprocessing-Including Nonverbal Trauma interventions and Self-regulation- techniques) for children between the age of 4 and 12. Which model should be used is hereby not only defined by the age as a number but also by the cognitive abilities and maturity that may differ from the average in some cases.

Both concepts include well known therapy-methods like narrative trauma-therapy, bibliotherapy, elements of EMDR, SURE, imaginative processes and cognitive behavioural therapy. Therefore, it is not to be considered as an experimental method. *(3)*

After successfully participating in the training program the Traumahelpers are allowed to take part in the therapy groups. Each Traumahelper will be responsible for a certain child, to promote the development of a relationship of trust between them. During therapy the Traumahelper`s presence also has a positive impact on the child's ability to focus and to fulfil the given task. Having the full attention of an adult has a disciplining effect on the child while it can also give a feeling of safety. As the Traumahelpers sit in front of their client they may affect the child's emotional state using the effect of so-called mirror-neurons. *(10)* Those specialized neurologic structures can process information about another person's emotional state leading to an adaption of someone's own feelings. Noticing that another person experiences for example fear, may cause fear in ourselves. During therapy the emotional state of the child can be influenced the same way. A calm and focused Trauma-Helper will lead to an adaption of the client and facilitate the process of therapy. Being a witness in the therapeutic process is one of the important tasks of the Traumahelper. Another task is to support the child by using certain techniques the Traumahelper has learned during his or her training. These techniques include visual (eye-movement), acoustic (snapping fingers) and sensitive (tapping on the shoulders) stimuli that lead to an activation of both brain hemispheres which in turn can increase concentration as well as helping to cope with overwhelming emotions during therapy.

Since working with traumatized people may have a psychological impact on the Traumahelper as well there are certain requirements for those who are willing to participate in the training. It is not possible for people with mental illness or a history of drug abuse to work as a Traumahelper. Also, only those who have successfully taken part in the course and earned the Traumahelper-certificate are allowed to assist in therapy groups.

While the Traumahelpers interact with the clients as described above, the Traumahelper Supervisor is responsible for the correct implementation of the therapy methods. Traumahelper Supervisors need a well-founded background-knowledge, so they are able to lead the therapy group and react adequately in case of any emerging difficulties.

1.1.3 Chances and perspectives of the project

After already successfully using the Traumahelper concept in many areas of Germany and the rest of the world, the goal is to further spread the project and to convince even more people to get involved as Traumahelpers. The creation of specialized education-centres in remote and catastrophe-areas can help to maintain a constant sufficient availability of psychological support even in situations where there is a sudden rise of demand. A long-term goal as well is to educate and qualify Traumahelper Supervisors who can lead therapy-groups even though professionals are not available in the area.

1.2 Medical background

1.2.1 The definition of Trauma and its sources

A traumatic event can be defined as an event that is so exceptionally threatening or painful that it would leave every person in deep terror and despair. Very negative experiences usually are processed by the human mind using certain compensatory mechanisms. But after a traumatic event these mechanisms may become overwhelmed. The affected person suffers from extremely high emotional stress and may also experience feelings of helplessness and fear.

Potentially traumatic events can be events that are connected to a fear of being hurt or even dying as well as the fear of other people, especially loved ones, being hurt or killed. Also, the experience of neglect during childhood as a so-called passive traumatization may be a source of trauma related diseases. These trauma-related diseases are not developed by everyone, even after facing a situation with a high traumatic potential.

Examples for traumatic experiences are rape, war, child abuse, accidents, violence, or natural disasters. Traumatic experiences can be divided into such that happen by coincidence like natural disasters and in so called “man-made” traumata. Man-made trauma is connected to one or more people as a source of the traumatic experience and usually is considered to have a higher chance of causing trauma related disorders. Examples for this type of trauma are rape or physical violence. Also, the duration of trauma and the number of traumatic experiences is influencing the probability of developing trauma related disorders. So called type I traumata which are usually single traumatic experiences in the past have a lesser impact than type II traumata which also contain man-made traumata and are defined as several traumatic experiences that took place over a long period of time or are still ongoing. Examples for type II traumata are torture or human trafficking. How likely the development of trauma related disorders is depends on the type of trauma and may vary as shown in the table. *(11)*

Type of trauma	Probability of PTSD in %
Rape	37,5-55,5
War	7,9-38,8
Child abuse	30,6-35,4
Child neglect	21,8
Being threatened with a weapon	17,2
Physical violence	1,7-11,5
Accidents	7,6-12,8
Witnessing violence or accidents	7,0
Natural disasters	4,5

Table 1 Probability of PTSD related to different types of trauma, Source: University hospital of Dresden

Not every person reacts to a traumatic event the same way. Weather a trauma related disorder develops or not also depends on the individuals' resources. Living in a stable social surrounding where lots of emotional support is provided has a positive influence on the individual's ability to process the traumatic experience. The same accounts for the presence of social acceptance towards the affected one including the acknowledgement of being a victim rather than the guilty one. It has also been shown that traumatic experiences during adulthood have a lesser impact than similar experiences during childhood. The individual's psychological health as well as the number of positive experiences collected before the trauma took place is known to affect the risk of developing trauma related disorders.



Illustration 1-painfull-hepatitis-treatment, Source: travel photography

During the traumatic experience several emotional reactions can be observed, ranging from feelings of numbness and confusion to extreme fear and terror. The high emotional stress may also lead to physical reactions or the sudden decrease of psych motoric abilities and even dissociative stupor. It is not unlikely that after the event happened an affected person will experience feelings of guilt, fear, or depression in addition. Some also may react with anger or are easy to scare. The person's thoughts may be circling around the traumatic event as a part of the processing, while surroundings and even the own person may feel surreal (derealisation, depersonalisation). There also can be a feeling of being constantly threatened and unsafe. Usually, these acute symptoms will decrease within hours or days and the experience is processed completely. But in some cases, due to the lack of compensatory mechanisms the processing may fail to be sufficient, and the emotional stress level will not return to normal. Without intervention there is a risk of these symptoms becoming chronic and for a trauma related disorder to develop. Up to 48h after a traumatic experience an acute stress reaction may be observed, followed by an acute stress disorder that can last up to four weeks. The presence of symptoms after a period of three months past the traumatic event is an indicator for the development of PTSD in a patient. *(12)*



Illustration 2 TUK-TUKs are often involved in accidents

1.2.2 The pathophysiology of PTSD

Several parts of the human brain and endocrine system are involved in the development of PTSD, explaining its various symptoms. Exceptionally intense experiences usually are remembered very well. Stress hormones like adrenalin activate several brain areas such as the Amygdala leading to a strong emotional memory that fades away or decreases after some time. This process is disturbed in people suffering from PTSD. Even though the detailed pathophysiological mechanism is not discovered yet, it is believed that the hormone Cortisol plays a major role in this process. *(17)*

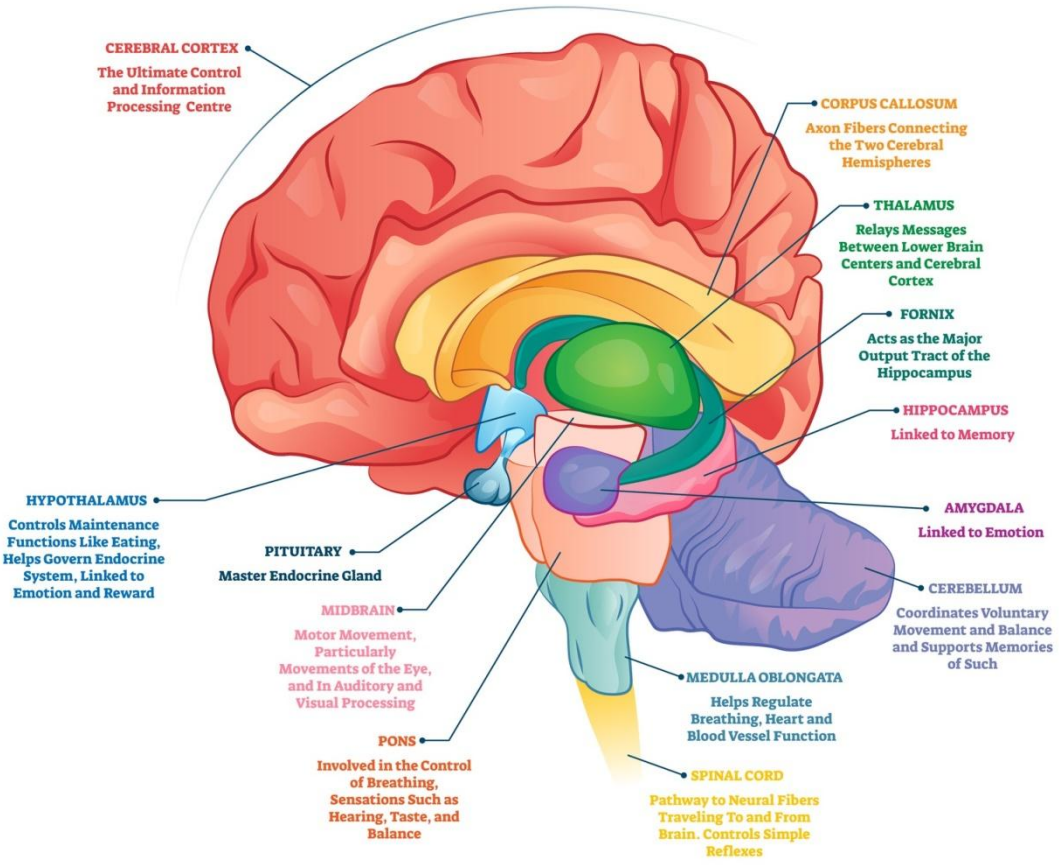


Illustration 3 The human brain, Source: stock photography

The most important structures that need to be mentioned in this context are the Thalamus, the Amygdala, the Hypothalamus and Hippocampus. They all play an important role in the processing of emotions and memory.

The Thalamus or as it is also called “the door to consciousness” can be understood as the control centre for all information transported from the periphery to the brain. It passes on information to the Cerebrum where in turn the conscious perception and reaction takes place. The Thalamus is involved in the creation and processing of emotions.

Another structure that needs to be mentioned is the Amygdala or Corpus Amygdaloideum which is responsible for the formation of fear and emotional memories and can be considered as the alarm or emergency centre of the human brain. Together with the Hippocampus which is responsible for learning and the formation of chronologic detailed memories, the amygdala is part of the limbic system. The limbic system plays an important role in the central nervous system regarding the regulation of emotions, memories, and vegetative functions.

There also is the Hypothalamus that regulates vegetative functions. It is responsible for the regulation of circulation, breathing and body temperature and it has an impact on the uptake of food and the sexual drive. By producing hormones and so-called release hormones the hypothalamus plays an important role in the endocrine system, controlling various body functions. By producing CRH it triggers the release of ACTH from the pituitary gland and as a participant in the Papez- neuronal circuit it is furthermore involved in the formation of memory. *(18)*

As mentioned before the hormone cortisol is believed to play a role in the pathophysiology of PTSD. The substance is produced in the suprarenal gland and is known to be a “stress hormone” that physiologically supports the body during phases of high physical or emotional stress by for example elevating the blood sugar and blood pressure. Its production is regulated by ACTH which in turn is produced by the Pituitary Gland. High levels of cortisol in a healthy organism inhibit the circle of production. The hormone Adrenalin also belongs to the body’s stress hormones. It differs from cortisol by the fact that it cannot be produced on reserve. Constant high levels of stress may lead to a reduced function of the immune system as well as decreased blood circulation

in the bowels, leading to impaired digestion and the formation of ulcera. The effect of stress hormones on vessels and circulation in this case may also lead to an elevated blood pressure and affect the heart function. *(19)*

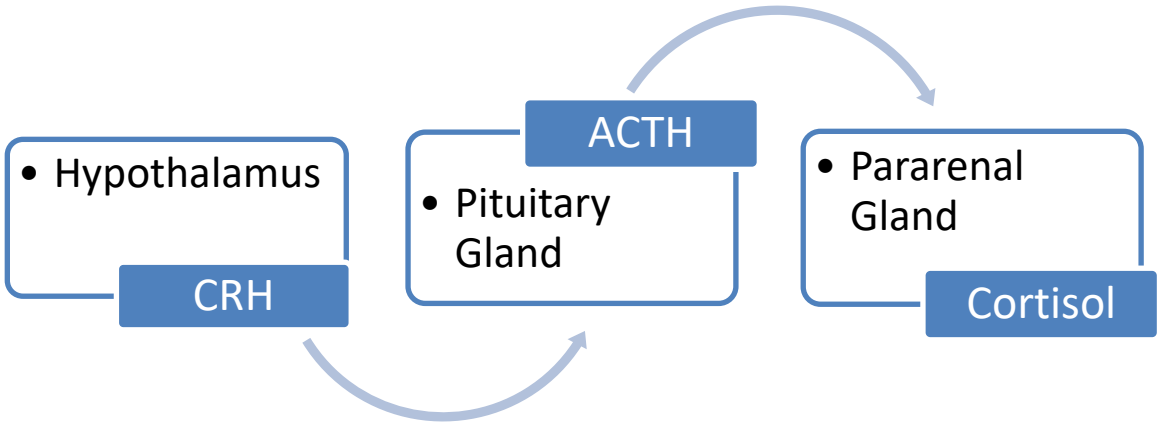


Illustration 4 Pathophysiology-Graphic

When a trauma is experienced by an individual the Thalamus gets activated and forms an emotion that in turn stimulates the Amygdala. In healthy individuals the emotional memory of the Amygdala will be processed within the Hippocampus and might be forgotten after some time. Furthermore, the alarm or stress reaction of the Amygdala is transmitted to the Hypothalamus which in turn produces CRH and by that influences the production of Cortisol. According to current theories in people with PTSD the interaction between Amygdala and Hippocampus is not sufficient. Chronic stress and traumatic experiences may lead to a reduction of the Hippocampus's volume and an impairment of its function while the Amygdala stays constantly active and alerted. The high levels of Cortisol are hereby believed to lead to an impaired memory.

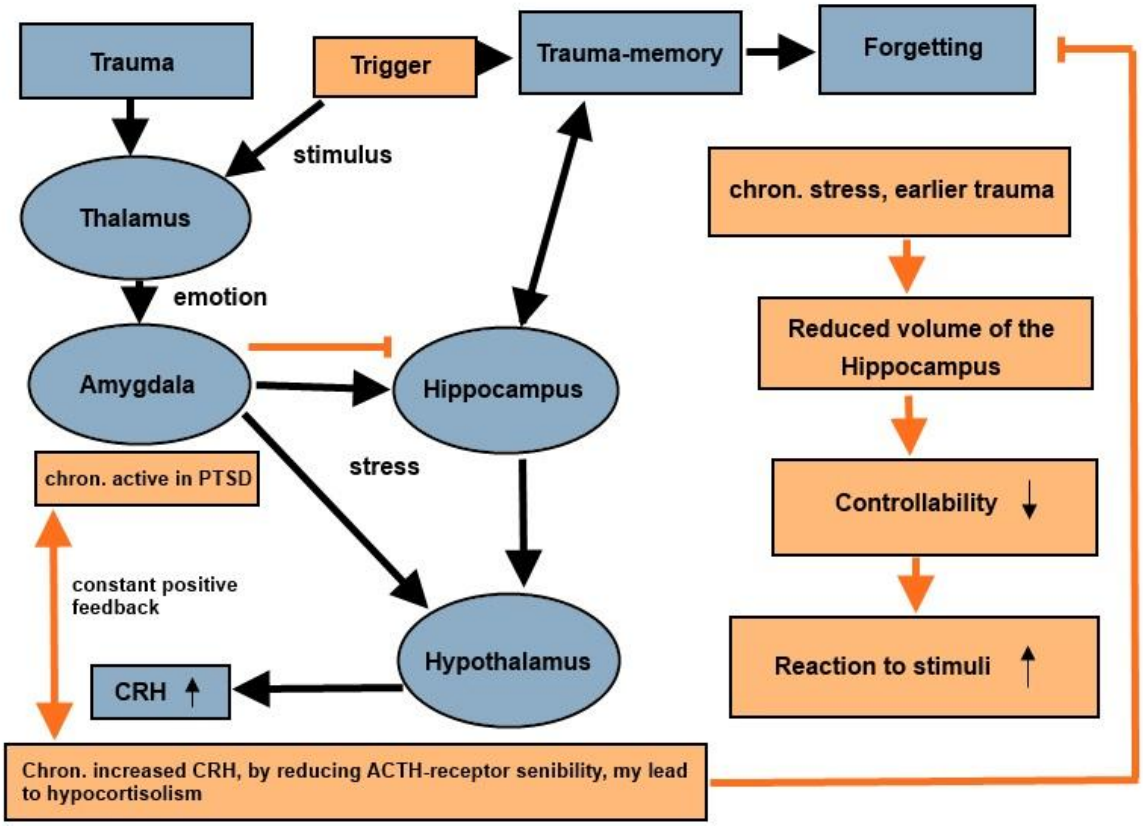


Illustration 5 The pathophysiology of PTSD, Source: Thieme 2020 (modified)

1.2.3 Symptoms of Trauma

The symptoms of trauma related disorders may vary from person to person. In many cases the affected person suffers from partial amnesia regarding the traumatic event. Since the experience was not sufficiently processed, memory of the event often cannot be recalled in detail. But fragments of memory may appear from time to time as intrusions, nightmares, or flashbacks in the patient's mind. These fragmented memories can present themselves in pictures or even sensory perceptions and may leave the impression of one reliving the traumatic situation. Seeing these pictures cannot be controlled by the individuals will and therefore is a heavy burden to them. After being traumatized the affected one experiences constantly high levels of emotional stress leading to a state of being alerted all the time. This may result in sleeping disorders and altered behaviour towards others.

Affected persons are often easy to scare and may show anger and aggression as well as fear and mistrust towards others. The high emotional stress can also affect physical reactions leading to an increased pulse and blood pressure as well as various unspecific somatic symptoms. It has been observed that in some situations inadequate affective behaviour such as laughing, crying, or decreased emotional reaction was shown by the client. After a trauma some people suffer from reduced psych motoric reactivity up to dissociative stupor.

Many people who experienced a traumatic event afterwards report a changed perception of their surroundings and their own person. The world and even the own self appears to be "unreal". Like all other symptoms this state of depersonalisation and derealisation is perceived very torturing by the affected ones. *(12)* People with trauma related disorders can also show auto aggressive behaviour like for example cutting their own skin. They are more likely to develop alcohol or drug addictions as well as depressive symptoms. In severe cases the impact of the traumatic experience in the end will even lead to the suicide of the affected person. *(13)* In a survey performed among victims of sexual violence in the United States 46% of the participants reported they had suicidal thoughts during the past three months. *(14)*

When diagnosing a trauma related disorder, A-, B-, C- and D-criteria can be defined. If A-criteria are present the client has experienced an event which is so terrifying that

it can be described as potentially traumatizing. The presence of intrusions, nightmares, and flashbacks as well as aversive reactions in situations resembling the traumatic event is considered B-criteria. C-criteria describe an avoiding behaviour when it comes to certain places, smells or conditions that might remind the affected person about the traumatic experience. Other symptoms such as sleeping disorders, or a lack of concentration ability are defined as D-criteria. *(1)*

The symptoms of trauma related disorders can also be classified as shown in the figure below. They are divided into four different clusters as recommended by the DSM-V.

