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**Sand Play Reprocessing Integrating Nonverbal Trauma-
Interventions and Self-Stabilization for Victimized Children**

Conceptualization and a Prospective Controlled Pilot-Study

**Sandspiel –Therapie als Trauma-Behandlungs-Methode in
Verbindung mit Selbststabilisierungs-Interventionen für belastete
Kinder**

Konzept und prospektive kontrollierte Pilotstudie

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HEAL THE WORLD

(by Michael Jackson)

There's a place in your heart and I know that it is love
and this place could be much brighter than tomorrow.
And if you really try you'll find there's no need to cry.
In this place you'll feel there's no hurt or sorrow

There are ways to get there, if you care enough for the living
make a little space make a better place

Heal the world, make it a better place for you and for me
and the entire human race.
There are people dying, if you care enough for the living.
Make a better place for you and for me

If you want to know why. There's a love that cannot lie.
Love is strong it only cares for joyful giving.
If we try, we shall see, in this bliss we cannot feel fear or dread.
We stop existing and start living

Then it feels that always love's enough for us growing.
So make a better world. Make a better world

And the dream we were conceived in will reveal a joyful face.
And the world we once believed in will shine again in grace
Then why do we keep strangling life. Wound this earth crucify its soul.
Though it's plain to see, this world is heavenly. Be God's glow.

We could fly so high. Let our spirits never die,
in my heart I feel you are all my brothers
Create a world with no fear. Together we'll cry happy tears.
See the nations turn their swords into plowshares.

We could really get there. If you cared enough for the living.
Make a little space to make a better place

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Next I would like to thank my son Elias, for me the greatest boy on earth who now is nearly 16 years old and the best child I could ever have. He accompanied our turbulent life with a chaotic and powerful mother who had lots of ideas about changing the world for other traumatized people while also loving and caring for him every minute. It gave him a strong character with a distinct opinion. It gave him an open mind and full perspective of the world, encouraging him to say things loud and clear and with the same sense for justice and mission against inequality. He also showed me since he was born what it is to have fun, relax and what the "bright side of life" really is. He has braved all the hard times during that "Sandplay-project" and felt alongside the children. He was an important camera man in India documenting all the dramatic situations happening to children on the streets trying to understand and create solutions. Finally, he was a very good actor in our DVD-production we recorded beside the main work to inform schools and other institutions about "First Aid for the Soul".

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CONTENT

SUMMARY	10
INTRODUCTION	17
ARGUMENTS FOR A NEW APPROACH.....	20
THE LANGUAGE PROBLEM	21
EMPIRICALLY BASED CONCEPTS – A SYSTEMATIC REVIEW	23
EVIDENCE IN STABILIZATION TECHNIQUES	27
“A“ for “Action“ in the sense of “Body-Movement”	30
"B" for “Breathing”	35
C...Stands for the Six Cognitive Components of Traumatherapy	42
D... Stands for Documentation or Diary.....	48
E... Stands for Emotions	51
F...Stands for Functional Relaxation (FR).....	58
THE MULTI-TRANSCULTURAL PROBLEMS IN PSYCHOTHERAPY	65
REASONS FOR NON VERBAL INTERVENTIONS	69
CLINICAL DIAGNOSTICS	72
Additional Clinical Diagnostics for Children.....	75
Youngest Children´s Special Trauma-Symptoms	80
Psychological Testing	84
INTRODUCING LAY HELPERS, CALLED TRAUMAHHELPERS.....	86
The Target Groups of the Traumahelper-Training	92
Prerequisites for Potential Traumahelpers	92
The Specific Traumahelper Training Concept in Detail	95
Prevention of Secondary Traumatization in Traumahelpers	99
Preventive Interventions Recommended to Traumahelpers Avoiding Secondary Traumatization	100
THE SANDPLAY-THERAPY CONCEPT	102

General Description of the Sandplay-Therapy	102
THE ROLE OF THE TRAUMAHHELPERS	108
The Session Itself.....	109
DEALING WITH DIFFICULTIES.....	116
<i>Passiveness and “Lack of Ideas”</i>	116
<i>Restlessness</i>	116
<i>Hyperarousals, Aggressive Outbursts, Raising Material</i>	117
EXAMPLES OF CASE WORK.....	118
ADAPTING THE CONCEPTS TO A TEACHING IN INDIA.....	123
STATISTICS.....	140
RESULTS	141
DISCUSSION.....	153
CONCLUSION AND OUTLOOK.....	160
LITERATURE.....	162
APPENDIX	185
EIGENSTÄNDIGKEITSERKLÄRUNG	209

List of Figures

	Page
Figure 1: The base of the cerebrum, demonstrating the origin of the cranial nerves (Source: http://teachmeanatomy.info/head/cranial-nerves/summary/).	38
Figure 2: A metaphor: The brain system as a music band	39
Figure 3: Localized Right Hippocampus Abnormality showing the location of the indentation in participants with severe PTSD symptoms.	53
Figure 4: Localized Right Amygdala showing the location of the indentation in participants with severe PTSD symptoms. S	55
Figure 5: Diagram of Qualifying in Trauma Therapy to Applicable Law in Germany and assigned as a Traumahelper	91
Figure 6: An example of a Trauma-Landscape	104
Figure 7: An example of a Genogram	106
Figure 8: Aramsamsam-The Action Song	110
Figure 9: a view on a typical Sandplay therapy session.	115
Figure 10: CRIES / DSRS Histograms	143
Figures 11 - 16: Comparisons	147
Figure 17: Comparisons	150
Figure 18: Schematic overview of all testing	151

List of Tables

	Page
Table 1: The First Page of the translated UCLA in Arabic	46
Table 2: Impact of Event Scale-Children Revised Edition in Arabic	46
Table 3: Depression Self Rating Scale for Children in Arabic Version	47
Table 4: Informed Consent in German and Arabic	50
Table 5: Clinical Signs of Dissociation	57
Table 6: Classification of Dissociative Phenomena DSM V	57
Table 7: The most common symptoms diagnosed in refugee children and adults with PTSD	65
Table 8: Trauma-Experiences causing PTSD in Refugees	67
Table 9: A sample of migrant population and medical care-services	70
Table 10: Clinical Diagnostics, PTSD-Criteria ICD-10 (F43.1)	73
Table 11: Clinical Diagnostics, PTSD-Criteria DSM V (309.81)	74
Table 12: Clinical Diagnostic Criteria in PTSD Especially to Children (inspired by Bessel van der Kolk)	77
Table 13: The Arab Refugee Children Sample: Symptom and Burden Changing after Sandplay	141
Table 14: The Indian Children: Symptom and Burden Changing after Sandplay	142
Table 15: Comparison of the Experimental- and a Matched Pair Control-Group (by Sex and Age)	143
Table 16: Comparison of the Intra-individual Changes (Experimental Group) and a Matched Pair Control-Group (by Sex and Age)	145
Table 17: All other children (n=21; without the controls)	146
Table 18: Comparison of the Indian Experimental Group and All Other Indian Children Having Had a Test-Re-Test Evaluation (= including controls)	150
Table 19: Comparison of the Intra-individual Differences	151
Table 20: Comparison of the Arabic Experimental and The Indian Experimental Group	151

List of Pictures

	page
Picture 1: An example of a diary	49
Picture 2: A look into the diary of a five-year-old boy from Syria	49
Picture 3: Marianne Fuchs, left side	61
Picture 4: Viktor von Weizsäcker, right side	61
Pictures 5-7: A sample of real Sandplay in Nablus, Westbanks, 2017	98
Picture 8: Interviewing burdened children and medical/psychological findings in real time, Nablus, Westbanks, 2017	99
Picture 9: A child Sandplay reprocessing. An example for the Sandplay setting; Regensburg	112
Picture 10: An example for the "lying eight", drawn by a refugee child in the Sandplay therapy group; Regensburg	113
Picture 11: An example for a scene after drawing the "lying eight" and ongoing playing with the sand, India.	114
Picture 12: A case work (1)	118
Picture 13: A case work (2)	119
Picture: 14: A case work (3)	119
Picture 15: A sample of another case work	122
Picture 16: The announcement of the two-days Traumahelper Course in India, Hyderabad	123
Picture 17: A "Balabata" in the district of "Andhra Pradesh"	125
Picture 18: Children in their only one "Balabata"-room	126
Picture 19: Girls living in a „Child Guidance Center“ at Guntur	127
Picture 20: Weekly prayer in Hyderabad	128
Picture 21: Traumahelper teaching in Guntur (1)	130
Picture 22: Traumahelper teaching in Guntur (2)	130
Picture 23: Traumahelper teaching in Guntur (3)	131
Picture 24: Traumahelper teaching in Guntur (4)	133
Picture 25: Traumahelper teaching in Guntur (5)	136
Picture 26: Traumahelper teaching in Guntur (6)	136
Picture 27: Traumahelper teaching in Guntur (7)	137
Picture 28: Traumahelper teaching in Guntur (8)	137
Picture 29: Traumahelper teaching in Guntur (9)	139

List of Abbreviations

ARAS	Ascending Reticular Activation System
BS	Bilateral Stimulation
CRIES - 8	Children`s Revised Impact of Event Scale - 8
DSRS	Depression Self Rating Scale
EEG	Electroencephalogram
EMDR	Eye Movement Desensitization and Reprocessing
fMRI	Functional Magnetic Resonance Imaging
FR	Functional Relaxation
IES	Impact of Event Scale
PR	Progressive Relaxation
PTSD	Post-Traumatic Stress Disorder
SPB	Slow Paced Breathing
SURE	Short (Somatic) Universal Regulative Exercise
UCLA	University of California Los Angeles Children`s Posttraumatic Stress Disorder Reaction Index

SUMMARY

Germany seems to be the synonym for refugee crisis. Up to now in the last two years more than a million people arrived, half of them younger than 20 years old, most of them more or less traumatized. Just now the 5000 psychotherapists specialized for this age group have enough work with the 12 million children and adolescents living already in our country serving about 200.000 patients a year. So what should we do with the new roundabout 150.000 patients? The idea is to integrate multipliers as co-therapists within trauma-therapy group sessions so that one professional therapist minimum doubles the effectiveness. These specially trained non-professionals we call "Traumahelpers". In the last three years the procedures have been applied in pilot projects in different German Cities, Telangana (India), Palestine and Gaza City (Multicenter Approach). The Children got the same diagnostics: levels of burden are comparable, reason of traumatization as different as societies are (parental power, social, psychological and physical violence, severe disease, rape, terrorism, flight, war etc.).

Method: Traumahelpers first learn a bundle of self-stabilization techniques: Slow Paced Breathing (SPB), Somatic Universal Regulative Exercise (SURE) and different techniques of Bilateral Stimulation like tapping or "lying eight", which are near to daily habits children have (e.g. swinging, drawing slopes, singing songs, play instruments, move and run) and at the end the Traumahelpers experience the Sandplay-Therapy by themselves via role play to get an idea what children will do in the real therapy sessions.

15 children, aged 5 to 12 years, sectioned in two groups (one in Germany and one in Andhra Pradesh, India), both groups diagnosed with the Depression Self Rating Scale (DSRS) and the Children – Impact of Event Scale – CRIES-8, had over the time of three to five

months altogether ten Sandplay sessions. Every child had its own individual Traumahelper who had to stay beside its foster child during all the ten sessions. If the Traumahelper observed emotion or excitation in the child, he or she offered self-stabilization exercises which he or she performed together, with the child in a manner that the child was able to perform the techniques even alone. The sessions were both started and closed with a song together including all described self-stabilization techniques, a simple way to introduce and perform the established methods for self-stabilization: Singing actually as a kind of Slow Paced Breathing, tapping as a kind of Bilateral Stimulation and walking on the place as a kind of Somatic Universal Regulative Exercise (SURE).

Results: The children improved their scores significant, comparing pre-post results (see mentioned tests) and in comparison to the not yet treated multicenter control-group. There was no need for translation during the sessions, because children after an at least 3 month stay in Germany knew enough German words to cope with the situation, a large knowledge of the language is not needed, because construed as a non-verbal functioning therapy technique; under homeland conditions the question of understanding each other's language didn't rise up in therapy sessions but in Traumahelper training, therefore an interpreter was needed. In general the therapy sessions took place in rooms, the children already knew from school or after school programs, which, was very helpful.

Discussion and Conclusions: If enough people could be motivated to do this 2 day preparation course for Traumahelpers and commit themselves to assist in 10 one hour therapy sessions followed by one hour supervision each time (learning on the job) and at least one children psychotherapist this Sandplay-Therapy concept is an easy to applicate and more cost-effective, too: ten traumatized children in an

individual setting would need at least altogether 50 hours of diagnostics (for each child five sessions scheduled) and at least about 450 hours of treatment. In this concept 20 hours of diagnostics are altogether followed by only 20 hours of engagement in group therapy and supervision and maybe followed by about 20 hours individual therapy sessions for in average on or two still suffering children after the Sandplay group therapy. The capacity of one therapist at least doubles and could even amount on five times more patients in the same time. Beside this the trained Traumahelpers could profit besides the special setting: personally but even in contact with burdened children, they have to deal with; the clinical improvements are even in the not specifically treated group significant.

The concept can be easily transferred in other cultural spaces, as proven in this multicenter study.

ZUSAMMENFASSUNG

Deutschland scheint mehr denn je als Synonym für den Begriff „Flüchtlingskrise“ zu stehen bis jetzt sind in den letzten drei Jahren mehr als 1 Million Menschen in unserem Land angekommen, die Hälfte von diesen waren bei Ankunft jünger als 20 Jahre, viele von ihnen mehr oder weniger traumatisiert. Augenblicklich arbeiten in Deutschland etwa 5000 Kinder- und Jugendlichen-Psychotherapeuten, die sich auf diese Altersgruppe spezialisiert haben, diese hätten eigentlich mit den 12 Millionen Kindern und Jugendlichen, die bereits in unserem Land Leben und von denen sie im Jahr etwa 200.000 versorgen, genug zu tun. Was sollen wir also nun mit den 150.000 neu angekommenen Patienten machen?

Die Idee ist, Multiplikatoren in die Traumatherapie zu integrieren, so dass ein professioneller Therapeut zehnmal effektiver sein kann. Diese speziell trainierten Laien werden im vorliegenden Konzept „Traumahelfer“ genannt. Das Konzept wurde innerhalb der letzten drei Jahre in Pilotprojekten in verschiedenen deutschen Städten umgesetzt, aber auch im Ausland: in Telangana (Indien), Palästina und Gaza City.

Für die Evaluation wurde ein multizentrisches Vorgehen gewählt. Alle Kinder durchliefen dieselbe Diagnostik und wiesen vergleichbare Belastungsraten auf, wobei die Gründe der Traumatisierung so verschieden sind wie die Gesellschaften (elterliche, soziale, psychische oder physische Gewalt, schwere Krankheiten Vergewaltigungen Terrorismus, Flucht oder Krieg).

Methode: Die Traumahelfer lernten zunächst verschiedene effektive Selbstregulations- und Stabilisierungstechniken kennen: Slow Paced Breathing (SPB), Somatic Universal Regulative Exercise (SURE) und Bilaterale Stimulation (BS) wie Tapping oder die „liegende Acht“ ; Techniken, die nahe an den Alltagserfahrungen von Kindern sind, (z.B.

Malen von Schleifen oder “Liegenden Achten”, Stricken, Häkeln, Schaukeln, Singen, Instrumente spielen, sich bewegen und rennen), um am Ende eigene Erfahrungen beim supervidierten Sandspieltraining zu erleben und zu bearbeiten.

15 Kinder, zwischen 5 und 12 Jahre alt, verteilt auf zwei Experimentalgruppen (eine in Deutschland und eine in Telangana), wurden mit der „Depression Self Rating Scale“ (DSRS) und der “Children – Impact of Event Scale“ (CRIES-8), vom Schweregrad her eingestuft, sie erhielten insgesamt 10 Sitzungen innerhalb eines Zeitraums von 3-5 Monaten, die mit wenigen Unterbrechungen, z.B. durch Ferien, wöchentlich stattfanden. Jedes Kind hatte seinen eigenen, persönlichen Traumahelfer, der ihm kontinuierlich über den ganzen Therapiezeitraum hinweg zur Verfügung stand. In Situationen, in denen der Traumahelfer Emotionen oder Aufregung beim Kind wahrnahm, war er angehalten, zunächst selbst Stabilisierungsübungen anzuwenden, die er bei Bedarf auch zusammen mit dem Kind durchführte, und zwar in der Form, dass es das Kind, später eigenständig umsetzen konnte. Die Sitzungen begannen und endeten jeweils mit einem gemeinsamen Lied, dass in Form einer Choreografie alle Selbststabilisierungstechniken enthielt: vom Singen, in welchem das Entschleunigte Atmen enthalten ist, über Somatic Universal Regulative Exercise (SURE), durch Gehen auf der Stelle sowie durch Tapping als Form der Bilateralen Stimulation.

Ergebnisse: Die Kinder konnten ihre Belastungswerte signifikant im Vorher-Nachher-Vergleich verbessern, auch im Vergleich zur noch nicht behandelten Kontrollgruppen, die im Rahmen des multizentrischen Vorgehens rekrutiert werden konnten. Tatsächlich war es nicht notwendig, während der Sitzungen zu übersetzen, denn in Deutschland hatten die Kinder nach etwa drei Monaten Aufenthalt so viel Sprachverständnis entwickelt, dass sie einfache Anweisungen

verstanden, insgesamt ist das Konzept auf non-verbaler Basis aufgebaut, so dass kein weiterführendes, umfangreiches Sprachverständnis notwendig war. Unter muttersprachlichen Bedingungen, wie in Indien, trat das Übersetzungsproblem in den Therapiestunden nicht auf, jedoch im Traumahelfer-Trainingsprogramm, in welchem dann Dolmetscher rekrutiert wurden.

Die Therapiesitzungen fanden dort statt, wo die Kinder sich üblicherweise aufhielten. Dies war zum Beispiel in den Schulen oder Asylbewerberunterkünften der Fall. In Deutschland ergab sich die Problematik des zu bewältigenden Weges vom Wohnort zu einem potenziellen Therapieplatz, der durch das Vorgehen der dezentralen Unterbringung weite Wege mit sich brachte, die über viele Stunden Busfahrten hätten bewältigt werden müssen. Dies wäre den Eltern, die selbst meist unter starken psychischen Belastungen litten als auch den Traumahelfern in ihrer ehrenamtlichen Funktion nicht zuzumuten gewesen. Auch in Indien stellte sich die Durchführung der Sandspieltherapie an den gewöhnlichen Aufenthaltsorten der Kinder (Schule und „Happy Home“) als praktikabel und umsetzbar heraus, denn es hatte den Vorteil, dass nur wenige Therapiestunden ausfielen, bzw. sich um eine weitere Woche verschoben und die „Drop-out-Quote“ möglichst gering gehalten werden konnte.

Diskussion und abschließende Bemerkungen:

Können genügend Menschen motiviert werden, an diesem zwei-tägigen Traumahelfer-Trainingskurs teilzunehmen und können sich diese dazu bereit erklären, am 10-wöchigen Sandspieltherapieprogramm unterstützend teilzunehmen (pro Woche 1h Sandspieltherapie plus im Anschluss 1h Supervision und sich wenigstens ein Kinder-und Jugendlichenpsychotherapeut findet, der die Gruppe verantwortlich betreut ist das hier beschriebene Sandspieltherapiekonzept ein einfach

anzuwendendes und auch wirtschaftlich effektiveres Konzept. Werden hierzulande zehn traumatisierte Kinder im Einzelsetting behandelt, erhalten sie je fünf (= insgesamt 50h) probatorische Sitzungen für Diagnostik, Psychoedukation und Aufklärung. Anschließend erhalten Patienten üblicherweise im verhaltenstherapeutischen Behandlungssetting 45h Einzelpsychotherapie, was bei zehn Patienten ca. 450h Gesamtbehandlung bedeutet. Mit diesem Sandspieltherapiekonzept werden pro Kind 2h (= 20h bei zehn Kindern) Diagnostik, Psychoedukation und Aufklärung benötigt, sowie zehn Doppelstunden (1h Sandspieltherapie plus 1h Supervision im Anschluss) Psychotherapie im Gruppensetting (= 200h). Erfahrungsgemäß resultieren aus einer Sandspielgruppe 1-2 Einzelfälle, die dann doch eine ambulante Einzeltherapie benötigen, weil die Belastung schwerwiegender war oder die Lebenssituation komplexer ist. So wird zeitlich gesehen die Kapazität eines Psychotherapeuten, konservativ berechnet, wenigstens verdoppelt.

Daneben können die ausgebildeten Traumahelfer unabhängig vom speziellen Setting vom Gelernten persönlich profitieren, indem sie die Selbststabilisierungstechniken in eigenen schwierigen und/oder belasteten Lebenssituationen anwenden, die klinischen Verbesserungen waren allein durch Anwendung der Stabilisierungstechniken auch ohne traumatherapeutische Intervention in der nicht spezifisch behandelten Gruppe signifikant.

Wie gezeigt, kann das hier vorliegende Sandspielkonzept leicht in andere Kulturräume übertragen, exportiert, werden, insbesondere in Kriegs- und Krisengebiete, wie diese multizentrische Studie belegt.

INTRODUCTION

History books and films about wars always draw a terrible picture of horror. But the experienced reality often is different than printed pages that we read. Fear, pain and suffering accompany traumatized people for the rest of their lives. Experts estimate that a minimum of 50% of all the refugees are mentally ill. Most of them (40-50%) suffer from Posttraumatic stress disorder, many of them, about 50%, suffer from depression, usually a major depression. Frequently 40% of the refugees suffer from PTSD accompanied with suicidal ideations, attempted suicides or completed suicide. Beneath the adults also 20% of the refugee children have PTSD (Bundespsychotherapeutenkammer 2015). What we do not know is the number of children which are traumatized without developing PTSD, because only a few show the recognizable symptoms of the International Classification Systems as DSM V or ICD 10. What we know is that many children until the age of 14 mostly show expressive behavior disorders or depressive symptoms when they are traumatized as described by Bessel van der Kolk and others (In: Korittko 2017). So we are talking about hundreds of thousands of people who now live in Germany and take support capacities to their limits and even children are often affected, because they can assess or describe the traumatic experiences and the following symptoms worse than adults.

The world seems to be “on the run”. The number of refugees has nearly doubled in the last ten years from 37,5 Million people to 65,6 Million people in the year 2016 and half of them are children under 18 years old. In 2016 about 75.000 children running without parents were registered by application for asylum in different countries. Most of the refugees (40,3 Millions) are within their own countries on the run, the most affected country by people on the flight in 2016 is Syria with altogether 5,5 Million people, followed by the Iraq (3,3 Millions),

Afghanistan (2,5 Millions) and South Sudan (1,4 Millions). About 9 of 10 refugees got asylum in developing countries like Ethiopia and Uganda. Also the Islamic Republic of Iran is one of the first six intake nations (UNO Flüchtlingshilfe e.V. 2018). In Germany we had from 2015 to 2017 altogether 1,368.000 asylum seekers. Most of them come from Syria, Afghanistan and Iraq, countries where the people are on the run because of war, crime, torture and prosecution („BAMF Asylgeschäftsbericht 12/2017“ 2017). 37% of the arriving refugees are younger than 18 years, most of them younger than 12 years („BAMF Asylgeschäftsstatistik 2016“). All of them experienced – with or without their parents – flight because of war, crimes, violence, sexual abuse, but also extreme hunger or poverty or difficult environments, e.g. earthquakes, landslips, avalanches, flooding or forest fires: With more or less personal consequences. Not seldom they flew over thousands of kilometers, so that caregiving in these children requires new focusing – on all these different kinds of traumatization, work over language-borders and clever concepts because of a lack of specialists. The most common symptoms in these children are disturbances of sleep, bad dreams, flashback memories, somatic and / or somatoform problems, nervousness and a reduction of the capacities to concentrate. In many cases these could be simply eased using relaxation, self-stabilization or regulation techniques, the concept of “safe place”, information and behavior modification. (Fegert 2015; Ärzteblatt. „Traumatisierte Flüchtlinge und Asylbewerber: Hilfe für Opfer von Kriegsgewalt“ 2016; Ärzteblatt. „Bericht zur psychischen Gesundheit bei Kindern und Jugendlichen in Bayern“ 2016; Fegert et al., 2018)

But symptoms are not limited within the therapy sessions, they are shown even in the daily life time at home, in school lessons and day care. So it does make sense to train teachers, educators and similar professions identifying the symptoms of posttraumatic stress disorders,

to bring the children to a specialized treatment or to assist themselves teaching self-stabilization to the victims. Because all of the children most time of the day stay in groups (school, day care), and because our supply system of psychotherapy is limited, we created possibilities to treat the stressed and burdened children in group-therapy sessions. Group therapy in Germany is a common and accepted treatment in all terms of references (Behavior Therapy, Psychodynamic Therapy) and under consideration of the few amount of children psychotherapists - about 6.000 for the whole country (Uhlemann 2018) – it seems to be the best solution to treat as many mental ill children as possible. Thinking about the more than 1 Million refugees coming to Germany since 2015 and the number of 506.000 children in the age until 18, most of them younger than 12 years old and most of them with traumatic experiences and more than 20% = 101.232 of them with the full symptoms of post traumatic disorder would be a challenge for the children psychotherapists: 17.000 mental ill refugee kids for one caregiver! So Sandplay is the main means of treatment, it's a very common and investigated therapy tool in psychotherapy sessions with children where they can process their maltreatments, experiences of misbehavior or other bad situations in their lives which caused mental illness or - in this case -especially traumatization. Sandplay is a very suitable tool to use it in therapy groups when every child has its own sandpit to show its own experiences (Kalff 2000). And because one psychotherapist cannot rule a group of ten traumatized children it is necessary to introduce and involve lay helpers to assist the psychotherapist and support the psychotherapeutic process.

ARGUMENTS FOR A NEW APPROACH

Because of the urging necessities a concept is needed which does not only work for refugee kids in Germany whereas already the problem has to be solved with different cultures and at least different languages (e.g. Arab, Farsi, Pashto, Urdu, Dari, Albanian, Russian, Ukrainian, Somali) and which also could be exported to other sites. For this inaugural thesis a concept was developed to introduce engaged lay helpers as assistants for professional trauma-psychotherapists into a manageable straightforward concept, to train them in two pilot groups – one in Germany with Syrian and Iraqi children and one in Hyderabad, Telangana, India with former homeless and abandoned children.

The so called “Sandplay”-concept in which mostly teachers and educators are qualified serving as future multipliers consists in two compounds: On one hand they should assist as multipliers to the specialized trauma psychotherapists. On the other hand they can support the children to resolve their daily life conflict situations autonomously adapted to their age with instructing to them simple self-stabilization techniques and resolve their daily conflicts beside the professional psychotherapy, at school or other institutions where the children stay. Furthermore the Traumahelpers can teach the parents or other relevant attachment figures in the self-stabilization techniques which are useful also in other fields of destabilization or insecure mental states.

THE LANGUAGE PROBLEM

The most convincing advantage of Sandplay is the nonverbal approach. That means, the presence of an interpreter during the sessions is usually not required. Most of the Arabic refugee children coming to the project in Germany had already spent enough time in Germany, mostly several months, so they understood some easy words like “yes” or “no” e.g. which is helpful to explain several rules or to stop unwanted behavior, that can happen. While playing in the sand silence is very important to give the children enough space to be focused on the setting in self-concentration. To be silent in the therapy session is much easier, when languages between child and Traumahelper is not or less understood. The project in India was different. The psychologists, the Traumahelpers and the children all spoke the same language (Telugu), so the advantage was to keep the silence and not to talk too much to the children and disturb the therapeutic process at the same time. Sandplay works especially in a nonverbal type, if we understand each other language or not. For the supervisors in India coming from abroad it was easy – while understanding nothing of the language - directly to watch and come along with the process while the children were playing their scenes.

This leads to the next question: Despite the language barrier is there understanding? From the behavioral biology the answer is clear: Yes. Because the Traumahelpers get the neuro-scientific, social and developmental psychological and psychopathological basic knowledge and, to some extent, as well culture-specific information. These four main blocks amount in the structured Traumahelper training a total of four hours. Furthermore basically simple techniques of self-regulation are explained, which can also be transferred non-verbal by learning from a model (in this case the Traumahelper). Self-regulation is a complex concept, namely, which describes simply a possible

psychosomatic influence: People can calm down themselves, but also others throughout using behavior patterns with proven psychophysiological effects, for example, Slow Paced Breathing, or weighing themselves. At the end Traumahelpers should be like "god parents", competent in attachment and care giving (Brisch 2017). The presence of another person, who is attentive and principally addressed to the child and rudimentary communicates with him, is - even without understanding the language – per se biologically effective and inducing learning of the new behavior patterns subconsciously. In doing so, we have to deal with a phenomenon that can be observed already in many animal species, but also in humans. Dogs, for instance, respond systematically heavily on non-verbal cues, such as body posture, whereas not the gestures, but the shift of the center of gravity is the trigger or stimulus (Ganslosser and Kitchenham 2012).

Humans even have this communication channel. The exchange of sounds is used, for example, to assure the attention of an accompanying person, even if there is no eye contact. These phenomena are biologically very deeply entrenched, e.g. geese use this procedure to check mutually the presence of the other individuals in the swarm even without eye contact (Christian, Kotrschal and Thomas 2007; Scheiber et al., 2005) That the presence of the person to whom is developed a relationship in course of the sessions is reducing fear, is already scientifically proven, in addition to the mechanisms described above. It is the basis for the deeper emotional processing of the trauma by means of the later on described methods.

The multipliers model was, as already mentioned, used in South America, and also in other crisis regions, for example in Kosovo and in Central Africa where NET ("Narrative Exposure Therapy") or KIDNET ("Narrative Exposure Therapy for Children") were used to treat

traumatized children there (M. Schauer, Elbert and Neuner 2011; E. Schauer et al., 2004; Neuner et al., 2008).

EMPIRICALLY BASED CONCEPTS – A SYSTEMATIC REVIEW

In this chapter the experiences with lay counselors in general and especially in psychotherapy, the basics of the Sandplay-Therapy are presented.

Collaboration with lay counselors

The first project offering partially culture-specific trauma-management in a group setting was reported almost 30 years ago, for example on the occasion of the mine disaster in Borken, Germany, in 1989, in which more than 60 families were hidden, with 51 minors dead and 8 severely injured, as well as 6 rescued, including many Turkish-born guest workers with a total of 81 involved children (Brandtner et al., 1992) This treatment-offer followed the usual tradition of psychodynamic groups lasting about one year, with a total of about 80 group sessions (refers to all lots), for 10 parallel groups with different targets, including three children- and one youth-group, with approximately ten appointments for each target group.

Taken for granted are the trainings and in accordance the participation of familiar persons and so-called confidants in the vicinity of the patients in the therapy, e.g. in pediatrics in the treatment of atopic dermatitis or diabetics (Kupfer et al., 2010; Staab et al., 2002; Johansson et al., 2016) and in many mental disorders: from the dyslexia to schizophrenia (Yesufu-Udechuku et al., 2015) as well for overweight-children or other behavioral problems (Franz et al., 2009; Kuschka 2014). In these contexts now the multiplier concept in the narrower sense has its premiere. Trained personnel are educators, nurses, medical assistants or teachers, which will transfer the contents of self-stabilization to the

parents and other to children related persons, too.

The starting point of the “Regensburger Weg” (“Path of Regensburg”) (Beate Leinberger und Loew 2016) was to combine the established Sandplay therapy and the group setting with the teaching of self-stabilization techniques to improve the trauma-processing and the lasting effects with the concept of therapy assistance. Therefore the integration of trained lays was chosen. This is first of all not quite new in medicine: The best example of this is the first-aid-trained, for example during the driving license acquisition. In Germany in the last 50 years, about 50 million people have gone through it. First-aid-trained lays in medical assistance are firmly established meanwhile in all civilized countries. Let us remain in the chosen picture: None of these trained lay helpers would claim to be able to operate on the basis of the course as an emergency doctor. The distribution of the supply on several levels, especially in emergency medicine has proven its worth, but what’s more also in the laity self-help for minor injuries and the self-sufficiency is proven to be very effective.

The Method of Sandplay-Therapy

Sandplay-Therapy is established over 50 years for all age groups (Kalff 2000; Gontard 2013), which has found entrance in behavior therapy, too (Höfer 2014). In children therapy it is a standard procedure; in Germany often used in the single setting - approved and financed by the health insurances, and therefore no experimental method (Kalff 2000; Baggerly, Ray and Bratton 2010; Seidler, Freyberger, and Maercker 2011; Lennertz 2011; Murray 2012; Höfer 2014; Gontard 2013; Landolt and Hensel 2012).

In other words, the children take extra selected to their experiences figures, houses, vehicles, plants, animals and nature materials collected

in the countryside to play approximately in an 1/4 of an acre large sand box, what comes to their mind.

To clarify: Sandplay is used by psychotherapists within the therapies of thousands of children for decades. The effects very likely are found in the Triassic of most common Traumatherapy conceptions, especially in terms of behavior therapy conceptions and the references of the guidelines to Posttraumatic Stress Disorder (PTSD) (Flatten u.a. 2011) and obviously in the current revised edition of the new guidelines probably published in 2018:

1. coming out with the traumatic experiences in front of witnesses
by replaying or telling and simultaneously by using stabilization
techniques which patients learned before,
2. restructuring and
3. reprocessing emotions.

The concept of the Sandplay accompanied by lays was originally developed for traumatized children in the favelas of South America, and was due to the hardship that the psychologists, which via auxiliary organizations such as “Médecins Sans Frontières / Ärzte ohne Grenzen” have arrived on the place, were only for a few weeks available. In order to be able to reach as many children as possible, this multiplier model was invented (Green et al., 2013) The here presented conception is similar to this, what is introduced newly are the self-stabilization techniques but we can work under much better conditions.

The advantage of this approach lies in the fact that no understanding of the native language of the child is necessary, because there is no need to speak on a highly elaborated level during the sessions. An explanation of the procedure in advance, for example in the context of the preliminary diagnostic procedure and informed consent is recommended. Traumahelpers by themselves use self-stabilization-

techniques which enrich the concept like Slow Paced Breathing (SPB), the smallest common denominator of many relaxation techniques from autogenic training to yoga, which is also used for physiological regulation, or Somatic Universal Regulative Exercises (SURE) as a swing exercise for self-calming (Aliev and Kunze 2006). Both stabilization techniques are not yet explicit clinically evaluated for children; but in adults and life experience and observations throughout the whole world it is intuitively, without doubt, the most frequently used self-stabilization technique and thus undoubtedly "drug of choice". What works first and foremost in the whole therapy session is the structured and regulated function of the Traumahelpers, an important person with whom the child can identify with, those interacts alone by their presence and attentiveness already supportive. In case that the child is excited or anxious on the interventional level, the Traumahelper offers any self-stabilization technique to regulate the child while acting out the inner life experiences.

However, stress prevention is increasingly a theme and the self-treatment according to the instructions - from a CD course up to further educated doctor, for example, with the progressive muscle relaxation and slow paced breathing exercises for self-relaxation (Regehr, Glancy and Pitts 2013; Eppley, Abrams and Shear 1989).

EVIDENCE IN STABILIZATION TECHNIQUES

The here to operation coming techniques are borrowed from the current trauma treatment methods and are based mostly on behavioral methods, further developed on a non-verbal level respectively well suited in case of working with language barriers. It is the quintessence of the Sandplay-Therapy, imaginative procedures, the Narrative Exposition Therapy, Cognitive-Behavioral Therapy, EMDR (“Eye Movement Desensitization and Reprocessing”, as well as scientifically based rural stabilization techniques like SURE (Somatic Universal Regulative Exercise), Bilateral Stimulation, SPB (“Slow Paced Breathing”) and Functional Relaxation (FR).

In the following sections the techniques are presented in an escalating mode: It gets started with the less time-consuming or less visible technique, but combinations in different constellations are possible, too.

One aim of the concept is, that at the end of the therapy the single child knows what kind of self-stabilization technique works best for it. Therefore the individual proceedings are documented in a small book, which the child at the end of the program will take home. The stabilization techniques as the Bilateral Stimulation or Slow Paced Breathing are stress reducing techniques in general, so they can be applied by every person. The best method to “repair” the partial dysfunction in the front and/or central brain connection which is found in patients with Post-Traumatic Stress Disorder (Askovic et al., 2017; Gapen et al., 2016; B. A. van der Kolk et al., 2016; Nicholson et al., 2016; Reiter, Andersen, and Carlsson 2016), including high activities in special brain-frequencies is Bilateral Stimulation, which is the key to reintegrate traumatic emotions in correlation to the traumatic memory of a patient, while it gets reprocessed. In this project not via telling the memories as in the sessions with adult patients but via Sandplay-a

possibility for children as well as for adults with difficulties to talk about the traumatic experiences because of the lack of language knowledge as well as impossibility to clothe the thoughts, feelings and inner pictures in words. For adults and adolescents and even for children older than 12 years the main means of Bilateral Stimulation are the eye movements, but more than eye movements in children self-tapping with crossed arms alternately (Butterfly-Tapping) is used (Fukui, Oura, und Matsuo 2017; Oura, Fukui, und Matsuo 2017). Young children can't follow good enough the fast-eye movements induced by the therapist or the Traumahelper (Ahmad, Larsson, and Sundelin-Wahlsten 2007). Equally for the Traumahelper it needs more introduction to learn the eye movements than the tapping.

Another important aspect of this group therapy concept is the emotional positive arousal the children have. Positive emotions are existential for a positive growth and overcome negative experiences (Reagon et al., 2016). That happens while doing the stabilization techniques which are all packed into a willful funny senseless and meaningless song. The song marks every beginning and every end of every therapy session, so that the children know what to expect and develop a sense of safety by repetitive rituals (Dücker 2007). Furthermore singing makes a good mood, reduces fear and in combination with the self-stabilization techniques it produces emotional and physical relaxation (Kreutz 2015; Bossinger 2006). Moreover the children touch the toys and the sand, so they activate the senses of touch, vision and hearing. Perception with all senses is a basic requirement for movement, thinking, action, behavior and speech. If there is an disturbance in any case children behave conspicuously in social, emotional and physical contexts (Steininger 2016; Deuser 2016). They move their bodies and they are together with other friendly children and adults so the mostly in traumatized people hurt confidence can become calm and increase. An

important requirement to overcome the traumatic experiences (Bowlby et al., 2014).

But beside all technical aspects. The most important therapeutic agent is the relationship between Traumahelper and/or psychotherapist as the professionals and the child which is rather not on the linguistic-communicative or psychological level, but on the neurophysiological activities (König 2018).

In the non-verbal therapy process the unconscious perception of facial expressions and posture is the most important power factor, more than any direct human communication. In short words: Every human being is copying permanently other people inwardly, when they meet each other; there is a functional system in the brain, located anatomically mainly in the so-called "Insula". That means: Every relaxation method the Traumahelpers practice for themselves, can be effective because of these mutual processes and so bring a positive effect immediately in the stressed children; and this also works backwards. The child or the adolescent get rid of physical tension via the detour of "infecting" the adult supporter. Imagine the cycle as follows:

The Traumahelpers internalize involuntarily and unconsciously the muscular respectively affected image of the tensed child about the described functional circuit and does calm it now down just "internally" by using his self-reassurance-ways; in a second step he or she hands over this physiological sedation the same pathway. Everybody is mirroring the other vis-à-vis. So, in a certain sense we feel like the others and we can make feeling the others how we feel (Bauer 2014). If we bring that mostly unconscious mechanism to mind we call it "empathy".

“A“ for “Action“ in the sense of “Body-Movement”

A fundamental property arising from the development history of the brain is the ability of putting preferences because of the usually sequential processing of information. In order to understand this it is important to realize that the principles are working well for thousands of years of evolution, the fact is that surviving is only safe by movements: No matter whether an attack must be repelled, a fruit must be grabbed, or a protection against rain had to be built, always movements were important and so the most important sense of our six senses - not the view, not the hearing, not the smelling or tasting or superficial feeling of pressure, pain, heat or cold - it is the body self-perception, processing in a bidirectional way information from the muscles, joints, but also the inner organs, the sense of position, the optic, the acoustic and the haptic system which, of course, also on their way to the higher structures and functional instances of the brain, as the limbic system, something like the home-base of the emotions. The most important part of the limbic system in this case is the “Nucleus Accumbens”, because it is the interface between limbic system and motor system = limbic-motoric-interface. Beside the main function, transact motivation behavior into activities or actions which enables the dopamine system for better functioning. The idea is nearby that versa-vice outside motivated action – animated by the Traumahelpers or psychotherapists could also cause intrinsic motivation behavior, flow out dopamine and stimulate emotional learning processes, empathy, sympathy, a feeling for friendship which makes us feel safe and relaxed („Gehirn und Lernen - Das limbische System oder das „Säugergehirn““ 2018; Loonen and Ivanova 2016).

A metaphor is used to get the picture clearer: There are happening the same things like at a fast road which is interrupted by a crossing. The vehicle flow on the main road, in physiology the information is from the

proprioception upwards and the steering impulses for the muscles downwards, will not allow to a functional switching the “traffic light” to let the cross traffic pass - in physiology to give way to the limbic system functioning and allowing to process further the actual emotions. The later explained interventions follow basically these mentioned principles (nerve impulses which in consequence ultimately serve the movement, either because they bring information from the body or into the body, will have the “right of way” transport "); this explains why emotional or negative experiences indirectly are to become "turned down", at least a little. Less a person is stressed, less effort is needed to reach (Wojdat et al., 2017; Bornheimer and Gangwisch 2009; Ströhle 2018; Niles et al., 2016; Rosenbaum, Sherrington and Tiedemann 2015) SURE is a simple looking but deep effective movement, discovered by the Russian psychiatrist Hassai Aliev in the 1970s. The first letter “S” stands for “Short”, because applying it for two to three minutes will be effective in most people. “S” can also stand for “Somatic”, because of the detectable physiological stress reduction while practicing. The autonomic nervous system switches in minutes from the sympathetic activation to the parasympathetic activation. “U” means “Universal”, everybody can do it in every situation at any time. “R” stands for “Regulative”, it regulates dysregulated stress systems while doing “E” = “Exercises”. Sure is originally coming from Asian Islamic meditation exercises, practiced by the Sufis, a Hindu-Islamic hybrid religion. Basically it consists in a simple swinging or weighing like mothers cradle their babies or as we can be swayed by a rocking chair, hammock or swing. The movement in our case is stimulated by the Traumahelpers the children benefit from their movements via mirror neurons or they motivate the children to make the movements altogether.

It is a body oriented relaxation technique based on the execution of a monotonous repetitive, slightly rocking motion sequence which can be performed while standing, sitting or lying (Aliev and Kunze 2006). The application of the Short Universal Regulative Exercise usually takes the form of a brief introduction and application demonstration by trained personnel but also lay helpers or by audio-visual media. In the strictest sense of the word, it is a slight, spontaneous and continuous body movement, which is influenced as small as possible. Operators should be aware of the movement but not strengthened. They move their hip-joints in a small circle while standing or in a sideways weighing while sitting on a chair or on the floor. It is important to move the upper part of the body beginning with the hip region while sitting or standing. The arms should hang beside the torso always relaxed, with the frontal-related palms using only the force of gravity. Normally, preserving the constant motion sequence after a few minutes the motion will continue autonomously, so that it doesn't have to be executed willingly by the operator and lead to deep relaxation. It is used in Russia and there it is known as the "key method" (Kunze und Aliev 2006). In 2007 for the first time a study in Western Europe was performed to test applicability and the stress-reducing effects. Participants were employees of German rescue services. 46 persons were randomly assigned to a video supported introduction either to Progressive Relaxation (PR), developed by Edmund Jacobson or SURE. The effect has been tested after 8 weeks of application by a property list of words with the dimensions activity, intro/outro version, general well-being, emotional irritability, anxiety; SURE, improved the last two significantly; in addition, the user gets significantly tired. The recreation-impact questionnaire (German: Erholungs-Belastungsfragebogen) reveals an increased lack of energy, but also improved recovery. Both relaxation procedures were equally successful (Loew and Kutz 2010). In the Moscow rescue services SURE has already been introduced.

For most people within a few minutes relaxation can be reached. The time until the occurrence of this state can be further reduced with increasing routine within the method. A liberating laughing or exculpatory crying can be induced. The movement can also be induced from outside, for example, through intervention of another person by touching and moving to the shoulders or neck actively. Especially traumatized people show very fixed joins so they could need help in the first sessions to overcome the inflexibility and merge into a self-activated movement.

The analysis of the Russian literature allows the assumption that SURE seems to be a very effective tool to help patients, who do not want to or who cannot talk about their experiences, to entry into a psychotherapeutic -oriented conversation (Kunze and Aliev 2006).

In addition, the combination of SURE with content which must be trained or learned, e.g. in training sessions or preparation of examinations several Russian studies have shown an increase of efficiency and a reduction of effort (especially expenditure of time) can be achieved (Kunze and Aliev 2006). SURE is one of the most rapidly effectual methods to increase stress symptoms or dissociative phenomena.

The “A” for “Action” also stands for the “Lying Eight, a kinesiologic or motopedagogic drawing exercise (Drabben-Thiemann et al., 2005) and a kind of Bilateral Stimulation, too, which seems to calm down the overexcited children (Weber and Kampanaros 2015). It is connected, and if not sufficient supported by the Traumahelpers tapping the shoulders bilateral from the rear while the children draw the figure of the “lying eight” (Shapiro und Silk Forrest 2010; A. Hofmann und Barre 2014; Hensel 2007; Parnell 2008; Hyo-weon u. a. 2018).

The “lying-eight” is another good working method to reduce high stress levels on a biological plane. If people have fear or panic during a traumatic experience, typically the physiological “alarm system” in the brain, the “amygdala” as a part of the limbic system shows very high stress activities and asymmetric activity in the brain structures as we can see in magnetic resonance tomography. What happens in the limbic system is a cognitive response that alerts us in the face of trouble (Murkar and Koninck 2018; Lanius et al., 2017; Lee, Lee, and Kim 2017; Zach et al., 2016). If excited or fearful children are painting the „lying-eight“ as a kinesiology exercise they can reduce aggravating emotions. Subsequently the amygdala activities calm down, the child feels less stressed and is more disposed for overcoming traumatized experiences or -for example at school- more regulated and concentrated as before. These effects were first observed in a study with Alzheimer Disease. In this survey the old people regulated their fears and increased concentration skills very quickly while and after drawing the “lying-eight” or doing other kinesiology exercises which implemented Bilateral Stimulation (Drabben-Thiemann et al., 2005; Weber and Kampanaros 2015). Every exercise which involves both parts of the body, the left and the right side, for example, by just following a moving repetitive signal from left to right and backwards with the eyes or fulfill practices with hands, arms or other bodily parts is called “Bilateral Stimulation” and can help reducing the stress level in the amygdala (Shapiro und Silk Forrest 2010; A. Hofmann und Barre 2014; Hensel 2007; Wittje-Berger 2012). Traumahelpers are introduced to practice the „lying-eight“ together with all children between the two parts of Sandplay in the psychotherapy group session. This particular interruption leads to enable remarkable stress reduction when stress rises up while playing sand and - what we observed - it makes sure, that children can play more restructured and focused manner than

before. This is the effect of Bilateral Stimulation, which effectuates positive transformation in the brain.

"B" for "Breathing"

"B" as the second letter of the alphabet, first of all it stands for "Breathing", particularly "Slow Paced Breathing" (SPB). Already 5000 years ago the people in Judea had recognized that there is more than physiology behind. Their word for "to consolate" in the deeper sense of the word means "support somebody that he or she can inhale easier". 3000 years ago Yoga breathing exercises have already been established; in India SPB is a part of a - modern one would say - "holistic total treatment plan" (Loew 2017). Controlled studies as conventional medicine demands, you will find already since the 1980s for asthma and high blood pressure (Posadzki et al., 2014; Nagarathna and Nagendra 1985)

Breathing is the interface between the stripped muscle system and the autonomic nervous system; motor function of the respiratory muscles is transferred via the controlling nerve cells in the so-called anterior horn of the spinal cord which are influenced by higher motor brain structures, but at the same time also by the autonomic nervous system, the vegetative control centers of the brain which are working unconsciously, are evolutionary older –or in other words- "deeper". There are more vegetative control centers: the reticular formation and the ascending reticular activation system (ARAS) as a part of the reticular formation, the hypothalamus, the limbic system with its amygdaloid body, the cingulum and the thalamus.

The reticular formation is located in the brain stem, cerebellum and medulla as a "somato-autonomic control point". It is not only a part of the brain, it is an accumulation of nerve cells and axonal-fibers which draw through other brain regions. It is a neuron network that extends

from the brain stem - the medulla oblongata - and extends to the center of the brain. It collects all the sensory information which is available. After a categorization of their importance the information will be forehanded to the cerebrum where they get conscious. But already in the reticular formation all obtained information can cause unconscious behavior. This could be one of the effects of the "Trauma Brain" which is more explained later on: An overflow of information while a trauma happens – sensory overload - cannot be sent to the cerebrum, but is independently processed in the reticular formation followed by bodily and emotional reactions but don't get conscious subsequently. ARAS is an important part of the reticular formation, its function is comparable with something like an "alarm-device" of the brain. And as a part of the reticular formation it cannot already been located, because it's built up of diffuse scattered nerve cells in the space of reticular formation. ARAS sends immediate signals to the consciousness so we can react before we will realize entirely what has happened. For example: When we walk in the woods and see a stick looking like a snake we at once stop walking stand still and fix all body reactions for a little while until we realize entirely that it is only a stick and not a snake. After consciousness we finish "freezing" and walk along. The basic principles are the provision of energy for physical strains by the activation of the sympathetic nervous system and to build-up the energy reserves of the parasympathetic nervous system.

The reticular formation also gets information from the optical system - "it sees", from the trigeminal nucleus - "it feels in the face and mouth", from the acoustic and the vestibular system "it hears" and it knows where is up and where is down and from the proprioceptive and extraceptive sensory system - "it has a body sensation" and a "feeling" for the world (heat/cold, pressure, pain). Within the reticular formation

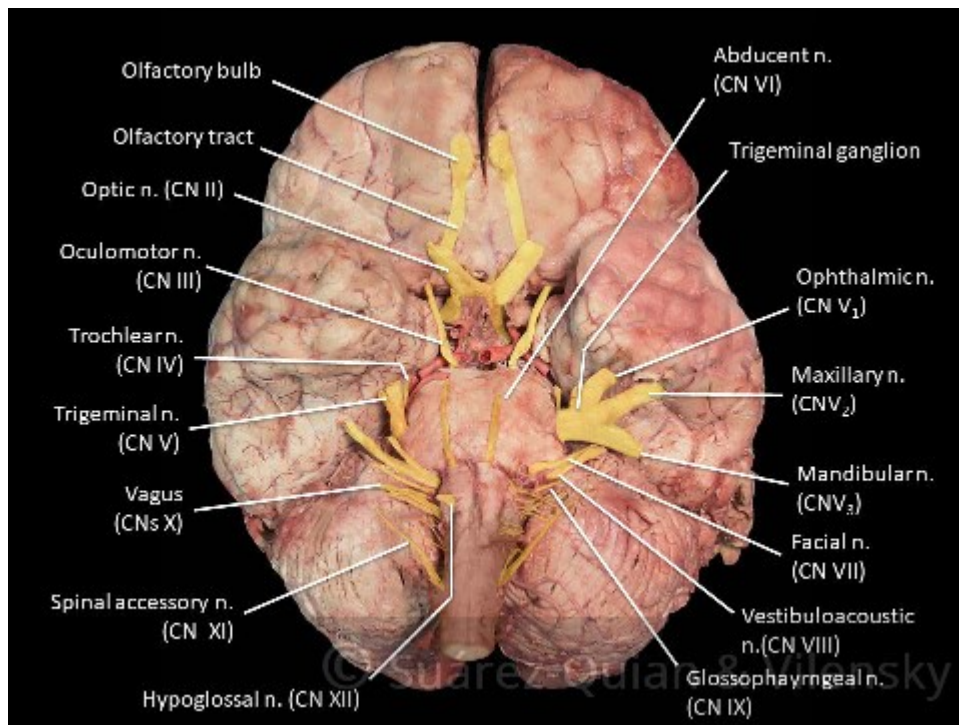
we find three formations of core groups being responsible for the controls and the vegetative functions.

The caudal - rear - group is around the nuclei of the cranial nerves: N. IX = Nervus Glossopharyngeus, responsible for swallowing, N. X = Nervus Vagus, mainly responsible for the activity of the Parasympathetic Nervous System and the regulation of all internal organs and N. XII = Nervus Hypoglossus, responsible for the tongue movements and motoric innervations of the tongue. Here are also located the vegetative individual functions for vascular systems, heart activity, inspiration and expiration, blood pressure, blood pH, as well as the coordination of somatic reflexes while swallowing food or transporting vomitus. The frontal group of the nuclei are N. V = Nervus Trigemini, responsible for sensible innervation of mouth and face and for chewing (N. VII = Nervus Facialis, responsible for facial expressions and N. VIII = Nervus Vestibulocochlearis, responsible for the sense of balance, hearing and the vegetative functions of breathing and circulation. It regulates autonomously the different kind of breathing e.g. while running or in relaxation via vestibular and acoustic spatial orientation and as well during the food intake (suck, lick, chew). The mesencephale- higher - group around the nuclei are N. III = Nervus Oculomotorius and N. IV = Nervus Trochlearis, both responsible for eye movements and eye activities, sensory perceptions of the face, and in series for controlling the vegetative coordination in connection with the optical orientation in space.

Autonomous reticular formation nerve cells are able to do rhythmic excitation; so they are spontaneously active. The cells of the respiratory centers are constantly active and independent. They have a pacemaker function.

Figure 1:
The base of the cerebrum, demonstrating the origin of the cranial

nerves (Source: <http://teachmeanatomy.info/head/cranial-nerves/summary/>).



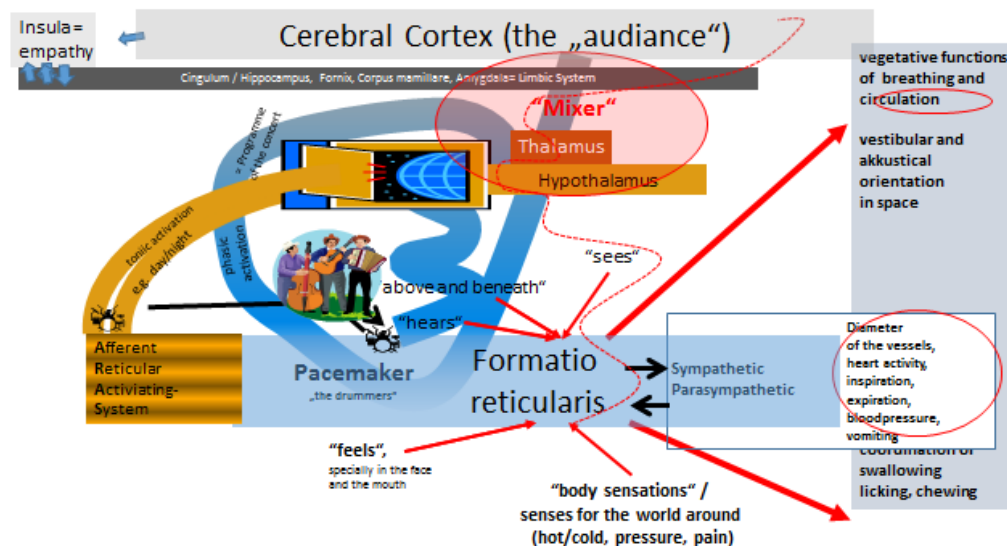
While this pacemaker function in lower vertebrates leads to a rhythmic self-activity of normal breathing, in non-human primates initially there is only a permanent activation. To maintain the respiratory activity other influences are necessary, both from the other vegetative cells as well as from higher brain regions, as described in the functional context.

The other important structure is the ascending reticular activating system autonomous rhythm center (ARAS). This so called brain pacemaker, is also a part of the reticular formation and also developing additional rhythmic activity.

To understand better a metaphor is chosen: If our organs (or better: functional systems) would be a music-band (e.g. the intestine a bass tuba and the stomach a saxophone etc.) the reticular formation would be the drummer who has at its disposal various drums. So far have been discovered two types of activity, a more tonic and a more phasic.

The tonic activation in the midbrain regulates the hypothalamus and thus controls longer rhythms, such as the day-night rhythm. The phasic activation consists in excitation loops which the basal ganglia and the thalamus to the short-term activation of individual areas of the cerebral cortex. These loops lead from the pacemaker neurons in the midbrain to the thalamus and from there in several steps in the diencephalon and back into the thalamus.

Figure 2:
A metaphor: The brain system as a music band
(T. Loew 2017b)



Only having done this loop the unspecific excitations reach the so-called pyramid cells of the cortex of the brain to "inform" the higher centers, for to stay in the metaphor: the audition about the rhythms. But the music will be played in the basement. So the cortex of the brain gets "ears", so it can also feel disturbed or being kindly involved, if the band sometimes performs quieter, sometimes louder, sometimes is playing fast and sometimes slow. That close relationship between the control of breathing and the other vital functions, but also the immediate muscular power development, the perception and mental functions, the sensations and feelings, and on the other hand intensive muscular

activity e.g. to control the viewing and the postural functions of the body which leads to the action oriented interventions in this program of self-stabilization. It is important to understand these interactions of movement, respiration, awareness, vegetative system and cerebral cortex to retrace that e.g. SPB or just a simple prolonged exhaling as used in Functional Relaxation or a movement-pattern like SURE can serve to relieve emotional distress or serve to sedate (Ungerer 1999; T. Loew 2017; Willich u.a. 2004).

A relaxation technique from an archetypic point of view consists in an induction of the so-called relaxation response. In a second step, this reaction is conditioned by practicing the technique. Is a permanent reduction of the biological stress response reached, on the other hand backwards the felt body response after using the relaxation technique could give an conscious access to a before not identified stress-loaded situation.

If focusing on breathing and conscious changing in the rhythm of breathing is possible, leaded via a not yet clarified way to a modulation of the phasic activity of the ARAS it changes the rhythmic activation of the cerebral cortex. These changing of rhythms are basically measurable in EEG activities (Ahani et al., 2014). Concluded: The breathing rhythm, performed in a conscious way can change the autonomic nervous system and in series the EEG patterns; especially done via SPB (4 seconds inhaling and 6 seconds exhaling about 3 to 5 minutes) the rhythm of breathing is found overlaying the EEG alpha waves. The alpha waves come to the fore when we are in alert relaxation or meditation (Hinterberger u.a. 2014). Starting with a conscious respiration pattern or a movement like SURE via descending paths the reticular formation will be modulated in a way that parasympathetic functions dominate: The heart rhythm and respiratory

rate slow down and the vessels will widen (Schmidt et al., 2017; T. Loew, Leinberger, and Hinterberger 2017).