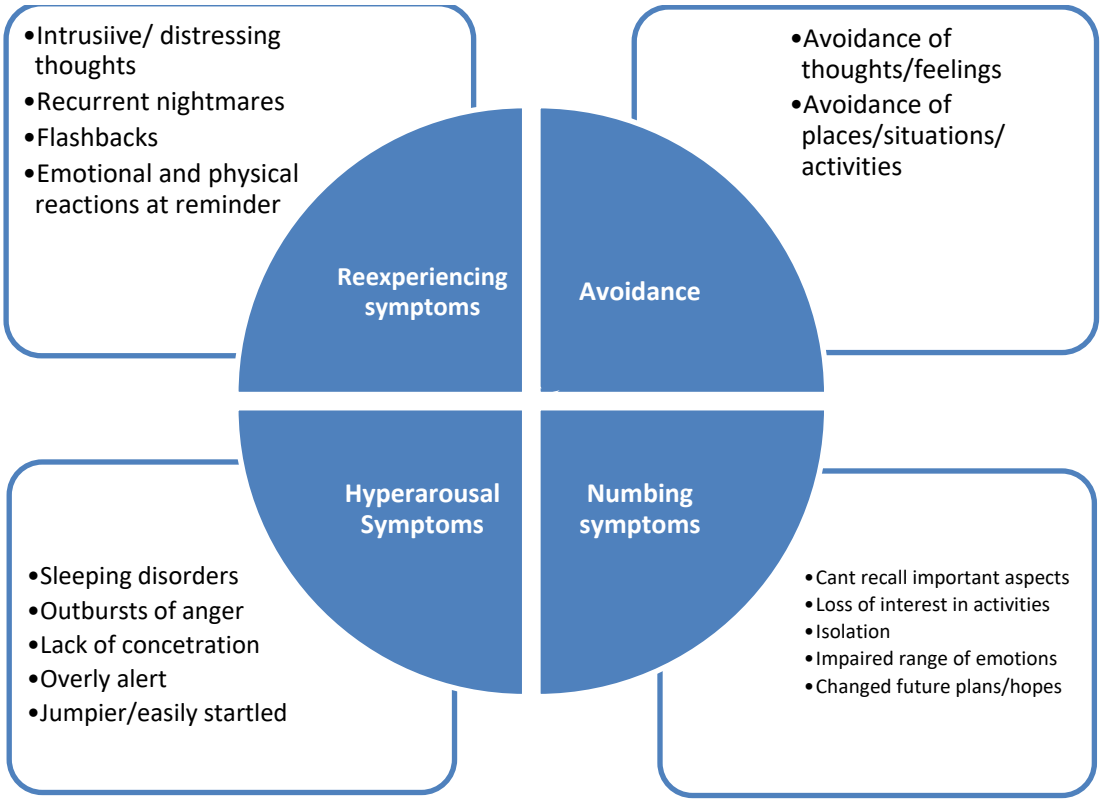


Illustration 6 Trauma symptoms, Source: DSM-V (modified)

When working with children who have experienced potentially traumatic events it must be taken into consideration that the typical symptoms may be different from those of adults. Children more often show somatic reactions such as abdominal pain or body regulative disorders regarding eating, sleeping or defecation. Depending on the age and developmental state they have difficulties verbalizing negative emotions and to describe inner processes. Special attention therefore should also be paid towards a child's behaviour. Non favourable behaviour such as hyperactivity and lack of

concentration might be a sign of traumatic experiences in some cases. Also, reactions that seem to be inappropriate like body swinging, rhythmic knocking, licking or mandibular movements can occur. Many children with a history of trauma show hypersensitivity towards touch or certain smells as well as noises and some may tend to show aggressive behaviour towards their caretakers and other children. There are children who suffer from a lack of empathy after being traumatized as well as a feeling of helplessness and low self-esteem. An unusual strong fear of losing a loved one as well as difficulties in regulating distance towards other people may occur.

Children can also show dissociative symptoms such as very ambivalent behaviour and a personality that seems to change from one moment to another. In some cases, imaginary friends can be considered as dissociative symptom, too. Due to the extremely high emotional stress even psychogenic seizures sometimes can be observed. The behavioural changes that might be notices by care takers after a traumatic event may differ depending on the child's age as shown in the table below.

There has been a tendency observed in children to include traumatic experiences in their play, re-enacting the event. *(15)* When for example a child experienced war in its past life it might use elements like weapons in its play.

Common reactions of small children	Common reactions of adolescence
• Fearful of new situations • Separation anxiety • Clinging to parents • Loss of bladder or bowel control • Speech difficulties • Loss of appetite • Become passive/quiet • Thumb sucking • Irritability • Aggressive behaviour • Competing for attention • Nightmares • School avoidance • Isolation • Poor concentration • Physical complaints • Constant fear • Thoughts circling around the traumatic event	• Sleep disturbance • Appetite disturbance • School problems • Loss of interests • Rebellion at home • Poor performance • Physical complaints • Changes in peer group and friends • Low energy level or agitation • Avoiding behaviour • Irresponsible behaviour • Isolation • Use of alcohol or drugs

Table 2 Trauma symptoms according to age (modified) Source: Adapted from new south Wales Health, Disaster and mental Health Handbook, North Sydney, NSW Health 2000

Contraindications for trauma-therapeutic interventions

Before any interventions that aim to work on the traumatic memories can be performed it is necessary to make sure that the traumatized person is no longer exposed to the traumatic experience or the perpetrator. Acute risk of suicide and psychotic state also are contraindications. In cases of uncontrolled auto aggressive behaviour or severe dissociation the indication must be done very carefully. This also accounts for cases when there is a high psychosocial and physical burden that does not allow successfully work on the traumatic experience. (*16*)

1.3 The current situation and society in India

1.3.1 The Caste System

Most participants in the Traumahelper groups are females who belong to the social group of Dalits. Those people are especially vulnerable when it comes to potentially traumatizing events. To get a further understanding of their situation a basic knowledge of the Indian caste system and society is required.
The caste-system or Varna Vyavastha *(25)* is believed to exist since approximately 3000 years. It was first mentioned in the Law of Manu (Manusmriti), an important rulebook of Hinduism,1000 B.C. The hierarchic system divides the Indian society in four castes according to their karma (work) and dharma (religion/ duty). An ancient believe says that the four castes have developed from the god Brahma`s (god of creation) body parts. The highest caste of Brahmins has developed from his head, the Kshatriyas from his arms, the Vaishyas from the legs and the Shudras from his feet.

The Brahmins traditionally are teachers or priests that have the highest social status of all castes while the caste of Kshatriyas are warriors and rulers. Vaishyas are the social group of merchants and Shudras are simple workers. Each of the four main castes is further divided in 3000 castes and 25000 subcastes according to the individual's occupation. The membership in a caste is inherited from one generation to the other and marriages are only allowed within the own caste. A marriage between members of different castes can even lead to the punishment or killing of the lower caste member. Members of higher castes enjoy many privileges compared to the lower castes and will not accept any food or drink from lower castes as they consider it polluted. Often all members of a caste will live together in certain areas, leading to a social as well as a spatial separation between the different castes. *(26)*

A special group that needs to be mentioned here are the Dalits or so-called untouchables. This group is not particularly a part of the caste-system but can rather be understood as outcasts. They are not even part of the hierarchic caste-system and therefore form the social group with the lowest status. Dalits traditionally have been

servants, doing dirty work like for example cleaning latrines. Today there are living about 300 million Dalits in India making up 15 to 20% of India's population.

Officially the caste-system has been abolished by the Indian state years ago, but it still continues in practice and people's minds. There have been many attempts by the state to support Dalits leading to an increasing number of Dalits in important political and social positions. But especially in rural areas there still is a strong connection between education, income, and caste. Dalits still must face discrimination in education as well as in work-environment.

The changes and improvements among Dalit community are not favoured by everyone. Especially members of higher castes sometimes feel offended by Dalits speaking out against them and threatening their privileges. The result has been an increase in violence against Dalits during the past years. In 2016 there have been 41.000 crimes based on hate against Dalits, an increase of 25% compared to the year 2010. *(27)* Often the intention is to" put the Dalit in his place". Torture and humiliation are used to scare people, preventing them from demanding their rights. Dalits formerly had almost no human rights and therefore have been exploited and abused for many years without any consequences for the perpetrator.

"When I was young, I once heard a girl screaming. When I came to see what is happening, I saw that she got raped by some men of higher caste. Even though I was shocked, I was not able to help her because if I try, they would beat me to death." – Member of the Dalit community and human rights activist

Recently many cases of violence against Dalits have become a centre of public attention. But still, it is rather difficult to receive any form of justice for a Dalit whenever the opponent is a member of higher caste. To reduce public attention sometimes the fact that an attack was based on hate against Dalits is simply ignored and legal proceedings are declined since also the police usually consists of caste members.

1.3.2 The situation of women and girls in India

In 2018 a survey by the Thomas Reuter Foundation has found India to be “the most dangerous country” for women. For the survey 548 specialists on women’s issues have been contacted and asked to evaluate the 193 countries of United Nations regarding six main topics. For each topic they had to name the country in which the situation for women is the worst. India got rated number one in three of them- “Sexual Violence: including rape as a weapon of war; domestic rape; rape by a stranger; the lack of access to justice in rape cases; sexual harassment and coercion into sex as a form of corruption”, “Culture & Religion: including acid attacks, female genital mutilation, child marriage, forced marriage, punishment/retribution through stoning or physical abuse or mutilation and female infanticide/foeticide”, Human Trafficking: including domestic servitude, forced labour, forced marriage and sexual slavery". The country also was rated number three in the categories non-sexual violence and discrimination as well as number 4 when it comes to health-related difficulties. *(28)*

Especially sexual violence in India became a topic of public discussion after the case of the young student Nirbhaya - the fearless one, a name that was given to her by the media, who became a victim of rape and murder in 2012. The incident caused mass demonstrations around India, especially in Delhi, and the suddenly increased attention towards the topic has led to a new, harder law against sexual violence. All six convicts got punished by the Supreme Court-four of them even had to face death penalty. *(29)*

But since that time the situation has not improved for women as the number of sexual crimes is still extremely high and only few cases are reported to the police. According to Reuters (2019) there have been 32.500 officially registered cases of rape in 2017 leading to the conclusion that there are about 90 cases of sexual violence in India per day. In many cases, especially when the victim is of lower social status, the police is not even taking the victim seriously and often refuses to take notes or to investigate the case. There are centres that are supposed to provide support to victims of sexual violence, but most people working there are not properly educated and only few know about official laws and how to file charges. Another problem is the lack of health professionals who could perform an examination that allows to collect further evidence which might be needed in court later. Even if there is someone to perform the

examination this process for the victim can be very degrading as there are still practitioners who evaluate how much the victim was “used to sex” or who perform so called “two finger tests “. These very unscientific tests are forbidden by the Indian government since 2014 but the law is handled differently among the states and many people are not informed about their rights leading to a rather high number of practitioners who still perform this degrading kind of examinations. STD-testing, information about abortion or psychological help in most cases is not offered to any victims. In general, the victim often is suspected to be responsible for what has happened and even in court some judges try to shame the victim so she will take back her accusations *(30)*. These circumstances are preventing many women from reporting the crime that has happened to them as they fear the negative consequences for themselves and their families.

A possible reason for the rising cases of sexual violence against women is the misbalance in the number of men and women in India. According to the Indian Census of 2011 for every 1000 males there are only about 944 females. This misbalance may cause frustration among young Indian men who fail to find a partner and is discussed to be a possible source of increasing sexual violence. The fact that there are fewer females in comparison to males is hereby based on several reasons.

One of the causes with the highest impact is that most families still prefer a boy-child over a girl resulting in the abortion of the unborn girl. Traditionally only male offspring will earn money in the future and stay with the family to support them, while girls leave the family after marriage to become a mother and due to the required marriage portion will rather create costs for the family than bringing any benefit *(31)*. Since 2018, at least officially, medical doctors in India therefore are no longer allowed to tell the unborn child’s sex to the future parents *(32)*. But also, after birth the chance to die for a girl under the age of 5 (79/1000) is higher, according to UNICEF, than it is for a boy (70/1000). Financial resources will preferably be spent for the male offspring leading to lesser food and healthcare, provided to the female, in families with low income. In some cases, the female child gets even killed by their family who, for example, wraps the child in wet blankets to provoke pneumonia. About 25.000 girls become victims of these practices each year. *(33)*

The idea that girls will leave their families at some point to become a housewife is still very prevalent among the Indian society. Therefore, many families prefer to invest in their son's education rather than in the education of their daughters *(34)*. Especially in rural areas there is a big discrepancy between the average educational status of boys and girls. While 63% of men have some secondary educations there are only 39% of women who do so *(35)*.

The lack of education is leading to a dependency of women on their husbands and families. Even though 30% of married women do have a job, only 16% get paid for it (*103*). After marriage women and girls belong to their husband's family and have the lowest possible status in the family's hierarchy. In many cases those women are exposed to violence by their new family when showing any behaviour that is not favoured by them. Domestic violence against women is still accepted in wide parts of Indian society. About 52% of men and 42% of women are convinced that it is legit that a woman gets physically punished by her husband or family whenever they think it might be necessary. Starting from the age of 15 about 30% of girls have already experienced violence – 6% even sexual violence (*103*). In some cases, the husband's family claims that there has not been paid enough dowry for the girl and kills her in case her family refuses to pay more. Those murders are often pretended to be kitchen-accidents, since the women get burned by their husbands or parents in law and many households still use kerosene-ovens for cooking *(33)*.

Reaching out for medical help for women and girls can be difficult, too since 30% of India's female population doesn't have any kind of health insurance or health scheme coverage. Therefore, for many women it is not possible to pay for necessary examinations and treatments. But even if the financial resources are available there are still other borders to overcome when medical help is needed. Especially in rural areas women sometimes must travel long distances until they reach the next village where a doctor can be found. 27% of women in rural areas name transport as a main reason why they cannot receive necessary treatments. Another 20% says they even got troubles getting their husbands permission to see a doctor.

Most Indians are Hindu and Hinduism traditionally is not only a religion but a way of life. To understand women's role in Indian society it is therefore necessary to take a look at women's role according to Hinduism. In this religion family is one of the highest

values which is why society worships women as the keeper of the family as well as the mother giving birth to children. It is her duty to teach her children about traditions and to make sure they will be maintained in the future. According to Hindu believes a woman's nature (prakrti) is the soil, while a man's nature is the seed. When it comes to the result of the combination of soil and seed only the seed is of importance and the soil or vessel can be exchanged. The culture (male) according to this picture has to control the wilderness (female). In the Laws of Manu (200 C.E.) women's role is defined as being obedient to her husband under any circumstances. To worship her husband regardless of his flaws is considered religious act for women. This idea of the ideal woman can also be found in Ramayana, an ancient saga. Sita, who got kidnapped, refuses to be rescued by the monkey-god Hanuman as she will not allow to be touched by any other man than her husband.

Women participate in many religious rites and according to the Dharma are even equal to men on a spiritual base. While performing a ritual it is believed that the female energy will be provided to the husband as well. There also are many female gods and the concept of duality is worshipped. The male and female concept in Hinduism together forms a unity and one cannot exist without the other. But a woman's energy is considered to be strong and dangerous as well which is why it must be controlled by a man. A woman can bring a very positive or very negative energy and is perceived as a highly sexual creature that therefore has the ability to distract men on their spiritual pathway. For Hindu men their son is believed to be some kind of reincarnation of the father leading to the importance of sons among Indian society. But it also increases the importance for a father to know who their son is for sure. The aspect of control over women is mentioned many times in religious texts and has become a strong part of society's structure. Women are believed to not being able to live without their family and the male control. They therefore are highly dependent on their relatives. As a child they will be controlled by the father and after marriage by their husband and the parents in law.

In Hinduism women often face a lot of contrasting ideas regarding their value. The ideas also differ among Hindu societies as there is not the one Hinduism but several different traditions and believe, depending on the region, caste or tribe. It would be not correct to say a woman's value is low according to Hinduism but the worshipping of

women is linked to many conditions that in turn are based on a patriarchal view of the world. Since tradition, moral values and religion are closely linked in India, female rights activists try to avoid the term feminism as it often is considered as a western idea threatening traditions and Indian culture. *(37, 38)*

1.3.3 Child labor in India

The Indian law states that every child under the age of 14 must visit school regularly but especially in rural areas this is not always possible. Next to financial reasons as well as difficulties regarding transport in some cases the family depends on an extra income, leading to poverty being one of the main reasons for child labor in India.

An estimated amount of 10 million children under the age of 14 must work instead of visiting school which makes India one of the countries with the highest number of underage workers. Often these children's parents have been working since their childhood as well and never had any education which is why there has never been a chance for them to escape poverty. The family depends on every possible income to survive but at the same time the children cannot visit school and will grow up to live in poverty and send their children to work as well. The development can be understood as a continuing circle of child labor and poverty. The risk for child labor is much higher in remote areas of the country compared to the big cities and the social group that is mostly affected are Dalits.

Doing heavy physical work at an early age does not only mean that children will not receive education. The work can be also very damaging to the child's health. There are several typical fields for children to work in like for example the textile industry where the children are exposed to toxic chemicals and monotone tasks. Especially girls are sewing clothes in factories or work on cotton fields. Many of them must work for 12 hours straight and even live inside the factories under inhumane circumstances. In some cases, there are long term contracts offered to the girls that promise they will receive enough money to afford a marriage after some years. But in the end, they never receive the promised payment.

Other children produce carpets. Working with knives and no protection there are many accidents that can even result in losing a hand or finger. Often children work in quarries since the age of 5 years. There are no masks to protect them from the dust and no protection from the loud noise as well. Many of those children suffer from lung diseases and the loss of hearing. A child working at a quarry usually doesn't grow older than 30 years in average. The health effects of child labor are various and severe. The children usually suffer from a delay in development as well as from joint-injuries and the effects of toxic substances, poor hygiene, and long working time without any breaks. Especially girls are often secretly exploited as housemaids. While working these children are under no protection and in many cases become victims of sexual abuse as well.

Since child labour officially is forbidden for many years, it is difficult to collect exact data on the amount of child workers but the fact that one of the main reasons for child labor is poverty allows the conclusion that especially during catastrophes and conflicts the number of affected children even rises. *(39)*

1.3.4 The situation of disabled people in India

According to Census of 2011 2,21% of India's population suffers from any kind of disability. Out of them only 52% are literates and 27% in the age range of 5-19 have never visited any educational institution. *(40, 43)*

Every citizen of India has the right to become educated but for disabled people this cannot always be realized. The chances for everyone hereby differ a lot depending on their family's wealth and on the disability being physical or mental. While the attitude towards physically disabled at least in most cases is rather positive it is much different in case of a mental retardation. To have a disabled child especially by very traditional Indians often is perceived to be a punishment the gods have sent to the child's family. According to Catherine Novi, the regional coordinator for rehabilitation projects of Handicap international, there still are strong believes among Indian society that disability is caused by black magic, wrong doings in a past life or karma rather than by physical reasons. Families therefore try to hide their disabled members leading to a lack of medical and educational support for them. Especially in rural areas where families often do not have the financial resources to afford any therapies or special education disabled children often have no chance to become an active member of society. Recently the public opinion slowly starts to change as people noticed that with a certain amount of support also disabled can be valuable workforce but the old believes are still strong among many people. *(41, 44)*

In many cases disabled become victims of abuse as well because they may not be able to speak out for themselves. According to Human Rights Watch especially disabled women are in danger to experience sexual abuse and violence. *(42)*

1.3.5 Psychotherapy in India

India, with its 1.3 billion inhabitants, is one of the countries in this world with the highest population. It is estimated that about 150 million people suffer from psychiatric illnesses. *(45)* For young people at the age of 15 to 29 a leading cause of death is suicide. At the same time only about 1-4% of India's gross domestic product is invested in the health sector resulting in a high number of private clinics to overcome the gap. *(46)* For psychiatrists in many cases it is not attractive to work in India or open a clinic since the acknowledgement and income in this field, compared to other medical fields, is rather low. There is a tendency of psychiatrists and psychotherapists to leave India and work abroad what in turn is one of the reasons for India's general lack of psychiatric workforce. *(45)*

According to the Minister of Health and Welfare, Anupriya Patel, only 898 psychologists are available, while the requirement would be at least 20250. *(47)* The overall number of psychiatrists, psychologists, psychiatric social workers and psychiatric nurses in India is 7000 but an estimated number of 55000 would be needed according to the data of the National Crime Records Bureau in 2015. *(45)*

Besides the financial reasons there is also a lack of educational possibilities that is responsible for the low numbers of professionals in India's psychiatric workforce. There are only few centres that offer courses focused on psychotherapy and they usually only have few places. Undergraduate medical courses that address specialized psychology and psychotherapy, as well as possibilities for postgraduates to increase their knowledge in this field, are still rare. *(48)*

In India mental illness also is connected to strong stigmata resulting in many people not seeking out for psychological help even though they are in need. As mentioned, before there are approximately 150 million people in India who suffer from mental illness but only about 30 million ever reached out for treatment. According to the results of a survey by Bhumika et al. about 14.4% of people did not even know where to search for psychiatric help while 60% have shown to be not much informed about mental health in general. A high number of participants were not able to even name psychiatric illnesses while 18.9% mention movies and media as their main source of information. Especially in rural areas mentally ill people are stigmatized but also among members

of higher social class there are many who are scared to be judged by the community when speaking about their illness in public. *(49)*

To offer psychotherapy in India can be difficult as well, since many therapy-concepts have been developed in western communities and therefore cannot always be used in other socio-cultural environments. While there are fewer problems with western therapy-methods in India's big cities, especially in rural areas the ideas often seem "alien" to the locals. *(48)* According to Varma there are at least seven reasons why western psychotherapy may be difficult to use among Indian society. *(50)*

"1. Dependence/ Interdependence, 2. Lack of psychologic sophistication, 3. Social distance between doctor and patient, 4. Religious believes in rebirth and fatalism, 5. Guilt attributed to misdeeds in past life, 6. Confidentiality, 7.Personal responsibility in decision making"

Western psychotherapy is often focused on the individual while in Indian languages there is not even a word for "privacy". Neki therefore suggests therapy-methods that include the whole family or at least the partner, since Indians are usually highly dependent on their family. *(51)* There are also many attempts to include local religious and symbolic elements in the therapy, such as the idea of karma/ dharma or philosophical approaches but only few studies regarding this topic are available. *(48)* The lack of evidential studies in the field of psychiatry has become a matter of discussion among Indian psychotherapists. Many now demand an increase of psychiatric workforce as well as research performed in India.