Coming back to the music band metaphor: Depending on the impressions the audience has, in which the mood, the concert, is received, the musicians will get a feedback. In this way, the psychological effects of the relaxation response (change in the thinking and feeling) through the modulation of the "bias" – the ideas people have, when they feel their bodies or emotions - of the cerebral cortex, as well as the relaxation of skeletal muscles, will influence the biological reactions again and so on. The control loops are not clarified in detail, but the effects on the target organs are described sufficiently. Also the effects of the conditioning by repeated practice are, in principle, clear; a proliferation of synapses on the neurons can be shown. How this is happening in particular: In which regions and by which kind of relaxation technique the conditioning and the increasing of the numbers of synapses work best, is not known yet. The function of the neurophysiological cerebral control circuits is also due to the different concentrations of neurotransmitters and their receptors determining the modulation of sensitivity. Since the control of the relaxation response many brain structures are involved, it is unlikely that studies -e.g. fMRI studies - can prove a localized increase in volume, such it is well established for cognitive conditioning processes.

It's a common wisdom that deep breathing is an immediate help for self-regulation in fright or emergency situations in conjunction with high expressed emotions. Also in the case of a co-morbidity SPB may reduce fears as shown in a study with adult asthma patients, having learned breathing exercises 6 months later got a reduction in their asthma symptoms, an increase in the quality of life and a reduction of anxiety and depression scores (Bruton and Thomas 2011). So SPB is often integrated in relaxation techniques, sometimes in the form of a

direct instruction or practical advice, sometimes indirectly due to the general sedation in the context of techniques like autogenic training or meditation or yoga exercises. For the demands in this project lowering of the respiratory frequency to 6 breaths per minute over several minutes is meaningful, with demonstrable physiological effects: The Traumahelpers practice slow paced breathing (SPB) to regulate themselves. While SPB they lower their blood pressure, increase the baroreceptor sensitivity, decrease the carbonic acid levels in the blood, and increase the chemo-receptor sensitivity. Via the so called mirror neurons the same effect as illustrated before in SURE and practicing the “lying eight” – the children relax unconsciously automatically together with the Traumahelpers which practice that self-regulation exercises. Additionally the children sing a special song at the beginning and at the end of the Sandplay-session which includes the rhythm of SPB, inhaling 4 seconds and exhaling six seconds. So they are able to calm down when the session starts to give them the chance to take part in a maximized concentrated way. As well they should go home after the therapy session in a calm and self-focused way without excitement or fear, because of singing the song again as a finishing ritual.

C...Stands for the Six Cognitive Components of Traumatherapy

Traumahelpers have many things to know and it's clear that they can't get all the information needed within a two day structured course. But believing that they as interested adults will take their responsibility and broaden and deepen their knowledge by self-instruction. Therefore they get a collection of scientific papers, public videos from open-available media library and further material used and developed for this concept. Another way to ease the gain of information was to develop acronyms or simple mnemotechnical hints or as alliterations created rows like the following six “C”s.

1. **Composed:** Means the conception consists in different elements. The leading construction is the change of the point of view. Having received the opportunity to play along the child is encouraged to slip into different roles and test different scenarios. The Sandplay-session is synonymous to a psychotherapy session where all participants are in conversation or dialogue. The Sandplay is the possibility to get in contact, to inform without words and to “tell” face-to-face the individual story. Not to talk allows the child to focus all concentration on itself without deviations and not – as for children usual – to lead the point on what the adults want, because usually children want to please to adults and be aware of the emotional needs of their company which is not the desired effect. Composed also implies a timeline: Starting with a common ritual, followed by individual Sandplay in the group to improve the sense of coherence (T. Loew 2017; Antônôvsqî and Franke 1997) to develop self-efficacy strategies to feel and to control emotional over-flooding, to reduce the individual stress levels and to reprocess the bad experiences (Hall, Barden, and Conley 2014; Kalff 2000; Shapiro 2018).
2. **Common** stands for the group procedure and the “tridem”- (tandem for three persons) structure: Traumahelper - child - psychotherapist.
3. **Companion:** Is the child not forced from outside to jump into and through the scenes played, the change of perspective can be emotionally worked up and be integrated; the child has its companion, the Traumahelper, it is not alone. Moreover the Traumahelper can assist in moments when self-regulation could help but the child isn’t able to have the control by itself. The second reason of companion is the role of a witness

Traumahelpers have. As we know very well in the trauma psychotherapy the patients are looking for witnesses to reflect their own apperceptions according to the traumatized situation. They often can't believe by themselves what has happened so they need a trusted party they can show their emotions and impressions to the trauma without any doubt.

4. Coordination: Changes of perspective becomes more probable. This is achieved by control of the process, a planned, coordinated and structured prospective stepwise approach whereas the child can concentrate on the most important aspect, if it is not sidetracked. The group therapy always begins with a ritualized song, followed by about fifteen minutes Sandplay - session, interrupted by the already mentioned bilateral and kinesiological technique of the "lying-eight", followed by the second Sandplay-session about ten minutes and ending with the same song they sang at the beginning. This structure helps to feel safe and orientated, gives self-confidence ("I know what happens, so I feel safe and comfort") and self-esteem ("I am valuable"), allows the child to have an overview (self-control) and at least action replay allows brain conditioning what we need to give the self-regulation techniques the chance to get called up in emergency situations like trauma confrontation or, outside of therapy-session, in intrusions, flashbacks or in sudden emotional over-flooding situations.
5. Comparison: In addition the impact of event and the symptoms are measured, the processes of the children can be compared with others and the treatment effects can be calculated and discussed with other approaches.

6. Calculation: For that we use intercultural assessments which are established in the psychotherapy work with migrants and refugees also in other places around the world. First of all we measure the PTSD-Index and mental stress score with different assessments which are tried and tested in several war-traumatized children. This is amongst others the “UCLA” (The University of California at Los Angeles post-traumatic stress disorder reaction index). The UCLA “reports on psychometric properties for the PTSD index have shown high test-retest reliability and validity, with no significant differences in scores between racial/ethnic groups” (Ellis et al., 2006; Steinberg et al., 2013). Screening results from the UCLA-Index “...are consistent with the results from other PTSD symptom instruments (PTSD Checklist, PTSD Symptom Scale, and Harvard Trauma Questionnaire...” (Elhai et al., 2013). The UCLA –Inventory asks first trauma experiences people can have. Then follows a list of 13 behavioral patterns people could show directly after the traumatic experience and – important for the diagnose PTSD – a list of 20 symptoms according to the PTSD symptoms referred to DSM V (Diagnostic and Statistical Manual of Mental Disorders) (Falkai et al., 2015; American Psychiatric Association 2013) which allows a reliable rating of the level of disease. Another assessment is the *Impact of Event Scale* which enables to verify the severity of PTSD (Rosner and Hagl 2008). In this conception we use the Impact of Event Scale for Children, called *CRIES*, an adopted version of the Impact of Event Scale, especially for this age group which is often used for measuring children after traumatic experiences (Dyregrov, Kuterovac and Barath 1996; Kuterovac, Dyregrov and Stuvland 1994; Smith et al., 2002; Yule 1992; Sean Perrin, Meiser-Stedman and Smith 2005).

Table 1

The First Page of the translated UCLA in Arabic (Prof. Dr. Thomas Loew, Abteilung für Psychosomatik, Universitätsklinikum Regensburg / Dept. of Psychosomatics, Regensburg, University-Hospital, Germany), see appendix

استبيان

الاسم : _____
العمر : _____
الصف : _____
المعلم : _____

التاريخ : _____
الجنس : ذكر / أنثى
المدرسة : _____
المدينة : _____

في الأسفل مجموعة من الحوادث والأشياء الصعبة التي يمكن ان يتعرض لها النسان في حياته ، في تعرضك للحادثة الرجاء الإجابة بنعم وان لم تتعرض لها فاجب بلا .

Name _____ Datum _____ Alter _____ Geschlecht: Weiblich () Männlich ()

Schulklasse _____ Schule _____ Lehrer _____ Stadt _____

Unten aufgeführt ist eine Liste von SEHR ERSCHRECKENDEN, GEFÄHRLICHEN ODER GEWALTSAMEN Dingen, die manchmal Menschen passieren. Dies sind Situationen, bei denen jemand SEHR SCHWER VERLETZT ODER GETÖTET wurde, oder dies beinahe geschehen wäre. Es gibt Menschen, die diese Erfahrung gemacht haben, andere nicht. Bitte sei ehrlich wenn Du darauf antwortest, ob diese gewaltsamen Dinge Dir passiert sind, oder nicht.
Für jede Frage: Kreuze „Ja“ an, wenn dir diese erschreckende Sache Dir passiert ist.
Kreuze „Nein“ an, wenn Dir das **nicht** passiert ist.

© Prof. Dr. Thomas Loew, Abteilung für Psychosomatik, Universitätsklinikum Regensburg / Dept. of Psychosomatics, Regensburg, University-Hospital, Germany

Table 2

Impact of Event Scale-Children Revised Edition in Arabic
(<http://www.childrenandwar.org/measures/children%E2%80%99s-revised-impact-of-event-scale-8-%E2%80%93-cries-8/>) – see also appendix

Children's Impact of Event Scale
CRIS-8
مقياس تأثير الحدث للأطفال - 8
ترجمة : د. نعمان سريخان طي

الاسم : _____
التاريخ : _____

هذه قائمة بأستجابات أناس تعرضوا إلى أحداث مكررة . الرجاء قراءتها ونكر مدى تكرارها خلال الـ ١٤ يوم الماضية.ضع علامة (صح) أمام الإجابة المناسبة.أما في حالة عدم حدوثها فالرجاء أن تضع علامة صح في حقل أبدا

	أبدا	نادرا	أحيانا	غالبا
1. ما تفكر بالأمر حتى لو لم تقصد أن تفعل ؟				
2. هل تحاول أن تسحوا من ذاكرتك ؟				
3. هل تتذكر موجات من المشاعر الشديدة حول هذه الحادثة ؟				
4. هل تبقى بعيدا عما يذكرك بها (مثل الأماكن أو المواقف) ؟				
5. هل تحاول تجنب الحديث عن الحادث ؟				
6. هل تتر صور الحادثة إلى مخيلتك من حين لآخر ؟				
7. هل حاولت أن تشرح ما حدث لغيرك ؟				
8. هل تحاول أن تتعلم عن التفكير بالحادث ؟				

The third assessment is used for screening depressive symptoms because traumatization often is coming along with depression symptoms, sometimes in a lower occurrence but not unusual in a major depression. The assessment is called “Depression Self Rating Scale”, *DSRS*, it was developed by Birleson, already in 1978 (Birleson 1981; Birleson et al., 1987) for children from 8 to 14 years old. It is used for screening children in war situations and translated in about 12 languages by *The Children and War Foundation* (www.childrenandwar.org). In our opinion it also can be used for younger children (parents or caregivers can help to fill in) or adolescents (Ivarsson, Lidberg and Gillberg 1994) and not only after war experiences

Table 3

Depression Self Rating Scale for Children in Arabic Version
(<http://www.childrenandwar.org/measures/depression-self-rating-scale-for-children-birleson/>) – see also appendix

Depression Self-Rating Scale for Children			
الجمال الثقافية تصف شعورك خلال الشهر الماضي . لا يوجد إجابة صحيحة أو خاطئة . من الضروري أن تصف كيف شعرت . الرجاء يمتدق قدر استطاعتك .			
أبداً	أحياناً	غالباً	خلال الشهر الماضي
2	1	0	1. كنت قلق بشأن الأمور بغير ما كنت أفعل سابقاً
2	1	0	2. كان جيد جداً
0	1	2	3. أكثر برغبة في البكاء
2	1	0	4. أحب أن أخرج وألعب
0	1	2	5. أكثر برغبة في الهرب
0	1	2	6. أعاني من أوجاع في المعدة
2	1	0	7. لدي طاقة كثيرة
2	1	0	8. أستمتع بتناول الطعام
2	1	0	9. أستطيع أن أضع عن نفسي
0	1	2	10. أعتقد أن الحياة لا تستحق العيش
2	1	0	11. أجيد ما أكرهه من أعمال
2	1	0	12. أستمتع بالقيام بالأمور بغير ما كنت أفعل
2	1	0	13. أحب التحدث مع أفراد عائلتي
0	1	2	14. أعاني من الأوجاع العروية
0	1	2	15. أكثر بوحدة كبيرة
2	1	0	16. يسهل إدخال الهدية إلي
0	1	2	17. أكثر بوحدة شديدة لا أكاد أقبلها
0	1	2	18. أكثر بهيئاً كبير

Birleson (1981)

D... Stands for Documentation or Diary

Trauma needs testimony. As simple as it is: Traumatized people handle their experiences better by sharing the memories with somebody else. Trauma-therapists know about the impulse of traumatized people to tell repeatedly the experiences. What they additionally know, is that simply telling does not help enough. We also need extra effective trauma techniques. One of them is testimony. For that reason every child gets a diary, a DIN A4 book. Traumahelpers are important witnesses for the traumatized children. The "pictures" children show in the sand are the documents of what has happened to them. The Traumahelpers and the psychotherapists have to recognize and dignify the terror in every phase of the Sandplay-session so the child can be sure that the scene and itself has been seen by somebody else. It is helpful to deepen the dignity by keeping photographs of the Sandplay scenes in a diary. The children feel valued and they also like to take a look on their Sandplay pictures from past Sandplay sessions which the Traumahelpers recorded with their smartphones or cameras and stuck into the child's diary. Additionally the children add drawings into their diaries, sometimes in relation to the played scenarios, sometimes not. Both is possible, drawing is similar effective to Sandplay, just another creative method which can help therefore to support the change of perspective by using drawing as a known neurophysiological effective mechanism in trauma-psychotherapy. Over and above the drawn "lying eights" can sequentially be glued in the diary so the child has every work collected in its diary. The Traumahelpers support actively their child to keep this diary in a proper manner. During the therapy the booklet stays with the Traumahelper and can also be used for supervision. When the therapy is finished after some months in the last session it will be handed out to the children in a final ritual. Due to the fact that it is composed by the child and the Traumahelper the diary works as a symbol for the shared

process in the Sandplay-therapy and it could work as a concrete memory support or as a transitional object.

Picture 1

An example of a diary
(Leinberger, private)



Picture 2

A look into the diary of a five-year-old boy from Syria
(Leinberger, private)



Of course the assessments described before are another important type of documentation. The psychological testing before and after the therapy allows quality assurance and evaluation. Each unit is fully

E... Stands for Emotions

Emotions play a key role in overcoming trauma situations. Normally emotions have a signal function to range unknown information coming up from the own body or from outside advising real danger or uprising interpersonal problems. Relevant experiences get generally connected with the adapted emotion to catalyze reactions or start coping patterns. In a traumatic situation the amygdala regulates into high activity firing many neurons: The alarm system of the brain reacts immediately; we need that first line reaction in worst case situations to save our lives. While the amygdala is in a highly activated state the brain connects in the first instance with the brain stem which instinctively offers four main possibilities to handle stressful and life-threatening situations: fright, fight, flight or freeze. These reactions are even very common not only in the traumatic situation but also in the trauma-therapy sessions, because psychotherapists can observe them months or years later in their patients because it remains as a continues vital element in their behavior pattern (Malivoire et al., 2018; Akiki et al., 2017). That subsequently makes their life and interpersonal environment exhausting, stressful and –if there is no way out – it has morbid consequences like hypertension, a reduction in heart rate variability, high blood levels of cortisol and, recently known, even on the cellular level, a reduced length of the telomeres, special structures at both ends of the chromosomes (Kim et al., 2017; Li et al., 2017; Solomon et al., 2017; Roberts et al., 2017; Boks et al., 2015; Fudim et al., 2018; Husky, Mazure, and Kovess-Masfety 2018; Howard et al., 2018; Donadon, Martin-Santos and Osório 2018; Dajani et al., 2018) and also in brain structures as hippocampus and amygdala, where we can see via structural magnetic resonance tomography (fMRT) chronic abnormalities localized on the right side which could explain the less

emotional modulation traumatized people often have, see figure 3 and figure 4.

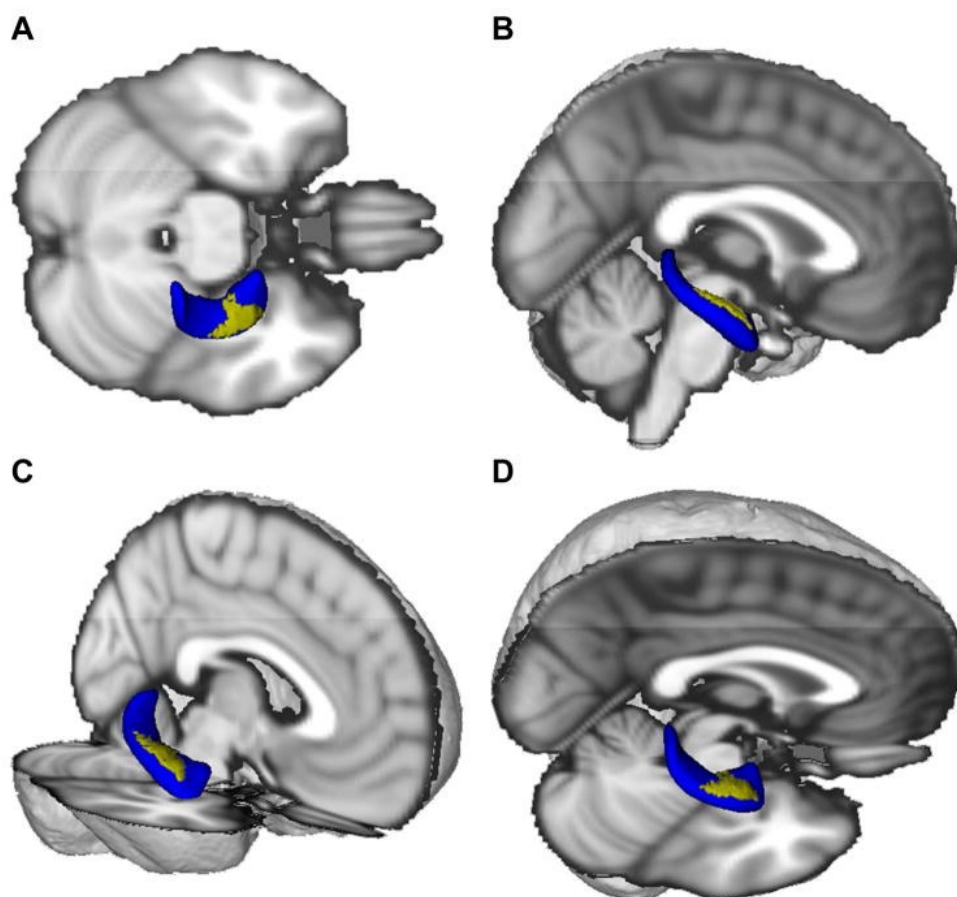
Traumatized patients can't integrate the biographical memory of the traumatic situations together with the emotions. Instead of that they start more or less to dissociate beside reacting aggressively or fighting, flying, being obviously frightening or freezing. This is caused in simple words by an emergency-disconnection of the hippocampus and the amygdala which creates fear memories in flashbacks on aversive stimuli: "When context is associated with an aversive stimulus, a permanent contextual fear memory is formed. Context is hypothesized to greatly influence the treatability of various fear-based pathologies, in particular, post-traumatic stress disorder (PTSD).

In order to understand how contextual fear memories are encoded and impact underlying fear pathology, delineation of the underlying neural circuitry of contextual fear memory consolidation and maintenance is essential. Past understandings of contextual fear suggest that the hippocampus only creates a unitary, or single, representation of context. This representation is sent to the amygdala, which creates the associative contextual fear memory (Chaaya, Battle and Johnson 2018). Additional deeper brain regions in the brain stem where the instincts are located ("reptile brain") are activated so that a traumatized person reacts spontaneously according to the momentarily subjective perception which is leaded by the emotion of fear and belief of mortal danger (Baldwin 2013). In the further development so called intrusions, rising past cognitions and memories related to the trauma experience, block the present cognitions and acting possibilities and flashbacks, nightmares of the trauma-event, brooding, cycles of thoughts, particular amnesia and avoidance behavior are regarding the traumatic situation. Strong emotions can occur at the same time, as well as dissociations.

In the therapeutic situation although reprocessed in “slow motion” either the strong feelings either dissociative symptoms can occur.

Figure 3:

Localized Right Hippocampus Abnormality Three-dimensional (3D) depiction (blue) of the right hippocampus showing the location of the indentation (yellow) in participants with severe PTSD symptoms. Standard brain added to aid visualization. Superior (A), lateral (B), anterolateral (C), superolateral (D) views (Malivoire et al., 2018).



The most effective formula either in dissociative states in real live and in regulating affective overreactions in therapeutic situations is a dosed Bilateral Stimulation. To make it clearer: That means a forced afferent and/or efferent nerve stimulation, for example by movements, of both halves of the brain. Mostly known since more than 20 years is EMDR

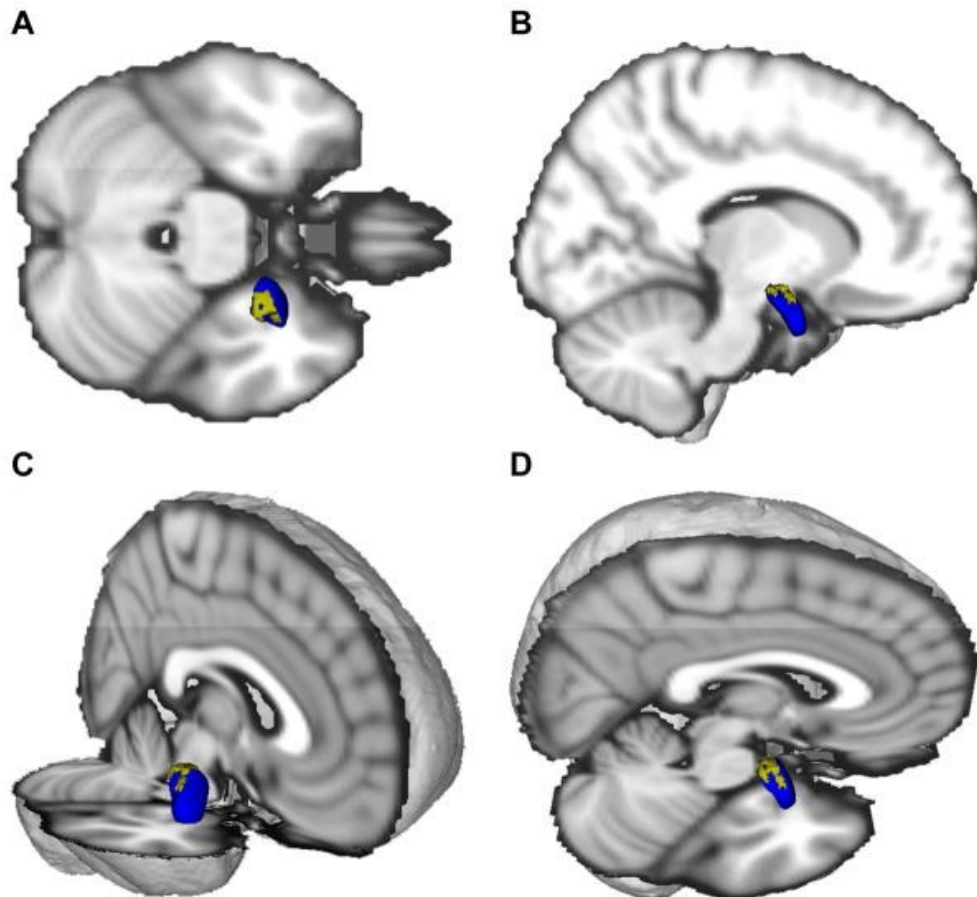
(Eye Movement Desensitization and Reprocessing) (Chen et al., 2014; Ostacoli et al., 2018; Zepeda Méndez et al., 2018; González, Del Río-Casanova and Justo-Alonso 2017) or “Butterfly Tapping” as an intensely Bilateral Stimulation technique by cross-clapping the arms (Pagani u. a. 2017; A. Hofmann und Barre 2014; Shapiro 2018). Eye Movement Desensitization is a very intensive stimulation: via left-right activation of the oculomotoric muscles and – more important - the activation of the motoric nerve cells left and right from the sagittalis line in the middle of the brain stem as described before. If the Bilateral Stimulation of the eyes with the help of finger movements for various reasons is not possible – maybe because of an eye surgery, epileptic disease or wearing eye glasses, the rhythmic “Butterfly-Tapping” or self-tapping on the patient’s knees seems similar effective (Nakatani u.a. 2009).

While playing in the sand emotions can overflow, in this case Traumahelpers are needed to stimulate the children as described before, because even SURE and the “lying-eight” are techniques to stimulate bilateral. In the Sandplay situation reciprocally touching the shoulders of the children left and right from the neck in a comfortable frequency to help the child calm down and play along.

When traumatized people slip into past pictures, cognitions, emotions and/or body sensations they easily can develop dissociative phenomena as drifting away with alertness up to non-responsiveness to any other person (clinically called “Dissociative Phenomenons”). Often you can see e.g. “twisted pupils”, “fixed pupils”, “closed eyes”, “flittering eyelids” or “wide opened eyes” or in a worse case losing consciousness.

Figure 4:

Localized Right Amygdala Abnormality Three-dimensional (3D) depiction (blue) of the right amygdala showing the location of the indentation (yellow) in participants with severe PTSD symptoms. Standard brain added to aid visualization. Superior (A), lateral (B), anterolateral (C), superolateral (D) views (Malivoire et al., 2018).



If this happens the therapeutic process must be interrupted. It's a sign of excessive need. The patient must immediately but calm and circumspectly be fetched back into the here and now – into consciousness - and be stabilized by the psychotherapist.

For that the psychotherapist uses the common methods and skills as described in many therapy manuals: e.g.

- speak to the child loud and clear,
- call the name,
- stand up together with the child and walk along in the room for a little while,
- clap the hands together with the child,
- lead the child to clap itself along the arms and legs (as you can see also in the concept of Bilateral Stimulation some lines before (Wieland, Brisch, and Lutz 2014; Brunner 2012))

If needed, repeatedly up to the moment, that the therapist is sure, that the dissociative state is getting interrupted. Sometimes it leads to a short sleep of exhaustion. In these situations the persons should be left sleeping until they rise by themselves, but companied during this time; they feel the reassuring presence of another person unconsciously while they sleep.

Summarizing: Dissociation phenomena can be prevented by SURE, Slow Paced Breathing, "lying-eight" and Bilateral Stimulation, but the techniques are also possibilities to interrupt them. After a dissociation the patient should not brought again in the stressful reminding process, it is better to continue to stabilize. For the detection of dissociative phenomena and a professional handling as well as a stable discharge from the therapy hour the present psychotherapist is responsible (Leinberger and Loew 2016; Leinberger and Schwibach 2017; T. Loew, Leinberger, and Hinterberger 2017; T. Loew 2016; T. H. Loew and Kutz 2010). Patients are often not aware of this situation and must be

supported as mentioned through another trust person. Retrospectively, patients usually have no memory of these dissociative moments.

Table 5
Clinical Signs of Dissociation (Remschmidt et. al., 2017)

Clinical signs of Dissociation	
F44.0	Dissociative Amnesia
F44.1	Dissociative Fugue
F44.2	Dissociative Stupor
F44.3	Trance and Obsession
F44.4	Dissociative Motor Disorders
F44.5	Dissociative Convulsions
F44.6	<u>Dissociative Anaesthesia</u> and Sensory Loss
F44.7	Mixed Dissociative (Conversion) Disorders
F44.8	Other Dissociative (Conversion) Disorders
F44.80	Ganser-Syndrome
F44.81	Dissociative Personality Disorder
F44.82	Transient Dissociative (Conversion) Disorders occurring in Childhood and Adolescents
F44.9	– Dissociative Disorders (Conversion) not otherwise specified

Table 6
Classification of Dissociative Phenomena DSM V (American Psychiatric Association 2013; Falkai u.a. 2015)

Classification DSM V	
300.12 (F44.0)	Dissociative Amnesia
300.13 (F44.1)	Dissociative Fugue
300.14 (F44.81)	Dissociative Identity Disorder
300.6 (F48.1)	Depersonalization Disorder
300.15 (F44.9)	not otherwise specified Dissociative Disorder

Emotions are required within the reprocessing and to activate them is one purpose desired. To perceive, to feel and to act out emotions can support the healing process and - if possible - should not be stopped. It is important to ensure that the patient remains responsive and deflectable and not get into dissociation. If support should be necessary the present psychotherapist intervenes to improve the experiences of the Traumahelpers in dealing with his fosterling to develop more security within the progress for all involved people.

It can happen that there is subjectively no perceived improvement within one session. This is not considered to be a failure. Sometimes more sessions are needed to reprocess effectively.

The child still has the opportunity in the following hours to progress the work with the stressful trauma sequences. Sometimes it is necessary for it to start with a different situation, in order to be able to classify the first event as less stressful. A not finished work on a stressful event should be then interrupted, the session is to complete with a recall of a positive image supported by tapping, practicing the lying-eight or with the ritual "action song" Aramsamsam, which combines all self-regulation techniques, as mentioned.

Our program is designed in such a way that lay helpers can effectively stabilize the children in their context and places where they are normally in contact (schools, kindergarten, asylum home or in family) with the techniques described, so that over-excitation states, dissociation phenomena and concentration problems can be reduced.

F...Stands for Functional Relaxation (FR)

The neuroscience-based method of Functional Relaxation (FR) is located between progressive relaxation, developed by Edmund Jacobson, having in common the active body activation and body-

awareness on the one side, bilateral strategies (E. Hofmann 2012), because both halves of the body-parts are involved reciprocally, and the Autogenic Training on the other side, here in particular with the compound of the induced SPB (J. H. Schultz 2016; Johannes Heinrich Schultz 2003), targeting the reduction of the vegetative stress. In the quintessence it is an integrating method, which in this context is used to support the Traumahelper him or herself, to downregulate uprising stress during the interaction with the child. As a “side-effect” applying Functional Relaxation (FR) can induce also relaxation within the child, because of the reciprocally unconscious communication processes between a relaxing person, here the Traumahelper, and the opposite. FR was developed by Marianne Fuchs (1908-2010; Picture 3) in the 1950ies together with Viktor von Weizsäcker (Picture 4), one of the founders of the psychosomatic medicine. First Marianne Fuchs was accomplished as a gymnastic teacher, in the early twentieth century a common profession, now extinct. Beside she worked in a psychiatric hospital where she could study different mental disorders. After her youngest child, a boy, was born 1942 he felt ill with at that time so called spasmoide bronchitis, in our days most probably asthma. Knowing different ideas about physical and psychological conceptions of causal relations in diseases Marianne Fuchs tried body mind oriented physical treatments on her son. She pushed her two hands under the boy’s back near the thoracic vertebra while the child was lying on the back and therefore on her both opened hands. Softly Marianne Fuchs moved her hands a little bit up and down and back and forth, just to move the kid’s ribs and therefore it’s joints near to the ribs (shoulder, jaw, head). Quickly the asthma attack stopped and the boy felt much better. After that experience she tried that experiment in any asthma attack of her son and every time she had the same success. This was the beginning of Functional Relaxation (Schott 2010; Fuchs 1989). Her book title “Funktionelle Entspannung. Theorie und Praxis einer

organismischen Entspannung über den rhythmisierten Atem” provides information that Functional Relaxation has mainly to do with rhythm and breathing. While people mind their breathing in their own rhythm –and especially the exhalation – together with body sensations which they perceive and describe in their own way called “Subjektive Anatomie” (Uexküll, Fuchs, and Müller-Braunschweig 1997) they come in a state of proprioception, a very deep awareness of its own. Proprioception is also termed as “the sixth sense” which allows us deep sensibility. Information about body sensations like posture, moves or positions are conducted forward along the proprioceptors in the muscles, tendons, ligaments, joints and organs to the cerebellum and cortex where the individual perceptions are processed. Therefore in the hypothalamus the proprioceptors are going to be linked via hormones to the autonomic nervous system which regulates our stress system. In a state of awareness (body mind) what Functional Relaxation is, the proprioception can be felt conscious, the stress regulation system can be affected conscious by the practicing person. All that can be done is to comply with the rules of FR (“Spielregeln der Funktionellen Entspannung”) which are:

1. Every movement do while exhalation
2. Do little movements while exhalation in the joints
3. Few repeats (3x)
4. In sense and awareness (body mind) and with preferable descriptions of the subjective phenomena (“subjective anatomy”)

(Herholz et al., 2009)

Starting with the conscious awareness of the external hold by solid ground under the feet, a stable wall or a rest in the back or a solid sit on mediates using the proprioception security in the here and now.

Picture 3

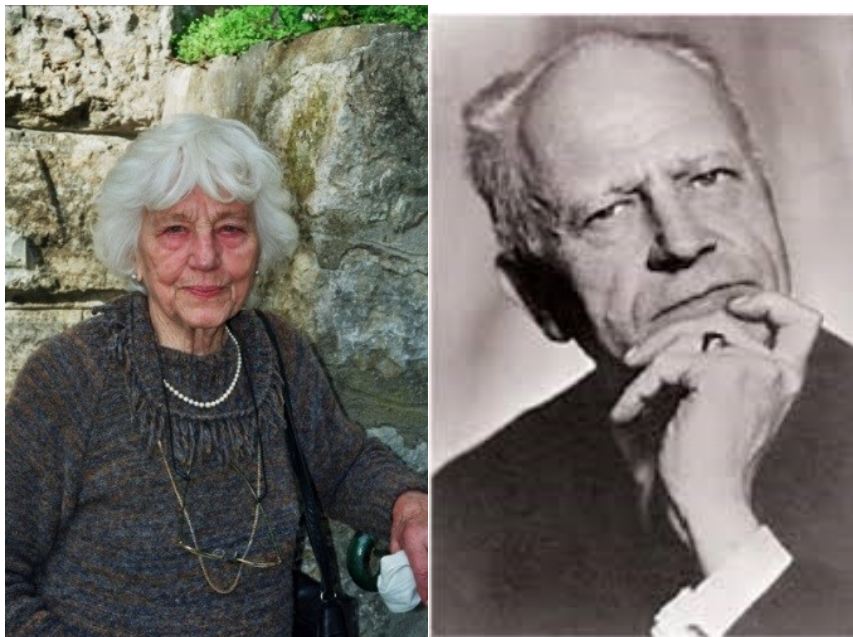
Marianne Fuchs, left side

(Loew, private)

Picture 4

Viktor von Weizsäcker, right side

(Ärzteblatt 2006)



„Im Mittelpunkt...steht der Leib, mit dem der Mensch sich und die Welt erlebt und mit dem er sich in der Welt verhält. Am Atemrhythmus, in seinem Bewegtsein und Sich-Bewegen-Lassen stellt sich der Leib am deutlichsten dar..." (T. Loew 2018).

„In the centre... there is the body, with it man is experiencing himself and the world and with it he or she is acting in the world. By the rhythm of respiring, by moving him- or herself and being moved he or she is presenting most clearly..."

FR consists an awareness oriented, careful approach to the proprioceptive system to feel the individual structures of the own body in a differentiated manner (Fuchs 1989; Herholz et al., 2009). Marianne Fuchs, the inventor of this method, geniusly made the proposals to use small movements to get the special body perception into the conscious and at the same time the associated sensations and to put the perceived into words, with the aim to anchor the sensations coming from the body level and to re-identify them again later more easily in the case of need. From the point of view of the developmental psychology “the feeling, having hold, is created by being hold”...from the baby`s point of perception in the arms of the mother or another attachment figures” as described by one of the pioneers of Functional Relaxation, Sophie Krietsch in “Functional Relaxation strengthens bodily resources, opens ways to body perceptions and self-regulation in form of rhythm and hold giving bodywork, which makes limits perceptible and conveys self-assurance” (von Arnim 2009). Krietsch referred to Donald Winnicott (1896-1971), an English pediatrician and psychoanalyst, who searched in the cases of emotional bonding, emotional deprivation in childhood, emotional development in childhood and the meaning of transitional objects to the psychological development of children, who described the floor as a hold giving substitute, after experienced the safe hold throughout a reference person, mostly the mother. After 6 to 8 months the child unravels from the mother`s body where it was hold and supported by the nearby of the mother`s body-structures before, while step by step sitting, toddling, standing and finally walking is conquering the solid ground and accepting it as a surrogate for a security landing structure (Winnicott 1992; Krietsch, Sophie 2009). Elucidating the ground that holds, improves confidence in the capacity to hold him or herself and at the same time to be held, to release, to slump and to let loose weight, indulging in him- or herself. Working with the extern hold promotes confidence, self-esteem and encourages the person to expect

oneself or others without preconditions. The inner conviction and the self-image of "I am here with you!" is supported in the setting by the Traumahelper actively with awareness and promoted lovingly and simultaneously to the fostering child. The conqueror of the external spaces (walking in the room with variations of the speed and rhythm, lying in the room) the inner concepts of this important function for orientation can be consciously trained. A safe place in the external space opens leeway for the more freighting and more difficult experiences while exploring the inner spaces of the body. Does the Traumahelper regulate him or herself, there is a high probability that it will be copied unconsciously by the child, too, because of the functional feedback loops, already described, without the need that the child has to do something active or consciously (Bauer 2014).

This is very similar to the processes we observe when a child does learn to speak; even here we find the same kind of unconscious bodily copying. The searching and finding of the own rhythm is a central element of FR. Traumatized children are often oriented at external rhythms and requirements. They very fast pick up the moods of attachment figures in their life and orient themselves on their wishes and needs. The children are far away from their own body sensations and can feel and realize their own needs and rhythms only hardly.

Extern rhythms give safety, trust and allow a limited time partial conscious loss of control. At home this can be repetitive daily structures and rituals, in the therapeutic setting a reliable group with constant participates and repeating temporal structure and a content, as shown and represented in the Sandplay conception. The indirect training of Functional Relaxation can support children in their natural needs for attachment, safety, improvement of self-confidence, hold, orientation and the balance between a developmental space and borders (Grawe 2000; Young, Klosko, and Weishaar 2008) within the contact with the

attachment figure empowering and science-based reduce the perceived stress, anxiety and aggressions and calm down the organism (Bartens, W. 2010; Beate Leinberger und Schwibach 2017).

THE MULTI-TRANSCULTURAL PROBLEMS IN PSYCHOTHERAPY

Migrants usually do not search for help in psychological problems by psychotherapists, psychiatrists or other psychosocial professionals. First they try to help themselves and solve their problems in family ties. So they come often very late when symptoms became manifest or problems in social relations e. g schools, Kindergarten or other child care facilities seem insolvable (Gün 2007). 2016 in Germany about 18,6 Million people were migrants coming from 190 different countries. These were more than 22,5% of the German population (Bundeszentrale für politische Bildung 2018; Destatis.Statistisches Bundesamt 2018). To take care of them is a big challenge for all professionals because of the different languages, cultural differences and the lack of knowledge in medicine treatments on the part of the migrants which often e. g have no idea of psychotherapy. Especially in refugees the number of people with PTSD is very high. The Federal Chamber of Psychological Psychotherapists and Children and Adolescent-Psychotherapists (Bundespsychotherapeutenkammer) estimated 40.000 affected adults and children, 30-40% of them additional suicidal (Lokshin 2016). To treat them is already due to the number hard realizable, because it means a quote of one psychotherapist to seven refugee children and adolescents with full distinctive PTSD symptoms as seen in table 7 and/or acute suicide impulses beneath the lower or otherwise pronounced burdened children and adolescents – the number only can be estimated - which also need the psychotherapist's help. To say it in simple words: Starting from these numbers German psychotherapists could work exclusively with refugee patients for the next few years. For those and because of this the group therapy program introducing Traumahelpers was created.

Table 7
The most common symptoms diagnosed in refugee children and adults with PTSD (Ruf, Schauer, and Elbert 2010; Gäbel et al., 2006).

Most common Symptoms in PTSD in Refugees		
Symptom	Children	Adults
Hyperarousal	57%	75%
Intrusions	55%	70%
Avoidance	52%	73%
Nightmares	49%	43%
Alertness/Trouble	42%	45%
Trauma Affected Body Sensations	39%	60%
Sleep Disorders	35%	63%
Concentration Disorders	28%	55%
Scariness	25%	65%
Flashbacks	22%	53%
Increasing Excitability	16%	40%

Almost all refugees have trauma- experiences as you can see in table 8, they lost important attachment figures, relatives, friends, their home and properties, and their livelihood. They experienced war, torture, imprisonment, terror attacks, maltreatments, rapes and other expressions of force and violence. On the flight they were exposed to freeze, heat, hunger, thirst and lack of medical treatment, they felt no shelter or assurance.

What refugee children experienced mostly (Ruf, Schauer and Elbert 2010; Gäbel et al., 2006) is shown in table 8.

Table 8 also shows, that parents experienced traumatic situations, too. They are heavily burdened as well. The risk for PTSD or other mental disorder caused by their horrible live events is extreme high. In this

case neither they are able to stabilize their own kids enough nor stay as co-therapists in the Sandplay-sessions as mental health parents could do.

Table 8

Trauma-Experiences causing PTSD in Refugees (Ruf, Schauer, und Elbert 2010; Gäbel u.a. 2006)

Trauma-Experiences causing PTSD in Refugees		
Kind of experience	Children	Adults
Witness of crime	41%	70%
Accident	39%	35%
War	38%	35%
Seen dead bodies	25%	58%
Nature disasters	24%	38%
Violence against own person	15%	55%
Rape/Sexual abuse	5%	20%

When the refugees have arrived in Germany, they had to find their way in a strange culture far away from their own lives before. Many of them experienced further aggression and discrimination. They have to handle their difficulties in reside, they often live in „collecting accomodations“ (Sammelunterkünften) with many others from many other countries with many other problems, backgrounds and cultures. They cannot travel along for the next months or years because they have to stay in one place while applying for asylum. They regularly have no permission to work; so they have a lot of time, they cannot use active and positive. They often have no visions for the future and they live permanently in fear because of imminent and threatening deportation even if they stay here over years. Beside the traumatic experiences the kind of living and the lack of future add up to more stress especially in children and

adolescents. Much worse, more than 70% of the refugees are younger than 30 years old (Hauth et al., 2016).

Summarized: Beside the less treated mental ill migrants (10% of migrants receive attention in psychological counseling or psychotherapy treatment) Germany has a plenty of untreated traumatized and otherwise mental ill refugees since 2014. It makes sense to think about and develop concepts for group therapy sessions as this Sandplay-Therapy group treatment concept to multiply the capacities.

REASONS FOR NON VERBAL INTERVENTIONS

The final judgement to the subject of treatment by native speakers was negative (§19 Absatz 1 SGB X hat der Gesetzgeber zudem den Grundsatz aufgestellt, dass die Amtssprache deutsch ist. Urteil vom 6. Februar 2008, Az.: B 6 KA 40/06 R). Consequential refugee or migrant patients have no right to sue for a psychotherapist which speaks their language and what is more not so many psychotherapists in Germany are able to offer treatments in other languages.

In the same final judgement was defined that interpreting is no offer of the health insurance companies (Ärzteblatt 2008). Exemplary is a survey in Bielefeld showing the situation of migrants and the possibilities of intercultural medical management of all medicines and psychotherapists offering medical and therapeutic treatment there. Bielefeld is a German town in the district "Nordrhein Westfalen". It has nearly 350.000 residents (31.12.2016) and every third inhabitant has migration background. These are about 100.000 (30,57%) people (Amt für Integration and interkulturelle Angelegenheiten u.a. 2011). Children and adolescents younger than 18 years old are about 23.000 and 33.000 are younger than 25 years. As table 3 shows. Most of them immigrated from European States as Turkey, Poland, Balkan States, Russia, Greek and Italy. Most of other nations in the year 2010 are African States as Morocco or from Asia like the Republic of China and Sri Lanka. Since refugees came to Germany in a big amount also the numbers of refugees from Syria and Iraq increased in Bielefeld, in 2015 there were 2400 counted? (Reichenbach 2015). So how is the patient-centered care in this languages, especially for psychotherapy?

Table 9

A sample of migrant population and medical care-services

(Arbeitskreis Interkulturelle Frauenberatung, Bielefeld 2009; Amt für Integration und interkulturelle Angelegenheiten et al., 2011)

	Children and adolescent psycho-therapists	Adult psycho-therapists	Other medical professions	Population
Albanian	0	0	1	243
Arab (Iraq, Morocco, Syria)	0	0	1	3.134
Bosnian	0	0	5	799
Bulgarian	0	0	2	191
Chinese	0	0	1	345
English	4	8	78	744
French	2	3	42	214
Greek	0	0	10	2.869
Indonesia	0	0	1	44
Italian	0	0	14	1.151
Kazakh	0	0	1	344
Croatian	0	0	10	917
Malaysian	0	0	1	13
Macedonian	0	0	3	430
Dutch	0	0	5	305
Farsi	0	0	1	227
Polish	0	1	42	1.951
Portuguese	0	0	3	180
Romanian	0	0	8	249
Russian	0	0	95	1.448
Swedish	0	0	2	37
Serbo-Croatian	0	0	6	3.642
Spanish	0	1	16	390
Swahili	0	0	1	70
Tamil	0	0	5	495
Czech	0	0	2	17
Turkish	0	1	78	12.974
Hungarian	0	0	1	95
Complete	6	14	468	33.518

In conclusion: In Bielefeld as an example for a German big town („Bielefeld“ 2018) summarized are six foreign spoken children - and adolescent psychotherapists and summarized 14 adult psychotherapists, half of them only speaking English. So there are 20 foreign language speaking psychotherapists for about 100.000 foreign people. In details e. g. one native speaking psychotherapist for 12.974 Turkish people, no native speaking psychotherapist for 3.642 Serbo-Croatian speaking people, no native speaking psychotherapist for Arabic people and no native speaking psychotherapist for the 2.869 Greek people.

One quarter of the German population suffers from mental illness with medical conditions (Reuben and Schäfer 2017; Robert-Koch-Institut 2018), so in Bielefeld more than 25.000 migrants would need psychotherapist treatment which they only very rarely can get in their native language. Working with an interpreter is almost impossible, because mostly there is no funding for the costs. What is measured for the whole migrant population is the same situation for the refugees, too. The most spoken refugee languages are Arabic, Dari, Farsi, Pashtu, Turkish, Turkish-Kurdish, Syrian-Kurdish, Special Nigerian Languages (altogether about 500 different), Tigrinya (Eritrea), Somali or Kartuli (Georgia). As to be seen in the table 9 less medicals are competent in speaking one of that languages, still less informed about the different cultural rituals, ways of thinking, practices and conventions or handling medical and psychological problems.

Because of this reasons it was extremely necessary to develop a non-verbal functioning psychotherapy concept to offer ways for all of the burdened and under-served migrant children including the refugee kids which are currently the most burdened population.

CLINICAL DIAGNOSTICS

The diagnosis of posttraumatic stress disorder is based on the occurrence of specific symptom patterns in defined temporal contexts, also in the field of pediatric and adolescent psychotherapy. The guidelines according to which the diagnoses are to be referred are called classification systems. The currently most common are the International Classification of Diseases in the 10th revision, shortly (ICD-10) (Remschmidt, Schmidt, und Poustka 2017; Dilling, Schulte-Markwort, und Weltgesundheitsorganisation 2014) and Diagnostic and Statistical Manual for Mental Disorders (DSM V) (American Psychiatric Association 2015).

All symptoms of post-traumatic stress disorder for the appropriate diagnoses in adults are listed in one section. But these do not measure the more extensive behavioral symptoms of children and young people, which is why the existence of PTSD is often overlooked and/or misdiagnosed. The specific symptoms of children and young people were first described and continued by van der Kolk since the late 1990s (Van der Kolk 2000; Van der Kolk, McFarlane, und Weisæth 2007; B. A. van der Kolk u.a. 2009) . These criteria will be applied in this project with children.

In the following tables symptoms of PTSD according to ICD 10 (Remschmidt, Schmidt, und Poustka 2017) are described, then the symptoms according to the DSM V (American Psychiatric Association 2015) and at least the specific children's symptoms are explained (B. A. van der Kolk et al., 2009).

Table 10

Clinical Diagnostics, PTSD-Criteria ICD-10 (F43.1)

Clinical Diagnostics: ICD-10 (F43.1)
The affected was exposed to a stressful event of exceptional threat or exposed to catastrophic amount for a short or a long time which would provoke in everybody almost every time a deep despair
There must be lasting memories of the traumatic experience or the repeated experience of the trauma in re-urging memories (imagines, flashbacks, dreams or nightmares) or an inner distress in situations that are similar or related to the impact.
The affected avoids (in fact or as far as possible) the circumstances similar to the impact.
At least one of the following criteria (1 or 2) is fulfilled:
1 st) A partial or complete inability to recall some important aspects of the stressful experience; or
2 nd) Persistent symptoms of increased psychic sensitivity and excitation, with at least two of the following characteristics fulfilled sleep disturbances increased scariness hypervigilance (an increased attention of all the senses, targeted on everything difficulties in concentration Irritability and outbursts of rage
The symptoms must occur within six months after the stressful event (or the period of the impact)

Table 11
Clinical Diagnostics, PTSD-Criteria DSM V (309.81)

Clinical Diagnostics: DSM V (309.81)	
Criterion A (one required): The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in the following way(s):	Direct exposure
	Witnessing the trauma
	Learning that a relative or close friend was exposed to a trauma
	Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)
Criterion B (one required): The traumatic event is persistently re-experienced, in the following way(s):	Unwanted upsetting memories
	Nightmares
	Flashbacks
	Emotional distress after exposure to traumatic reminders
	Physical reactivity after exposure to traumatic reminders
Criterion C (one required): Avoidance of trauma-related stimuli after the trauma, in the following way(s):	Trauma-related thoughts or feelings
	Trauma-related reminders
Criterion D (two required): Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):	Inability to recall key features of the trauma
	Exaggerated blame of self or others for causing the trauma
	Overly negative thoughts and assumptions about oneself or the world
	Negative affect
	Decreased interest in activities
	Feeling isolated
	Difficulty experiencing positive affect

to be continued...

Criterion E (two required): Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s)	Irritability or aggression
	Risky or destructive behavior
	Hypervigilance
	Heightened startle reaction
	Difficulty concentrating
	Difficulty sleeping
Criterion F (required)	Symptoms last for more than 1 month.
Criterion G (required)	Symptoms create distress or functional impairment (e.g., social, occupational).
Criterion H (required)	Symptoms are not due to medication, substance use, or other illness
Two Specifications	Dissociative Specification. In addition to meeting criteria for diagnosis, an individual experiences high levels of either of the following in reaction to trauma-related stimuli:
	Depersonalization. Experience of being an outside observer of or detached from oneself (e.g., feeling as if "this is not happening to me" or one were in a dream)
	Derealization. Experience of unreality, distance, or distortion (e.g., "things are not real")
Delayed Specification.	Full diagnostic criteria are not met until at least six months after the trauma(s), although onset of symptoms may occur immediately.

Additional Clinical Diagnostics for Children

PTSD and its described symptoms in classification systems as DSM V and ICD 10 is a good definition in adults but it doesn't consider well the spread of PTSD symptoms in children, because children's brains are still developing, trauma as a much more pervasive and long-range influence on their self-concept, on their sense of the world and on their

ability to regulate themselves (B. A. van der Kolk 2003) "Childhood exposure to victimization is prevalent and has been shown to contribute to significant immediate and long-term psychological distress and functional impairment. Children exposed to interpersonal victimization often meet criteria for psychiatric disorders other than posttraumatic stress disorder (PTSD)" (D'Andrea u.a. 2012). To give consideration to children's special possibilities in converting traumatization it is well spoken of "Developmental Trauma Disorder" ("Entwicklungsstraumastörung") (B. A. van der Kolk 2009). Beside the acute PTSD symptoms in the German "Traumafolgekostenstudie" (Habetha 2012) was compiled a series of other harms people can have if they are exposed early traumatization: Depression Disorder, Anxiety Disorder, Personality Disorder, Suicidality, Addictive Disorder, Somatoform Disorders, Behavioral Disorders, Developmental Disorders, Obesity, Diabetes Mellitus, Hypertension, Heart Disease, Chronic Obstructive Lung Disease (COLD), Liver Disease, Fractures as a consequence of traumatization, Nicotine Abuse, Delinquency, Deviant Sex Behavior, Deviant School Carrier. The reason why such a spread of Disease can arise is the disability of the stress regulation system to manage the over-flooding of high stress provoking experiences as described before.

The children related trauma symptoms are very well described in the proposal by Bessel van der Kolk where he plead for including specified trauma criterions into DSM V (B. A. van der Kolk et al., 2009). There was written down what he and his research group experienced and evaluated over years. Unfortunately the criterions weren't placed yet in the Diagnostic System for Mental Disorders (DSM V) what would have given all the professionals working with traumatized children the chance of a diagnose and subsequently would have given the chance for the right treatment.

Table 12

**Clinical Diagnostic Criteria in PTSD Especially to Children
described by Bessel van der Kolk**

Clinical Diagnostic Criteria in PTSD Especially to Children described by Bessel van der Kolk (B. A. van der Kolk u.a. 2009)
<p>A. Exposure. The child or adolescent has experienced or witnessed multiple or prolonged adverse events over a period of at least one year beginning in childhood or early adolescence, including:</p> <ul style="list-style-type: none"> A. 1. Direct experience or witnessing of repeated and severe episodes of interpersonal violence; and A. 2. Significant disruptions of protective caregiving as the result of repeated changes in primary caregiver; repeated separation from the primary caregiver; or exposure to severe and persistent emotional abuse
<p>B. Affective and Physiological Dysregulation. The child exhibits impaired normative developmental competencies related to arousal regulation, including at least two of the following:</p> <ul style="list-style-type: none"> B. 1. Inability to modulate, tolerate, or recover from extreme affect states (e.g., fear, anger, shame), including prolonged and extreme tantrums, or immobilization B. 2. Disturbances in regulation in bodily functions (e.g. persistent disturbances in sleeping, eating, and elimination; over-reactivity or under-reactivity to touch and sounds; disorganization during routine transitions) B. 3. Diminished awareness/dissociation of sensations, emotions and bodily states B. 4. Impaired capacity to describe emotions or bodily states

to be continued...

C. Attentional and Behavioral Dysregulation: The child exhibits impaired normative developmental competencies related to sustained attention, learning, or coping with stress, including at least three of the following:

- C. 1. Preoccupation with threat, or impaired capacity to perceive threat, including misreading of safety and danger cues
- C. 2. Impaired capacity for self-protection, including extreme risk-taking or thrill-seeking
- C. 3. Maladaptive attempts at self-soothing (e.g., rocking and other rhythmical movements, compulsive masturbation)
- C. 4. Habitual (intentional or automatic) or reactive self-harm
- C. 5. Inability to initiate or sustain goal-directed behavior

D. Self and Relational Dysregulation. The child exhibits impaired normative developmental competencies in their sense of personal identity and involvement in relationships, including at least three of the following

- D. 1. Intense preoccupation with safety of the caregiver or other loved ones (including precocious caregiving) or difficulty tolerating reunion with them after separation
- D. 2. Persistent negative sense of self, including self-loathing, helplessness, worthlessness, ineffectiveness, or defectiveness
- D. 3. Extreme and persistent distrust, defiance or lack of reciprocal behavior in close relationships with adults or peers
- D. 4. Reactive physical or verbal aggression toward peers, caregivers, or other adults
- D. 5. Inappropriate (excessive or promiscuous) attempts to get intimate contact (including but not limited to sexual or physical intimacy) or excessive reliance on peers or adults for safety and reassurance
- D. 6. Impaired capacity to regulate empathic arousal as evidenced by lack of empathy for, or intolerance of, expressions of distress of others, or excessive responsiveness to the distress of others

E. Posttraumatic Spectrum Symptoms. The child exhibits at least one symptom in at least two of the three PTSD symptom clusters B, C, & D.

F. Duration of disturbance (symptoms in DTD Criteria B, C, D, and E) at least 6 months.

to be continued...

G. Functional Impairment. The disturbance causes clinically significant distress or impairment in at two of the following areas of functioning:

- Scholastic: under-performance, non-attendance, disciplinary problems, drop-out, failure to complete degree/credential(s), conflict with school personnel, learning disabilities or intellectual impairment that cannot be accounted for by neurological or other factors.
- Familial: conflict, avoidance/passivity, running away, detachment and surrogate replacements, attempts to physically or emotionally hurt family members, non-fulfillment of responsibilities within the family.
- Peer Group: isolation, deviant affiliations, persistent physical or emotional conflict, avoidance/passivity, involvement in violence or unsafe acts, age-inappropriate affiliations or style of interaction.
- Legal: arrests/recidivism, detention, convictions, incarceration, violation of probation or other court orders, increasingly severe offenses, crimes against other persons, disregard or contempt for the law or for conventional moral standards.
- Health: physical illness or problems that cannot be fully accounted for physical injury or degeneration, involving the digestive, neurological (including conversion symptoms and analgesia), sexual, immune, cardiopulmonary, proprioceptive, or sensory systems, or severe headaches (including migraine) or chronic pain or fatigue.
- Vocational (*for youth involved in, seeking or referred for employment, volunteer work or job training*): disinterest in work/vocation, inability to get or keep jobs, persistent conflict with co-workers or supervisors, under-employment in relation to abilities, failure to achieve expectable advancements.

(B. A. van der Kolk et al., 2009)

Young children are exposed to many types of traumatic experiences, placing them at risk for PTSD. These include:

- Abuse
- Witnessing interpersonal violence
- Motor vehicle accidents

- Experiences of natural disasters
- Conditions of war
- Dog bites

Youngest Children's Special Trauma-Symptoms

Beside van der Kolk also Scheeringa evaluated trauma symptoms in children but specialized to preschool age and elementary school age. He especially collected subtypes to the categories "Intrusion", "Avoidance" and "Hyperarousal Symptoms". The allocation we find in the "Children's Impact of Event Scale (CRIES), the assessment used in the Sandplay conception (Scheeringa u.a. 2012, 1995, 2003; De Young, Kenardy, and Cobham 2011; Meiser-Stedman u.a. 2008). Because young children have emerging abstract cognitive and verbal expression capacities, research has shown that the criteria need to be more behaviorally anchored and developmentally sensitive to detect PTSD in preschool children (Scheeringa u.a. 2001, 1995). The criterion that the children's reactions at the time of the traumatic events showed extreme distress has been deleted. If children were too young to verbalize their acute reactions to traumatic experiences, and there were no adults present to witness their reactions, there was no feasible way to know about these reactions. This criterion, which has been shown to lack predictive validity for both adult and preschool populations, has also been deleted for the regular PTSD criteria in DSM-5 (Scheeringa, Zeanah, and Cohen 2011).

Children under six years old mostly do not show intrusive unwanted thoughts as well as elementary school kids which show intrusions a bit more but not as a main symptom. Much more after traumatization they seem neutral to the traumatic situation or "over-bright" (Scheeringa u.a. 2001, 1995), often they show no affect or any sign of agitation.

Nevertheless children showed overtly PTSD symptoms were as well severely affected as children who showed less intrusion symptoms (Scheeringa, Zeanah, and Cohen 2011). Additionally they can of course have symptoms like “flashbacks”, over-flooding of memories and emotions or panic attacks, but often they do not really realize what is happening to them so they just act out, with an “outside vision” it looks like aggressive or hyperarousal behavior or vacant expression with “unseeing eyes” (Krüger 2008).