1.3.6 Andhra Pradesh

The southern Indian state of Andhra Pradesh is located at the golf of Bengal. It has over 49 million inhabitants *(20)* and therefore as most Indian states is rather densely populated. Andhra Pradesh's capital city is Amaravati but formerly has been Hyderabad. *(21)* In 2014 the region of Telangana became an independent state which is why the capital city had to be changed. As Amaravati is still under construction, Hyderabad will function as both states' capital until 2024. For Andhra Pradesh without Telangana the name Seemandhra has become common, which is a combination of the biggest areas of Andhra Pradesh, Rayalaseema and the coast of Andhra. *(24)*

The state's official language is Telugu (ఆంధ్ర ప్రదేశ్), a Dravidic language that has its own letters. The language is spoken by the majority of people but there are also other languages spoken in the area. The biggest minority are muslim people living in Andhra Pradesh. They speak Urdu which is an indoarian language that is closely related to Hindi but contains many Persian-Arabic words as well as an Arabic writing system. About 5% of Andhra's population are members of scheduled indigenous tribes, also called Adivasi. Their biggest groups are the Yanadi, Yerukula and Sugali in the southwest and the Kond, Bagata, Jatapu, Savara and Kondh in the northern areas. Many of them speak their own language, such as Savara, a Munda language. Nearly 570 500 people also speak Tamil and especially in higher education and science English still plays an important role. *(20)*

Most people in Andhra Pradesh are Hindus (91%) but there are also Muslims (7.3%), Christians (1.4%) and some smaller other religious groups (0.4%). Christians can be mostly found among Dalits.

Even though India is a democratic parliamentary system since 1980 a maoistic group called Naxalites fights to establish a communist system in some areas of Andhra Pradesh. Since that time many hundreds of people died during fights between Naxalites and the police and there have been multiple violations of human rights on both sides. There also have been assassination attacks especially on politicians and landowners as well as on other opponents of the movement. *(22)*

According to Census of 2011 33% of rural population in Andhra Pradesh are illiterates while the Indian average for this group is about 27%. For children stating from the age of 6 visiting the school is mandatory but in reality, many children especially from rural areas do not visit school regularly or at all since their help is required at home and in agriculture. *(23)*

2 Method

For the education of Trauma-Supervisors a curriculum as presented in detail later has been developed. Five young Indian women received training and afterwards worked as Traumahelper Supervisors during several therapy-sessions. None of these women were professional psychotherapists but all of them were pedagogues, or at least have collected a high amount of experience, when it comes to working with children, during their history of education.

Using specialized questionnaires like the UCLA-Traumascore, RISK, CRIES and the Depression-Self-Rating-Scale many children, living in an orphanage of CARDS-project and who experienced potentially traumatizing events, got screened for signs of posttraumatic stress reactions. According to their results the participation in therapy-groups has been offered to the children with the highest scores. While answering the questionnaire each child was assisted by a teacher or social-worker and had the chance to discuss any ambiguities with the Traumahelper Supervisors.

Over a total of two months, except for the school holidays, the children participated two times a week in trauma therapy groups. Each group consisted of eight to ten children and an equal number of Traumahelpers. The Traumahelpers who assisted in the therapy have been educated by the Traumahelper Supervisors and were mostly older college-students visiting one of CARDS-project`s several colleges for girls. Most of the students grew up in CARDS-project themselves and volunteered as Traumahelpers as they wanted to support their younger peers as well as they declared a personal interest in choosing a psychotherapeutic career later on. Before the first therapy took place

each Traumahelper got paired up with one child they would be responsible for during the next two months.

Each therapy-session lasted for about 50 minutes and followed a strict scheme. In the beginning Traumahelpers and children formed a circle and sang a song, while performing choreography. The song “Aramsamsam” was chosen for this process as it consists of simple to learn words regardless the mother tongue of the singer. After repeating the song three times at different speed levels the children are allowed to pick toys from many plastic boxes that have been placed in the middle of the room. Those toys included dolls and animal figurines as well as cars, furniture, plants, or minerals. Some soldiers and weapons could be found as well. While picking toys the children got supported by their Trauma-Helper assisting them in carrying the toys from the box to their sitting place.

For those children who received Sandplay-Therapy, boxes filled with sand were placed in the room, one for each child. Half-rolled up ropes for those participating in the lifeline-therapy were available as well. Furthermore, a camera was placed in one part of the room to record the therapeutic process. During therapy pictures of the sandboxes and ropes have been taken to later add them to a “therapy-diary”. The therapy-session ended with another round of singing.

Afterwards Traumahelpers and Traumahelper Supervisors gathered around a circle to place the previously taken pictures in the therapy-diary of their child and to write down some impressions. Problems and questions could be discussed with the supervisors and the supervisors gave instructions on how to further improve the Traumahelpers work and reduce possible mistakes. As the children should visit school the therapy was scheduled according to the school’s timetable to prevent the children from missing any classes. As some therapy sessions took place in CRAC-school as well, the Traumahelpers and Supervisors regularly visited the school by bus and held therapy-sessions following the same scheme as in the orphanage.

To provide the best possible environment for therapy, all participants were asked to switch their phones to silent mode. Other students who didn’t participate were not allowed in the room to make sure there is enough privacy for the children during the therapy-process.

After the last therapy-session each child was asked to answer the previously mentioned questionnaires again so their results can be compared to those of the initial screening. Again, the children got assisted by an adult who knows the child for a minimum period of four weeks. In this study the gained data is statistically analysed to prove the curriculums efficiency.

2.1 The Sandplay-Therapy

Sandplay-Therapy was developed by the swiss psychotherapist Dora M. Kalff (1904-1990). The method is based on the analytic psychology of Carl Gustav Jung as well as the “World-technique” of the London doctor Margaret Löwenstein. *(52)* It has been also influenced by Buddhism as a spiritual tradition and was initially developed for the therapy of children. *(53)* Today Sandplay-Therapy is also used for adults and adolescents.

During therapy a safe and protected environment is created for the client. He or she can unfold themselves freely without any fear or restriction. While playing in the sand an “inner situation” can be displayed as well as subconscious processes may become visible. Even negative and destructive tendencies are not supposed to be supressed but can be shown in the well-known safe environment of play. The goal is to enable the client to consciously feel his own self during the process. Body, mind and soul are supposed to reunite while playing in the sand becoming whole again. The language of symbols used in the pictures presented in the sand may be interpreted by the therapist. But to not interrupt the client’s flow of playing he or she should not be confronted with the therapist’s interpretation during the Sandplay-Therapy. *(54)*

As typical for children’s behavioural therapy each session follows the same structure. The child will receive a box filled with sand. Dora M. Kalff suggests a size of 57x72x7cm as this size resembles the human field of view and enables the client to always observe every process that is taking place in his box. This in turn causes a feeling of control and security to the child.

Every therapy-session consists of two episodes of play that will last for 10-15 minutes. In between those episodes the child will draw a horizontal eight on a piece of paper. For the available toys and figurines used to create pictures in the sand a high quality and large offer is suggested as it will meet the child’s aesthetic sense and therefore increase the will to play. *(55)* The collection should be updated and increased frequently to take the constant change of the world and society into account. *(56)* Especially when working with children it might be helpful to give them enough time to examine the offered toys before the first therapy starts.

While playing in the sand the child can show traumatic experiences and negative emotions through its creations. The depiction of memories as well as unconscious processes may assist the client to reconnect formerly fragmented memories of the traumatic event. As it is not necessary to describe what happened by the help of words even the “unspeakable” can be made visible. In contrast to the often-experienced feeling of helplessness during a traumatic experience while playing in the sand the child experiences a feeling of control. Whatever picture can be seen afterwards will be determined by the child’s free will. The traumatic event can even be “changed” to an positive outcome.



Illustration 7 Sandplay-Therapy Source: Travel photography

During the therapy-session the therapist will sit in front of the child acting as a witness of the processes presented in the sand. The presence of the other person hereby helps the client to focus and increase concentration. According to Kalff it is necessary that the therapist not only follows the play with his eyes but to also shows that he or she follows it emotionally. Whenever the psychotherapist will lose focus or does not pay enough attention it might affect the client as well as, inhibiting his play.

2.2 The Lifeline

The concept of Lifeline-Therapy is based on narrative exposure therapy and was initially created by Margarete Schauer, Frank Neuner and Thomas Elbert. Narrative exposure therapy (NET) is a short-term therapy concept that is especially useful whenever there is a limited amount of financial or personal resources as it has been the case for example during the refugee crisis. *(58, 59, 60, 61)* The centre of this therapeutic process is to put the most important events of a client's life into chronologic order. While doing these memories shall be reconnected and his or her own self is supposed to be consciously experienced by the client. Hereby not only the traumatic experience is the focus of attention but also the connected emotions and the goal of seeing it in the overall context of life. *(62)* During this process the therapist is supposed to be an empathic support to the client providing him with a feeling of security and control. *(70, 71, 72, 73)*

After experiencing a traumatic event people may develop a posttraumatic stress disorder. The symptoms of it can be decreased by the help of NET and chronification of the disease prevented. In many cases after trauma memories are only fragmented and cannot be recalled in a chronologic context what in turn leads to fading borders between the past and present time. Due to the defective distinction between memory and the present time people will re-experience the traumatic event again and again in so called flashbacks. By recalling and telling their own biography people are able to reconnect memories and let the line between reality and memory become clear again. *(63, 64)*

While telling his story the client will be in an "eccentric positionality" so he can observe his own experience during the process and is able to keep a certain distance to the emotions and events without losing his perception of the self. (Schauer 2017)

According to Schauer the NET follows a three-step system starting with the collection of life events as a first step. Questions that can be answered with yes and no help to collect certain events and symptoms that may afterward be brought into context according to the concept of psychoeducation. Afterwards the further process will be discussed with the client.

As a second step the lifeline will be created. The client will therefore be asked to place toys or stones representing certain life events that had a big impact on him along a string or rope lying on the ground. The rope hereby represents the person's life and at one end is curled up to symbolize the yet unknown future. This way the events are brought into an order and can be observed in context.

In a last step the client will now write down his story and afterwards tell it to the therapist who will act as an active, focused listener. This step usually takes six to 12 therapy-sessions. During this phase the therapist is not supposed to judge any of the told things but to show empathy. Only in the case of human rights being violated in the clients story the therapist is supposed to condemn those events and by that help the client to regain confidence. Sometimes the therapist may repeat parts of the client's story to assure himself he understood it the right way and to underline his role as an active listener.

More and more details will be added by the client as he is telling his story, and the therapist will support this process by asking questions from time to time. Together they investigate the client's memory rediscovering the missing parts. *(65, 66)* The client's perception of past events hereby can be even changed due to the interpersonal contact and the therapist's attitude. After the last therapy-session the written memories will be handed to the client.

During the process of therapy according to Schauer different concepts are used; "slowing down", "deepen" and "contrast". A traumatic event is often experienced as overwhelming. People will get the feeling that events followed each other much faster than usual. By slowing down the flow of speech emotions occurring during the several events can be observed consciously. By telling the story more slowly the client gets the chance to take a closer look at the past events. At the same time the therapist will ask questions helping to deepen and to bring up further details. Because of these questions the client will be encouraged to make aware his own emotions as well as physical perceptions during the event. He is further asked to maybe rethink what the event changed about him and hereby increase the client's awareness. The search for details will also assist in the process of slowing down, thus creating an environment that contrast the fast and unruly traumatic event.

The concept of contrast is supposed to help the client recreating the line between past and present time and to prevent flashbacks. During therapy the client therefore is asked from time to time to focus on his surroundings taking his consciousness back into the here and now. He also is supposed to pay attention to the perception of his own body.

NET can also be used in cases of multiple traumatized people and is suitable for any cultural background. But as NET requires a high amount of communication a translator might be needed. The easy structure allows also lays to understand the therapy-concept very fast and results can be seen quickly. NET is an evidence-based method and its effect on patient's symptoms has been proven in metanalysis before. *(67, 68, 69)*



Illustration 8 The Lifeline-Therapy, Source: Travel photography

2.3 The use of the Sandplay Therapy and Lifeline during Traumahelper assisted therapy

As already mentioned, five young women received training in advance according to the curriculum for the education of Traumahelper Supervisors presented in this work. Their educational background hereby differed a lot.

The first participant has a degree in laboratory-technology and therefore already had some basic knowledge about anatomy, biology and in lesser amount paediatrics. Neurology and neuroanatomy so far have not been a part of her education. In a post-graduate course, she also received the Bachelor of Arts in the field of politics, history and sociology. After finishing her education, the participant worked as a teacher for disabled children in several institutions of CARDS. During this work she was able to collect some experience in psychology and student counselling. The educational background of the second participant resembled the first ones in many points. She additionally has a Bachelor of Education and already had her main emphasis in student counselling during her studies.

The third participant has not finished any education so far. As a senior student in 13th grade, she has chosen “science” as her main subject and is interested in a psychotherapeutic carrier after completing school. She is already investing her free-time in studying human physiology.

Another participant has also no degree but is working in the CARDS-institutions already for 12 years and by that collected a lot of experience being a supervisor for children. The fifth participant did study psychology but is not working as a psychotherapist. Her main task is administrative and public-relations work for the many projects of CARDS as well as participating in various supervisory boards responsible for the quality control of orphanages in the region.

All these women have in common that they are part of the same social group as the children participating in therapy. They also grew up in one of the CARDS-institutions or at least received a lot of support by CARDS during their educational pathway. Due to this background during the training of Traumahelpers there have been no language or cultural borders between Supervisors and Traumahelpers.

After successfully completing the curriculum to become a Traumahelper Supervisor these five women started to educate Traumahelpers following the already well tested concept of Prof. Loew and Dr. Leinberger. During the course they provided the Traumahelpers with the necessary information about trauma and its physiological background and they offered several training-rounds to the participants to experience the effect of the newly learned techniques by themselves and get used to the procedure of therapy-sessions.

As mentioned before the Traumahelpers have been mainly college-students. Therefore, during training, the Traumahelper Supervisors used pictograms and similes that could be understood easily by people with the same socio-cultural background, to explain connections and to answer questions.

Therapy-sessions took place in three different institutions of CARDS-project. The first one is the Child Guidance Centre in Hyderabad, a school for disabled children. Even though CARDS has focused on the support of Dalits the school welcomes disabled children of all other social groups as well, presupposing respect and equal treatment regardless of their background. Disabled people, especially those with mental disability, in many parts of India still are not socially accepted so their families often try to hide them from public, considering the child to be a shame or even a punishment. Therefore, only few institutions offer teaching and training according to the special needs of these children. At the Child Guidance Centre they receive basic education according to their abilities as well as physiotherapy,ergotherapy and logopaedy.

Another institution is CRAC-school which is located in one of the workers settlements close to a limestone factory. The CRAC-school offers education to many children working in the factory and provides a small payment to the parents to compensate the loss of income due to their children’s reduced time to work. Many of those children had to perform very heavy work at an early age leading to a delayed mental and physical development. The lack of occupational safety and health protection in the factories for some children caused injuries as well as pulmonic diseases due to the unprotected exposure towards dust and pollution. Since medical help is expensive the children often receive painful alternative treatments or even no treatment at all. An example for such an alternative treatment is the burning of an arm or leg with hot iron to treat hepatitis infections.

The third institution is the Girls-Project. The project includes an orphanage as well as a school for girls where they can not only get basic education but also receive craft training and the possibility to earn their own money as they get older. The loss of their parents especially for girls in India can potentially cause a lot of suffering since orphan girls in many cases become victims of physical and mental abuse. Sometimes families also decide to abandon female children and new-borns as women and girls still are considered to only cause costs while males will be a source of income to the family.

In each institution Traumahelpers and Traumahelper Supervisors screened the children for symptoms of post-traumatic stress disorder by the help of the already mentioned questionnaires. Those children with a history of traumatic events who have reached high scores in the testing were invited to participate in trauma-therapy. The groups consisted of eight to ten children and each child got paired up with one Traumahelper. Which kind of therapy is suitable, Sandplay or Lifeline, was decided according to the age of the child as well as the children's personal preference. While younger children preferred the Sandplay-Therapy for older ones and adolescents "playing" appeared to be not age appropriate which is why some of them have chosen Lifeline-Therapy. An exception can be found among the children in CRAC-school. As many of those children only recently started to visit the school, they have not been able to properly write down their experiences. Also, when they were asked to draw what happened some participants had difficulties as those children due to the history of child labour did not have the chance to unfold any kind of creativity so far and therefore have not developed the motoric and imaginary skills needed to properly display their thoughts by drawing. In these cases, also for adolescents Sandplay-Therapy was the preferred method.

During the next two months, following the initial screening, each group received two therapy-sessions a week. Before the first therapy-session all children have been invited to take a closer look at the provided toys and the sandboxes. While doing so they also got to know their Traumahelper and spent some time together playing and exploring the toys. The materials for therapy had been brought to the room and been prepared by the Traumahelper Supervisors in advance. As most of the children already knew each other from school they did not need to get used to each other. During this first meeting the Traumahelper Supervisors explained the therapy-process to the children in simple words and introduced them to the Aramsamsam-song with its movements. By the help of the singing and the movements included in this song the singer will automatically slow down his breathing rate and activate both brain hemispheres, an effect that, as explained later, has a stabilizing effect on the psyche. Before each therapy-session the song was repeated three times at different speed levels to increase the singers focus and conscious perception. The repetition of actions during the session is also supposed to increase the feeling of security as the child always knows what to expect next.

After finishing the song, the children were allowed to pick toys they want to use for Sandplay or Lifeline. While doing so they have been supported by their Traumahelper bringing the toys to their sitting place. The Traumahelper did not interfere in the process of choosing the toys. There also have been no restrictions regarding the amount or type of toys that could be chosen by the child. To make the process of picking toys easier they got divided by topic in advance. There has been one box filled with dolls, one with cars, one with animals and another filled with furniture and household supplies. Also, boxes with stones and nature-materials as well as some soldiers and weapons could be found. The wide variety of toys was increasing the children’s will to play as well as it made them not lose interest over time.

Each Therapy-session followed the same scheme. First the song was performed, followed by Sandplay or Lifeline-Therapy. During the session Traumahelper Supervisors took over responsibility for the organization and order of events as well as they were answering questions and helping with any arising difficulties. They also supervised the correct implementation of stabilizing techniques and if needed showed how to perform them again.

During therapy a camera was placed in the room, recording the session. Also pictures of the Lifeline as well as the Sandbox have been taken to document the process. The session always ended with performing the song again.

To perform the Sandplay-Therapy each child was given a box with sand in the by D. Kalff recommended size. The children could now use the previously picked toys to play in the sand building up sceneries of all kinds inside of their box. During this process the Traumahelper followed the events in the box with interest and empathy. Whenever the child was losing focus or faced very intense feelings the Traumahelper offered to use stabilizing techniques on the child and by that bringing it back to the here and know. The Traumahelper was also asked not to interpret the pictures in the sand and to discuss their theories with the child but only to be a witness in that moment. While being very calm and focused themselves, the Traumahelpers also affected the children's state of mind by being a "mirror" and increased the feeling of safety for their children during therapy.

After 15 minutes of play, the children were asked to draw a horizontal eight on a piece of paper, following the lines for about five minutes while performing a smooth movement. Due to this movement both child's brain hemispheres become activated as well as the hand-eye coordination gets improved. The repetitive movement can lead to a meditative state of mind helping to reduce stress and fear. For their drawing the children were allowed to use pencils of different colours to make the drawing more interesting for them. Some children needed assistance by their Traumahelpers to get used to the movement and to perform it in a proper way. Each picture drawn during therapy was collected by the Traumahelper Supervisors and handed to the Helpers afterwards to place it in the children's trauma-diary. After drawing the horizontal eight another round of play for again 15 minutes took place. The Traumahelpers took pictures of the sandboxes before and after drawing and placed those pictures in the trauma-diary.

Those children who received Lifeline-Therapy got asked during the first therapy session to place toys along the prepared rope. Each toy hereby should represent an important positive or negative event in the child's life, helping to create a so called "trauma-landscape". Afterwards each event got rated by the child on a scale from 1-10. The higher the number the more intense the positive or negative experience has

been. By the help of this numeric system negative events could be brought into an order as well as, indicating which of those memories should be worked on. The next step for the child was to draw his or her “safe place”. The safe place didn’t necessarily have to be a place as it could also be people or a certain situation the child feels comfortable with. In the following therapy-process the safe place, as a very positive aspect of the child’s life, was used to stabilize the child when being confronted with traumatic memories.

Therapy then was started by working on the second worst event to enable the child to get used to the process and gain trust and confidence before facing its worst memory. The child was asked to write down a sentence that describes its feelings during the traumatic situation. An example for such a sentence could be:” I am helpless.” Afterwards he or she had to transform the sentence, giving it a positive meaning. To stay with the previous example, it could be like this:” I felt helpless at that time but today I am strong.” In a next step the child presented the traumatic memory while drawing a picture of it or writing it down like a history. The Trauma-Helper in this process had the same responsibilities as in Sandplay-Therapy.

After this step the child focused again on the previously drawn safe place while being supported by the Traumahelper. The Helper is performing light tapping on the child’s back or can use some of the other learned techniques. Then the severity of the memory was rated on the scale from 1-10 again. With each round the number is supposed to decrease as a sign of also decreasing impact of the traumatic memories on the child. While writing down or drawing the event, slowly more and more detailed memories will come up as well. As soon as a very low rating on the scale has been reached for the second worst memory, the Traumahelper and the child started to work on the event with the highest impact. The therapeutic process was documented by photos and video in the same way as it was for the Sandplay-Therapy.

As already mentioned earlier each therapy-session was followed by a gathering of all Traumahelpers and Supervisors to discuss problems and reduce possible mistakes. Getting some feedback for their work and to exchange their experiences with each other was important for the Traumahelpers as well. As in some cases they have been exposed to the traumatic history of their client it was necessary to spend enough time

for the Traumahelpers to share their feelings and impressions as well and hereby prevent the Helpers from experiencing an impact on their own mental health.

Some Traumahelpers at first had difficulties to stick to the concept and to not share their theories about the picture in the sand with the child. During the first sessions Traumahelpers sometimes felt the urge to just “talk things trough”. The gathering at the end of each session gave them the chance to share their ideas with other Traumahelpers and the Supervisor instead of with the children and to stick to the role of a non-judging empathic listener. Traumahelpers after each therapy-session also wrote down their impressions in the children’s trauma-diary documenting their progress.

After two months of therapy the questionnaires used for screening got answered by the children again and their results have been compared to those two months ago. There has been an improvement regarding the symptoms of trauma related diseases in nearly all cases, presupposing that the course was visited regularly. When talking to the supervisors and teachers of the children their impression of the children’s development was also very positive. Many of them reported a significant improvement regarding the affected children’s everyday performance.



Illustration 9 Teaching Trauma Helpers Souce: Travel photography

2.4 Functional Relaxion, SURE and EMDR

Next to Sandplay and Lifeline also Functional Relaxion, Elements of EMDR and SURE have been used during therapy. These methods as well as Sandplay and Lifeline have been proven to be effective before and therefore are no experimental approach.

Functional Relaxion

Functional Relaxion is used to turn the clients focus on the perception of his own body. While experiencing the body the client also may be enabled to notice unconscious processes and by that to regain access to formerly lost memory. The concept was initially developed by Marianne Fuchs, a German gymnastics teacher, and is based on depth psychology. *(83, 84)* Together with Viktor von Weizensäcker, who worked as a neurologist and psychotherapist, she developed the psychodynamic method of Functional Relaxion. According to their view the human being needs to be understood as a whole entity that is in a constant exchange with its surroundings. This exchange happens during breathing as the exchange of gas as well as during eating when taking up substances. But also, impressions constantly exchanged. By the help of the eye, nose, mouth, ears, or the skin we perceive our environment while also being noticed by our environment. The same accounts to expressed emotions that can affect others as well as people's emotions may affect us. In the same way the physical body interacts with its surrounding and is in a constant exchange the unconscious does as well. Psyche, body, environment, and relationships are building up a dynamic system in which interaction occurs at any given time. Each individual part therefore can affect the other parts of this system. Certain situations or emotions therefore may cause physical reactions like for example muscular contractions. Those unconscious processes can become visible to the person and might be controlled, causing a preferable reaction in other parts of the system. Consciously relaxing the muscles therefore may lead to a reduced stress level. *(74)*

Especially the breathing as a "seismograph for constant or short-term irritation" as Fuchs called it, plays an important role in Functional Relaxion. By consciously experiencing the breathing process a natural breathing rhythm can be regained. So-

called slow-paced breathing will then lead to a psychological effect and reduce stress. *(85)* The reduced breathing rhythm is activating the cerebral cortex and will induce neuronal signals to be transferred via the descending neurons leading to an increased activity of the parasympathic nervous system. The parasympathicus, which is the part of the nervous system responsible for “rest and digest”, is regulating body functions as the heartbeat or breathing. Whenever these functions get altered and become slower due to the parasympathic influence sensible nerve fibres will transfer the information back to the brain, causing a physical and psychological stress reduction. The initially conscious reduction of the breathing-rhythm therefore may lead to a circulus vitiosus and to an unconscious decrease in heartrate as well as slower breathing over time. *(75)*

By the help of slow-paced breathing therefore not only can the symptoms of psychological stress and anxiety be reduced, but also positive physiological changes like, decreasing a formerly high blood pressure can be induced as well. (*76, 77)*

To achieve the effects of slow-paced breathing Prof. Loew recommends conscious breathing for about 2-11 minutes. During this time the person will breathe in for 4 seconds and breathe out 7 seconds. The relaxing effect of the altered breathing rhythm afterwards will last for minutes up to hours as the brain stem gets activated. Like in meditation the focus will be led to the breathing for a certain amount of time and is hereby increasing a person’s perception of the own body and the self. While doing so he or she will be enabled to also be receptive towards unconscious processes. A similar effect can be reached while doing yoga or singing as well since both activities contain slow paced and controlled breathing.

Another aspect of the focused perception is to experience hold. This can be done by consciously feeling a wall or the ground or even the chair a person is sitting on. The hereby resulting feelings of security and stability resemble the experience of being hold by the parents in childhood. Surrounding structures can therefore have a similar effect as the presence of another person holding someone.

EMDR and NOBIS

EMDR or Eye Movement Desensitization and Reprocessing is a concept developed by Francine Shapiro PhD to treat psychotraumatic stress disorders. Her method is based on the assumption that after birth every person develops a so-called AIP-system (Adaptive Information Processing). This mechanism is responsible for the ordering and processing of traumatic experiences. In the case of post-traumatic stress disorder this system is disturbed leading to fragmented memory that cannot be properly processed. Whenever there is a trigger like for example a certain smell or noise, the person can be transferred back to the traumatic event or at least their emotional condition during this experience. This “flashbacks” will in turn lead to the dysfunctional behaviour of the affected person.

EMDR and the bilateral stimulation of both brain hemispheres can again induce the processing of those fragmented memories and hereby slowly decrease their impact on the client whose symptoms by that can be reduced. During therapy the patient is asked to focus on the non-processed memory. The psychotherapist will then move his finger in front of the patients face slowly from one side to the other while the patient follows it with his eyes. One theory to explain the effect of EMDR is that the created eye-movement resembles the one of REM-sleep. REM-sleep is the sleeping-phase during which the experiences and memories get processed and consolidated. Any disturbances during this phase may even lead to symptoms of dementia. *(78)* EMDR is also effective when it comes to helping the client to deal with overwhelming emotions and stress reactions during therapy. In studies using electroencephalography after EMDR a normalized cerebral activity could be observed. *(79)*

As well as the other so far presented concepts of therapy EMDR is not an experimental method. Its efficiency in the treatment of trauma-related diseases has been proven making EMDR a well-established therapy-concept. Since 2006 EMDR got accepted as a therapy for PTSD in adults by the advisory board for psychotherapy in Germany. *(81)* After further studies during the following years an application for the allowance to use this method for children and adolescents has been already handed in. In 2013 WHO officially declared EMDR to be one of the two accepted methods for the therapy of PTSD in children, adolescents, and adults. *(81)*

Francine Shapiro developed a well-structured system for EMDR-therapy that is based on the idea of three different levels. The first level can be understood as the past where the traumatic event happened. Working on this level is focused on the reprocessing of traumatic fragmented memory. The second level is the present time with triggers that cause flashbacks. And the third level is the future. During therapy there should be found a strategy how to prevent the dysfunctional behaviour from occurring in the future. The whole therapy-process is hereby divided in eight phases. To describe the traumatic event to the psychotherapist during these phases is not absolutely necessary.



Illustration 10 Singing slows down the breathing- Source: travel photography

The first therapy-phase is focused on the patient's history and the planning of therapy. The indication for EMDR is stated and possible contraindications are ruled out. How long the therapy should last is hereby dependent on the complexity of symptoms. A higher complexity may require more therapy-sessions.

In the second phase the patient is prepared for the therapy-process by learning relaxation-techniques as well as, if it is necessary, receiving medication. By that he or she is supposed to reach enough mental stability to be able to participate in the therapy. Methods as well as the therapy-plan will also be discussed with the patient in this phase.

The next phase includes the reactivation of the pathogenic memory to enable the patient to process it. To do so the client will create a positive as well as a negative

cognition that can be used during the therapeutic process. In the “Working-through-phase” the client is the asked to focus on the traumatic memory and the negative cognition as well as on his perceptions and reactions while doing so. The therapist supports the processing of memory by performing the previously described finger movement in front of the patients face. During this phase strong emotions and affects may occur. Thoughts and associations can change quickly. Because of that in this situation it is important for the therapist to provide his client with as much stability and security as possible while not interrupting the process. The client will experience a decrease of his burden which will be strengthened and manifested in the next step.

The positive cognition in this step is recalled by the patient and its impact on the patient is increased by the help of bilateral stimulation. The bilateral stimulation is preventing the patient’s emotion from becoming overwhelming due to its impact on the limbic system as mentioned before. At the same time, it helps with the manifestation of emotions and memories.

During the sixth step the client focuses on his sensory body perceptions connected to the memory. By the help of bilateral stimulation these unfavourable perceptions can be decreased as well.

In the next step the experiences during therapy are discussed with the therapist and the client is getting prepared for the post-therapy-time. The processing of memory may still continue after finishing the actual therapy, manifesting itself for example during dreams.

After some time, the client again meets up with his therapist, discussing newly arisen memories that might be a base for further reprocessing. EMDR is a complete therapy-method on its own. During Traumahelper-Therapy, elements of EMDR-Therapy, such as nonverbal bilateral stimulation (NOBIS) are used.

SURE

SURE (Somatic Universal Regulative Exercise) is a body- focused method developed in Russia and based on Kunze and Dr. Alliev (2006). By performing a soft swaying movement while sitting, lying, or standing stress can be reduced. It is also possible to archive this effect only by moving the head or feet as well as the movement can be assisted by another person. The goal is to initiate an automatic, autonomous movement over time after at first performing the swaying on purpose. When the automatic movement has been achieved it then leads to a decrease of stress experienced by the person performing it. The more trained a person is in this technique the faster he or she will achieve the automatic state.

The concept has been already successfully used by rescue services *(82)* and can be easily learned by lays too. SURE the “swaying in safety” is a preventive measure for PTSD in catastrophe situations. It can also be used to support the therapy of phobias and impulse-control-disorders.

3 Curriculum for the education of certified Traumahelper Supervisors

3.1 Structure of the course

The Traumahelper Supervisor course is an additional education that enables the participants to lead Traumahelper groups and to educate Traumahelpers in advance. To allow as many interested people as possible to participate in the Traumahelper Supervisor educational program, in discussion with the leader of CARDS, a time span of two weeks for the education was defined. As the course offer also addresses college students with a scientific or medical major subject as well as experienced student counsellors the course should preferably be held during school holidays. It offers the chance for participants to achieve deeper knowledge about trauma and trauma therapies as well as the participants get the chance to receive the Traumahelper Supervisor certificate after successfully finishing the course.

In total the course consists of 36 hours of theory and another 36 hours of practical training. The theory should preferably be taught during the morning session and the practical training should take place in the afternoon. On the last day of the course program a test that includes knowledge of all theoretical topics must be taken by the participants. This test can be taken either written or orally. The Traumahelper Supervisor Certificate can only be achieved after passing the final test as well as attending all course lessons. Lessons should be held in English to enable the future Traumahelper Supervisors to work on an international level as well as in their local communities.

During the two weeks of education different theoretical topics will be presented, starting with background-knowledge about trauma related diseases during the first week and the presentation of therapy-methods during the second week. While the practical training in the first week is focused on understanding and revising the topic, during the second week it also includes practicing the therapy methods as well as experiencing

their effect. The table shows the courses schedule with the topics that should be discussed on a certain day.

Day of the course	**Topic**
1	The definition of trauma and its source
2	Symptoms of trauma related disorders
3	Basic anatomical knowledge
4	Neurologic and physiological background
5	Introduction of the screening tools
Weekend	
6	Sandplay-Therapy
7	The Lifeline
8	SURE and EMDR
9	Teaching Traumahelpers
10	Exam

Table 3 Table Schedule of the course

On day five there also should be some time for participants to revise the first topics with their teacher as well as asking questions about what might not be understood so far.

3.2 Content

Curriculum for the education of

„Certified Traumahelper Supervisors”

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as experiencing their effect. The table shows the courses schedule with the topics that should be discussed on a certain day.

All in total the course consists of 36 learning sessions (LS) of 45 minutes each.

- Theory 18 LS
- Practice 18 LS

Two learning sessions take place in the morning and another two in the afternoon.

Overview of the contentment and time distribution

Day of the course	**Topic** **4 LS each**
1	The definition of trauma and its source
2	Symptoms of trauma related disorders
3	Basic anatomy and physiology
4	Traumahelpers and Supervisors
5	Introduction of the screening tools
Weekend	
6	Sandplay-Therapy
7	The Lifeline
8	SURE and EMDR
9	Teaching Traumahelpers
10	Exam (1 LS)

On day five there also should be some time for participants to revise the first topics with their teacher as well as asking questions about anything that might not be understood so far.

3.2.1 Instructions for implementation

The curriculum contains learning goals as well as action competences. Theoretical knowledge and practical training are combined in the two-week Traumahelper Supervisor course. The content is structured according to a subject specific point of view. It can be accentuated depending on the previous knowledge of the participants. Learning methods that are focused on praxis like roleplays, group-projects and others should be preferred over cognitive learning methods such as presentations.

Action competences

- Knowledge about trauma and trauma related disorders
- Symptoms and diagnostics
- Basic knowledge of the relevant anatomical and physiological background
- Basic knowledge of therapy methods and prevention of chronic disorders
- Correctly using screening tools
- Noticing and preventing common difficulties and mistakes during therapy

Further competences

- Cooperative and goal-oriented working
- Meaningful documentation of the therapy sessions and results
- Presenting and teaching the achieved knowledge

3.2.2 Knowledge and abilities

1. Trauma and trauma related disorders

1.1. Define what a trauma is

1.2. Name possible traumatizing events and situations

1.3. Understand reasons for the development of trauma related disorders

2. Symptoms of trauma and trauma related disorder

2.1. Understand and describe intrusive symptoms

2.2. Be able to name symptoms of avoidance

2.3. Be able to name symptoms of hyperarousal

2.4. Be able to name and explain numbing symptoms

3. Anatomical and physiological background

3.1. Have basic knowledge about the structures of the human brain

3.2. Can name the structures that are relevant for the development of trauma

3.3. Describe the function of these structures

3.4. Understand and be able to describe those structures interaction

4. Performing a successful screening

4.1. UCLA questionnaire, being able to explain its use, items and cut offs

4.2. DSRS questionnaire, being able to explain its use, items and cut offs

4.3. RISK questionnaire, being able to explain its use, items and cut offs

4.4. CRIES questionnaire, being able to explain its use, items and cut offs

4.5. Understand when and how to perform the screening

4.6. Know the difficulties that may be connected to working with questionnaires

5. Traumahelpers and Traumahelper Supervisors

5.1. Understand why Traumahelpers and Supervisors are necessary

5.2. Understand and being able to describe the task of a Traumahelper

5.3. Understand and being able to describe the task of Traumahelper Supervisors

5.4. Be able to notice the borders of competence as Traumahelper Supervisors

6. Sandplay-Therapy

6.1. Achieve knowledge about the historical background and previous usage

6.2. Be able to prepare the therapy setting

6.3. Know all steps of the therapy method

6.4. Understand the effect of this therapy

6.5. Be able to perform and supervise a Sandplay-Therapy session

7. Lifeline-Therapy

7.1. Achieve knowledge about the historical background and previous useage

7.2. Be able to prepare the therapy setting

7.3. Know all steps of therapy

7.4. Understand the effect of this therapy

7.5. Be able to perform and supervise a lifeline therapy session

8. EMDR, SURE and Functional Relaxion

8.1. Define the terms EMDR, SURE and Functional Relaxion

8.2. Be able to understand and describe their effect on the client

8.3. Understand when to use the techniques, know the Aramsamsam-Song

8.4. Be able to explain and supervise the techniques during practical use

9. Teaching of Traumahelpers

9.1. Achieve knowledge about the different teaching methods and their use

9.2. Be able to name reasons for denying a request to become Traumahelper

9.3. Understand how to create a suitable therapy setting

9.4. Be able to perform an appropriate documentation of the therapeutic process

9.5. Know about the time span and content of the Traumahelper education

9.6. Be able to successfully educate Traumahelpers

10. Exam

3.3 Practical tasks and teaching

The theoretical knowledge that has been achieved during the morning lessons should be further deepened and revised during practical tasks in the afternoon. The use of group works, role plays etc. is helpful to better memorize the theoretical content as well as the training prepares the future Traumahelper Supervisors for the implementation of therapeutic interventions.

Day 1

Theoretical knowledge can be revised by the help of work sheets that contain the most important topics. In addition it is possible to further clarify the emotions experienced during Trauma in a roleplay connected to a group discussion about the content. To explain and better understand the change of perception after experiencing a traumatic event group games like “the falling experience” can be used. In this game the participant is asked to trust his peers, resembling the trust in safety healthy persons who never experienced a trauma possess. After a traumatic experience or in this case not being caught when falling the feeling of security and trust will be lost even though the incident doesn’t repeat itself. The process of falling hereby can be discussed theoretical or, if mattresses are available to provide the necessary safety, can be experienced in practice.

Day 2

Symptoms of trauma related disorders can be shown in short videos that are afterwards discussed within the group. The abstract idea of depersonalization and derealisation can for example be further clarified by asking the participants to create a drawing that describes these feelings.

Day 3

For better memorizing the different relevant brain areas and their function pictures that are supposed to be labelled by the participants can be used. It is also possible to perform a roleplay with the participants representing the different brain structures and substances.

Day 4

The participants are creating their own mind maps out of cardboard in a group work, summarizing the tasks and duties of Traumahelpers and Supervisors. Afterwards the results are presented to the group and the teacher.

Day 5

After discussing the theoretical content regarding the screening tools the participants are supposed to use the questionnaires on each other during the afternoon session. Remaining questions regarding the items and scores may be discussed.

Day 6

The participants will split in two groups. One group is the Trauma Helper group and the other one is the client group. Afterwards the participants will perform a Sandplay-Therapy session according to the scheme presented in theory during the morning session. This also includes the correct documentation.

Day 7

The participants will be split into two groups. One group is the Traumahelper group and the other one is the client group. Afterwards the participants will perform a Lifeline-Therapy session according to the scheme presented in theory during the morning session. This also includes the correct documentation.