Beside the described symptoms of avoidance in adults it can also affect children as the assessment “Children’s Impact of Event Scale (CRIES)” gathers. In addition can be observed constricted play, feelings of detachment or estrangement (Scheeringa 2006). Children compensate unbearable intensity with compulsive activity, Dissociations, Denial, Suppression, Regression in former states of development, false interpretation or self-harming behavior. In extreme they have disposition to sensation seeking. In a harmless variety adolescents or adults do bungee jumping, in a more harmful variety as precarious “free climbing” in mountains or on sky scrapers, or, for example, in Germany walking along bridge railings. Young children do the same in other ways. They place also themselves in danger for example in traffic, jumping on the streets, expecting being overrun or not, they jump from giddy heights or climb up high trees knowing about the danger and possibility to hurt themselves or die.

Children cannot describe mental, emotional or body related processes as well as adults can do. So beside showing angry outbursts instead, children also show extreme temper tantrums to handle not explicable emotions and affects. In daily contexts it can be observed as concentration disorders, motor disturbances, inner pent-up tension, sleep disorders compared with terror dreams, lability of affects, impulse control disorders with aggressive and brutal acts (Krüger 2008).

Children cannot change their affective state in a conscious way adults could do. They feel “bad” and they act it out in a hyper-motoric or hypo-motoric way. They also have regulation disturbances as eating disorder (eating only special chosen food like “white things” as yoghurt or noodles; eating lots of fast food and sugared food; or they develop eating disorders as “binge eating”, “bulimia nervosa” or “anorexia nervosa” as classified in ICD-10 or DSM V or at least elimination disorders like enuresis and encopresis. Impulsive out-acting could be caused by over-flooding of sensory input. For traumatized children often things are too loud, too noisy, too bright, too dark, too much smell, too intensive taste which they cannot fade down, block or control. If input is too much another way of symptom could be a suddenly mental drifting away so the child is not responsive for a little while. It’s like a “time-out” for the brain in a chaotic, overloaded and over-flooded situation. To regulate hyperarousal children use to do swinging movements, rhythmic movements or rhythmic hits with body parts or in an extreme way beating the head against the wall or through window panes. They do masturbation in an excessive and self-harming way, they suck intensive one’s thumb or any part of clothes and they occasionally bite their finger- or hand-joints until they bleed (Krüger 2008; Krüger and Reddemann 2012; Weinberg 2013; B. A. van der Kolk 2009).

Additional to all ages of traumatized children can be observed is the changing of personalities in seconds, the children are unable to create future perspectives, they have separation anxiety, desolation anxiety, a negative self-concept, persuasion of worthlessness, less occurrence of self-efficacy and learned helplessness as depressive people also use to have. Furthermore they lose confidence and show reduced empathy, they show lack of emotional detachment or long range of distance, rapid changing constitutional clinical symptoms like headache, stomachache or pain in any region of the body without somatic findings . They could

collect intensive abnormal, useless things and/or they refuse unwaveringly to cut hairs, finger nails or to change clothes for washing them. At least they could have lack of time, amnesia or forgetfulness (Krüger 2008; Krüger and Reddemann 2012; B. van der Kolk, McFarlane, and Weisaeth 2000; Weinberg 2013).

The most important supplements are the child specific typical patterns of behavior, thinking and expression of feelings, adding to the neglect and the change in the duration (ICD-10 = symptom development within the first 6 months, DSM V = duration of symptoms for at least 6 months). The clinical observation shows, that children and young people - and probably also adults – often develop the symptoms not within this period but years after the stressful event based on individual resilience and/or trigger events that occur later.

In the diagnostic context the demarcation to ADHD, fault of social behavior, depression and anxiety disorder must be done properly and carefully in order to avoid a false diagnosis. But this within the responsibility of the professionals. For the interests of the Traumahelpers it is only important to have understood how the disease presents, the diagnoses shouldn't and mustn't be done by Traumahelpers but by psychotherapists. But of course Traumahelpers they should recognize the children with impact.

Especially when a traumatic event (A criterion) is present, a trauma-sequence-disorder must be taken into consideration (B. A. van der Kolk et al., 2009).

Psychological Testing

As already mentioned in chapter “C...Stands for the Six Cognitive Components of Traumatherapy” psychological testing is in order to determine and define a post-traumatic stress disorder and/or depression symptoms. In this conception all assessments are without license fee to use them all over the world and as often as necessary without high costs. The specific impact of PTSD is gathered by the “UCLA Posttraumatic Stress Reaction Index”, developed by a Working Group of the University of California at Los Angeles (UCLA) and can be used in German, English, Arabic, Farsi, Dari and Pashto for children (assessment by parents) adolescents and also possible for adults as self-assessments. In India we didn’t use it only because in the short time we had there was no translation into Telugu available. So the UCLA – Posttraumatic Stress Reaction Index is not part of the results. But at both sites the following tests were operated.

Furthermore the CRIES (“Children's Impact of Event Scale”) can be used additionally, also without a license fee. It is available via download among others in German, English, Arabic and Farsi, Dari, Pashto (Sean Perrin, Meiser-Stedman, and Smith 2005; S. Perrin 2005). In adolescents over the age of 13 years and adults, the IES (“Impact of event scale”) is been used, it is including the same questions, but in other words (Rosner and Hagl 2008). All these assessments will be found in the appendix or most of them as a download on www.gewiss-ev.de

In addition the DSRS (“Depression Self-Rating Scale”) is used with 18 questions, an evaluated instrument for children from 8-14 (due to a lack of alternatives on the basis of language); the advantage is that it can

also be used for adolescents and young adults (Ivarsson, Lidberg, and
Gillberg 1994; Birleson et al., 1987)

INTRODUCING LAY HELPERS, CALLED TRAUMAHHELPERS

Usually lay helpers are volunteers. People who are interested in helping professionals to support them in their daily work. Very common in Germany lay helpers are volunteers in the so called “crisis line” (“Telefonseelsorge”). In a survey 2010 – after 55 years of existence - about 8.529 volunteers were counted working actually in the “crisis line”, at the same time another 997 were in education. The survey showed that most volunteers are in the age between 30 and 59 years old (ca. 55%), mostly women (80%), more than 60% married, more than 50% graduates and another 12% with high school diploma (Abitur) and 24,9% with ordinary level (Mittlere Reife). Altogether a pool of high educated people so that this population is seen as a high qualified, dedicated group with a lot of life experience: a group with stable resources and high quality of life. In this survey also the motivation of volunteering was asked. Most of them declared among others e.g. getting precious experiences, extending skills, personal progress, the wish anything to do for community, to give help, to carry responsibility and the deep persuasion that without volunteers many projects and help doesn't function. The qualification of “crisis line” ensued by a 120h tutorial with supervision every two or four weeks. The difference between volunteers in “crisis lines” and our Traumahelpers is that our Traumahelpers never act alone, they work always beside the group therapist so they do not need as much tutorial before. Most of what they learn in theory they implement at once in the Sandplay-sessions and give directly support after every therapy session to the psychotherapist which offers obligatory and committing supervision to the Traumahelpers directly after the therapy sessions to clarify open questions and deepen knowledge and skills. The Traumahelpers learn by doing and getting advices from the psychotherapist during all therapy sessions. Lay helpers in “crisis lines” have to do their job completely autonomous and independent. In their work they are confronted with

critical situations like suicidality, victimization or several mental disorders. They have to stabilize the caller, give him hope and future perspective and they have to encourage or try to find out useful solutions for the problems for that was called. Altogether the lay-helpers have to have a lot of mental stability, empathy and stabilization and talking skills to help in the necessary way. In our concept this is consequently proved by special assessments (resources, life quality and secondary traumatization). Another interesting result of the survey is the question of satisfaction. Being a volunteer less than 30 hours per month makes satisfied (more than 90%), more time makes them discontented. In the Traumahelper concept is propagated 2h a week about altogether 10 weeks. This is a realizable commitment which works and prevents dissatisfaction and drop out. What does volunteers need as a recognition? In the survey most of them indicated supervision, education, teamwork with professionals and professional support before financial benefits Germans often can get by being volunteer (Evangelische Konferenz für u.a. 2011). The “crisis line” is not the only example for involving volunteers into social or medical professional work. Mainly they are used as connector between professional and patient e.g. in penal system (Cyrus 1982), pedagogical system (Gerlicher, Bebber, and Stockhammer 1979) or crisis intervention in disaster situations as nature disasters like the flood in Simbach am Inn/Germany in 2016 (Beate Leinberger und Loew 2016) or traffic disasters as the train accident in Eschede / Germany in 1998 or the mine disaster in Borken/Germany 1998 (Schüffel et al., 1998). What is clear is that our rules accept the more lay-helpers the more disastrous and confused a strong situation is. But lay-helpers could also give support in less disastrous situations as another survey from Ghana shows: pregnant women were asked if they would rather accept a lay companion while delivery or not. 58% of them issued desire of lay companion mostly with intention of social support, emotional support,

“witnessing the pain” (Alexander et al., 2014). Involving lay counselors (lay helpers) in helping traumatized people was implemented in Vanni/Sri Lanka after the terror against civil Tamils in 1996 or after Tsunami in 2004 (Saveripillai and Schuetz-Mueller 2014). Another positive effect involving lay counselors is described in a review where different trauma therapy projects were evaluated including NET (Narrative Exposure Therapy) and KIDNET (Narrative Exposure Therapy for Children) applied on refugees in Asia and Africa (Gwozdziewicz and Mehl-Madrona 2013).

In case of refugee children there is the need of indispensable elements of social and emotional support to calm down and feel safe as well as having a witness for terror experiences they have had. Furthermore people at all need attachment figures to live their lives in a comfort mental state of health. Often the reason for mental illness is a lack of positive family systems or relationships. Especially traumatized people, which experienced “man-made terror”, lost their faith in others. Recognizing that traumatized children – for example the refugee children – survived horrible situations, often lost their relatives and at least lost their home countries, arrived in a new setting with complete different culture accompanied by high burdened parents or relatives which are less able to care for their children. These children need alternative attachment figures to stabilize, give trust and faith, orientation safety in a doubtful living situation. This attachment figure could be the Traumahelper. She or he (mostly women) stands beside the child in every minute of the group therapy to give the positive support above described. Every Traumahelper is like a “god parent” for one child over the three months, the group sessions last. She or he attends the child through the therapy process: She or he gives self-confidence and self-esteem with positive reactions in mimics, gestures and words, she or he is the witness for the terror scenes the child

shows in the Sandplay, he mediates self-confidence, stabilization and good future prospects in a safe space. The Traumahelper is the principal supporter to the psychotherapist, who has to lead the group session. Often the different roles of Traumahelpers and psychotherapists are not well and clear enough understood, so first of all, the formal starting point is to clarify: The term psychotherapy or psychotherapist in Germany is protected by law since 16.06.1998 and defined („Gesetz über die Berufe des Psychologischen Psychotherapeuten und des Kinder- und Jugendlichenpsychotherapeuten (Psychotherapeutengesetz - PsychThG)“ 1998). According to this only psychological and medical psychotherapists as well as child and adolescent psychotherapists can call themselves this way only when they absolved an approved training in subject to the regulations of psychotherapy methods like behavior therapy or psychodynamic psychotherapy. In the best way these psychotherapists have additional qualifications in special methods like trauma- or family therapy or something else. In the world of psychotherapy the definition of trauma therapist at that point abbreviates not precisely: In the best case, these are approbated psychotherapists in the sense above with an additional special expertise in the diagnosis and treatment of patients with mental disorders or psychosomatic disturbances as a result of a traumatization.

Only in the last few years in the German scene of psychotherapists took place a rethinking from a "school"-oriented, i.e. from a variety of psychotherapists recognized procedure, the treatments developed in the direction to pragmatic proceedings - adjusted over the years through learning by doing from various methods - but usually have not been empirically proven, mostly compound eclectic combinations of different therapy techniques increasingly toward an evidence-based approach, for example, as the most prominent representative (Krüger

and Reddemann 2012) or others (Landolt and Hensel 2012; Foa, Chrestman, and Gilboa-Schechtman 2016; Weinberg 2013).

Here also the "Path of Regensburg" ("Regensburger Weg") is to place, respectively the projects of the medical and non-medical child and adolescent psychotherapists which use this treatment approach in other regions and countries. It would be justified via the methods now used as a starting point - at the moment not protected by law - the name: "trauma psychotherapist"; this corresponds in principle to the current efforts of the federal chamber of psychological psychotherapists and child and adolescent psychotherapists, which now has brought a specific training curriculum on the way (Bundespsychotherapeutenkammer 2016). As with many other mental disorders also the topic of psychological trauma is dealing with people who suffer from such diseases, not limited to the therapeutic situation in the narrow sense: for example, children who have lived through such a trauma and clinically relevant symptoms show them not only in the treatment situation, but at the same time even in other living settings, e.g. in school, in the caregiving institutions or in the family. The symptoms are of course not limited to the therapy session, but can also be seen in everyday life and in the classroom. That's why it makes sense to qualify educators, caregivers and related professional groups as Traumahelpers, for example in specifically designed trainings to improve the handling of these traumatized children as shown in this program. In this case, it appears justified to speak of "trauma-educators which are specifically qualified to handle traumatization in educational or caregiving situations as basically as a stabilizer.

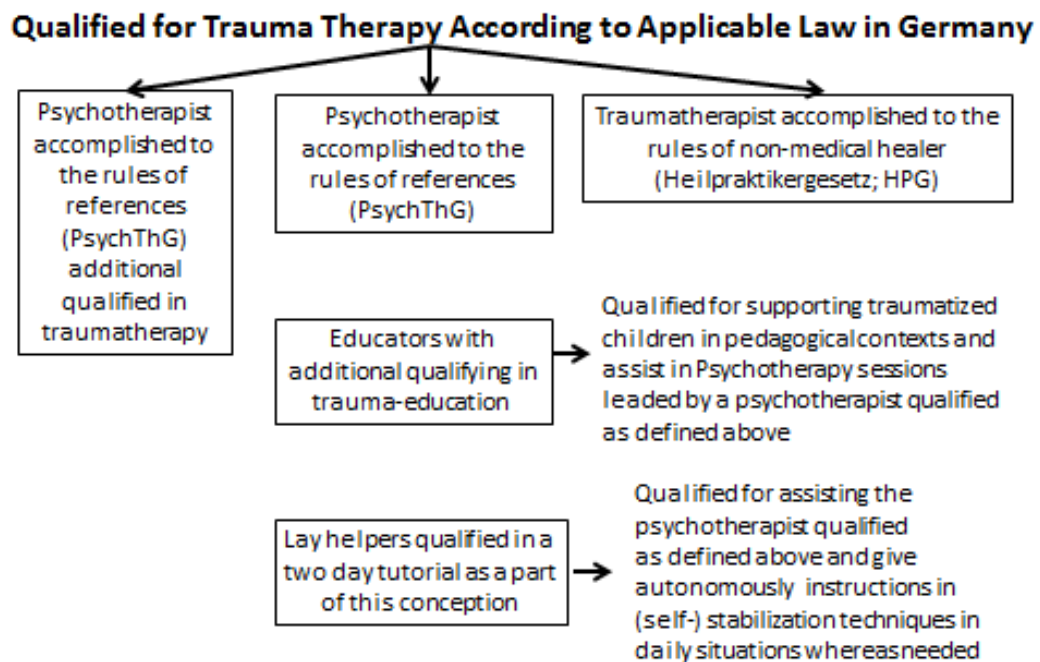
In this conception we work on a level "lower" and train "Traumahelpers", functionally similar to the first aid trained lay helping at the scene of an accident providing support at the immediate treatment to and at the side

of the professionals; such as helping ensuring auto-transfusion or a pressure bandage or observing the vital signs of the accident-victims.

For this rudimentary medical knowledge and - for the next step - courage and at the same time, careful action, ideally under the guidance of a supervisor on the scene is necessary. And this is exactly where the here presented concept is placed.

Traumahelper's knowledge of useful intervention techniques can be used to assist either in the field of psychotherapy in the narrow sense either in pedagogics and in other contexts- school, day-care centers, sports etc.

Figure 5:
Diagram of Qualifying in Trauma Therapy to Applicable Law in Germany and assigned as a Traumahelper



The Target Groups of the Traumahelper-Training

Primarily three groups of participants can profit:

A: The honorary refugee helper, in collaboration with the professional helpers paired with refugee families and unaccompanied minors. There they can give faith, trust, safety and support in instructing the (self-) stabilization techniques they have learned in the two-day-tutorial.

B: Professionals, for example, teachers, educators, psychologists, nurses and social workers which can use the (self-) stabilization techniques in their daily pedagogical context and they also profit from neurophysiologic-based knowledge for psychoeducation to inform people burdened by trauma and help them to understand their special symptoms and behavioral patterns.

C: Child and Adolescent psychotherapists in Germany in the narrow sense (see figure 5), in other countries without that special rules, India for example, this also could be psychologists or physicians without the additional training in psychotherapy, because lots of countries don't have. The conception of the two-day-tutorial gives them an expertise of children trauma-psychotherapy as multipliers, who with the support of absolvents of the group A and B could offer within the respective national legal framework or within institutions financed the Sandplay-Therapy as a group therapy session for up to ten children supported by co-therapists, Traumahelpers are.

Prerequisites for Potential Traumahelpers

The concept has been first explicitly developed for the integration of lay-helpers in the trauma-psychotherapy having the function of co-therapists like it is clearly described in the new psychotherapy restructuring law from 2017 "Social surroundings: A new approach is,

that in the future “relevant attachment figures from the direct surroundings” can be included in the treatment. For this for example, beside the parents, even teachers or educators, which are directly and regularly confronted with the disease of the patient”.

(Kassenärztliche Bundesvereinigung, Körperschaft des öffentlichen Rechts 2017)” and in several therapy manuals like physical therapy (Bergerhoff 2011) or learning therapy (Multhauf and Buschmann 2014) or behavior therapy conceptions (Wewetzer and Wewetzer 2012; Döpfner, Schürmann, and Frölich 2007).

Traumahelpers as co-therapists must have participated at one two-day-tutorial to get certificated as a Traumahelper. With this certification Traumahelpers all over the world (by now Germany, Austria, Switzerland, Italy, India, Israel/Westbanks, Israel/Gaza City, Cuba and in a few weeks Egypt) who are qualified follow strictly this conception can be identified immediately and work together knowing what to do; Altogether at the moment about 1800 are qualified depending on that conception.

Of course not every interested person can get a Traumahelper. It is in the responsibility of the trainees to recognize inappropriate participants. Sometimes people must be refused because of defined exclusion criteria. Potential Traumahelpers, who are in need of treatment because of mental illness by themselves or having an abuse of psychotropic substances or alcohol or living in acute unstable situations cannot enter this project.

An overview of the training program:

1. Basic information about the current state of political affairs in handling the procedure for the right of asylum in Germany, because many Traumahelpers are involved as volunteers or

professional helpers for refugees or migrants and they should know about the current circumstances to understand possibilities of treatments according to the shifting political situations.

2. Neurophysiological basic knowledge about traumatization to get a deeper understanding in the special behavior of traumatized people.
3. Detection of trauma and trauma-consequence disorders in children and adolescents with all the symptoms which are classified in DSM V (American Psychiatric Association 2015) or ICD 10 (Remschmidt, Schmidt, and Poustka 2017) and additional children-specified symptoms (Weinberg 2013; B. A. van der Kolk u.a. 2009; Scheeringa u.a. 2012).
4. Use of evidence-based screening procedures.
5. Secure usage of effective interventions of stabilization techniques to reduce trauma symptoms as far as necessary.
6. Safe usage of verbal and non-verbal methods in the Sandplay-Therapy groups also if children may not know the German language (Beate Leinberger und Loew 2016).
7. The transfer of the self-stabilization techniques to the affected children and assisting in the right application and support in prevention of the development of chronic mental disorders caused by traumatization (PTSD, depression, impulse control disorder, anxiety disorder, etc.)
8. Decrease of the development of comorbidities
9. Psycho-hygienic exercises for Traumahelpers in order to avoid a secondary traumatization.

10. Follow-up of the participating lay- and professional helpers, as far as necessary towards effectiveness of the trained tools and secondary traumatization.

The treatment concept is structured. The essentials can be learned by lay helpers in a weekend workshop if they are willing to study the handouts and backgrounds material provided (e.g. 3 hours of videos and 1 GB of written manuscripts). It is based on the current findings on the development of mental disorders caused after having experiencing a severe traumatic event and, above all, it provides preventive strategies, because chronic changes in the brain after trauma should be prevented through the use of the presented techniques and as a result serious disorders such as post-traumatic stress disorder, depression and anxiety disorders and social incompatible behavior disorders do not manifest or become less pronounced. With help of the use of the here presented techniques chronic neurologic changes after traumatization should be averted. To prevent that grave disturbances like PTSD, depression, anxiety disorders and abnormal social behavior do not or less pronounced establish.

The Specific Traumahelper Training Concept in Detail

The Traumahelper-training consists in a 16 educational units set on two days eight hours per day. Unusually there are trained 50 to 90 participants (better 50), which for half of the time have plenary lectures and for the technical training and the self-experience are split. Furthermore they get as already mentioned papers, written material (as letters to the diverse institutions involved in the local projects: to the parents, the teachers, the local sanitary units etc.) Also information-material in the native languages of the target groups as well as short videos on youtube are available, free psychological testing, which could be helpful, material lists etc. All together offered about three hours

videos and about 500 pages to read and a reader with information about 200 pages. Furthermore a website does exist, where put new information about the scientific background, new teaching formats, if developed, press information etc.

The First Day

A plenary session is been started with general information about the project giving some background information about the real situation of the refugee kids (2 units).

Then follows a lecture about the symptomatology, especially for the children and the clinical diagnostic (UCLA-Child –traumatic stress inventory, DSRS and CRIES.

In the afternoon the group splits: In one group the first self-regulation-techniques and the neuroscientific background (SPB, SURE and Bilateral Stimulating techniques are explained and experienced by the participants in order to understand how they can be used in an escalating manner to prevent symptoms in children – while reprocessing later on but also in daily life situations e.g. at school or in family (2 units).

The other group gets the Sandplay-Therapy where the special setting is explained and they experience the Sandplay by themselves in groups of three (one plays the child, one the Traumahelper, one is observing the scene; than they reflect their experiences and change position, so that everybody can feel how a child feels playing and reprocessing or the Traumahelper is acting (2 units). Most participants very fast play real more or less traumatic scenes out of their lives and can experience the emotional control realized by using the self-stabilization techniques and the relationship between Traumahelper and child.

After 90 minutes the groups change, so that all will have both: theory and practice.

The Second Day

Starting again in splitted groups. One group will get presented the use concepts of Lifeline-Therapy, another technique used for adolescents and adults, here not further explained in detail, role and use of the “safe inner place”, that means to picture a safe place with crayons on paper and to implement the safe place memory as an inner picture they could use for the future to stabilize themselves supporting the process overlaying the inner image of the save place with in this case slow eye movements or tapping. Every participant will do this for him or herself in teams of two to three where they practice Bilateral Stimulation. The participants than study their personal Trauma-Landscape with trying to use the visual analogue scale by themselves. (3 units).

The other group starts with a cultural lecture, if needed, in the case that the refugee children and adolescents disposed to come to the Sandplay-groups will have another religion and ethnicity than the Traumahelpers have and further self-stabilization techniques as FR, again with the scientific background and self-experience (3 units).

Even at the second day the groups rotate.

For the last two units the groups join together again. They get presented now a real reprocessing of a traumatic experience shown by a volunteer including documentation before and after the Bilateral Stimulation; and more information about the problems of secondary traumatization and self-testing to monitor their own burden during the work. At the end the last open questions (e.g. setting, recruiting etc.) are cleared.

At the end an evaluation form is filled, which will be done again after 6 month`s to see whether the participants could use what they did learn and how helpful it was.

If it`s possible – so it was in India and Palestine – it has been started with local real burdened children, which were screened before. They fulfill together with their Traumahelpers the psychological tests and then they start a normal Sandplay-session as seen in pictures 5 to 8, followed by one hour supervision.

Pictures 5-7

A sample of real Sandplay in Nablus, Westbanks, 2017
(Leinberger, private)



Picture 8

Interviewing burdened children and medical/psychological findings in real time, Nablus, Westbanks, 2017
(Leinberger, private)



Prevention of Secondary Traumatization in Traumahelpers

The work with traumatized children and adolescents also provides for the helpers of a very high emotional strain, so that mental stability is a prerequisite for this task (Denkinger u.a. 2018). In consequence within the course there is an support to determinate the state of vulnerability regarding secondary traumatization through appropriate tests because secondary traumatization is a high risk in working with traumatized people (Krampl 2007; B. van der Kolk, McFarlane, and Weisaeth 2000; Ärzteblatt 2010; Lemke 2006; Dagan, Itzhaky, and Ben-Porat 2015; Maercker and Reinhard 2003; Daniels 2006). So Traumahelpers are regularly invited to check themselves with evidence based assessments. The underestimated disorder in helping professions (Sendera and Sendera 2012) is a slow creeping process, which affected people rarely notice by themselves; so awareness about what others tell them according to changing habits or behaviors and the use of self-report-questionnaires could be preventive and meaningful. In this conception therefore is recommended the “Secondary Trauma Questionnaire” (Maercker und Reinhard 2003), see appendix, is also

available as an online-based-questionnaire with online analysis (Daniels 2006, 2007, 2018), and the “Fragebogen zur Erfassung der aktuellen Ressourcenrealisierung-RES” developed by Troesken (Troesken und Grawe 2004; Troesken 2018), see appendix. Every questionnaire which is used in that conception is license-free available so no additional costs arise to Traumahelpers or professionals. Symptoms secondary traumatized people can have are very similar to the PTSD symptoms, characterized as abrupt irritabilities, sleep disorders often with nightmares, avoidance of social contacts, indifferences, hyperarousal, frightening, continued thinking about the bad experiences the Traumahelper heard about other’s lives, fear about harm comes to themselves, lack of empathy, lack of enjoyment of life, increasing problems of concentration, feeling threatened without concrete reasons and/or strained memories to what traumatized people told. In consequence of avoidance and losing enjoyment of life the risk to inactivate formerly available resources is high increasing. So beside the “Secondary Trauma Questionnaire” it makes sense to check the present accessible resources, which has no analysis but the facility of comparison before and after some time of caring for traumatized people.

Preventive Interventions Recommended to Traumahelpers Avoiding Secondary Traumatization

Very effective preventive interventions are the stabilization techniques which Traumahelpers learn in the training to stabilize the children: Somatic Universal Regulative Exercise (SURE), Slow Paced Breathing (SPB), Bilateral Stimulation and Functional Relaxation (FR). Last named is now detailed described, because it’s – measured via “biofeedback”, which gives stress-related testimonies about physical parameters like heart rate variability or skin conductance level, in several workshops – an excellent functioning self-stabilization method

and even as a body mind method, measured in several studies (Choi and Park 2018; Lahmann 2009b, 2009a).

Practicing FR Traumahelpers in the therapy session while they sit in front of the burdened child, via mirror neurons the relaxation feeling passes over to the child automatically. For themselves the Traumahelper should practice FR in the therapy session to keep relaxed as possible to prevent own stress related impacts. To strengthen the mental hygiene it is advisable to practice FR daily in any life situation: being located in a traffic jam or red traffic lights, standing in a waiting line, having a discourse, feeling uncomfortable or feeling the need to refresh at work and so on

According to mental hygiene Traumahelpers should do activities which obtain or raise their life-satisfaction like doing hobbies, leisure activities, having positive relationships and family ties including a faithful partnership to prevent secondary traumatization.

THE SANDPLAY-THERAPY CONCEPT

The program is designed to work with larger groups of traumatized children. The goal is stabilization, stress reduction and prevention of chronic trauma resulting disturbances. The concept can be implemented in an outpatient or an inpatient context.

For the Sandplay-Therapy concept a group size of ten children is recommended, of course also possible with less than ten children, each accompanied by one Traumahelper; the sessions should take place in a big enough room e. g. a classroom. For each Traumahelper-child couple a table, two chairs, a sandbox, sand play material, sheets of paper, wax crayons and a diary (Din A4) should be prepared before starting the therapy session. The material needed to perform playing in the right way is sorted into ten separate boxes:

1. Plastic soldiers, war vehicles, weapons, 2. Different playing figures (males, females, children in any different dresses and in different cultures, 3. Trees, houses, fences, bridges, vehicles (not war toys), 4. Animals, 5. Building bricks, 6. Natural stones, 7. Shells, 8. Colorful glass stones, 9. Branches and timber, sticks and 10. Anything else which is helpful according to the children's traumatic experiences. The boxes are set up at the edge of the therapy room so that they are easily accessible for all participants.

General Description of the Sandplay-Therapy

Before describing in general the Sandplay-Therapy the preliminary steps are summarized and the roles of the Traumahelpers and the psychotherapist is clarified. Then a detailed description of an ideally session itself is given. To make clear on a phenomenological level what is happening during the sessions some case studies are presented. All

steps are well primed in the Traumahelper training before so they can feel well prepared on the scene.