Day 8

The participants will practice SURE, EMDR and Functional Relaxion on themselves and each other. Experiences are discussed within the group afterwards. In addition the Aramsamsam- Song is practiced by the participants, including the associated movements.

Day 9

Participants are asked to prepare small five-minute presentations about a topic of their choice and present them to the group, using the previously learned teaching methods. In a group work they can also design and present a trauma diary based on the training sessions of the days before. As it is the last day before the exam there is supposed to be the chance to ask some remaining questions in class.

3.4 Conditions for a good therapeutic environment

To provide good conditions to perform therapy Traumahelper Supervisors should pay special attention to privacy, relaxation, and concentration. A successful therapeutic Traumahelper assisted intervention can only take place if these things are provided by the surrounding conditions. It is important for the Traumahelper Supervisor to be a role model when it comes to following certain rules of behaviour that are necessary in this context. Based on former experiences some common disturbing factors and unpleasant conditions are mentioned here as an example.

Cell phones must be switched to silent mode during therapy as the sound may distract the children while trying to focus. Frequent calls and messages will also lead to the Traumahelper losing focus and hereby once again affecting the child's ability to concentrate. When choosing the place for therapy a closed room with little hearable noise such as traffic sounds or construction noise should be preferred. It is important that the children feel safe and relaxed during therapy. To prevent them from worrying about other people's thoughts when hearing they are in therapy, privacy must be provided. It should not be possible for anyone who is not part of the therapy process to access the room during the session as well as the answered questionnaires should not be shown on purpose or by accident to anyone else than the responsible Traumahelper and Supervisor. To achieve a high level of privacy and data security numbers instead of names can be used when storing the questionnaires. During screening, if possible, a certain distance between the participants may reduce the spreading of sensitive information, too. It is the Traumahelper Supervisors task to inform and educate the Traumahelpers about the importance of this issue and to ensure the implementation of the necessary measures.

If there is a possibility to do so it is furthermore helpful to allow children and Traumahelpers to get to know each other prior to the course. This measure increases the child's level of trust towards the Traumahelper and allows a feeling of security during therapy.

Traumahelper Supervisors must ensure that the therapy sessions take place regularly and that there is a clear structure and a correct implementation of the therapy methods.

Needed materials should be prepared prior to the session and each therapeutic intervention should be documented. All video and photographic data must be stored out of reach for unauthorised thirds.

3.5 Screening with questionnaires

When using questionnaires to screen for symptoms of trauma related disorders, several things must be taken into consideration. It is crucial for a successful screening procedure that all questions are properly understood by the participants. The Traumahelper Supervisor must therefore be able to explain the different items correctly and to motivate the participants to ask whenever something about the questions is not clear. Especially when it comes to the numeric scales used to answer the questionnaire, many Traumahelpers face difficulties in understanding. It might be necessary for the Traumahelper Supervisor to use other methods of explanation such like pictograms (e.g. smileys) to further clarify the numbers meaning. Considering that a Traumahelper Supervisor should plan enough time for screening and questions when leading a Trauma group.

To not influence the client's answers and make the survey as meaningful as possible, Traumahelper Supervisors must teach Traumahelpers not to ask any suggestive questions while explaining an item to their client. Even though the questions are already formulated in the questionnaire, the Traumahelpers way of asking and if necessary, explaining might have an impact on the clients answer whenever a certain preference is shown by the Traumahelper. If the client is not able to answer a question yet it can be helpful to skip this one and move over to the next question. The left-out part can be repeated after finishing the rest of questions as the client might be able to answer it after some time of thinking, without being under any pressure to answer immediately. Questions should also not be "combined" by the Traumahelpers but asked one by one. Asking more than one question at a time may lead to the client only answering one while the other gets left out. For a proper and representative result in the end all questions must be answered by the client. If there are any missing answers,

the questionnaire cannot be evaluated and the screening regarding this questionnaire must be repeated. As there are many questions, the screening can be exhausting for Traumahelpers and their clients. Traumahelper Supervisors should therefore offer breaks to the participants and should take this into consideration when scheduling the screening.

3.6 The education of Traumahelpers

All Traumahelpers should be educated according to the already established curriculum. Traumahelper Supervisors lead the 16 hours course and teach the participants the necessary knowledge to successfully perform as Traumahelpers. This knowledge includes:

- Neurobiological basics
- Basic knowledge about psych traumatology
- Typical symptoms of trauma
- Basic knowledge about the therapy methods used during Traumahelper sessions
- SURE, Functional Relaxion and EMDR
- Self-experience of the learned methods
- Prevention of secondary trauma
- Information about the Traumahelper project

While Traumahelper Supervisors receive a rather deep knowledge about these topics it is important that they are able to explain the most important aspects of them to the future Traumahelpers in simple words. Especially when working within their own community Traumahelper Supervisors should use parables and pictures from their everyday lives to further clarify the courses content. Practical training to memorize the therapy steps and to experience the effect of stabilizing techniques should be included in the education of Traumahelpers. It is important to follow a clear structure when

teaching Traumahelpers to maintain a constant quality of education. Traumahelper Supervisors should therefore prepare a schedule that they can show to the courses participants to help them getting an overview over the topics. When planning to include Traumahelpers in the screening process it is important to go through the questionnaires together and to clarify the meaning of certain items if necessary. Traumahelper Supervisors should also show and explain how to use the trauma diary and invite the Traumahelpers to share their feelings and impressions in a discussion round after the therapy session has finished.

During the therapy sessions Traumahelper Supervisors should take the age difference between Traumahelpers and clients into consideration when pairing them up. It has been experienced that it is more beneficial for teenage clients to be paired up with adults instead of peers with only a few years of age difference. To assist the Traumahelpers in memorizing the therapy steps it is possible to write down the steps on a board and leave them visible during therapy sessions. Traumahelper Supervisors should also explain the rules for a good therapeutic environment to the participants in advance.

3.7 Limitations of the Traumahelper project

Even though therapy supported by Traumahelpers has been proven to have a great impact on the symptoms of people suffering from trauma related disorders as well as on preventing their chronification, as a “first aid” intervention it cannot fully replace professional trauma therapy. Traumahelper-Therapy also does not include any medication to assist the therapeutic process and especially in very severe cases therapy with this method might not be sufficient. It is therefore important for Traumahelper Supervisors to know about the limitations of the project and seek for professional help whenever it is necessary and available. The Traumahelper-Therapy furthermore requires the cooperation of the client to be successful. A client who is not willing to actively participate in the process does not benefit from this therapy method.

3.8 Personal and professional requirements for becoming a Traumahelper Supervisor

Personal requirements

Since working with traumatized people can be challenging for the therapist as well, there are several requirements regarding the Traumahelper Supervisors personality that are crucial to ensure their ability to successfully lead a Traumahelper- group. To prevent any conditions from worsening because of the work as a Traumahelper Supervisor all participants in this course must be free of psychiatric illnesses like schizophrenia, depression, or others. If there is any known history of psychiatric disorders a person cannot work as a Traumahelper Supervisor and therefore not participate in this course. Any participant should be aware about the possible impact of this work on their own mental health. People with a stable social environment therefore are preferred. Becoming a Traumahelper Supervisor is also not possible for anyone suffering from drug or alcohol addiction. Participants furthermore should have a clean criminal record and no previous conflicts with the law.

Apart from a calm and friendly behaviour, a Traumahelper Supervisor must be able to maintain a professional approach towards their clients. Personal experiences and intense emotions regarding the client's destiny should not be shown by the Traumahelper Supervisor to not interfere with the therapeutic process. It is important that a Traumahelper Supervisor can function as a role model for the Traumahelpers especially when it comes to maintaining the rules for appropriate therapy conditions. Working as a Traumahelper Supervisor also requires high levels of motivation and reliability. The participant must be able to perform tasks correctly and to work well structured. He or she coordinates the Traumahelpers after successfully finishing the course and therefore must be able speak and perform in front of other people.

To maintain a good quality of the therapy sessions, a future Traumahelper Supervisor needs a high level of attentiveness and good observation. It is important for them to notice and to react appropriately to any unfavourable situations and problems during therapy. Since Traumahelpers do not necessarily share the same educational

background as the Traumahelper Supervisors, patience is required when answering questions and explaining interrelations.

Professional requirements

The course to become a Traumahelper Supervisor requires a certain amount of already present background knowledge regarding mental health issues. Experience in working with children or traumatized adults is favourable. Therefore, the course is suitable for teachers or caretakers who have worked in the field of counselling before. Due to the level of theoretical knowledge, it is also possible for college students whose major subject is natural science or psychology to participate in the course and achieve the extra qualification as a Traumahelper Supervisor. As the course will be held in English a good level of language, preferably B2, in speaking and writing is required. Every participant should at least have visited school for ten years or gained work experience of three years or more to make sure they are able to follow the courses content and have reached the necessary maturity to work as a Traumahelper Supervisor.

4 Methods of evaluation

4.1 Questionnaires and study-design

To archive results of high validity it was necessary to use standardized, transcultural tools that allow screening many children within a short period of time for symptoms of PTSD. The questionnaires mentioned below have been chosen since they meet those requirements as well as some of them have been used in previous studies about the topic, allowing to compare the results of this work to those of other studies. Including Traumahelpers as lay helpers in the therapeutic process has been proven to be successful before. *(1)* To evaluate the therapeutic outcome of Traumahelper groups led by Traumahelper Supervisors compared to traditional Traumahelper groups the post-therapy results of both got compared. Furthermore, the pre- and post-intervention scores of the participants got assessed to show the therapy effect.

As the data for this study was gained in several institutions of CARDS a randomization has already taken place. Which children would live in the institution at that time was selected by coincidence Since all children living in the institutions got screened there was no preselection.

Initially children were screened for symptoms of PTSD using the questionnaires and their results later got compared to those after attending therapy. While answering the questions every child was assisted by a social worker or relative who in turn was instructed by the Trauma-Supervisor before. During the screening-process Traumahelper Supervisors were available to answer any arising questions and to further clarify what is asked in the questionnaire whenever it was not understood.

4.1.1 UCLA Posttraumatic Stress Disorder Reaction Index for DSM

The UCLA-questionnaire (University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index for DSM) was developed in 1985 after a sniper attack at a school. Initially it consisted of 16 questions that could be answered with “yes” or “no” and was designed to screen children for symptoms of PTSD after traumatic events. Since that time the questionnaire has been improved several times leading to the more complex form used today. The questionnaire has shown to be effective regardless a person’s cultural background and has been translated into many different languages such as Spanish, Japanese, simplified Chinese, Korean, German, and Arabic. UCLA-questionnaire has been successfully used for PTSD-screening after violent religious fights in Nigeria as well as for Somalian refugees.

UCLA PTSD Reaction Index for DSM-IV *(86)* consists of different parts or clusters. In the first part the child is asked if any traumatic events have occurred to it in the past. A variety of examples like car accidents, diseases, violence, or war are mentioned and the child can answer with “yes” or “no”. It is also possible to describe a scenario different from those mentioned above. In case that there has not been any potentially traumatic event in the past no further screening with this method is required. A trauma-related disorder can only be diagnosed at least four weeks after the traumatic event.

If a traumatic experience has been made in the past the next parts of the questionnaire, then will focus on possible symptoms of PTSD during the last month as well as on their impact on the child’s everyday performance and life quality. When asking for symptoms they can be rated on a Likert scale from 0 (never) to 4 (most of the time). All numbers in the end will be added for a total score. According to the score there are unaffected children (cut-off score 0-11), borderline (cut-off score 12-24) and affected children (cut-off score >24). The cut-off score for the group of affected people has been chosen according to the results of a random sample survey, while the cut-off score for the borderline group was developed by clinical observation. Those children belonging to the unaffected group according to their test results do not need further diagnostics while the borderline group requires further diagnostics and eventually therapy. The evaluation with this questionnaire is based on the diagnostic criteria of DSM

(Diagnostic and statistical manual of the American Psychiatric Association) as well as on ICD-10.

Since the occurrence of symptoms over the last four weeks is evaluated, the social worker assisting the child when answering the questionnaire should know the child for at least a month or longer. The social worker is supposed to work through the questionnaire together with the child in an interview-style. UCLA-questionnaires are available in different versions. There is a version for young children (age 7-12) and adolescents (age 13-17) as well a parent-version. In the first two versions' questions are answered by the affected child while the parent version is answered by a parent or social worker. The parent-version is suitable for very young children and is based on the observations of the child's caregiver, but subjective perceptions like for example "flashbacks" in this version are hard to evaluate. When making a diagnose the caregiver´s experiences with the child as well as the social worker´s knowledge about PTDS can be combined.

In general, the UCLA-questionnaire requires a certain amount of cooperation and trust by the child when answering the questions since trivialization should be avoided. It is also necessary in some cases to further clarify questions so they can be understood by the child. Social-workers and caregivers therefore are instructed by a professional or in this specific case by the Traumahelper-Supervisor on how to perform the interview and explain the questions. Even though the different versions of questionnaire can be chosen according to age in some cases it is necessary to use another version due to the maturity-state of the child.

In various studies UCLA Posttraumatic Stress Disorder Reaction Index for DSM has already been proven to be a representative screening tool for PTSD and has therefore been used for many years. *(87-93)*

4.1.2 CRIES

The Childrens Revised Impact of Events Scale (CRIES) is based on a version that has been developed in 1979 by Horowitz et al. and was meant to be a measure for the emotions as well as the re-experiencing connected to a traumatic event in people with PTSD. Initially the questionnaire was not developed for children but after several changes over the years it is nowadays successfully used for children starting from the age of 8 years, to screen for PTSD.

CRIES first had 15 items, but studies have shown that some of the questions have been rather confusing which is why the items got reduced to 8 *(94)*. CRIES 8 doesn't contain arousal items that can be found in the CRIES 13 but is equally meaningful *(95)*.

The items of CRIES can be answered with "not at all" (0 points), "rarely" (1 point), "sometimes" (3 points) or "often" (5 points). The points are added to get a final score. According to this score the cut-off for being affected is 17 points for CRIES 8 and 30 points for CRIES 13. In this study the CRIES 8 version has been used.

CRIES is a short and simple questionnaire and therefore suitable for children. As not much time is required to answer all questions as well as to evaluate them, many people can be screened with this tool in short time. Especially during catastrophes this a clear advantage

The questionnaire has been already translated into 18 languages and is also used to measure the success of EMDR-Therapy.

4.1.3 Depression-Self-Rating-Scale

The Depression Self Rating Index was developed by Birleson in 1981 as a screening tool for symptoms of depression in children. DSRS consists of 18 Items that can have a positive or negative focus and are statements that apply to a certain situation. Each Item can be rated according to a scale (never = 0 points, sometimes = 1 point, most of the time = 2 points) and the results in the end will be added to a total score. The period that is evaluated hereby is the previous week.

According to different studies a cut-off between 11 – 15 points should be chosen. *(96)* In this study 11 points have been chosen as a cut off value to make the test as sensitive as possible since many of the participants have not been used to share negative emotions with adults before.

The questionnaire can be answered by the child itself or together with a caregiver in an interview-style. It is suitable for children in the age of 7 and above. *(97)*

DSRS has been successfully used to screen for symptoms of depression in children and its validity in comparison to other screening-tools has been proven in many studies. *(98, 99, 100, 101)*

4.1.4 RISK

The Regensburger Trauma Risk Score (RISK) has been developed by Prof. T. Loew and Dr. B. Leinberger and can be understood as a checklist to help identify children who suffer from trauma related disorders. Until 2016 the score has already been successfully used in 400 cases.

When diagnosing children with trauma related disorders it can be rather difficult because children do not show the same symptoms as adults do. In situations when there is also a different cultural background or language the asking of questions and discussion of emotions or behaviour is not always possible. To overcome these difficulties RISK was developed.

RISK is based exclusively on the observations of a child's caregiver. It can be a parent, teacher or social worker who is observing the child's behaviour and by the help of RISK is enabled to objectify their observations what in turn may help to discover typical trauma related symptoms and to quantify them. To go through the RISK-checklist not much observation-time is required but if a caregiver knows a child for longer time and already had many chances for observation the results will be even more precise. For adolescents there also is a self-observation version of RISK and the results can be compared later to those of the regular RISK, filled in by a caregiver.

RISK is suitable for refugee camps as well as for school classes and orphanages and has been translated in many languages such as Arabic, Kurdish, Syrian, Turkish, Farsi, Dari, Pashto, and Urdu. The questionnaire contains 25-33 items that can be answered by the caregiver in about one minute. Each item can be answered with "never" (0 points), "rarely" (1 point), "sometimes" (2 points), "often" (3 points) or "very often" (4 points). The points of every item then can be summed up to a score. Children with a score of lesser that 10 points are most likely not affected by a trauma-related disorder while those with a score of 20 or higher do probably require professional help. For those between 10- and 20-points individual decisions and further diagnostics should be made. RISK is an easy-to-use tool that does not need a lot of instructions and can be used for screening as well as for monitoring therapy results. *(102)*

4.2 The results

4.2.1 Descriptive Statistics

There have been 46 Children who took part in all therapy-sessions and who therefore could be included in the study. Each of them reached a score over the cut-off value in at least one of the used screening tools during pre-testing. As some of the children suffered from mental disability for those children only RISK was done by their caretakers. All in total there have been five mentally disabled children participating in the survey and all therapy sessions. Children who did not reach the cut-off score in a certain questionnaire are not included in its evaluation. Since the study was mainly performed in centres focused on the support of young girls, the vast majority (44 children) of participants is female. For each screening tool the mean, standard-deviation and the effect size r got calculated using the data collected before and after the intervention. The individual scores are presented in graphics and include the scores of the first and second evaluation. In addition, the number of participants with known traumatic history as well as with no known history was evaluated and presented in a table. All participating children at the time of testing were between 5 and 16 (in average 11, 7) years old. Due to the similar conditions and methods, there was the possibility to compare the gained post-therapy results to those of previously performed studies, using Mann Whitney U Testing.

4.2.1.1 UCLA Posttraumatic Stress Disorder Reaction Index for DSM

30 Children reached a cut-off score over 11 points in the UCLA-questionnaire during the pre-testing with this method. After receiving therapy there was a significant change regarding their scores. In 60% of cases according to UCLA the score describing the severity of trauma-related symptoms was reduced to 50% or less compared to the initial score. 16 Children have been not included in the testing with UCLA since they were too young, had a mental disability, that made it impossible for them to answer the questions, or did not reach the cut off score in this questionnaire.