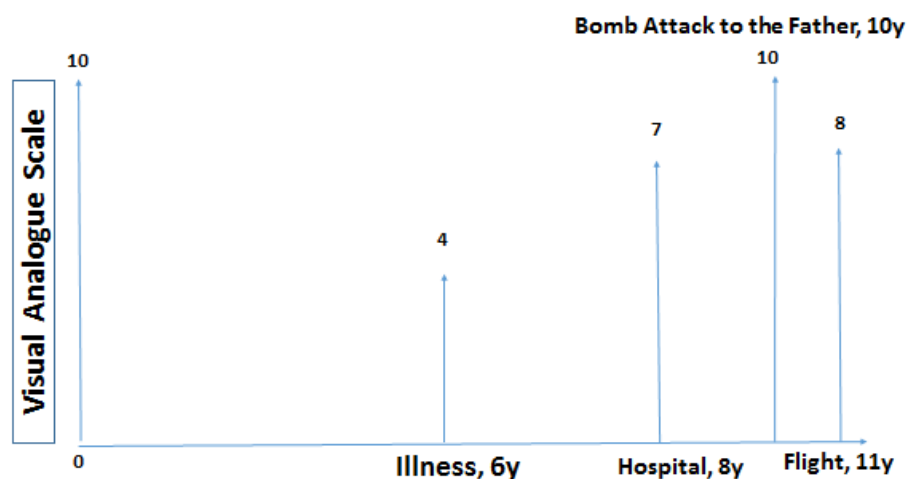
Preliminary Steps

There are some preliminary steps to prepare before starting Sandplay-Therapy: First the parents or care-givers of the participating children of the therapy group and also the children come to an appointment with the responsible approbated psychotherapist for the initial clinical interview to establish diagnosis via medical history, tests as described, psychoeducation and information about the therapy process and at the end the informed consent. At that moment for the only time an interpreter is translating; because it is legally important that parents or care-givers understand well in their native language – so far as possible - what is happening to the children in the therapy session and get the informed consent. Within these two hours the following content should be recorded: The method will be explained by the psychotherapist including the context-conditions: ten times a regular weekly attendance, except holidays, is obligatory; punctual starting time, duration of 50 minutes in total; if the children cannot arrive by themselves due to the public transportation or possibilities of the parents, they will be collected before by one of the Traumahelpers and brought home after the session; all these aspects are translated by the interpreter and must be confirmed. At least the parents or care-givers sign with their names the consent form to give permission for testing before and after the whole therapy also for follow-up history, the child's Sandplay-Therapy participation, the transport via Traumahelper, if necessary; and for the documentation by taking pictures and recording videos. Often dissociated as well as drastic emotionally moved patients cannot remember every part of the therapy session. In this case taking pictures is a possibility to show afterwards what happened also to give safety and guaranty for a faithful work. Another reason for having taking

pictures is the supervision subsequent to every therapy session for the Traumahelpers. Due to the fact that video-documentation is in German behavior therapies not unusual, it is especially in trauma therapy sessions important, because of the risk of dissociation phenomena children in this case can have, so it can be used for supervision to give the Traumahelpers more expertise. It helps to reconstruct difficult situations in the supervision group and to find good solutions for the future sessions.

Then the individual anamnesis is done using a biographical Interview via “Genogram” to visualize the family-system and -structure and at least the “Trauma Landscape”, done together with the parents or caregivers to get a visualization of all bad events, connected to the age of the child, when that experience happened using a visual analogue scale with a range between 0 and 10; 0 representing no burden to that event and 10 the highest thinkable burden. (Münker-Kramer 2011).

Figure 6:
An example of a Trauma-Landscape



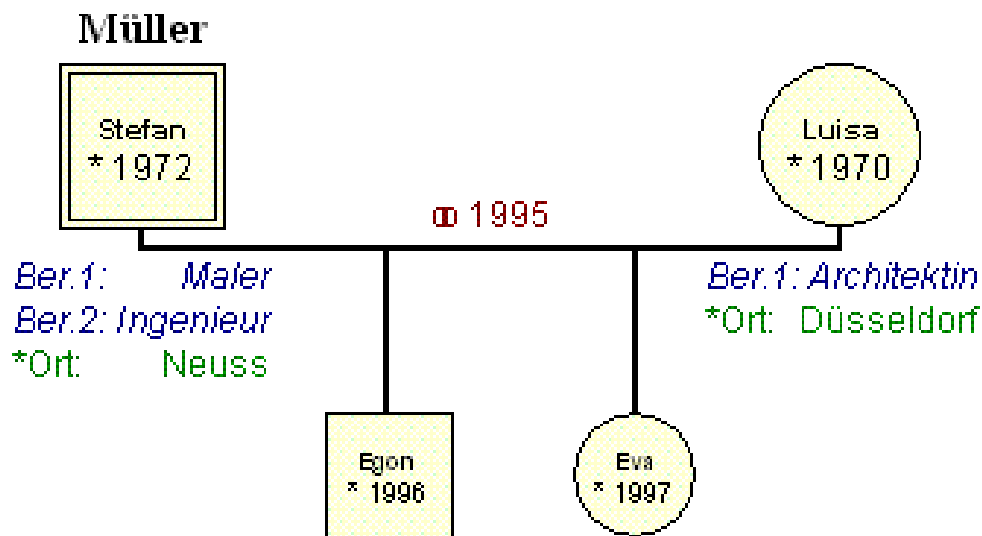
To the example of the trauma landscape (figure 6): The patient is a 12 year old Syrian boy. His first bad experience was a bad illness which caused fear of life when he was 6 years old, because he didn't know if he survives. Afterwards the illness couldn't be explained because of the lack of knowledge about it. The weight bearing was 4. Later, being 8 years old, he had an accident where he broke his leg and went to hospital the trauma was that he had to experience his neighbor in the next bed dying. The weight bearing on the visual analogue scale was 7. In the age of 10 he experienced a bomb attack to his father. He wasn't nearby but he has seen his very heavy injured father full with blood and looking very sick. He was in fear to lose his father. The weight bearing was 10. In the age of 11 years he flew with his parents and 4 younger siblings from Syria via Balkan-Route to Germany. The weight bearing to that experience was 8. The flight was a longer period with different traumatizing experiences they could also be splittet in single trauma events. The trauma landscapes help the psychotherapist to get an overview about all traumatic experiences. In the Sandplay-Therapy the child decides what to show and what to reprocess. In the work with older patients it could be helpful that the psychotherapist decides how to start using the established rule "last first or worst first or first first". That means to begin the reprocessing with the last traumatic experience OR with the worst scored experience OR with the first traumatic experience. But children cannot be structured by this rule. In the age of 4 to 12 – the age the Sandplay-Therapy is recommended - the brain is functionally still less developed, so impulse control, thought control and emotional control are not as steerable as in elder children and adolescents (Schneider and Lindenberger 2012); furthermore the capability to remember past life events is less effective and the memories are often crosslinked with parent's or attachment figure's experiences and emotions.

So the younger children are often not able to explain detailed stories but they can act out their own perceived realities at the traumatic moment so we have to trust in the body's and mind's selfregulation skills to act out what must be regulated. The Traumahelpers and psychotherapists never should rise to question or criticize.

The main focus in this concept lies on destressing harmful memories which are fixed in the children's brain causing impairing trauma symptoms.

In addition a genogram is done. It's a kind of family tree that shows at a glance family structures, family pathologies, morbidities and mortalities and the position of the psychotherapeutic treated child (Index-Patient) in that system (Beushausen 2012; McGoldrick et al., 2009; Roedel 2014).

Figure 7:
An example of a Genogram
(McGoldrick et al., 2009)



What also is done at that first date are psychopathological assessments collecting the presented facts and furthermore the impression of the

child by observation on the behavioral level. In conclusion the aim of the diagnostic procedure is the acquisition and taxation of the traumatic experience as well as the family structure of the child with the help of the genogram, and an understanding of the current symptoms of the child. Then psychological test-diagnostic is performed, as described before.

THE ROLE OF THE TRAUMAHHELPERS

The difference to the standard psychotherapeutic is simple: Not the psychotherapist, who is performing the session, will sit beside the child, but the Traumahelper. He or she will stay with the child as a “god parent” or “good parent”: His or her duties are to observe, to be aware in every minute whether stabilization as mentioned before is needed, will share faith and encouragement, take pictures of the Sandplay-scenes, will glue them in the diary of the child, which it could also use for drawing pictures of what it’s up to at that moment, if the child wants to. The professional therapist is observing all ten children and the ten Traumahelpers during the session and intervenes individually focusing the particular needs of the child supporting the Traumahelper to do the right things.


During the session the Traumahelper is mostly a silent witness, answering orienting questions of the child, and a supporter to keep the individual play running. Not allowed is, e.g. playing together with the child or small talking to children or other Traumahelpers. The reprocessing by playing is sometimes complicated by intrapsychic of the child, which are indications for the destressing and regulating interventions as described. The aim is to keep arousal on a functional tolerable level and the playing running. The Traumahelper holds the depicted scenes in general with inner strength and tranquility.

Often there is no necessity of deep emotional immersion in the traumatic situation during the session and it is explicitly counterproductive, if it is provoked by the professionals. If this would happen, the learned stress-regulation techniques and exercises to get the child distant from the immersion are applied (e.g. Bilateral Stimulation). Possible frequent ideal-typical critical situations are described later.

The Session Itself

The therapy hour starts with common ritual elements; all participants – the children, the Traumahelpers and the psychotherapist - first stand in a circle in the middle of the (class-) room whereat every child stands beside its Traumahelper and all side by side. Then all together start singing the action song “Aramsamsam”, (see also appendix) integrating most of the self-regulation techniques: SPB, SURE, Bilateral Stimulation. The calming breath (SPB) while singing a traditional children’s song (Regehr, Glancy, and Pitts 2013) bilateral tactile high-frequency self-activation while clapping hands over cross on the upper arms; SURE while walking on the place, which moves the hip joints automatically, moving the hand joints while presenting a roll circulating the lower arms around each other’s and at least, raising the stretched arms high over the heads to show presence and improve self-confidence. Mostly all effective interventions are included in this performance, which is continued about two minutes (3 rounds: normal speed, low speed, high-speed). It is practiced at the beginning of the therapy session and at the end before the kids are going home. The song is a very simple arranged song; lyrics and melody are easy to be learned simply by watching and copying. The kids do not need to master a foreign language as German for example, they just follow the syllables which have no concrete meanings and invest their concentration mainly on the special movements (self-regulation techniques) shown by the Traumahelpers while singing the song altogether. Who does not know the song, can get help by a free download on youtube („Aramsamsam-Bewegungslieder zum Mitsingen II Kinderlieder“ 2017).

Figure 8:
Aramsamsam-The Action Song, see also appendix



The image shows a musical score for a song in 4/4 time, key of D major. The melody is simple, using quarter and eighth notes. The lyrics are written below the notes, and specific actions are described for each line.

Lyrics and Actions:

- A - ram sam sam, a - ram sam sam, (We stand together in a circle.)
- gü - li gü - li gü - li gü - li ram sam sam (Aramsamsam: Walking on the place, hands across clapping the upper arms.)
- A - ra - bi, a - ra - bi, (Gulligulligulligulli: hands turning around each other like windmills)
- gü - li gü - li gü - li gü - li ram sam sam (Arabi: both arms stretched to the sky while walking along on the place)

Additional Action:

- Gulligulli: like above

(Quelle: <http://www.sdg-forum.de/tidcitrude/tidc006druck.htm>)

After the performance each Traumahelper leads his or her child first to the individual place; then he or she shows the sand play kit and the provided material as described before. The Traumahelper accompanies the child to the material boxes; the child can freely choose, which figures or objects it likes to play with, then it brings the material independently to his or her table. If the child likes, it can go back to the toy sets, if necessary, several times to choose other figures or change the selection done before. When the material from the child's point of view is complete, the Traumahelper sits at the table with the sandbox and will document the ongoing scenes with photos.

The Traumahelper speaks as less as possible; he or she supports with facing confirmations and interested views, gestures and sounds ("Yes", "hmm...", "ok"; any questions of the child are understood so far as factual. Short answers are allowed to show presence, give a safe feeling and demonstrate faith, but not adequate are longer talks or questions from the Traumahelper to the child about the Sandplay - scenes. The Traumahelper does not interfere with the child's play in any way.

The Traumahelpers should be aware that there can rise dramatic/sensitive or morally-ethically experienced difficult scenes which have not to be valued by emotionally colored remarks or sounds to the child. It should be not disturbed in its experiencing at the moment but maybe regulated emotionally using the already explained stabilization techniques (SURE, SPB, Bilateral Stimulation, FR) even unnoticed by the child. If ulterior proceedings are necessary the psychotherapist should be informed by the Traumahelper – even if he or she didn't notice before – to intervene in a professional therapeutic way like implementing Bilateral Stimulation for specifically reprocessing procedures or reducing dissociative processes Always being aware that the whole therapeutic process of every child is in the responsibility of the psychotherapist and not the Traumahelper (see picture 9).

In a next step after 15 minutes the psychotherapist interrupts the sand play and requests children and Traumahelpers to meet again in the middle of the room forming a circle, the children then are asked to sit on the ground; then they receive a paper form (Din A4) and crayons and are instructed to draw "lying eights" – a horizontal figures forming an "eight" with about 8-10 different colored pins again and again, with a fluent movement, if necessary guided by the Traumahelper which could, if necessary, at the beginning lead the child's hand for some ducts.

It has proved to be positive for the children to clap the children's shoulders slightly one side after the other reciprocally in a slow rhythm (1 Hz about) – a form of additional Bilateral Stimulation of both hemispheres of the brain (Nakatani u.a. 2009; Ortner 2018). For that the Traumahelper kneels behind the sitting child. Later the "lying-eight" form is glued into the diary together with a mark of the actual date having a follow up overview at the end. While drawing the child is encouraged to produce noises or sounds, such as a fast moving car, if

necessary assisted by the Traumahelper starting with the sounds and animating the child to do the same during the whole exercise.

Picture 9

A child Sandplay reprocessing. An example for the Sandplay setting: one table, two chairs, one sandbox and playing material, Sandplay therapy group, Regensburg
(Leinberger, private)



Giving the movement a sound activates collateral the system of vagus nerve (see the figure 1) so that relaxation can be introduced and/or strengthened (Johnson und Wilson 2018). The work is done, when the child rounded the “lying eight” about 50 times. With about ten different colors in the crayon box it keeps interesting enough to stay present and concentrated. (see picture 10)

Then the second unit “Sandplay” follows. The children can continue to work at the previous scenes or take new material. The Traumahelper accompanies the child continuously in doing so. Often observed in the second unit of Sandplay the children are more aware, more relaxed and more structured in their Sandplay, often they change materials or change scenes to rebuilt and reprocess. The Traumahelpers will

perform the same as in the first unit, give support and ask the psychotherapist for help, if necessary. (see picture 11)

Picture 10

An example for the “lying eight”, drawn by a refugee child in the Sandplay therapy group, Regensburg, 2016
(Leinberger, private)



At the end the ritual of the beginning is redone; again all participants will stand in a circle, singing the action song “Aramsamsam” as described before followed by a farewell and goodbye. The session ends after a 50 minutes.

The children will then be accompanied to the door, where they get picked up by related persons (parents, caregivers etc.) and brought home. The children have not to clean up the place, this will be done by the Traumahelpers, when the children have left the room; he or she also conceals the diary for the next date. Then obligatory supervision follows, which is essential after each Sandplay-Therapy group session.

The Traumahelpers; mostly lay helpers; have usually no experience in professional distancing to heavy emotional processes or withstanding terror stories truly experienced by the “story tellers”, the children. They need stabilization and regulation themselves, too, and a forum to share their own experiences during the Sandplay sessions. They also get every time in the supervision a guided practicing of techniques to prevent secondary traumatization. The psychotherapist is the continuous supervisor, has participated during the Sandplay session and so he can give recommendations and refer directly to the therapy session before.

Picture 11

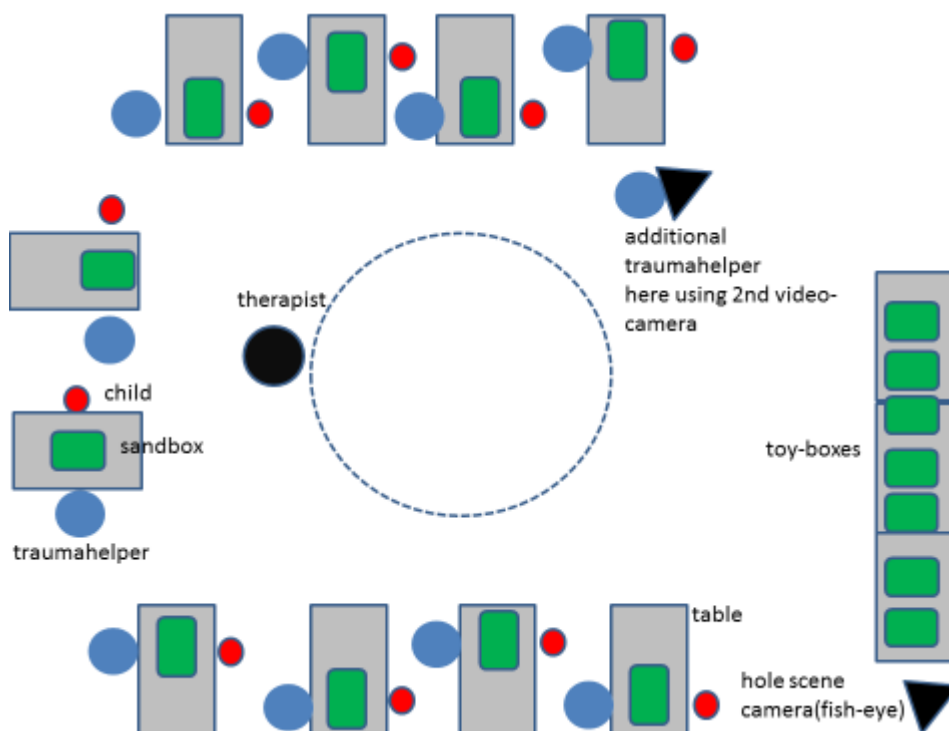
An example for a scene after drawing the “lying eight” and ongoing playing with the sand, India, 2017
(Leinberger, private)



In the supervision session Traumahelpers and psychotherapist meet sitting in a circle. Every Traumahelper gets time to share his or her impressions and gives the personal individual impact which is evaluated by a visual analogue scale.

Summarized: The Sandplay setting, starting with a ritual – phase of playing – stabilization – phase of playing- final ritual - is the same as a behavioral childhood trauma treatment used (Landolt and Hensel 2012; Krüger and Reddemann 2012). These treatments already have been the thousands of times each year done within the framework of the health insurance services and medical care companies (Krankenkassen and Kassenärztliche Vereinigung), manuals for the behavioral therapy complements exist (Ahrens-Eipper and Nelius 2014) as well as the supervision concepts for included lay helpers (Schüffel et al.. 1998). New in this Sandplay concept is the introduction of lay helpers after a short training-program.

Figure 9:
A view on a typical Sandplay therapy session.



Ten tables for each of the ten children and their Traumahelpers, the psychotherapist, which has a good overview to intervene timely, the toy-

boxes beside and one standing camera in the room angle and, if possible, a hand camera led by the back-up Traumahelper which is always the eleventh to act as a stand-in when necessary.

DEALING WITH DIFFICULTIES

Now the dealing with difficulties as passiveness and “lack of ideas” or restlessness are explained and situations, when the child experiences hyperarousal, aggressive outbursts or raises material.

Passiveness and “lack of ideas”

It may happen, that the child during the whole hour is doing nothing, sitting tight and still, inwardly focused and seeming dissociated. The task of the Traumahelper is in this case, to accompany the child in the (supposed) passivity of silence and attentiveness. There is no need for stimulation and entertainment from outside, even the Traumahelper feels under pressure to intervene. With his or her silent and distressed presence the Traumahelper gives the child a safe frame; so an internal process can keep ongoing in a reasonable period of time and the child has a chance to develop in its own biological grounded speed. The child needs the reassurance that its individual behavior is ok and will keep him safe. Otherwise: In cases the behavior seems like dissociation – what the present psychotherapist can ascertain, the child needs help from the professional to overcome the dissociative moment and can play along furthermore.

Restlessness

The child does not remain at the Sandplay-table, runs around, it disturbs others, bothers and can’t concentrate on playing in the group.

The child in this moment could express the inner restlessness and is agitated because of the emotional burden; its movement patterns are its

solution. This cannot be prevented. Important is not to disturb the other children, so the Traumahelper has to urge the child not to move but to use the stress regulation techniques such as SURE, tapping or doing other bilateral body exercises. If this doesn't help the Traumahelper could go outside and run together with the child to downregulate the adrenalin which up-rises in acute stressful moments, if the local arrangements allow this behavior without endanger the child or the Traumahelper. Alternative a sports hall (e.g. if the therapy group works in a school) could give the same possibilities. After burnt off energy the Traumahelper starts a new trial in the Sandplay group to reintegrate the child and finish the special role. Rarely a child always shows that behavior and it cannot be calmed down for minutes it must be considered to offer an individual therapy, where this child could be better treated. Such children need more help than a 10 hour Sandplay therapy session!

Hyperarousals, Aggressive Outbursts, Raising Material

First the Traumahelper ensures that no one has been injured, tries to calm down the child with SURE or tapping and recollects the material. During the outbreaks the child will may be in a dissociative state in which it cognitively cannot be addressed. By means of clear speech and movement-exercises (action) the dissociation can be stopped. The psychotherapist has to assume responsibility. When the child is ok again, it will give clear signs (at least to the professional psychotherapist).

EXAMPLES OF CASE WORK

A 12-year-old Syrian boy has seen his Father being killed through an IS-attack in his hometown. He, his mother and his two years older sister survived.

The most critical strain comes from the moment in which the 12-year-old boy had to observe out of his hiding place what is happening and that he couldn't help his father. In addition to the threat he feels great guilt and ashamed, because from his point of view, he should have supported his father

Picture 12
A case work (1)
(Leinberger, private)



The tank is coming. The attacker gives the command to shoot. The tank shoots. The rocket hits the father. The child is hiding behind the tent and watching.

Picture 13
A case work (2)
(Leinberger, private)



The men storm to the tent. They are armed. The commander orders to shoot. They shoot the father. The father dies. The child peers anxiously behind the tent.

Picture: 14
A case work (3)
(Leinberger, private)



The man stands on a rocky outcrop with a grenade. He throws it. She lands next to the father and explodes. The father is dead. The child peers behind the tent and observes what happened.

The young boy provides the experienced scene in different variants. It comes clear, how he is processing the trauma in his memory. The same scene is experienced over and over again. The child tries not only to form a complete history, but also a good and thus emotionally tolerable outcome.

Less dramatically more or less everyone knows these processes in normal everyday life, for example by embarrassing or generally living unpleasant experiences in different variants. We go through them in the mind again and again and imagine different sceneries, until the emotionally stressful, themselves suggesting thoughts fall silent. Therefore we use cognitive tricks in our imagination as long as we generate a possible solution and imagine to have acted differently, until the memories and feelings increasingly are displaced and do no longer depresses us, as long as the real happening is not directly addressed or activated again by an external trigger (best seen in the movie "Run Lola Run", Tom Tykwer, 1998).



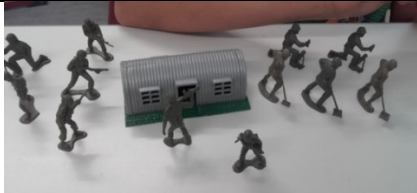






Preschool children practice this form of processing naturally. A perceived unpleasant behavior (Mama scolds) is project on a fantasy figure. They then say for example: "*Pumuckl* (a German phantasy figure) was it. I wasn't!" and are also firmly convinced. This mechanism is used for the emotional discharge and reduction of the tension. It helps to maintain a positive image of themselves and to do not disappoint in this example the mother.

In therapy, the child will be encouraged to design alternative solutions/outputs of the situation in order to reduce the emotional strain. In addition, plying gives the opportunity to present fragmented remembered experiences as a whole history and to fictitiously relive it again. The repeated scenic presentation activates the memory and closes memory gaps little by little.

For the depicted scenes of the 12-year-old boy as an example here, this means:

haven't helped his father triggers an unbearable feeling of failure, guilt and shame in the child. Therefore he creates solution scenes, in which he is overwhelming the offender - at least in the imagination. Children put themselves in the game, as if it were a real scene happening now, so that they through self-invented changings in this way remodel and heal the real happened proceedings in the past. The child in the second example is 8 years old (picture 15; information about ages is given roundabout to preserve the anonymity of the children).

Picture 15
A sample of another case work
(Leinberger, private)

Week		lying „eight“
1st		
2nd		
5th		
10th 1st Play Round, before „lying eight“		
2nd play Round, after „lying eight“		

To see are the changings of the scenes in the Sandplay and self-stabilization drawing by the lying „eight“

ADAPTING THE CONCEPTS TO A TEACHING IN INDIA

In India at the moment live more than 1,3 billion people in 29 states in an area of 3,3 million km². That means 407 inhabitants per km². It is the most heavily populated state on earth after the Republic of China (1,4 billion people). The national spoken languages are Hindi and English. India is democratic governed and it predominates religious freedom („Indien“ 2018). Anyway the caste system is lived very active in many parts of India with all its difficulties in claim to power, indignity, violence, oppression, never ending poverty, denial of education and injustice to that who were born in lower castes or in worst case outside the case system as a Dalit.

Picture 16

The announcement of the two-days Traumahelper Course in India
(Leinberger, private)



The project was especially for teaching Dalits to help the traumatized children living in “Child Guidance Centers” or some also called “Happy Homes” which are founded in cooperation with European Church Organizations and Indian organizations to support that discriminated

population. One of these “Happy Homes” can be found in Hyderabad, the fourth largest Indian town in the State “Telangana” which was separated from the state “Andhra Pradesh” and new founded in 2014. In Hyderabad live nearly eight million people. The most favorite tourist attractions are the “Birla Mandir Temple” or “Lumbini Park” with its marvelous looking flying foxes around at sunset. In Hyderabad is the most percentage of Muslims (30%) which speak “Urdu”. The other people mostly are Hindi (65%), they speak “Telugu” („Hyderabad (Indien)“ 2018). Another location visited in India was Guntur, the third largest city of the Indian state “Andhra Pradesh”. The organization we joined and where we had another teaching was near where the Tsunami was located in 2014. The inhabitants still suffer under the consequences after that natural disaster. So parents often have no labor, because international tourism didn’t arise again. Children visit child care institutions called “Balabatas”, see pictures 17 and 18, founded and financed by International Projects, what means a room with 10 m² for 20-30 children aged five to twelve years. They get lunch there and support for homework and other school matters, older kids care for them or adults which get monthly a bottle of shampoo or other toilet articles as wage. The parents mostly are incredible poor.

The residents in both “Happy Homes”, Hyderabad and Guntur, as seen in pictures 19 and 20, were orphan children, collected from the street, because abandoned, or brought from parents because of violence in families or too much children in the family and/or poorness. Some girls also were picked up from several locations where they worked as “table dancers” which means child prostitution. The abandoned children were found in trash bins or on railway tracks before they were overrun by train. Many children have seen violence between parents, uncles, cousins, beating each other or – mostly happening - violence against

girls and women. Alcohol is a very big problem in India, so violence frequently happens under influence of alcohol.

Picture 17

A “Balabata” in the district of “Andhra Pradesh”, inside.
(Leinberger, private)



Picture 18
Children in their only one “Balabata”-room
(Leinberger, private)



Children in their “Balabata” in a slum near Hyderabad. In this room they do their homework, they eat, they sleep and they play and sing together. Standing on the wall you can see a bed where 4-5 children together sleep on.

Another problem is the lack of justice for women. If the husband wants to he can very easily kill his wife under the pretext of adultery, so children have seen when their mothers were stoned to death or spilled with petrol and burnt. Furthermore in India every 30 minute a girl between two and ten years is being raped, mostly without medical, social or justice help afterwards and because of exposed situation like living on the streets and being untouchable by caste system Dalits are particularly victims of crime („Alle 30 Minuten wird in Indien ein Kind vergewaltigt- 5-Jährige vergewaltigt, Krankenhaus verweigerte die

Behandlung - Schülerin darf nach Vergewaltigung Schule nicht mehr betreten - netzfrauen“ 2017; Hein and Singapur 2016).

Picture 19

Girls living in a "Child Guidance Center" at Guntur
(Leinberger, private)



All the children in "Happy Home" understandably express a lot of gratefulness having the chance to live there in safety. The "mantra" Indian kids learn very well as babies is to look hopefully in a bright future, this could be this life or the next life. That slogan carries them through a really hard life and gives them power to survive.

What they also learn is not to demonstrate weakness and feelings like sadness or rage. So at first appearance the trauma symptoms are not well seen. But they have and they are seen in school or in trauma related situations and in the nighttime. And in a private talk they break open. Some children feel so sad that they cry a long time while the

others sleep or some have bad dreams about their bad experiences. In school they often sit like in trance, with wide opened eyes not twinkling or motoric hyperactive, cannot sit and/or get uncontrolled in rage suddenly after an obscure situation.

Picture 20

Weekly prayer in Hyderabad
(Leinberger, private)



Another weekly stabilization ritual is the church service with all inhabitants, because all kids are christened and they live both, the Christian and the Hindu tradition.

The usual treatment is to punish them for misbehavior or to bring them to a psychiatrist getting medicine which could help in depression but not in traumatization. Because of that lack of treatment the idea was to teach Indian Traumahelpers locally so they can manage the Sandplay-groups after the two-day-tutorial and an assist-starting with us autonomously. In that “Happy Homes” our project took place the children and staff spoke “Telugu” or-some-“English”. That was the first

hurdle to take: we had to organize anybody to translate our meticulous scripted English presentations, because nearly none could understand what we had to tell. After a little while “Rajani”, the psychological staff member in Hyderabad, consented to help. All over the three weeks in five teachings she stood beside us as a very good interpreter and at the end as the professional psychologist who would lead the assist-started Sandplay-group after we toured back to Germany. What makes teaching Indian people easy is their strict discipline being silent and sit on the place over hours without lament – extremely other situation than in Germany. Furthermore because of the lack of chairs the participants mostly sat on the floor (picture 21).

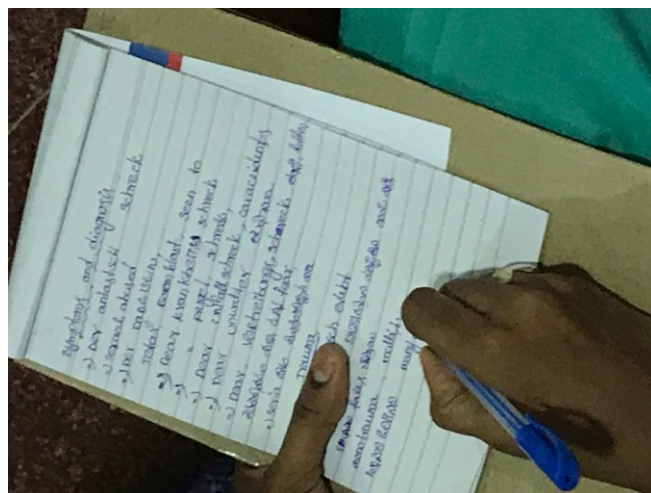
What it makes hard is the shy behavior not to ask questions if anything is misunderstood or not clear, so it was a challenge to develop a sixth sense to find out if anything was obscure. The next was that Indians copy and paste everything, indifferent if it makes sense or not. So we had funny situations where we presented power points with some German or English words which were accurate depicted by them (picture 22).

Picture 21
Traumahelper teaching in Guntur (1)
(T. Paeper, private)



Altogether one hundred sitting Indian participants in the third Traumahelper course in Guntur before starting Sandplay with traumatized girls in a live-demonstration, August 2017. In the front Beate Leinberger (left side) is talking and Rajani (right side) is translating.

Picture 22
Traumahelper teaching in Guntur (2)
(Leinberger, private)



Accurate copied power point slights in English by an only Telugu spoken participant.

Dalits working in “Happy Homes” normally are teachers or psychologists. But the study of these two professions is comparable with a child care worker in Germany. The profession “psychotherapist” is not known, but the study as a medicine is well comparable with European standards, but medicines are not present in Happy Homes. They must be payed private and it cannot be financed except life-threatening illness. So the work with traumatized children is in reality done by the teachers and psychologists or students in this professions and these were our participants of the tutorial beside some parents who wanted to be taught as well to handle their disabled children better, which go in daytime school in “Happy Home” e.g. with self-stabilization techniques which could also be applied to them.

Sandplay per se for the Indian Traumahelpers was easy to understand, Indian people love to play and to handle with creative materials. They also love to sing and dance, so we pushed open doors with our nonverbal but creative conception.

Beside the described tutorial before we used their skills to create a brain theatre and special “Traumahelper-songs” to train the self-regulation techniques with the children via singing and dancing (pictures 24 and 25).

Picture 23
Traumahelper teaching in Guntur (3)
(T, Paeper, private)



Teaching Traumahelpers in Guntur with a 90% humidity and 45°C among the shades what was in the afternoon only possible by sitting outside.

Picture 24
Traumahelper teaching in Guntur (4)
(T. Paeper, private)



Brain-Theatre in the inner court of a “Happy Home”, in monsoon time
what means 45°C and 90% humidity

To make an excursion explaining the brain theater with Traumahelpers
in Guntur:

Brain Theatre

Three girls on the scene. Two good friends bullying the third.

Children form a half circle around the other three, hold hands, one by one. They represent the brain which is now connected.

Out of this "brain" three children get to the first three in the center. These play the emotions: friendship, fear, gloating via mimics and gestures.

All children from the center join the outer circle. The center is now empty.

So the children learn, that real scenes are only a fiction, and part of the brain, and how memory works.

Now new three children come from outside into the center: A new scene: The children learn, how perception works. The three "emotions" join coming from the "brain" to the new three children in the center and play the bullying again, assisted by heavy emotions. The children learn how perception is assisted by the emotional memory or memory in general; they already from the beginning, from the first steps, the new three children do, expect, that the scene-play is treating a bullying situation.

More children come and form a second circle around the "brain", the motoneurons. Now the first "brain-cells" turn around to the "motoneurons", stop holding hands and lay their arms on both shoulders of the "motoneurons" inducing SURE.

The emotions calm down (sit down on the floor). The children learn, that SURE can regulate the emotions down.

The children presenting the "brain" turn again to the center and hold their hands, the SURE movements of the "motoneurons" stop.

Now in front of the open circle four new children get their positions on the left side, seen from the inside two children play a heart standing face to face, holding their hands and simulate a heart, two arms up and two arms down, pumping 80 times a minute.

The third child holds the arm stretched beside the body standing right from the "heart" and "respirates" 10 times a minute, lifting and lowering both arms: the lungs.

to be continued...

The fourth child, “vegetative nervous system” gets positioned near the center of the circle, having two lines in its hands, one directed to the “lungs” fixed around the limb of the child, the other line connects the children playing “the heart”; they hold it with their hands, while pumping. If the fourth child pulls the lines, correspondent the “heart” pumps faster or the “lungs”, if it reduces the tension, the respiration rate slows down. The children learn, how the vegetative nervous system commands the organs.

Now, the three “emotions” in the center of the brain get lines, too, which will be connected with the “vegetative nervous system”. If they pull, the “vegetative nervous system” gets more activated. The children are learning, that emotions have an influence on the organ function.

Now the “vegetative nervous system” gets the command from the “brain”, one child of the outer circle, to slow the breathing down to 6 times per minute: the children play “emotions” calming down. The children learn how one thought can induce a change of the respiration rate and how SPB regulates the vegetative nervous system.

Last scene: There are again heavy emotions going on in the center of the brain. Now the right half of the “brain”-children get the command to duck – this is the symbol for getting an afferent nervous impulse: like getting touched, e.g. during the tapping procedure. At the same time the “motorneurons” on the other side duck, too: This means an efferent activation, e.g. to regulate posture. In the next step, the “brain” children stand up again, and the not yet active “brain” children duck now, and at the same time the first “motorneurons” stand up again and the rest ducks, and so on. Now we have the symbol for “Bilateral Stimulation”, now in this fully activated brain, the emotions and the three children having played bullying can integrate themselves in the circle. At the end they learned, how thoughts and emotions can be integrated in the memory.

Picture 25
Traumahelper teaching in Guntur (5)
(T. Paeper, private)



Brain theatre with the traumatized children to explain the neurophysiological processes while and after traumatization to understand their symptoms in a child-oriented manner

Picture 26
Traumahelper teaching in Guntur (6)
(T. Paeper, private)



Preparing the “self-regulation-dance” together with the Indian music teacher, sitting in the front with the white shirt.

Picture 27
Traumahelper teaching in Guntur (7)
(T. Paeper, privat)



Singing Aramsamsam with Indian Traumahelpers, here the part with bilateral stimulation or tapping.

Picture 28
Traumahelper teaching in Guntur (8)
(T. Paeper, private)



Trauma-Landscape "Indian-style", drawn on the floor with a chalk because of lack of papers.

In the following the songs including the techniques of self-stabilization to give the chance to learn easier, because based on cultural learning habits, especially created for the Indian participants and children. Here in English, but also translated in Telugu:

Trauma-Self-Help-Song

Though afraid here I stay. Swinging move my fear away.
Count 4 while breathe in, count 6 while breath out.
I'll be calm in minutes though they shout me loud.
Cross clap my arms, look left and right won't freeze, I'm clear, can concentrate.

Sandplay

If men were cruel, nasty, mean,
turn Your inside out in scenes,
and catch your life, your thoughts, your dreams

Take sand and figures with your arms
and play the ugly things that harm
If fears rise up and tears will come
Traumahelpers use tapping slight
50 times bad thoughts will flight
and you will feel your chest gets light.

The sorrows vanish like a breeze
and you'll feel save and fill with ease.

Picture 29
Traumahelper teaching in Guntur (9)
(T. Paeper, private)



Trained Traumahelpers sing the Trauma-self-help-song in Telugu for the first time

STATISTICS

A relative small sample will be expected (about 50 subjects). Interval-scaled variables (age, CRIES, DSRS), will be described using means and standard deviations. To separate different groups beside age cutoffs, nominators (sex) and some dichotomous variables like trauma or not trauma in patient's history, being disabled or not disabled will serve categorically. For the experimental testing. Mann-Withney-U-Testing with independent samples (experimental- vs. control-group) will be used or Student -t- Tests for connected pairs. Significant ($p < 0,05$) and highly significant ($p < 0,001$) differences are searched and described, if the distribution does allow. Pre-post and the intra-individual comparisons are examined. Effect sizes r will be calculated wherever informative. Beside statistical description tables with the real numbers or percentage and figures will be used.

RESULTS

The Pilot-Group, refugee children from Iraq (n= 3) and Syria (n=5) got after the described above structured assessment 10 sessions Sandplay within three months and two follow ups at the end of the treatment and one year later. The sample consisted in 5 boys and 3 girls, mean age 9 years, SD 3. Table 7 shows means and SD for the standardized outcome testing. Figure 8 presents the raw values of CRIES and DSRS at the first assessment of the three groups (Arabic Children, Indian Children and Indian control group). There were significant reductions in the CRIES (paired t-testing), improvements in the first ($p < 0,05$) and a tendency ($p = 0,098$) in the second follow up. A not significant reduction of depressive symptoms (measured by DSRS) was found at the first follow up ($p = 0,081$), but highly significant after one year ($p < 0,001$). The effect sizes range between 0,45 and 0,63.

Table 13:

The Arab Refugee Children Sample: Symptom and Burden Changing after Sandplay

Tests (n=8)	Mean	Standard-Deviation	Effect size r
DSRS pre	18,1	7,1	0,45
DSRS 1st follow up	10,5	8,0	
DSRS 2nd follow up	6,9	6,4	0,64
CRIES pre	23,9	8,9	0,63
CRIES 1st follow up	9,1	9,4	
CRIES 2nd follow up	15,7	6,8	0,45
Middle effect size > 0,3, strong effects >0,5 (fat)			

Means and SD of the Indian experimental group and the effect sizes are shown in table 13. There are found high Effect sizes r .

Table 14:
The Indian Children: Symptom and Burden Changing after Sandplay

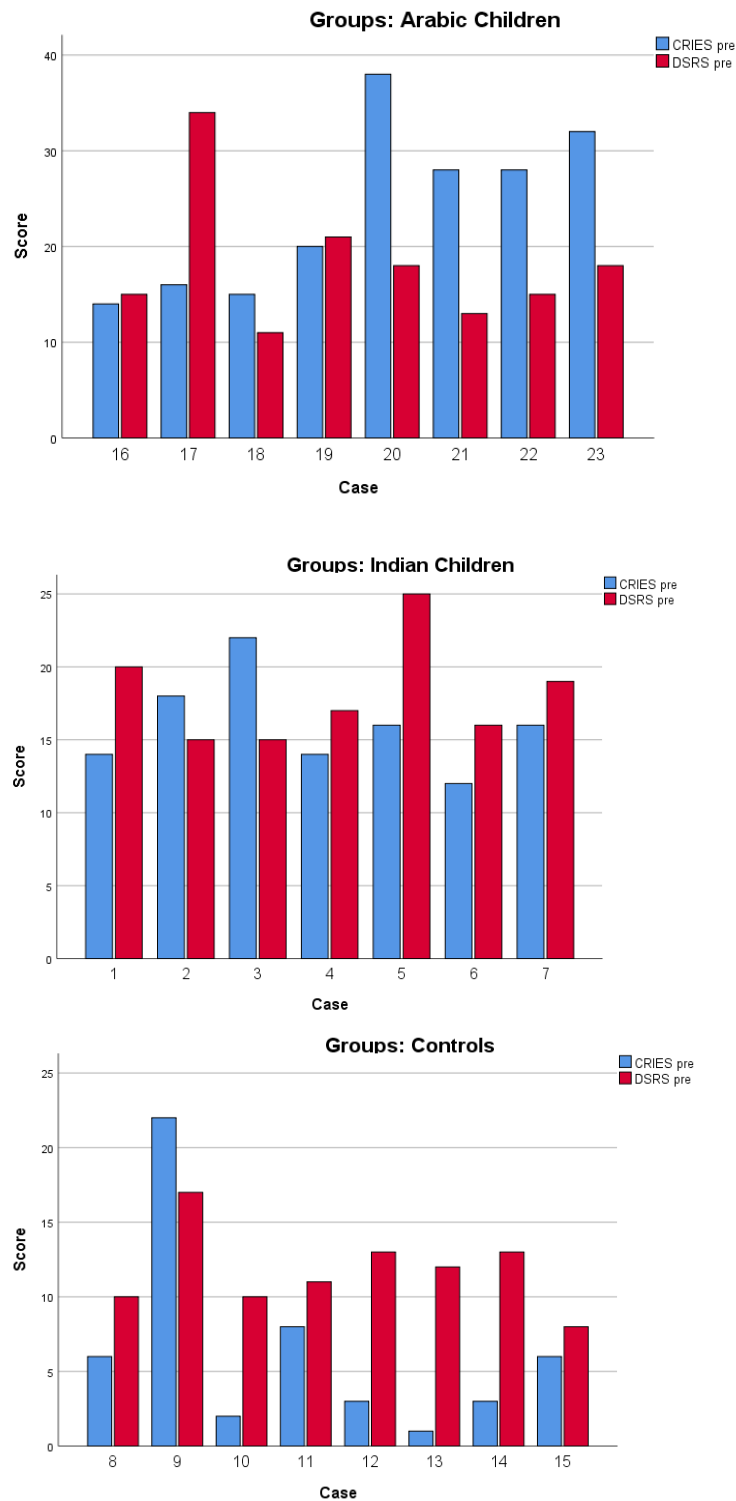
Tests (n=7)	Mean	Standard-Deviation	Effect size r
DSRS pre	18,1	3,6	0,75
DSRS 2nd follow up	10,3	4,3	
CRIES pre	16,0	3,3	0,55
CRIES 2nd follow up	12,0	2,8	
Middle effect size > 0,3, strong effects >0,5 (fat)			

After having shown the effectiveness of the concept, the next group was treated in India. There a control group could be recruited, because already from the beginning it was clear that the project will be continued.

So altogether at the Hyderabad Child Guidance Center 43 children and adolescents were examined. 74% ($n=32$) were girls (average age 14,4 years, SD 4,6) and 26% ($n=11$) were boys (average age 13,9 years, SD 4,2). In regard of the age there were no significant differences. 23% ($n=10$) of the participants were surely traumatized in their lives before, a probable traumatization was assumed by the educators in 63% ($n=27$) of the cases; no evidence was found in 14% ($n=6$).

There was no significant difference concerning sex and age (mean age in participants with a trauma history 15,6 years, SD 4,3, probable trauma-history : mean age 13,4 years, SD 4,4; no trauma: mean age ($n=2$), 11 years.

Figure 10:
CRIS / DSRS Histograms



14 out of the 43 had a mental or somatic disability, being as traumatized as the others, with a larger number of females, but they were older (mean age 18,6 years SD 3,1). The average score in CRIES was 11,1 (SD 5,8) compared to 13,3 (SD 8,5). Mean depression measured by DSRS at the beginning was 14,7 (SD 4,5).

Therefore the decision was made not to include in India so called "special" children in the first Indian Sandplay-group and a defined age limit was kept; only children not having past 13 years were evaluated. Because of the small numbers Mann-Whitney-U-Testing with independent samples (experimental- vs. control-group) was done. Both groups had significantly different assessments at the beginning. The treatment group in both testing (CRIES, DSRS) had higher scores; ($p > 0,05$) Means and SD see table 14. In regards to the depression-score of the experimental group the changes were significant either in the first and the second follow up, but not in the control group, which already had a lower score at the first assessment. The Impact of Event (CRIES) Scores improve significantly in the experimental group, too, but not in the control-group

Table 15 demonstrate the results of the Arabic Sandplay group reaching a high effect size r in comparison to the Indian control group, whereas in case of the depressive syndrome even a high effect size can be observed.

Table 15
Comparison of the Experimental- and a Matched Pair Control-Group (by Sex and Age)

n=8; Controls n= 7	Sandplay (Arabic)	Effect size r	Control-Group	Effect size r
CRIES pre: Mean (SD)	23,9 (8,9)	0,63	6,3 (6,7)	0,2
CRIES 2nd follow up: Mean (SD)	9,1 (9,4)		4,5 (2,6)	
DSRS pre: Mean (SD)	18,1 (7,1)	0,45	11,7 (2,7)	0,6
DSRS 2nd follow up: Mean (SD)	10,5 (8,0)		8,4 (1,9)	
Middle effect size > 0,3, strong effects >0,5 (fat)				

Analyzing the intra-individual changes in the treatment period there are found highly significant results for CRIES and significant results for the DSRS. The Changes remain stable up to the second follow up (See table 16; paired t-Test).

Nevertheless also in the control-group the depressive symptoms improved significantly.

Table 16:
Comparison of the Intra-individual Changes (Experimental Group) and a Matched Pair Control-Group (by Sex and Age)

n=8; Controls n= 7	Sandplay (Arabic)	Control Group
CRIES pre: 2nd follow up: Mean (SD)	8,4 (11,4)	1,9 (7,0)
DSRS pre: 2nd follow up: Mean (SD)	12,3 (4,7)	3,4 (2,6)

Because of the small number of participants, the individual changes could be presented in the following figures 9-14 showing the partially impressive improvements.

The remaining 21 of the sample participating at the second follow up, even showed significant improvements. All could benefit from the exercises. Whether they were disabled or not or having a probable psycho-traumatization or not didn't play a role.

Table 17

All other children (n=21; without the controls)

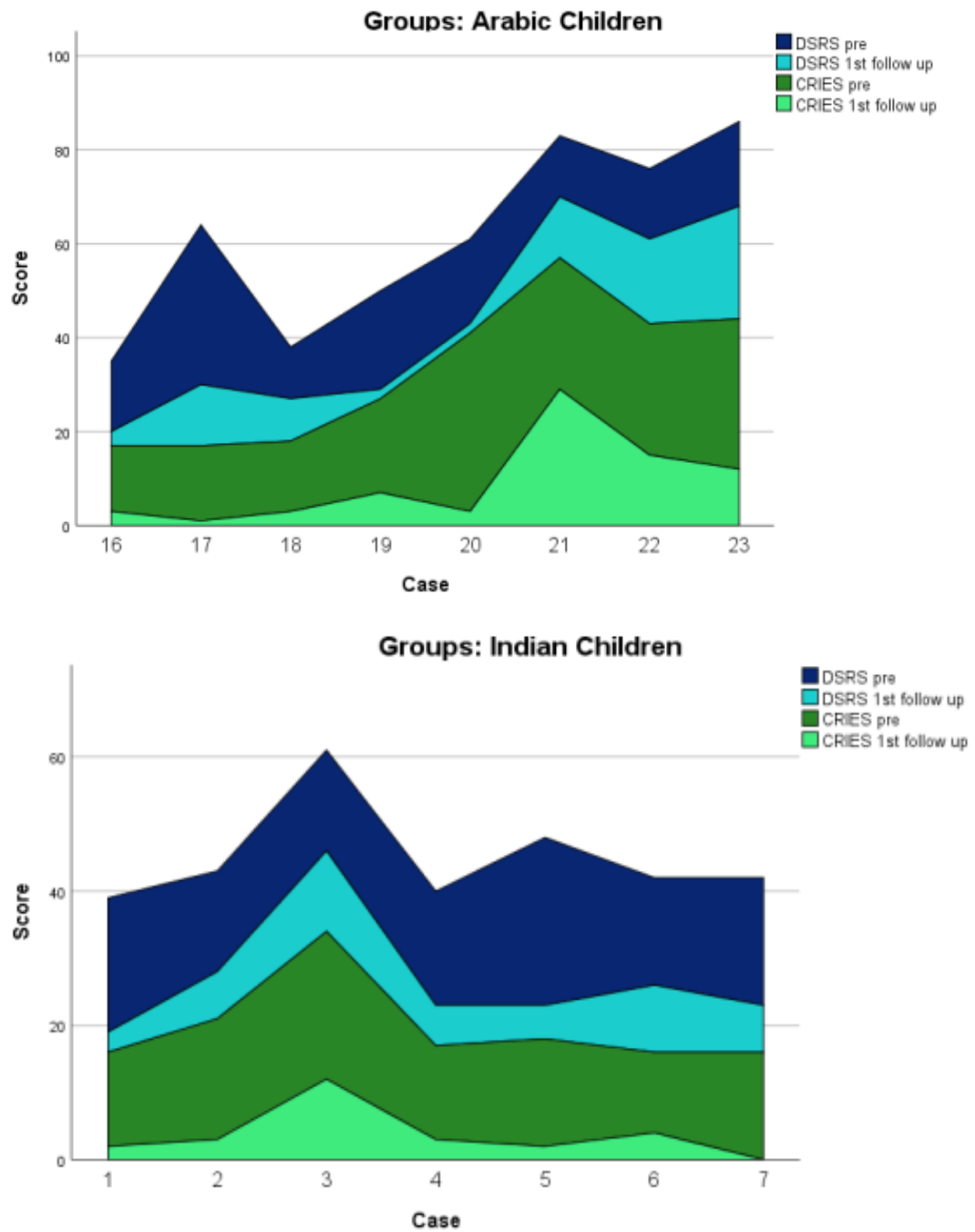
	Mean (SD)	Effect size r
CRIES pre	13,1 (7,6)	0,37
CRIES 2 nd follow up	8,2 (4,2)	
DSRS pre	14,1 (4,4)	0,55
DSRS 2 nd follow up	9,6 (2,0)	
Middle effect size > 0,3, strong effects >0,5 (fat)		

Comparing the children having participated at Sandplay with the other part of the Indian sample from which catamnesis data have been collected (n= 29), there is shown a significant advantage of the reprocessing, bothin the pre-post and the intra-individual comparison. (See table 17)

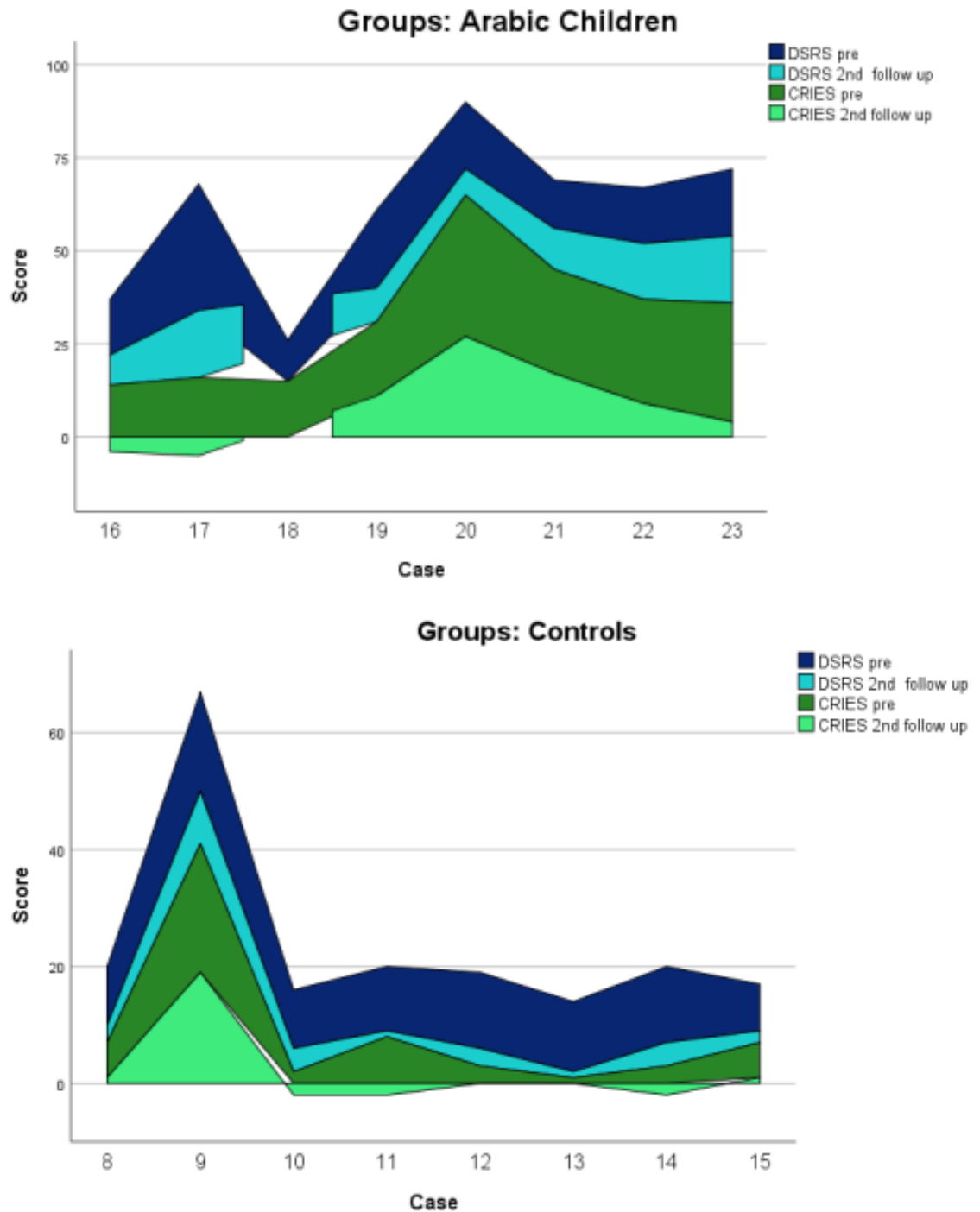
The level of depression is comparable, as expected the impact of event in the experimental group was higher. At the end of the first observation period and after 10 months there is a significant advantage in the Sandplay-group. Regarding the impact of event reaching the 1st follow up there was a significant reduction ($p < 0,05$), but not more at the 2nd follow up. Comparing the groups intra-individually the reductions are still more impressing. (Table 18, $p < 0,05$)

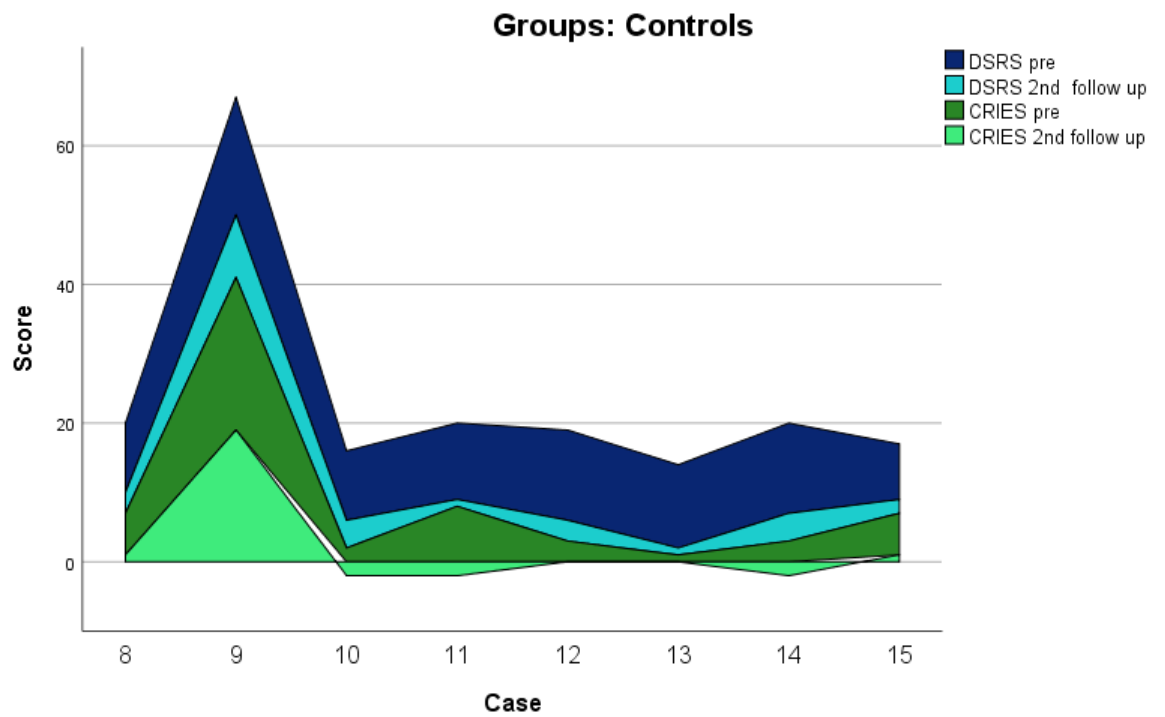
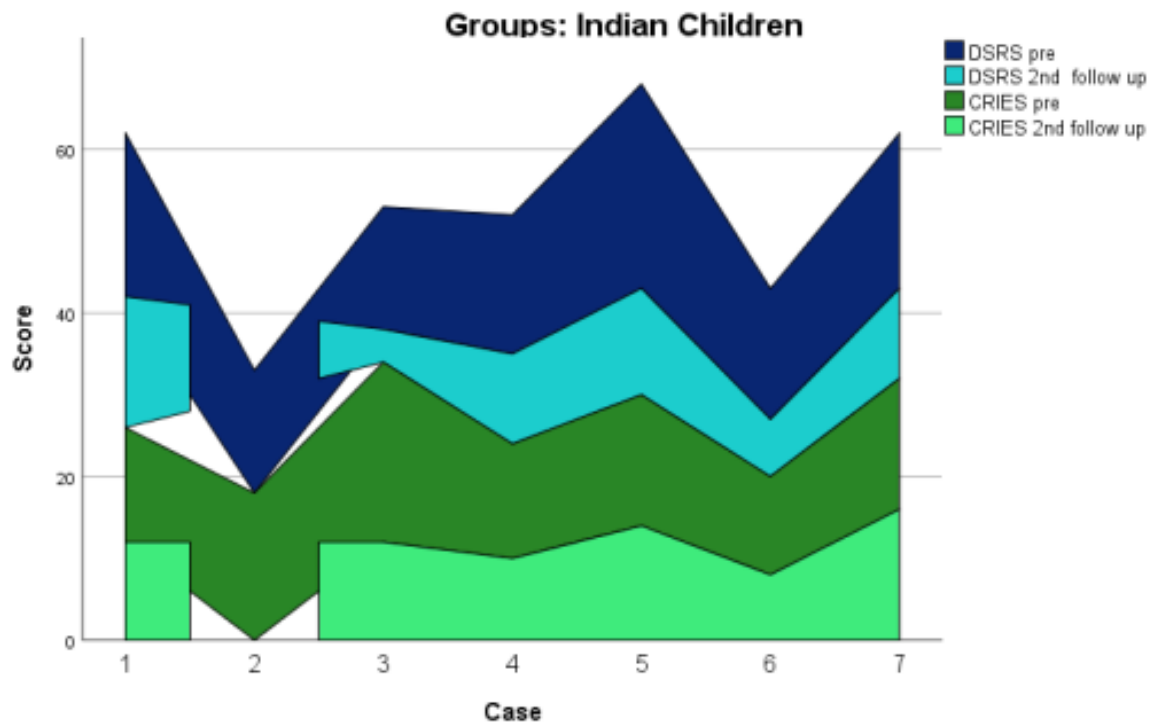
Figures 11 - 16: Comparisons