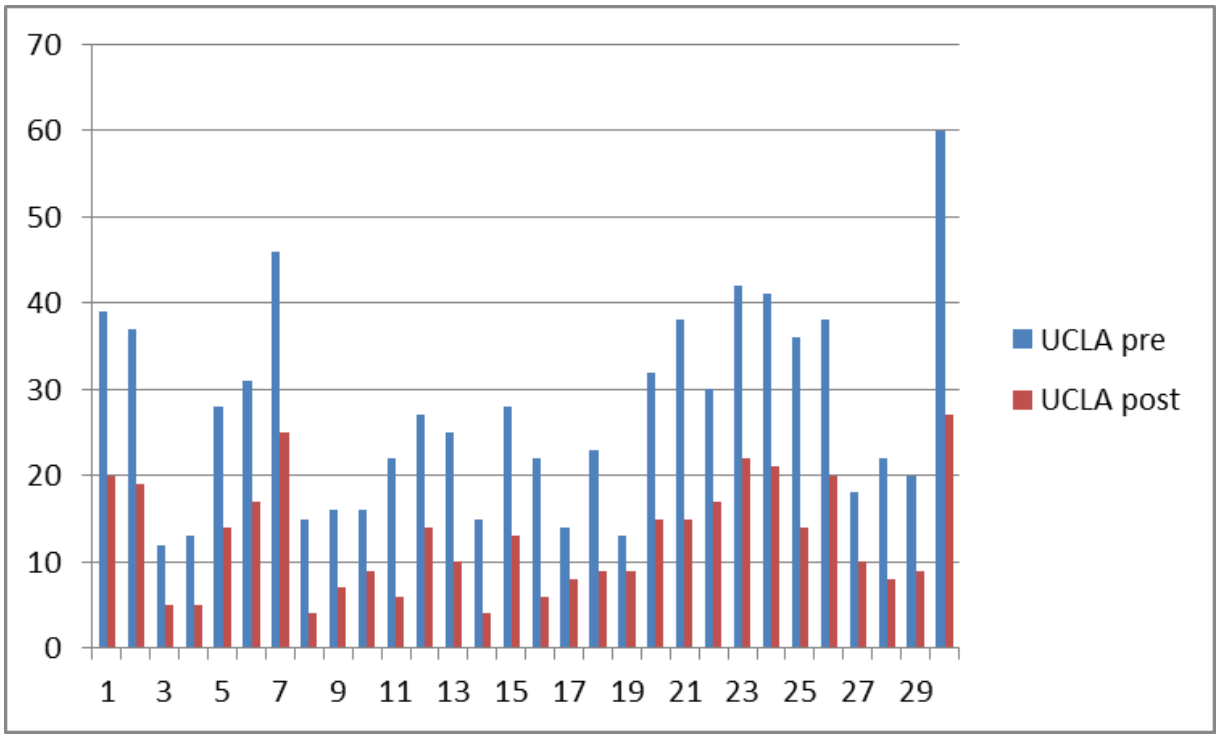


Table 4 UCLA-bar graph-questionnaire results

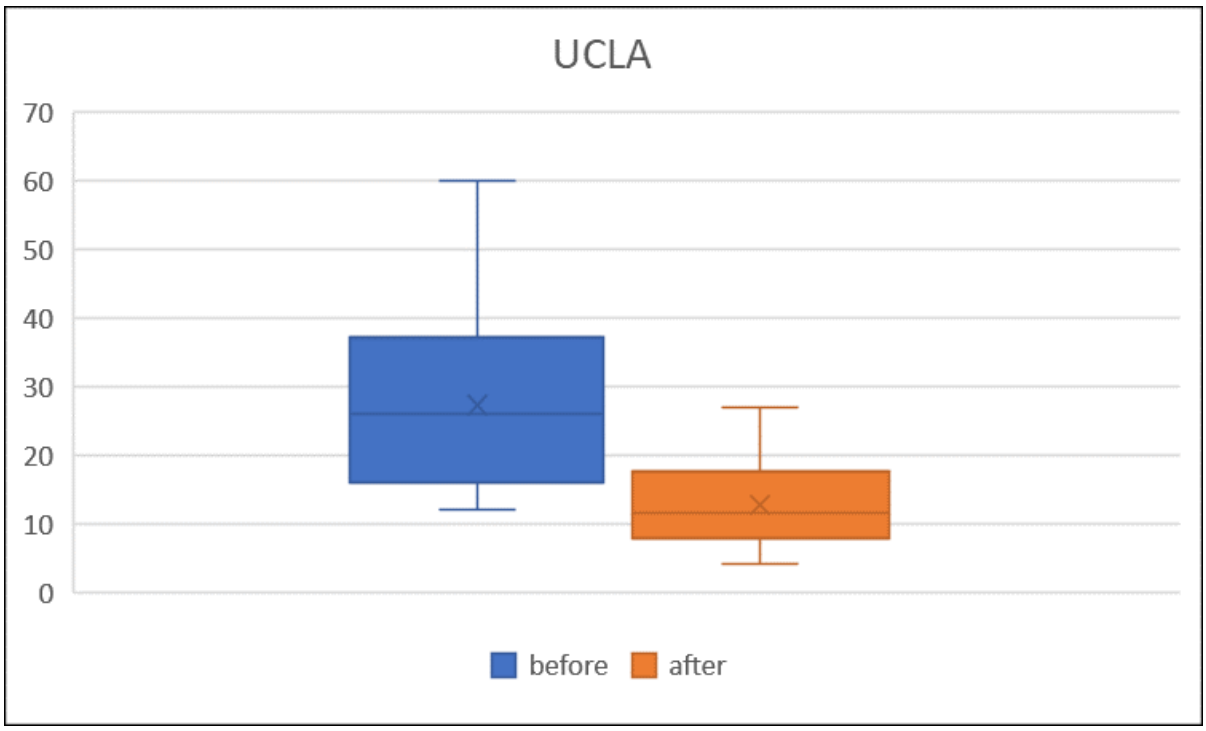


Table 5 UCLA-Box plot-questionnaire results

Test (N= 30)	Mean	Standard-Deviation	Effect size r
UCLA pre	27,3	11,78	0,61
UCLA post	12,73	6,36	
Middle effect size >0,3, strong effect size > 0,5			

Table 6 UCLA-questionnaire results

4.2.1.2 CRIES-8

33 children reached the 17-point cut off value for CRIES 8 questionnaire during the screening procedure. After the therapy period the score decreased for all participants. The minimum decrease was 12, the maximum 24 points. In average a decrease of 15,909 points has been achieved. All participants had at least a reduction of 50% compared to their initial score.

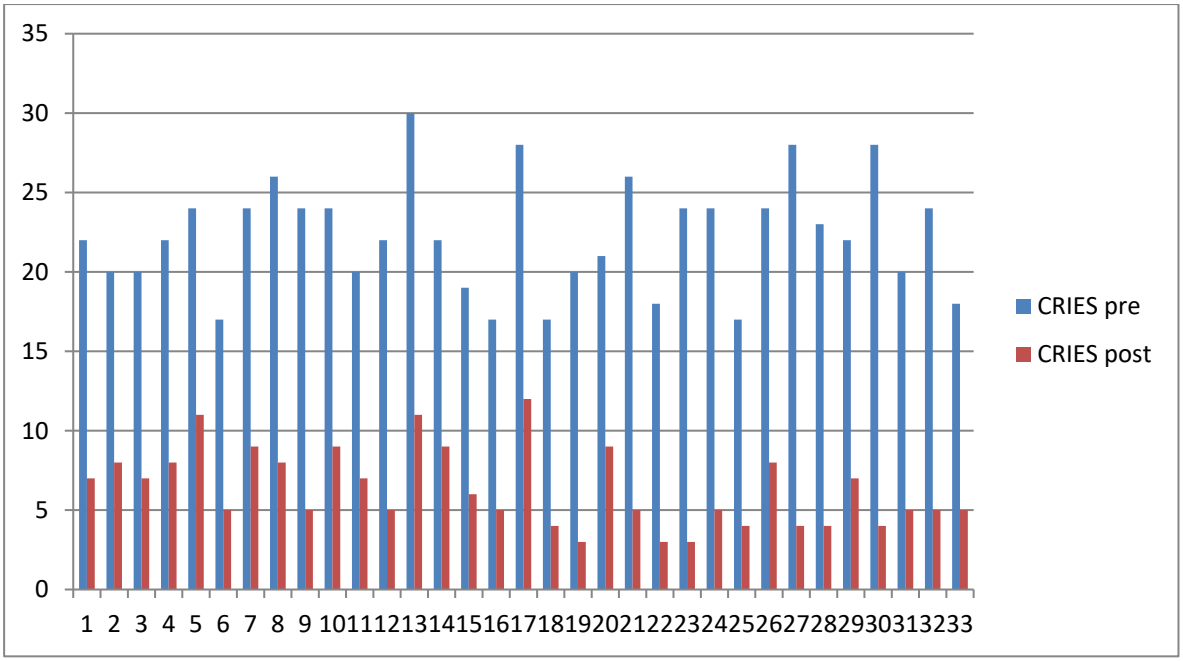


Table 7 CRIES-Bar graph-results

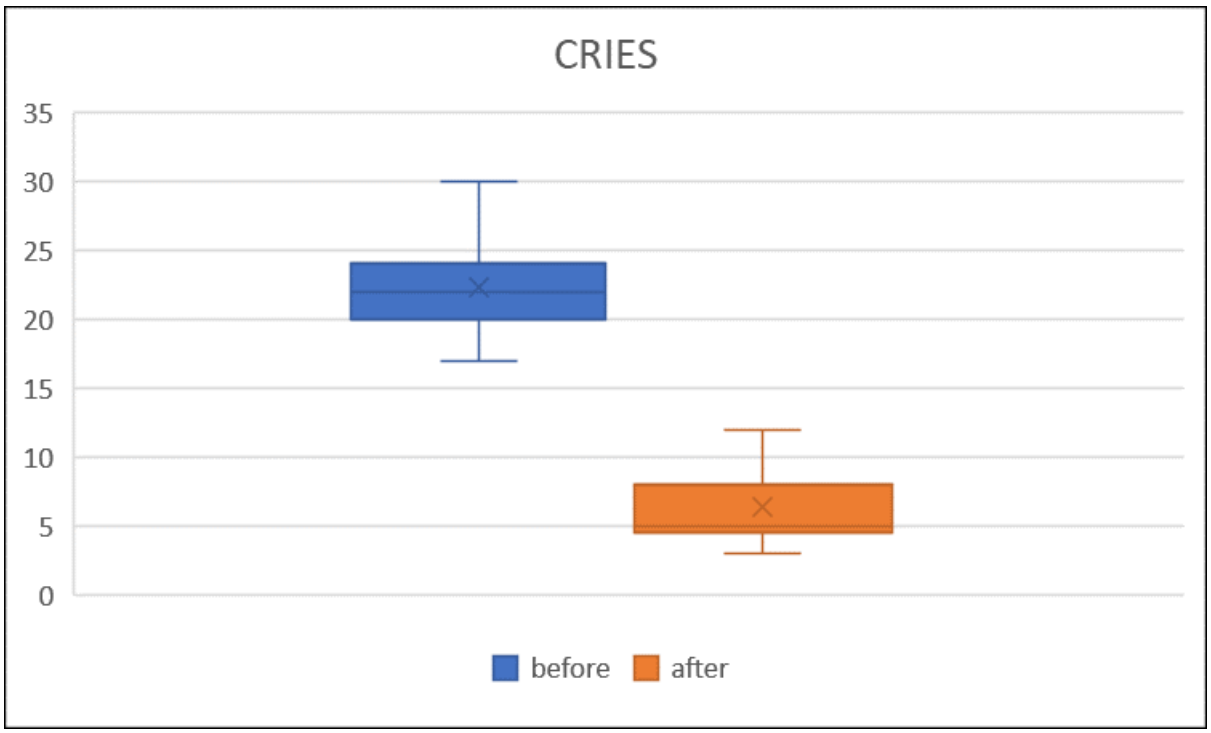


Table 8 CRIES-Boxplot-results

Test (n= 33)	Mean	Standard-Deviation	Effect size r
CRIES pre	22,27	3,466	0,94
CRIES post	6,36	2,422	
Middle effect size >0,3, large effect size >0,5			

Table 9 CRIES results

4.2.1.3 DSRS

27 children reached the cut off (11 points) for DSRS. Also, in this screening method there was a decrease of symptoms in all cases during re-evaluation. The minimum decrease has been 5 points, the maximum 16 points. In average there was a decrease of 9,074 points after therapy and 96,3 % of participants had a decrease of 50% compared to their initial score.

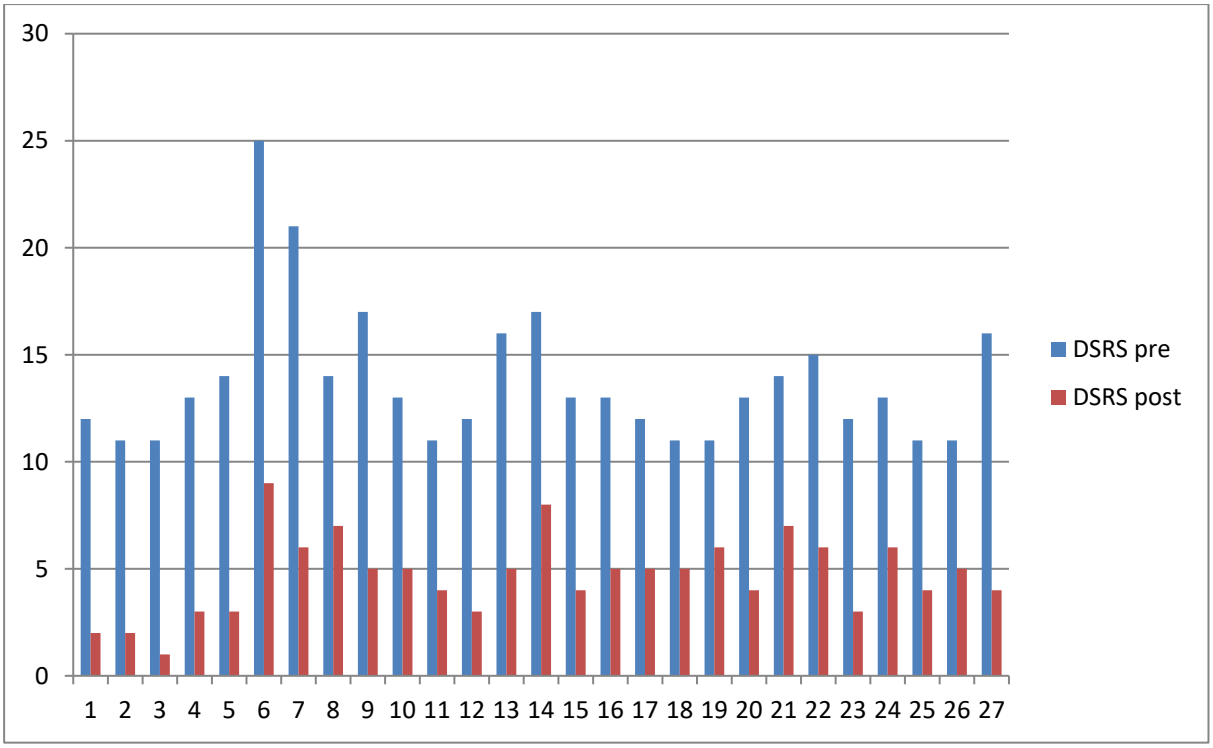


Table 10 DSRS-Bar graph-results

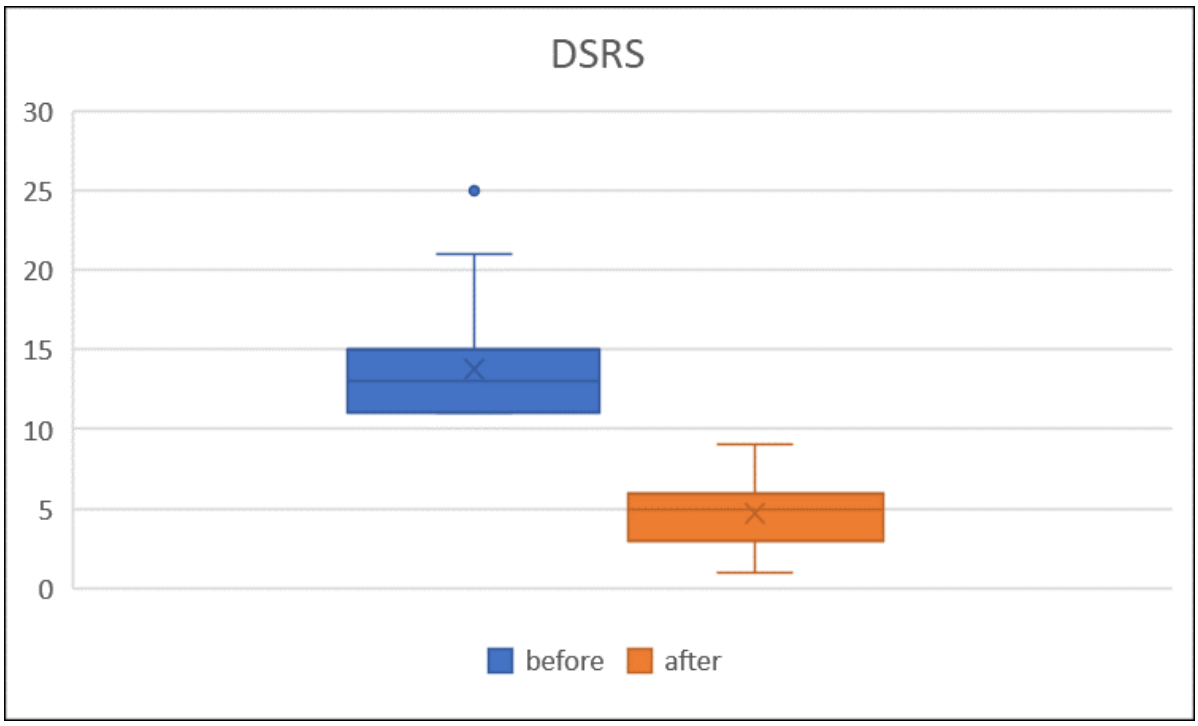


Table 11 DSRS-Box plot-results

Test (n=27)	Mean	Standard-Deviation	Effect size r
DSRS pre	13,78	3,22	0,86
DSRS post	4,70	1,82	
Middle effect size >0,3, large effect size >0,5			

Table 12 DSRS-results

4.2.1.4 RISK

There have been 43 children who reached a score of 10 points or higher during pre-testing with RISK. 39 of them initially even reached more than 20 points. After receiving therapy there was a significant decrease of scores, starting from one point up to a decrease of 37 points. The average decrease after therapy has been 21,046 points. There have been no cases of increasing or constant remaining scores after therapy. 90,7% of the participants decreased their scores even 50% or more compared to the initial value. Three children whose questionnaire was initially answered by their caretaker did not answer the questionnaire after the therapy period again since their responsible caretaker was not available on the day of re-evaluation. Their data was therefore not included in the RISK statistics.

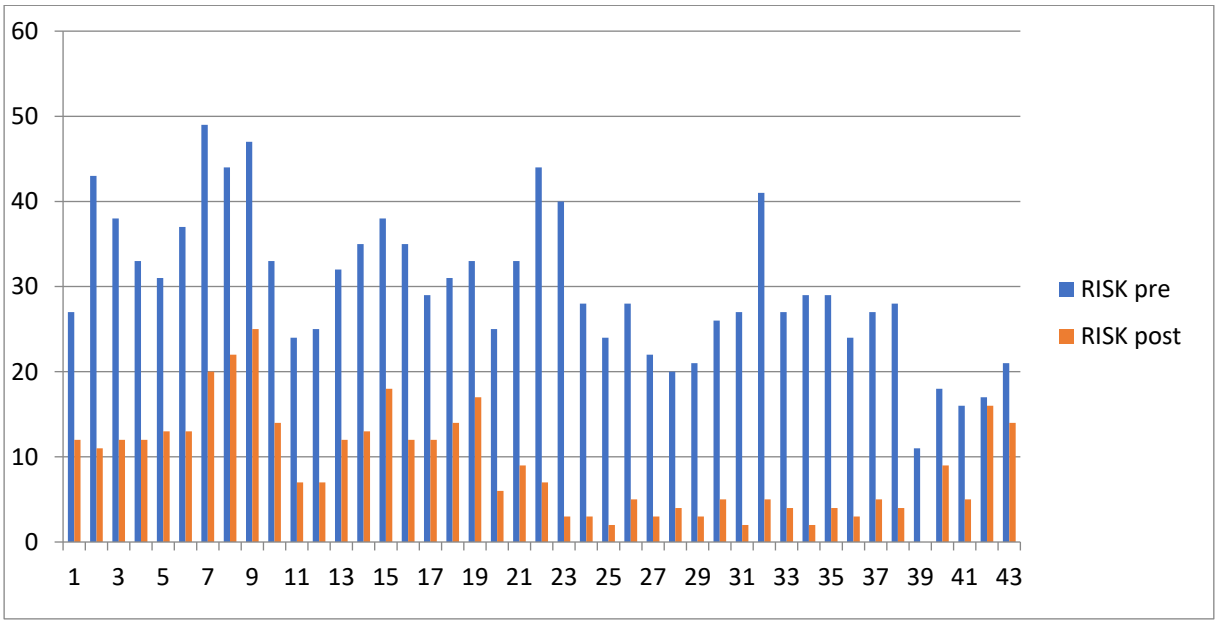


Table 13 RISK-Bar graph-results

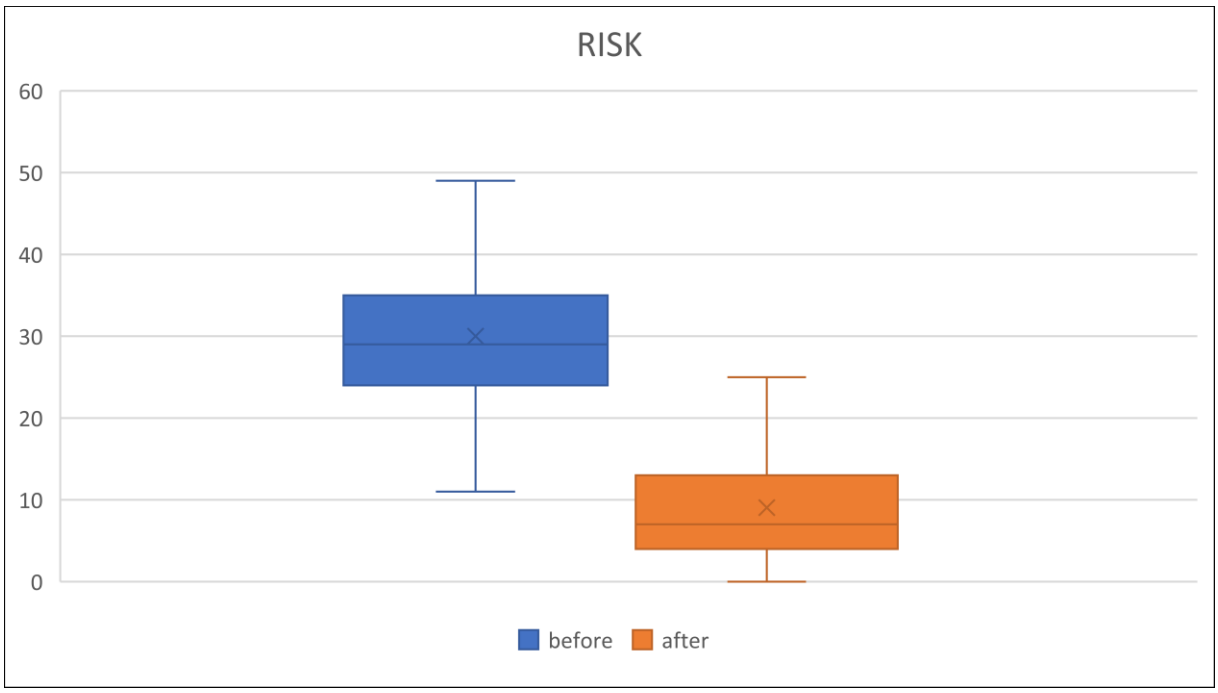


Table 14 RISK-Box plot-results

Test (n= 43)	Mean	Standard-Deviation	Effect size r
RISK pre	30	8,52	0,82
RISK post	9,05	5,96	
Middle effect size >0,3, large effect size >0,5			

Table 15 RISK-results

4.2.1.5 Comparison of the results of Traumahelper Supervisors and traditional Traumahelper-Groups

Mann-Whitney U-Test for DSRS

A Mann-Whitney U-Test has shown that there was no significant difference between pro and lay regarding the variable Improvement , *U*=188,5, *p*=0,724, *r*= 0,06

The effectsize *r* is 0,06. Which means there is only a small effect *r* = 0,06

Effectsize r Cohen (1988)

|r| < 0.1	No effect/ Very small effect
|r| = 0.1	small effect
|r| = 0.3	middle effectt
|r| = 0.5	large effect

	n	Mean ranking	Sum of Ranks
pro	15	22,43	336,5
lay	27	20,98	566,5
Total	42		

	U	z	asymptotisch p	exact p	r
Improvement	188,5	-0,37	0,712	0,724	0,06

The group „pro“ had higher values for the variable Improvement (*Mdn* = 11) than the group “lay” (*Mdn* = 9).

		n	Mean	Median	Standarddeviation
Improvement	pro	15	9,2	11	8,64
	lay	27	9,07	9	2,59

Table 16 Mann-Whitney U-Test for DSRS

Mann-Whitney U-Test for CRIES

A Mann-Whitney U-Test for the groups „pro“ and „lay“ regarding the variable Improvement has shown a statistical significance, *U*=141,5, *p*=0,035, *r*= 0,32.

The effectsize was 0,32. With *r* = 0,32 there can be observed a middle effect.

Effectsize r Cohen (1988)

|r| < 0.1	No effect / Very small effect
|r| = 0.1	small effect
|r| = 0.3	middle effect
|r| = 0.5	large effect

	n	Mean ranking	Sum of ranks
pro	15	17,43	261,5
lay	31	26,44	819,5
Total	46		

	U	z	asymptotisch p	exact p	r
Improvement	141,5	-2,15	0,031	0,035	0,32

The group “pro” had lower values for the variable Improvement (*Mdn* = 13) than the group “lay” (*Mdn* = 15).

		n	Mean value	Median	Standarddeviation
Improvement	pro	15	13,73	13	7,23
	lay	31	15,77	15	3,4

Table 17 Mann-Whitney U-Test for CRIES

As shown by the results above there is only a small difference regarding the outcome between the professionally led Traumahelper-groups and those that included Traumahelper Supervisors. In the CRIES-data there can even be observed a slight improvement compared to the traditional Traumahelper-groups. This might be caused by the reduced language borders between Taumahelper Supervisors and Traumahelpers.

4.2.1.6 Traumatic experiences of the sample

Disaster	Accident	Domestic violence	Witnessing the violent death of a loved one
15	19	20	15

Seeing a death body (excluding funerals)	Sexual violence	Painful medical treatment	War	Unknown
14	3	15	11	10

Table 18 Table of traumatic experiences

Most participants could name at least one or more potentially traumatizing events that happened in their past. In some cases, the children's history was also known by their care takers who answered the questionnaire. Some children did show symptoms of a trauma related disorder, but no specific event could be identified.

4.2.2 Summary of the results

All children and caretakers who participated in the project noticed an improvement regarding trauma associated symptoms after finishing therapy. The results are even comparable to those of professionally guided Traumahelper Groups.

4.2.3 Critical discussion about the usage of questionnaires in the screening process

As described before all diagnostic tools that have been used to acquire the presented data are well tested and have been already frequently used for many years. The usage of the questionnaires therefore was not experimental but a valid tool to screen for any symptoms of trauma related disorders. But when using those tools in practice some things must be taken into consideration.

The understanding of the questions is important to answer the questionnaires in an appropriate way. Since not all questionnaires have been translated to the local language before there happened to be a language barrier in some cases. To overcome these difficulties most of the questionnaires got translated in Telugu during the preparation of the screening process and all questions were discussed in detail to prevent any misunderstandings. It was important to invest time in detailed explanations, since questions regarding the meaning of an item usually where not asked by the Traumahelpers before a detailed discussion about the item took place in front of the whole class.

Apart from language barriers there are also cultural differences that need to be taken into consideration. Most items are rated on numeric scales that in turn are linked to a verbal description (e.g., 2= sometimes). This method was rather difficult to use for some of the Traumahelpers since in the Indian community usually pictures are used more frequently for description. To further clarify the meaning of the numeric scale smiley faces have been used during class.

Due to the various questionnaires used during the screening in some cases it was hard for the participants to focus for such a long time. Several breaks had to be taken for the participants to regain their concentration and motivation. During the screening process some questionnaires appeared to be easier to use for the participants than others according to the Traumahelpers feedback. Especially the question-style of RISK seemed to be easily understood among the participants.

When answering the questions some participants also were rather shy at first since talking openly about psychological issues is not as common as it is in western society.

The effect decreased slowly during the screening procedure. A possible explanation for this might be the presence of many other children and their Traumahelpers who performed the same task at that moment, creating the impression that it is accepted to open up and share negative emotions in this situation. Many children also had never use questionnaires before and therefore first needed to get used to this way of talking about an issue.

Since answering a questionnaire yourself requires a certain cognitive ability, for mentally disabled or very small children only evaluations by their care takers could be done. Care takers in this case must know the child well and be able to observe its behaviour carefully to successfully answer the questionnaire. Internal symptoms like intrusions cannot be described by this procedure but it includes the objective observations of another person.

5 Epilogue

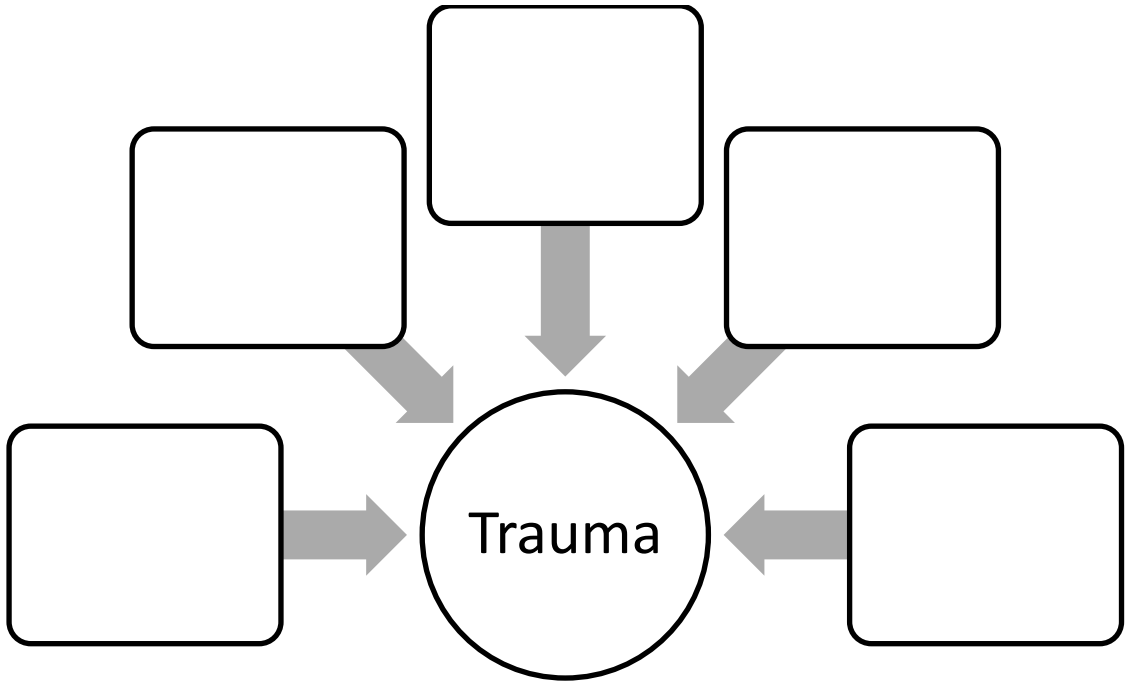
During this study several language barriers and organisational struggles had to be overcome. But due to successful teamwork these problems were solved. Since the length of the screening process as well as the numeric scales seemed to cause trouble to some of the participants their improvement might be a topic for further research.

6 Appendix

6.1 Example worksheet “Trauma and its source”

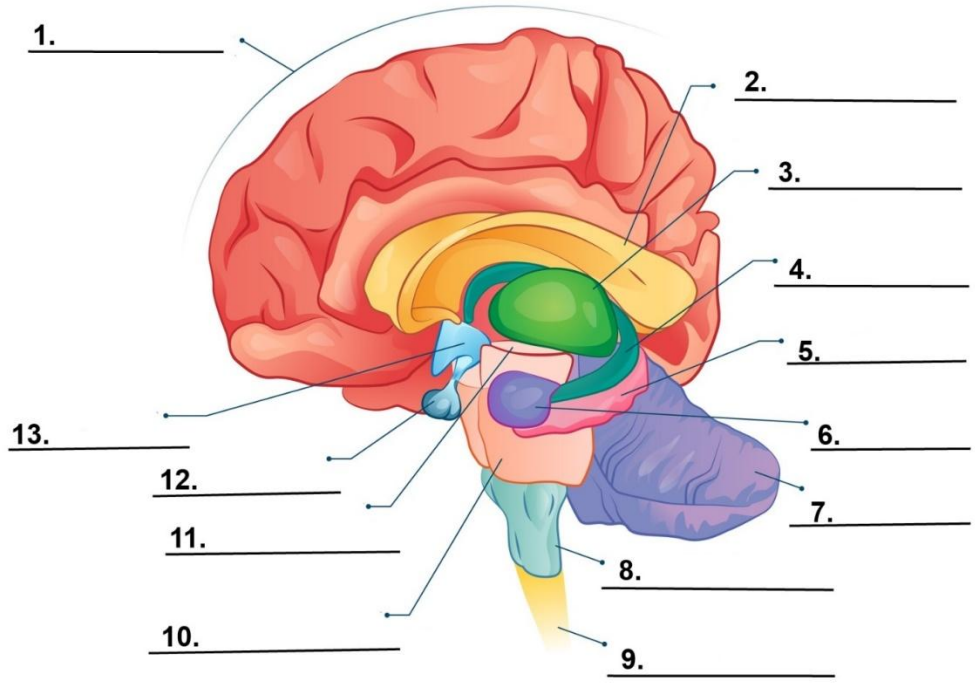
1. Please describe the term Trauma in your own words.

2. Name different examples for a traumatic event.



3. Which types of trauma do you know? (Name two) What is their main difference?

6.2 Example worksheet “The human brain”



Task: Please lable the different parts of the brain and add their function in the table below.

Brain area	Function
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10	
11.	
12.	
13.	

6.3 Example for the Final Exam – Trauma Supervisors

1. What is the correct definition of trauma?

[ ] An event/ experience that lasted for short or long time and was so extraordinary threatening and catastrophic that it would cause deep despair in every person.

[ ] An event/ experience that was unpleasant but has been forgotten after some time.

[ ] An event/ experience that was very exciting and caused a lot of joy.

2. Which disorder is usually not linked to previous trauma?

[ ] Depressive symptoms

[ ] Drug and alcohol addiction

[ ] Asperger Autism

3. Which area of the brain is responsible for fear and alertness?

[ ] Amygdala

[ ] Pons

[ ] Hippocampus

4. Which area of the brain is responsible for the creation of memory?

[ ] Amygdala

[ ] Pons

[ ] Hippocampus

5. What is the Cut-Off value for DSRS?

[ ] 18

[ ] 26

[ ] 11

6. How is slow paced breathing performed correctly?

[ ] Inhale for 7 seconds, exhale for 4 seconds

[ ] Inhale for 4 seconds, exhale for 7 seconds

[ ] Inhale for 8 seconds, hold breath for 4 seconds

7. Which tool is not needed for Sandplay-Therapy?

[ ] Box with sand

[ ] Rope

[ ] Different toys, stones and dolls

8. What is not the task of a Trauma Helper?

[ ] Pay a lot of attention to the childs play

[ ] Help the child to use stabilizing techniques

[ ] Discuss the traumatic event with the child and investigate who was responsible

9. Please name all steps of Sandplay-Therapy.

10. What is the purpose of singing the Aramsamsam-song?

[ ] Learn to dance at official events

[ ] Breath slowly and perform bilateral stimulation

[ ] Entertaining the Trauma Helpers and all visitors

11. What symbolizes the rope in Lifeline-Therapy?

[ ] Being bound to the event in the past

[ ] A snake as a symbol of constant danger

[ ] The individuals past and future life

12. What should be avoided during therapy sessions?

[ ] A quiet and calm surrounding because noise reduces stress

[ ] Visitors who are interested in the therapy of their class mates

[ ] Switching your cellphone to silentmode

13. How do you perform the rapid eye movement correctly?

[ ] Move two fingers slowly in front of the child’s face and ask it to follow them with its eyes

[ ] Move two fingers in front of the child’s face as fast as you can and ask it to follow them with its eyes.

[ ] Move your fingers slowly in front of the child’s face and ask it to follow them by turning the head from side to side.

14. How many children usually take part in a therapy group?

[ ] 5

[ ] 10

[ ] 20

15. Name the two main types of trauma.

16. Which type of Trauma has the highest risk of causing a trauma related disorder?

[ ] Natural disaster

[ ] Being involved in a car accident many times

[ ] Rape

17. What are possible resources that help to prevent trauma related disorders? (Name at least one)

18. In which case a person is not allowed to become a Traumahelper?

[ ] A mother who takes care of her own child and therefore can't help other children

[ ] A person who suffers from depression and therefore understands some of the possible symptoms very well
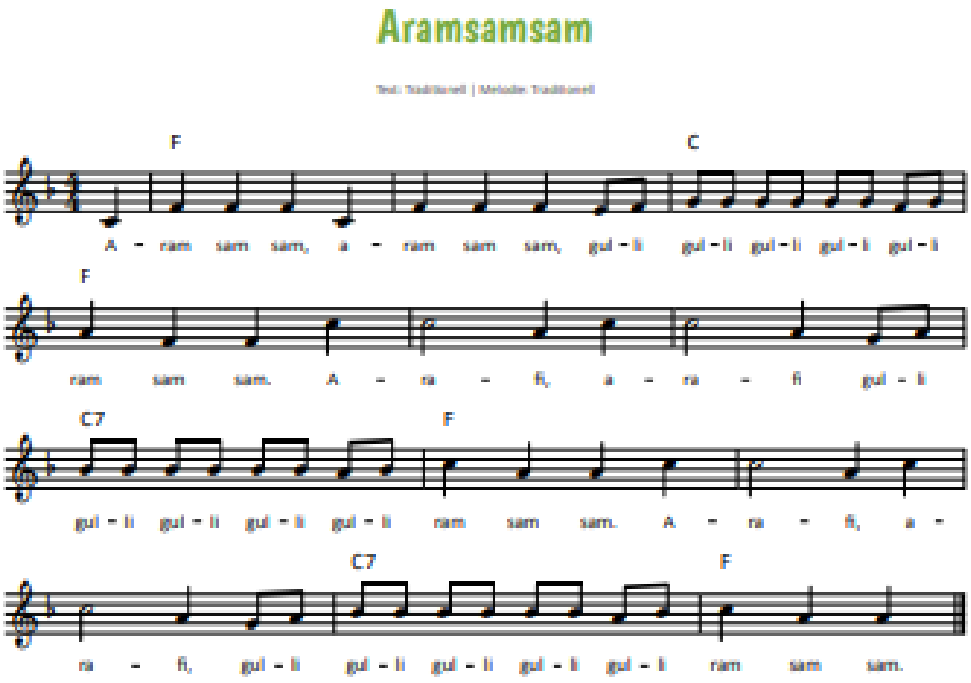
[ ] People who are older than the age of 50

19. Please give an example for the negative to positive changed sentence in Lifeline-Therapy.

20. Please define the main tasks of a Traumahelper Supervisor.

21. Name three symptoms of trauma.

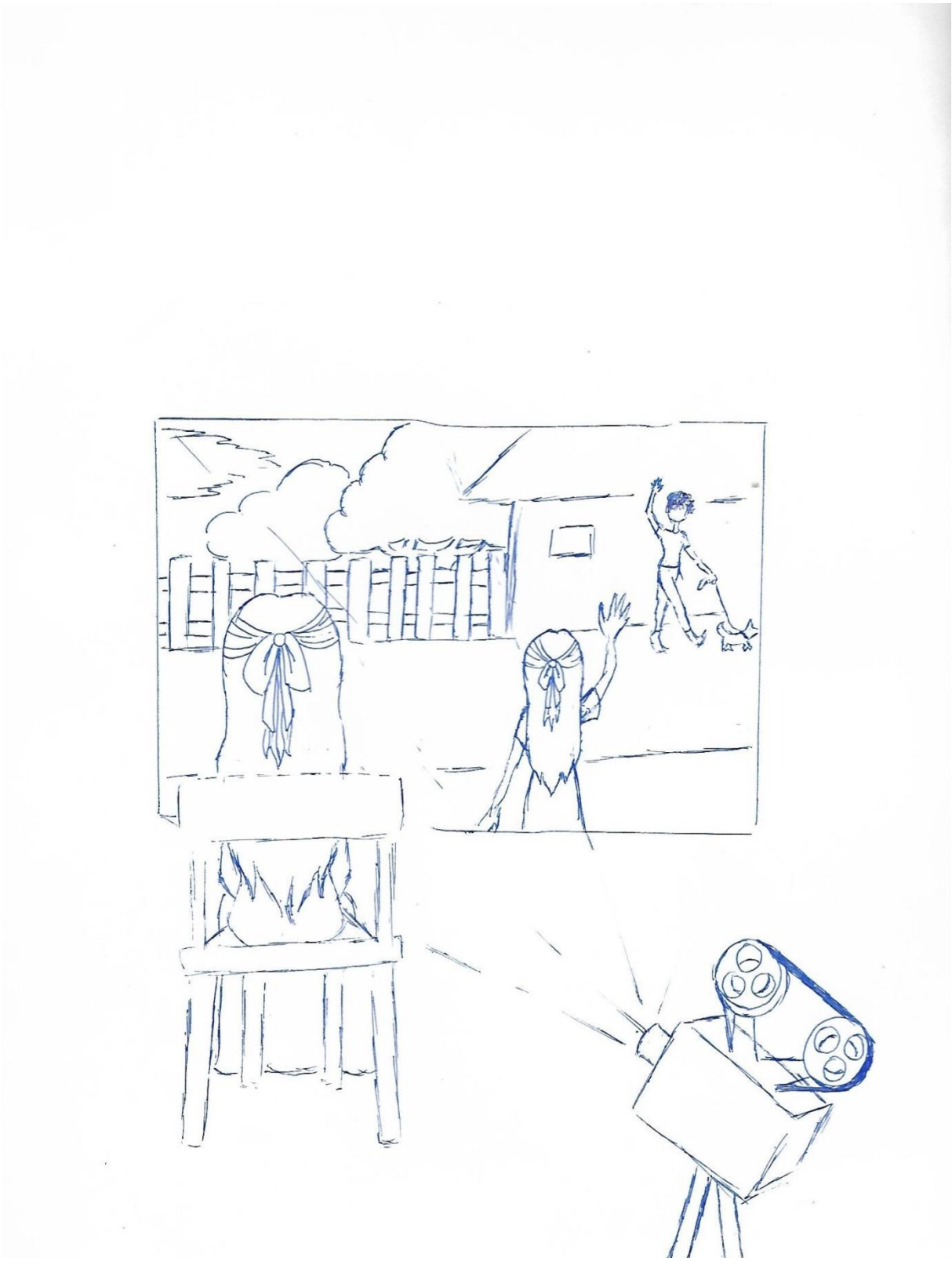
6.4 The Aramsamsam-Song







6.5 Example Drawing “Depersonalisation/ Derealisation”



6.6 The questionnaires

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Name _____ Age _____ Sex (Circle): Girl Boy

Today's Date (write month, day and year) _____ Grade in School _____

School _____ Teacher _____ Town _____

Below is a list of VERY SCARY, DANGEROUS, OR VIOLENT things that sometimes happen to people. These are times where someone was HURT VERY BADLY OR KILLED, or could have been. Some people have had these experiences, some people have not had these experiences. Please be honest in answering if the violent thing happened to you, or if it did not happen to you.

FOR EACH QUESTION:	Check "Yes" if this scary thing HAPPENED TO YOU Check "No" if it DID *NOT* HAPPEN TO YOU

1)	Being in a big earthquake that badly damaged the building you were in.	Yes [ ] No [ ]
2)	Being in another kind of **disaster**, like a fire, tornado, flood or hurricane.	Yes [ ] No [ ]
3)	Being in a bad **accident**, like a **very serious** car accident.	Yes [ ] No [ ]
4)	Being in place where a **war** was going on around you.	Yes [ ] No [ ]
5)	Being **hit, punched, or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ] No [ ]
6)	Seeing a family member being **hit, punched or kicked very hard** at home. (**DO NOT INCLUDE** ordinary fights between brothers & sisters).	Yes [ ] No [ ]
7)	Being **beaten up, shot at or threatened to be hurt badly** in your town.	Yes [ ] No [ ]
8)	Seeing someone in your town being **beaten up, shot at or killed.**	Yes [ ] No [ ]
9)	Seeing a **dead body** in your town (do not include funerals).	Yes [ ] No [ ]
10)	Having an adult or someone much older touch your **private sexual body parts** when you did not want them to.	Yes [ ] No [ ]
11)	Hearing about the **violent death or serious injury** of a loved one.	Yes [ ] No [ ]
12)	Having **painful and scary medical treatment in a hospital** when you were very sick or badly injured.	Yes [ ] No [ ]

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Contact: UCLA Trauma Psychiatry Service
300 UCLA Medical Plaza, Ste 2232
Los Angeles, CA 90095-6968 (310) 206-8973
EMAIL: rpynoos@mednet.ucla.edu

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13) **OTHER** than the situations described above, has **ANYTHING ELSE** ever happened to you that was **REALLY SCARY, DANGEROUS, OR VIOLENT?** Yes [ ] No [ ]

14) a) If you answered "YES" to only **ONE** thing in the above list of questions #1 to #13, place the number of that thing (#1 to #13) in this blank: # _____

b) If you answered "YES" to **MORE THAN ONE THING**, place the number of the thing that **BOTHERS YOU THE MOST NOW** in this blank: # _____

c) About how long ago did this bad thing (your answer to [a] or [b]) happen to you? _____

d) Please write what happened: _____

FOR THE *NEXT* QUESTIONS, please **CHECK [YES] or [NO]** to answer **HOW YOU FELT during or right after** the bad thing happened that you just wrote about in Question 14.	

15)	Were you scared that you would die?	Yes [ ] No [ ]
16)	Were you scared that you would be hurt badly?	Yes [ ] No [ ]
17)	Were you hurt badly?	Yes [ ] No [ ]
18)	Were you scared that someone else would die?	Yes [ ] No [ ]
19)	Were you scared that someone else would be hurt badly?	Yes [ ] No [ ]
20)	Was someone else hurt badly?	Yes [ ] No [ ]
21)	Did someone die?	Yes [ ] No [ ]

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22) Did you feel very scared, like this was one of your most scary experiences ever?	Yes [ ]	No [ ]
23) Did you feel that you could not stop what was happening or that you needed someone to help?	Yes [ ]	No [ ]
24) Did you feel that what you saw was disgusting or gross?	Yes [ ]	No [ ]
25) Did you run around or act like you were very upset?	Yes [ ]	No [ ]
26) Did you feel very confused?	Yes [ ]	No [ ]
27) Did you feel like what was happening did not seem real in some way, like it was going on in a movie instead of real life?	Yes [ ]	No [ ]

Here is a list of problems people sometimes have after very bad things happen. Please **THINK** about the bad thing that happened to you that you wrote about in Question #14 on the page 2. Then, **READ** each problem on the list carefully. **CIRCLE ONE** of the numbers (0, 1, 2, 3 or 4) that tells how often the problem has happened to you **in the past month**. Use the **Rating Sheet** on Page 5 to help you decide how often the problem has happened in the past month.

PLEASE BE SURE TO ANSWER ALL QUESTIONS

HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
1_{D4} I watch out for danger or things that I am afraid of.	0	1	2	3	4
2_{B4} When something reminds me of what happened, I get very upset, afraid, or sad.	0	1	2	3	4
3_{B1} I have upsetting thoughts, pictures, or sounds of what happened come into my mind when I do not want them to.	0	1	2	3	4
4_{D2} I feel grouchy, angry or mad.	0	1	2	3	4
5_{B2} I have dreams about what happened or other bad dreams.	0	1	2	3	4
6_{B3} I feel like I am back at the time when the bad thing happened, living through it again.	0	1	2	3	4
7_{C4} I feel like staying by myself and not being with my friends.	0	1	2	3	4

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HOW MUCH OF THE TIME DURING THE PAST MONTH	None	Little	Some	Much	Most
8_{C5} I feel alone inside and not close to other people.	0	1	2	3	4
9_{C1} I try not to talk about, think about, or have feelings about what happened.	0	1	2	3	4
10_{C6} I have trouble feeling happiness or love.	0	1	2	3	4
11_{C6} I have trouble feeling sadness or anger.	0	1	2	3	4
12_{D5} I feel jumpy or startle easily, like when I hear a loud noise or when something surprises me.	0	1	2	3	4
13_{D1} I have trouble going to sleep or I wake up often during the night.	0	1	2	3	4
14_{AF} I think that some part of what happened is my fault.	0	1	2	3	4
15_{C3} I have trouble remembering important parts of what happened.	0	1	2	3	4
16_{D3} I have trouble concentrating or paying attention.	0	1	2	3	4
17_{C2} I try to stay away from people, places, or things that make me remember what happened.	0	1	2	3	4
18_{B5} When something reminds me of what happened, I have strong feelings in my body, like my heart beats fast, my head aches, or my stomach aches.	0	1	2	3	4
19_{C7} I think that I will not live a long life.	0	1	2	3	4
20_{AF} I am afraid that the bad thing will happen again.	0	1	2	3	4

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DEPRESSION – SELF – RATING – SCALE – FOR CHILDREN (Birleson – 1978)

మానసిక ఒత్తిడి - పిల్లల

దయచేసి ఈ క్రింద ఇవ్వబడిన ప్రశ్నలకి సరియైన సమాదానాన్ని చదివి టిక్ చెయ్యవలెను. జాగ్రత్తగా సమాదానాన్ని ఆలోచించి చెయ్యవలెను. గడచిన వారం మీరు ఏవిధంగా ఉన్నారు?
నిజాయితీగా, జరిగిన విధంగా సమాధానాన్ని గుర్తించండి.

		అధికంగా	అస్సలులేదు	అప్పుడప్పుడు
1.	నేను - ఇంతక ముందుకుగానే నా భవిష్యత్ కోసం ఎదురుచూస్తున్నాను.	(0)	(1)	(2)
2.	నేను - బాగా నిద్రపొతాను.	(2)	(1)	(0)
3.	నాకు ఏడ్వాలనిపిస్తుంది.	(2)	(1)	(0)
4.	నాకు బయటికి వెళ్ళి ఆడుకోవాలని ఉంది	(0)	(1)	(2)
5.	నాకు పారిపోవాలని అనిపిస్తుంది.	(2)	(1)	(0)
6.	నాకు కడుపు నొప్పి వస్తుంది.	(2)	(1)	(0)
7.	నాకు చాలా శక్తి ఉంది.	(0)	(1)	(2)
8.	నేను నా ఆహారంతో ఆనందించాను.	(0)	(1)	(2)
9.	నేను నిర్ణయం తీసుకుంటే మార్చుకోను.	(0)	(1)	(2)
10.	నా ఉద్దేశంతో బ్రతకటం వృధా.	(2)	(1)	(0)
11.	నేను చేసే పని మంచిది	(0)	(1)	(2)
12.	నేను చేసే పనులను బట్టి సంతోషిస్తాను అని నమ్ముతాను.	(0)	(1)	(2)
13.	నా కుటుంబ సభ్యులతో మాట్లాడటం నాకు ఇష్టం.	(0)	(1)	(2)
14.	నాకు చెడ్డ కలలు వస్తాయి.	(2)	(1)	(0)
15.	నేను ఒంటరి తనాన్ని అనుభవిస్తున్నాను.	(2)	(1)	(0)
16.	నేను తేలికగా ఉల్లాసంగా ఉంటాను.	(0)	(1)	(2)
17.	నేను చాలా బాధపడుతున్నాను ఈ సమస్యని కష్టపడి ఎదుర్కొనగలను.	(2)	(1)	(0)
18.	నాకు విసుగుపుడుతుంది.	(2)	(1)	(0)

(Score)

Name/Cod [redacted] (for repeted measurements,e.g., after therapy) Date: 6/8/2018

పేరు / కోడ్ -ఆర్.మోనిక---(శిక్షణ తరువాత మళ్ళీ మళ్ళీ కొలతలు తీసుకున్నపుడు) తారీఖు: 6/8/2018.

Place:_____Child lives with father o mother o other person (who?)_____

నివాస స్థలము: ---------- తండ్రి/తల్లి/తండ్రి/ఇతర వ్యక్తులు(ఎవరు?)

RETROS - KE Regensburger Kinder -Trauma -Risik O - Score(Version 3.0-Telugu)

Children - Parents Checklist	Suitable form 4 to 13 years	m o f o	Age 10

Questions Rate always in comparison to the age group. If you can't give the answer, skip the question.

(√) Tick the Appropriate Box

		Not at all ఎప్పుడు కాదు/లేదు	Rarely చాలా తక్కువగా	Sometimes అప్పుడప్పుడు	Often తరుచూ చేస్తారు
1.	మీ అబ్బాయి లేదా అమ్మాయి వయస్సుకు తగినట్లు ప్రవర్తిస్తున్నారా?	( )	( )	( )	(√)
2.	మీ అబ్బాయి / అమ్మాయి ఒకచోట కుదురుగా కూర్చోలేకపోతున్నారా?	( )	( )	( )	(√)
3.	మీ అబ్బాయి / అమ్మాయి ఎప్పుడు వారు చేసే పనులు ఇతరులు గమనించాలని/గుర్తించాలని కోరుకుంటూ ఉంటారు?	( )	(√)	( )	( )
4.	మీ అబ్బాయి/అమ్మాయి పనిమీద ధ్యాస నిలపగలుగుతున్నారా?	( )	( )	( )	(√)
5.	మీ అబ్బాయి/అమ్మాయి ఎప్పుడు పరధ్యానంగా ఉంటారా?	( )	(√)	( )	( )
6	మీ అబ్బాయి/అమ్మాయి తరచుగా వారి పనులు మరచిపోతుంటారా?	( )	( )	(√)	( )
7.	మీ అబ్బాయి/అమ్మాయి వారి వస్తువులను లేదా పనులను అస్తవ్యస్తంగా చేస్తుంటారా?	( )	(√)	( )	( )
8.	మీ అబ్బాయి/అమ్మాయి కోపం వస్తే తిడతారు/కొడతారా?	(√)	( )	( )	( )
9.	మీ అబ్బాయి/అమ్మాయి శుభ్రము, /బాధన,/ స్పర్శ, కు కోపం ప్రదర్శిస్తారా?	(√)	( )	( )	( )
10.	మీ అబ్బాయి/అమ్మాయి ఎక్కువగా అసహనం ప్రదర్శిస్తారా?	(√)	( )	( )	( )
11.	మీ అబ్బాయి/అమ్మాయి ఇతర పిల్లలతోపోల్చి చూస్తే ఎక్కువగా బాధపడుతున్నట్లుగా మీరు అనుకుంటున్నారా?	( )	( )	( )	( )

12.	మీ అబ్బాయి/అమ్మాయి తనకు దగ్గరైన వారి నుండి వేరుగా ఉండవలసి వచ్చినపుడు ఏకాకిగా భయపడుతుంటారా?	(✓)	( )	( )	( )
13.	మీ అబ్బాయి/అమ్మాయి ఎప్పుడు ఇతరుల పట్ల సమ్మకంలేనట్లుగా ఉంటారా?	(✓)	( )	( )	( )
14.	మీ అబ్బాయి/అమ్మాయి వారి వయస్సు వారితో పోల్చిచూసినపుడు ఎప్పుడు నిస్సహాయంగా అనిపిస్తారా?	(✓)	( )	( )	( )
15.	మీ అబ్బాయి/అమ్మాయి శరీరంగా తనను తాను గాయపరచుకుంటారా?	(✓)	( )	( )	( )
16.	మీ అబ్బాయి/అమ్మాయి లో ప్రమాదం గురించి స్పృహ ఉన్నదా?	( )	( )	( )	(✓)
17	మీ అబ్బాయి/అమ్మాయి భాధ కలిగించే పరిస్థితులను ఎదుకుంటుంటారా?	(✓)	( )	( )	( )
18.	మీ అబ్బాయి/అమ్మాయి ఎప్పుడు నిద్ర సరిగ్గా పోదా/ లేదా చెడ్డ కలలు కంటుంటారా/ లేదా ఒక్కదే నిద్ర పోలేదా?	( )	( )	(✓)	( )
19.	మీ అబ్బాయి/అమ్మాయి తక్కువగా తింటున్నారా/ వాంతులు చేసుకుంటున్నారా/కొన్ని మాత్రమే తింటున్నారా?	( )	(✓)	( )	( )
20.	మీ అబ్బాయి/అమ్మాయి ఎప్పుడూ ఏదో ఒక నొప్పి అని అంటారా (కడుపు నొప్పి, తల నొప్పి) మొదలగునవి	( )	(✓)	( )	( )
21.	మీ అబ్బాయి/అమ్మాయి తనని తాను మనంగా ఉండటానికి సరియైన ప్రవర్తనను చూపించరు (ఉదా.:నోట్లో వేళ్ళుపెట్టుకుని చీకడం, గోళ్ళు కొరకడం)	(✓)	( )	( )	( )

అదనపు ప్రశ్నలు:

22.	ఆమె/అతడు తన స్వతహాగా భాధించే సంఘటనలను ఎదుర్కొన్నారా?	( )	( )	( )	( )
20.	లేదా తన కుటుంబంలో ఎవరికైనా భాధించే సంఘటనలు ఉన్నాయా?	( )	( )	( )	( )
21	లేదా ఆమె/అతడు వేరే వారి జీవితంలో జరిగిన బాధాకరమైన సంఘటనలను అనుభవించారా?	( )	( )	( )	( )

Evaluation: Count vlues of responses - the higher the number, the more likely a traumatic stress disorder is. if at least one of the following questions is marked 'yes'. Otherwise there may be behavioral disorder. Please ask for medical help.

కూడగా వచ్చిన మొత్తం విలువలలో అధిక సంఖ్య కలిగినది ఒత్తిడిని కలుగచేసేదిగా గుర్తిస్తాము. దానిని మనము లైటు మార్చు చేయవలెను.

Revised Child Impact of Events Scale

Below is a list of comments made by people after stressful like events. Please tick each item showing how frequently these comments were true for you during the past seven days. If they did not occur during that time please tick the 'not at all' box.

ప్రశ్న సంఖ్య		Not at all అస్సలు చెయ్యరు	Rarely బాలా తక్కువగా	Sometimes అప్పుడప్పుడు	Often తరుచుగా చేస్తారు
1.	అనవసరమైన ఆలోచనలు మీకు పదేపదే వస్తున్నాయా/ వాటిని మీరుఅధిగమించలేకపోతున్నారా?		✓		
2.	అనవసర ఆలోచనలు మీ జ్ఞాపకాలలో నుండి తొలగించుటకు ప్రయత్నిస్తున్నారా?			✓	
3.	నీ ఒత్తిడినుండి నీకు బలమైన భావన కలుగుతుంటా?			✓	
4.	నీకు ఒత్తిని కలిగించే జ్ఞాపకాలకు దూరంగా ఉంటున్నావా?			✓	
5.	నీకు ఒత్తిడి కలిగించే విషయాల గురించి మాట్లాడుటకు ఇష్టం చూపించవు				✓
6.	అనుకోకుండా నీకు ఒత్తిడిని కలుగజేసే సన్నివేశాలు గుర్తుకొస్తుంటాయా?		✓		
7.	ఇతర విషయాలు ఒత్తిడిని గూర్చి నిన్ను ఆలోచింప చేస్తున్నాయా?		✓		
8.	ఒత్తిని యొక్క ఆలోచనల నుండి బయటకు రావడానికి ప్రయత్నిస్తున్నారా?				✓

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Praxiserfahrung

Laufend seit 09/2020

Assistenzarzt Klinikum Worms

Klinik für Urologie und Kinderurologie

Besondere Kenntnisse und Erfahrungen:

- Dienstplanbeauftragte und Assistentenvertretung
- Assistenz am Da Vinci Roboter
- Betreuung der kinderurologischen Patienten
- Abgeschlossener Grundkurs und Kenntniskurs für den Erwerb der Fachkunde Röntgen
- (Spezialkurs voraussichtlich im März 2024 abgeschlossen)
- Mitbetreuung der Patienten des Beckenbodenzentrums

Bildungsweg

04/2016- 06/2020

Studium der Humanmedizin

Universität Duisburg-Essen

- 2. Staatsexamen 04/2019
- 3. Staatsexamen 06/2020

02/2013 – 04/2016

Studium der Humanmedizin

Riga Stradins Universitiy

- 1.Staatsexamen 09/2015

06/2003 – 06/2012

Liebfrauenschule Bensheim

Katholisches Gymnasium für Mädchen

Abschluss der Allgemeinen Hochschulreife

Besonderes Engagement

- 2020: Studentische Hilfskraft in der Fieberambulanz, Notaufnahme des Marienhofklinikums Koblenz
- 2019: DAAD-Stipendium für das Praktische Jahr Tertial Chirurgie im Ausland, Ulaanbaatar (Mongolei)
- 2018-2019: Studentische Hilfskraft im Universitätsklinikum Essen, Abteilung für Nuklearmedizin
- 2016-2018: Kontaktperson für internationale Studenten im Rahmen des bvmd Austauschprogramms
- 2016-2017: Studentische Hilfskraft im Klinikum Krefeld-Uerdingen, Abteilung für Innere Medizin
- 2016: Teilnahme am "Baltic Sea Symposium on Simulation and Virtual Health Care"
- 2015-2016: Mitglied und Engangement im International Rotaract-Club Riga

Weitere Kenntnisse

Sprachen:	Deutsch – Muttersprache
	Englisch – fließend in Wort und Schrift