Pre-Assessment – 1st follow up



Pre-Assessment – 2nd follow up





**Figure 17:
Comparisons**

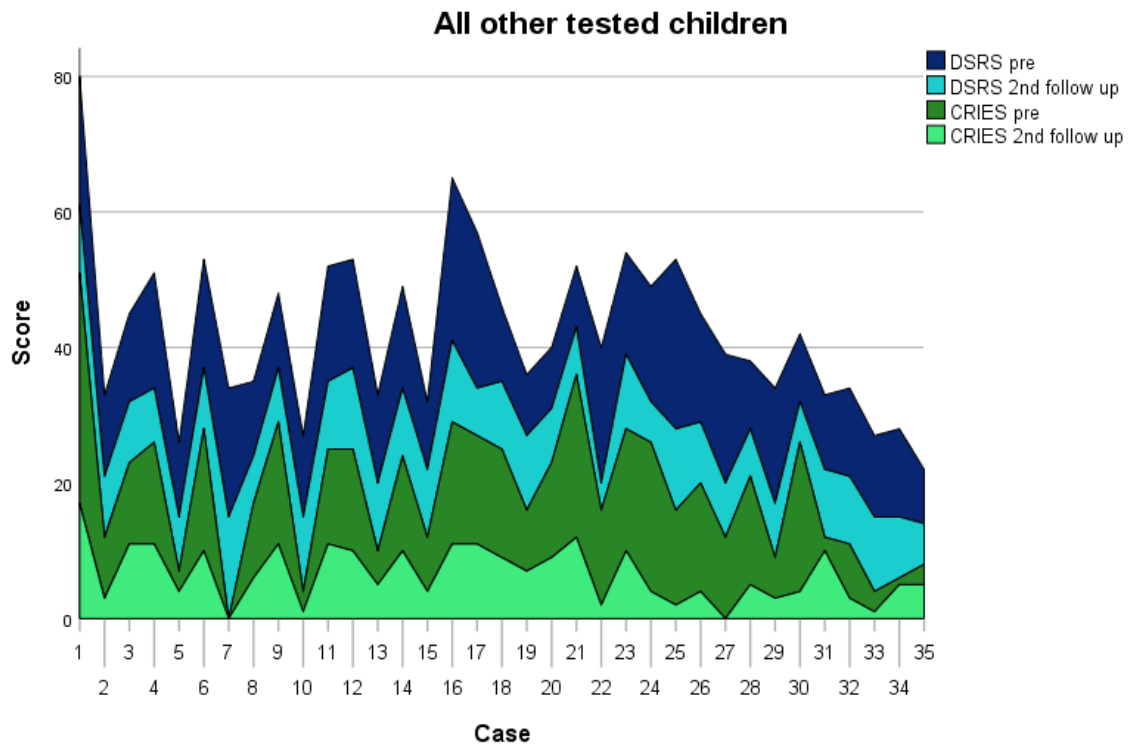


Table 18
Comparison of the Indian Experimental Group and All Other Indian Children Having Had a Test-Re-Test Evaluation (= including controls)

Impaired t-Test	Sandplay (n=6)	All others (29)
CRIES pre: Mean (SD)	18,0 (4,2)	11,2 (7,5)
CRIES 2nd follow up: Mean (SD)	5,7 (4,3)	6,8 (4,2)
DSRS pre: Mean (SD)	17,0 (5,3)	13,8 (4,2)
DSRS 2nd follow up: Mean (SD)	8,2 (3,1)	9,3 (2,0)

Table 19
Comparison of the Intra-individual Differences

	Sandplay (n=6)	All others (29)
CRIES pre – 2nd follow up: Mean (SD)	12,3(3,2)	4,4 (5,5)
DSRS pre – 2nd follow up: Mean (SD)	8,8 (5,4)	4,5 (4,0)

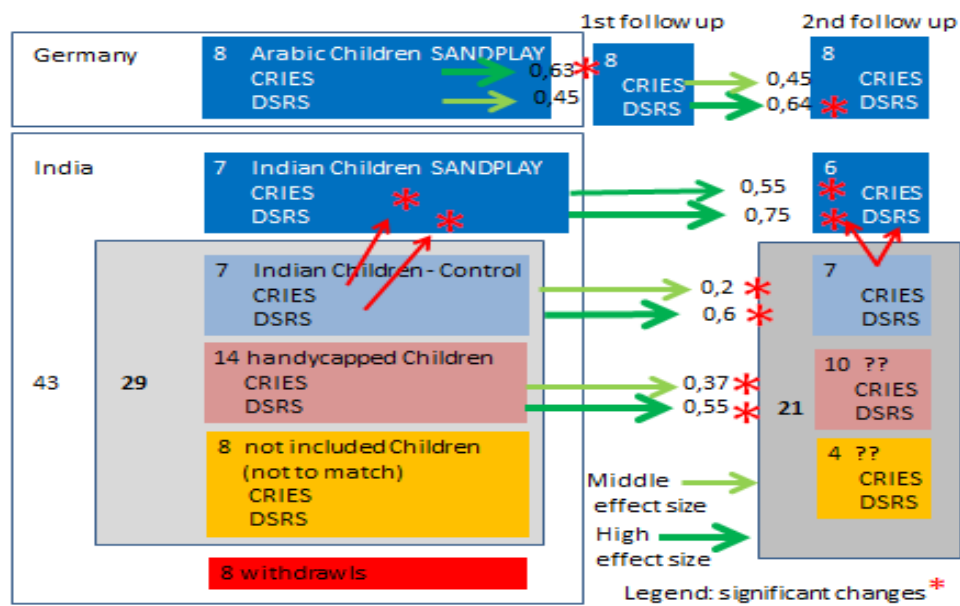
In a next step the intra-individual differences between the Indian control-group (n=8) and the Indian experimental group were compared. There were found highly significant changes ($p < 0,001$) in the case of the reduction of depressive symptoms in the long term follow up, but not in regards to the impact of event scales. No differences were found comparing the Indian and the Arabic experimental group.

The next figure will show an overview of all testing and levels of significant results.

Table 20
Comparison of the Arabic Experimental and The Indian Experimental Group

Sandplay (India, n=7) A Sandplay (Arabic, n=8) B	A	B
CRIES pre – 1 st follow up:- Mean (SD)	12,3 (4,7)	14,7 (5,5)
CRIES pre – 2nd follow up: Mean (SD)	12,0 (2,8)	8,4 (11,4)
DSRS pre- 1 st follow up: Mean (SD)	11,0 (6,0)	7,6 (10,6)
DSRS pre – 2nd follow up: Mean (SD)	10,3 (4,3)	12,3 (4,7)

Figure 18:
Schematic overview of all testing



DISCUSSION

The choice of the potential members of the first pilot-group was done more or less randomly by the teachers of the refugee- children in their first months in Germany. A screening procedure at that time in Germany seemed from the point of view of the authorities not politically correct, in the first months of the refugee crisis, as well as establishing a control-group. Therefore the control-group was recruited via the project at the Child Guidance Center, Hyderabad, being exactly a waiting list group, because there it was clear, that the Sandplay-groups will continue and earlier or later being open for all. In Comparison to the situation in Germany, where it could happen that the refugees could be moved very fast to a new residency, the Indian children should stay after admission in the so called happy homes for some years.

The significant reductions in regards to the denoted impact of events are up to the goal of the here presented therapeutic approach. Mostly high effect sizes are found, partially in the not experimental groups only by using the self-regulation techniques without reprocessing.

At the beginning in the German scientific and psychotherapeutic community the introduction of lay helpers was heavily discussed. But the results show, that the concept of assisting the professional child-psychotherapist and therefore allow to treat more children not in an individual therapeutic setting but in a group, is the right way.

The companionship of the automatically started and unconsciously controlled reprocessing by every single child is sufficient. More than that:

- Not to give verbal interpretations or clarifications or
- more than mimic or
- semantic emotional support, like “hmm” or sighing

regarding to the scenes, and

- not to force to play the dramas in the children`s life

but to support the unconscious time-planning of the child, helping him or her only by regulating down probable arousals or the stress level in general animating to use the self-stabilization techniques seems to be the efficient element.

The door is opened to do further interesting and required research, maybe using the videotapes of the sessions and the clinical knowledge about the children. The not statistical documented not sufficient reduction of the depressive syndromes seen in the first observation period in Germany could be also influenced by the very heavy living situation of the children and their parents, often also mentally ill or traumatized and not treated because of the circumstances and first of all the ongoing fear of sent back to the home country means back to sorrow, violence and war. But nevertheless, the results at the 2nd follow up after one year showing a highly significant reduction are satisfying.

The collaboration with India resulted from a Traumahelper-training in Germany, where a participant was identified working as a Lutheran pastor since many years in projects in India. The tasks to be mastered there were many: But to start with the easiest challenge: To recruit

parents or educators to be trained as Traumahelpers was not difficult, but the level of academic training is very different in comparison to the European standards. Even if English is the national official language in India, continuous translations in Telugu, and sometimes in Hindi had to be performed permanently. For that a sequential procedure was chosen. More than that, the transport of the information needed they had to be divided in small portions and local traditional teaching methods rather than power-point-presentations were necessary.

The content was to put information into short songs and visualized using models from the daily life of the participants, e.g. like

- a tree used as a symbol for at the same time the incapacity to move from the place but nevertheless the property to react by flexibility and having so something at ones command to overcome impacts, or
- fruits to have a symbol to build a bridge to the understanding of the vegetative nervous system, the role of energy support to the body and of the respiration to strengthen metabolism. Or a
- book (made from plants and woods) to integrate knowledge about physiology, active movements (like to thumb through) and respiration (while reading or singing loud) and to apply it (otherwise it wouldn't make sense to write it down).

Another way to spread information were lay theater performances as seen on pictures before. The inhabitants of the CGC already developed a role play to make clear, what kind of traumata can exist and what the consequences individually could be. To transport an idea of what is happening neurophysiological in the nervous system, a non-verbal brain-theatre was developed, as described before.

The statistical results obtained from the Indian sample are auspicious. At the Hyderabad Child Guidance Center 43 children and adolescents could be examined. To get information about traumatization in this population is sometimes difficult, because the Indian society is not very open. But in 10 of the participants (all orphans) the biography was clear and a trauma documented, because of the circumstances the children have been found in the streets, e.g. left alone in trash cans, railway stations or in front of “Happy Home”-doors. Sometimes a probable traumatization was assumed by the educators (in 63%; n=27).

A further aspect was the high rate of disabled children (14 out of the 43), having been traumatized in an equally coverage, with a larger number of females. The disabled were elder (mean age 18,6 years SD 3,1), because kept longer in the institutions like the CGC.

The Score in regard the trauma is little lower than in the reference groups (mean 11,71 (SD 5,85) compared to 13,31 (SD 8,55) and in the average slightly depressed (DSRS at the beginning mean 14,7 (SD 4,5)).

A nice side effect picked up of the training of the Traumahelpers which were recruited out of the staff of the institution, was the not expected development of the symptoms. Because of the narrow contact between the children, participating at the experimental group and the others not participating, all were learning the self-stabilization-techniques, e.g. the songs including SURE (walking on the place), SPB (while singing) and Bilateral Stimulation summarized as performed in the “action-song” Aramsamsam or SURE, in the original form, by simply copying or the “lying eight”, which they get like sweepstakes and was copied by all, too, as the educators reported, voluntarily performed even outside of the defined program, too.

The Traumahelper-training in India could be valued as a full success. More than that: The effects already seen in refugee kids in Germany participating Sandplay could set on a more stable ground using the Indian waiting list group as matched controls. At the beginning, as expected, because the more burdened children should have been treated first, so the experimental group had significantly higher scores in both testing; (CRIES, DSRS; $p > 0,05$), but in consequence also a significant improving either in the first and the second follow up. In the direct comparison, there was not so an impressive improvement in the control group, which had, as already mentioned, a lower score at the first assessment. The Impact of Event-Scores improved significantly in the experimental group, but not in the control-group, comparing pre – post scores. The effect size r can be valued as very effective ($r > 0,5$) meaning a good outcome. Even the intra-individual changes were highly significant for CRIES and significant for the DSRS. Beside: the depressive symptoms, even were lower scored at the beginning, the children improved significantly at the 2nd follow up. So clinically stated, there are seen very good effects after a treatment of 5 months in the Indian experimental group, performed due to external reasons and different from schedule, more or less only every second week for 5 months after a follow up of further 5 months not only stable but more improved. And the remaining 21 of the sample participating at the second follow up, even they showed significant improvements.

All CGC Children could profit from the exercises. Whether they were disabled or not or having a historical recorded potential psycho-traumatization or not, they all showed better results at the end.

In conclusion: A two day training of all teachers, educators and some helping parents (mostly of the disabled children) to enable the participants in diagnosing and scoring abnormal behavior but at the same time to instruct the children three different self-stabilization-

techniques and emotional control opens a very effective and helpful route. But not enough: The reevaluated special procedure Sandplay-Therapy combining reprocessing and applying self-regulating techniques plays the effect seen in the group of the other 29 children having been observed, out, both in the pre-post comparison and the intra-individual differences. So the effort, to realize Sandplay and not only to invest in a general Traumahelper instruction is profitable. But to offer “only” a Traumahelper training to improve the daily life potential is worth, too. Even the Traumahelpers by themselves can profit significantly for their self-regulation, as a recent study shows (B Leinberger, Dasi, und Loew 2018).

The first, now published German study about the consequences of trauma in children (Verlinden and Lindauer 2015) the authors conclude: 1st) Psycho-trauma is seen and has to be treated even in Germany. 2nd) Even if the German medical system is highly developed not even approximately all children with symptoms can get psychotherapy in the usual way (single sessions in ambulatories, private practice or institutions). There is no doubt, that this problem is seen world-wide.

So what is special in this Sandplay-Therapy concept? Capacities and efficacy of the nonverbal therapeutic approach is multiplied in consequence of the group concept. One child- and adolescent--psychotherapist can treat up to ten Children in weekly sessions for 12 weeks. So instead of two or three children in single settings, usually one hour a week with this Sandplay concept in the same time the psychotherapist can - with the help of the Traumahelpers treat about 30 children. The Traumahelpers are included as so called co-therapists, persons acting as attachment figures which stay stable with their fostering for these three months, so that they bridge the therapeutic process. This enables the children, to show and to share their traumatic experiences to a witness and helps to reduce their burden. The

presence of the Traumahelper in the group ensures the necessary awareness to the traumatized child all the time also offering and guiding self-regulation techniques like e.g. Bilateral Stimulation while the psychotherapist puts its attention on the whole group and intervenes, if needed, and supports the Traumahelper individually in critical situations.

CONCLUSION AND OUTLOOK

In this concept the groups are performed in places where the children could come easily and they were used to be. In Germany the refugees are often not allocated in the centers of the cities, so the children have to make complicated travels with public transportation to get to their schools. To run the same routes again in the afternoons is not reasonable, often impossible and often not to be performed by the parents, even if they are present – because of their own symptomatology. Sandplay-groups therefore are better performed in the residencies of the refugees, the camps or the schools, if possible.

In India also the places, where the children lived or went to school were chosen as therapy rooms, and not e.g. pediatric or psychiatric clinics, which are seldom and a long distance off. Also the Traumahelpers were chosen as the traumatized children's teachers and educators to guarantee continuity as far as possible.

Last but not least in this described manner trained lay-helpers could profit from the training for their lives. After training they were able to perform self-regulation and self-stabilization techniques. Burden and hassles are very common and part of the normal life as well as stress, not only in the western societies even in crisis regions so self-help-interventions are useful in every condition of life.

An introduction of the here presented easy to learn methods is helpful to reduce stress symptoms similar to yoga or other relaxation techniques as a side-effect.

Sympathy, understanding and attachment will rise. So Sandplay contributes to a process of the political correctness and a strongly needed integration of the people coming from a strange culture to Europe, but as shown, it also works abroad.

“The Path of Regensburg”, which multiplies psychotherapists using trained Traumahelpers can improve the care for all children and it doesn't matter whether local inhabitants or refugees.

The Sandplay-Therapy is good for children which have experienced flight or other traumatic events showing trauma-symptoms as mentioned. The aim is to prevent chronic symptoms which would influence the performance in the daily life activities and normal participation in their societies.

The main goal is to avoid chronic symptoms, which would affect the capacities to participate in the social life. Children having already PTSD diagnosis should be presented to an expert child psychiatrist or child psychotherapist, if it's possible to get. They need more treatment in single sessions. This also extends to children not being able to perform in groups because they have behavioral disorder in a manner that they disturb consequently and reduce the success of other participants.

But there are also intercultural aspects. The western way to understand stress phenomena and to handle them has to be emulsified with the different cultures and so the problems of the children can be considered, because of the narrow contact and cultural comprehension to the individual child's historical background during all the Sandplay-sessions. So the Traumahelper get something like a training about the living and attitudes the children have in their specific culture if they are abroad and learn about the effort the children show to establish in their own cultural conventions.

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APPENDIX

	Seite
1. Informed Consent, German/Arabic	188
2. UCLA-University California Los Angeles, Traumatic Stress Inventory, German/Arabic	190
3. CRIES, German/Arabic	194
4. CRIES, Telugu/English	196
5. DSRS-Depression Self Rating Scale for Children, Arabic	197
6. DSRS-Depression Self Rating Scale for Children, English	198
7. Aramsamsam-Song and Movements	199
8. Fragebogen zur Sekundären Traumatisierung	200
9. Fragebogen zur Erfassung der aktuellen Ressourcenrealisierung (RES)	202

Informed Consent German / Arabic

Einverständniserklärung

Name des Vaters: _____ geboren am: _____

Name der Mutter: _____ geboren am: _____

Name des Kindes: _____ geboren am: _____

Hiermit erkläre ich _____ mich mit Folgendem
einverstanden:

Filmaufnahmen meines Kindes während der Traumabehandlung zu Lehr- und
Dokumentationszwecken.

Durchführung diagnostischer Methoden im Rahmen der
psychotherapeutischen Behandlung wie z.B. QEEG, Speicheltest, HRV
(Herzratenvariabilitäts-) Test.

Psychotherapeutische Gruppenbehandlung mit Anwesenheit und
Unterstützung von zertifizierten Traumahelfern und/oder weiteren Kinder- und
Jugendpsychotherapeuten.

Kooperation mit Ärzten, Lehrkräften, Erziehern, Schulen, Ehrenamtlichen
Helfern und anderen Einrichtungen, die vor und während der Behandlung mit
dem Kind Kontakt hatten/haben.

(Ort, Datum)

(Unterschrift der Eltern)

وثيقة موافقة

اسم الاب:.....مولود بتاريخ.....
اسم الام:.....مولوده بتاريخ.....
اسم الطفل:.....مولود بتاريخ.....

أنا الموقع ادناه اوافق على ما يلي:

التصوير التلفزيوني لولدي أثناء تلقيه للعلاج النفسي لاستخدام ذلك لأغراض تعليمية وثائقية

اجراء فحوصات تشخيصية في اطار عملية العلاج النفسي كفحص التخطيط الدماغى الكهربائى وفحص
اللعاب ومعدل نبضات القلب.

اجراء العلاج الطبى بحضور ودعم مساعدين مدربين و/ أو اخصائى العلاج النفسى للأطفال .

التعاون مع الاطباء، المعلمين، المربين، المدارس، المتطوعين، وغيرهم من الجهات التي لها اتصال
بالطفل أثناء فترة العلاج.

المكان والتاريخ:

توقيع الوالدين

UCLA – Child Traumatic Stress Inventory German / Arabic

اسمك

الاسم :
الجنس :
الصف :
المعلم :
التاريخ :
الجنس :
المدرسة :
المدينة :
أنثى ذكر

في الأسفل مجموعة من الحوادث والأشياء الصعبة التي يمكن أن يتعرض لها الإنسان في حياته ، في تعرضك للحادثة الرجاء الإجابة بنعم وان لم تتعرض لها فاجب بلا .

Name _____ Datum _____ Alter _____ Geschlecht: Weiblich () Männlich ()
Schulklasse _____ Schule _____ Lehrer _____ Stadt _____

Unten aufgeführt ist eine Liste von SEHR ERSCHRECKENDEN, GEFÄHRICHEN ODER GEWALTSAMEN Dingen, die manchmal Menschen passieren. Dies sind Situationen, bei denen jemand SEHR SCHWER VERLETZT ODER GETÖTET wurde, oder dies beinahe geschehen wäre. Es gibt Menschen, die diese Erfahrung gemacht haben, andere nicht. Bitte sei ehrlich wenn Du darauf antwortest, ob diese gewaltsamen Dinge Dir passiert sind, oder nicht.
Für jede Frage: Kreuze „Ja“ an, wenn dir diese erschreckende Sache Dir passiert ist.
Kreuze „Nein“ an, wenn Dir das nicht passiert ist.

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لا Nein	نعم Ja	
		هل عاينت زلزال شديد أدى إلى تدمير المبني الذي تسكن فيه؟ 1) Erleben eines starken Erdbebens, sodass das Gebäude in dem du warst, zerstört wurde.
		هل عاينت كارثة ما كحريق، إحصار، فيضان أو عواصف شديدة؟ 2) Erleben einer anderen Katastrophe z.B. Feuer, Tornado, Überflutung oder Hurrikan.
		هل تعرضت لحادث صعب كحادث سير شديد مثلاً؟ 3) Erleben eines schlimmen Unfalls z.B. ein sehr schlimmer Autounfall.
		هل سبق لك التواجد في مكان ما تحدث فيه نشاطات حربية؟ 4) An einem Ort sein, an dem Kriegshandlungen stattfinden.
		هل سبق لك التعرض في البيت للركل الدفع أو التعرّب المبرح؟ 5) Zuhause sehr fest geschlagen, gestoßen oder getreten werden. (Nicht gemeint: normale Rangeleien zwischen Brüdern und Schwestern).
		هل سبق وإن شاهدت أحد أفراد عائلتك في البيت يضرب بشدة أو يركل؟ 6) Sehen wie ein Familienmitglied zu Hause sehr fest geschlagen, gestoßen oder getreten wird. (Nicht gemeint: normale Rangeleien zwischen Brüdern und Schwestern).
		هل سبق وإن تعرضت في مدينتك للضرب المبرح أو إطلاق النار عليك أو التهديد بالاعتداء عليك؟ 7) In deiner Stadt zusammengeschlagen, angeschossen oder bedroht werden, dass man sehr schwer verletzt wird.

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لا Nein	نعم Ja	
		هل سبق وإن شاهدت في مدينتك شخصاً ما يتعرض للضرب المبرح أو إطلاق النار عليه أو القتل؟ 8) Sehen, wie jemand in deiner Stadt zusammengeschlagen, angeschossen oder ermordet wird.
		هل سبق إن شاهدت جثة شخص مقتول في مدينتك (لا يشمل المشاركة في جنازة عادية)؟ 9) Einen toten Körper in deiner Stadt sehen (schließt keine Beerdigungen ein).
		هل سبق إن قام شخص بالغ أو شخص يكبرك سناً بملامستك في أماكن حساسة من جسمك ، حتى وإن لم ترد ذلك؟ 10) Von einem Erwachsenen oder jemanden der sehr viel älter als du ist, an intimen Körperstellen berührt werden, auch wenn du es nicht wolltest.
		هل سبق وسمعت بتعرض شخص عزيز عليك لإصابة خطيرة أو للقتل؟ 11) Vom gewaltsamen Tod oder einer ernsthaften Verletzung einer geliebten Person hören.
		هل سبق وإن خضعت لإجراء طبي صاحبه ألم شديدة، بسبب مرض شديد أو إصابة خطيرة؟ 12) Eine schmerzvolle und furchterregende medizinische Behandlung in einem Krankenhaus erhalten haben, als du sehr krank oder schwer verletzt warst.
		باستثناء الأمور المذكورة سابقاً ، هل سبق وإن تعرضت لحادثة مرعبة ، خطيرة أو مماثلية؟ 13) Außer den vorher beschriebenen Situationen, gab es je etwas, das Dir passiert ist und sehr erschreckend, gefährlich oder gewaltsam war?

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14:

إذا أجبت سؤال واحد فقط بنعم فاكُتب رقم السؤال

a) Falls du nur eine der Fragen 1-13 mit „Ja“ beantwortet hast, schreibe deren Nummer auf die Zeile _____

إذا أجبت أكثر من سؤال بنعم فاكُتب رقم الشيء الذي أثر بك أكثر

b) Falls du mehrere Fragen mit „Ja“ beantwortet hast, schreibe bitte die Nummer der Sache, die dich am meisten plagt, auf die Zeile: _____

كم مضي من الوقت طي الحادثة؟ _____

c) Wie lange ist es her, dass diese schlimme Sache (bei a) oder b) beantwortet) dir passierte? _____

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فيما يلي مجموعة من الأشياء التي يمكن أن تحدث للشخص بعد تعرضه لظروف شديدة الصعوبة ، الرجاء اختيار عدد المرات التي تكرر فيها كل أمر من الأشياء التالية خلال الشهر الأخير !.

Nun folgt eine Liste von Problemen, die Menschen manchmal haben, nachdem sehr schlimme Dinge passiert sind. Bitte denke über die schlimme Sache, die dir passiert ist und die du in Frage Nummer 14 beschrieben hast nach. Dann, lese bitte jedes Problem der Liste sorgfältig. Kreuze die Nummer (0, 1, 2, 3, oder 4) an, die beschreibt, wie oft das Problem im letzten Monat bei dir akut war.

0 = nie / 1= selten / 2= oft / 3 = häufig / 4 = fast immer oder immer

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0	1	2	3	4	كم مرة خلال آخر شهر؟ Wie häufig während des letzten Monats?
					تخضرتني أفكار، صور وأصوات مزعجة مما حصل ، بالرغم من عدم رغبتني بذلك 3 B1) Mir kommen bestürzende Gedanken, Bilder oder Geräusche von dem was passiert ist in den Sinn, wenn ich es nicht möchte.
					أحلم بما حصل ، أو أعاني من أحلام وكوابيس مزعجة 5 B2) Ich träume von dem was passiert ist oder habe andere schlechte Träume.
					أشعر بأنني أعود بالزمن إلى الوقت الذي حصلت به الحادثة. أعيش ما حصل مرة أخرى من جديد 6 B3) Ich fühle mich, als wäre ich zurück in der Zeit, in der mir diese schlimme Sache passierte. Ich durchlebe es noch einmal.
					عندما يذكرني أي شيء بما حصل ، أفقد السيطرة على نفسي ، أشعر بالخوف أو الحزن 2 B4) Wenn mich etwas an das Geschehene erinnert, gerate ich aus der Fassung, werde ängstlich oder traurig.
					عندما أتذكر الحادثة أشعر بكم في الرأس أو البطن أو تسارع في دقات القلب 18 B5) Wenn mich etwas an das Ereignis erinnert, habe ich starke körperliche Reaktionen, z.B. schlägt mein Herz schnell, mein Kopf schmerzt oder mein Bauch tut weh.

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0	1	2	3	4	كم مرة خلال آخر شهر؟ Wie häufig während des letzten Monats?
					أحاول تجنب الحديث عما حصل أو مجرد التفكير به ، وأحاول منع حضور أي مشاعر تتعلق بالحادثة. 9 C1) Ich versuche nicht über das was passiert ist, zu reden, nachzudenken oder Gefühle aufkommen zu lassen (absichtlich).
					أحاول الابتعاد عن الأشخاص والأشياء والأماكن التي تذكرني بالحادث 17 C2) Ich versuche mich von Leuten, Orten oder Dingen (Aktivitäten) fernzuhalten, die mich an das Ereignis erinnern.
					لدي مشاكل وصعوبة في تذكر أجزاء مهمة من الحادثة 15 C3) Ich habe Probleme mich an wichtige Teile des Ereignisses zu erinnern.
					أحياناً أشعر بأنني أريد البقاء لوحدي وأن لا أكون مع أصدقائي 7 C4) Ich fühle mich, als würde ich lieber für mich bleiben und nicht mit meinen Freunden zusammen sein.
					أشعر بداخلي بأنني وحيد وأنني بعيد عن الآخرين. 8 C5) Ich fühle mich innerlich einsam und anderen Menschen nicht nah.

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0	1	2	3	4	
					من الصعب علي الشعور بالحب أو السعادة 10 C6) Ich habe Schwierigkeiten Glück oder Liebe zu empfinden.
					من الصعب علي الشعور بالحزن أو الغضب. 11 C6) Ich habe Schwierigkeiten Traurigkeit oder Ärger zu spüren.
					أعتقد بأنني لن أعيش طويلاً . 19 C7) Ich denke, dass ich nicht lange leben werde.
					أركز كثيراً على المخاطر والأشياء التي أخاف منها. 1 D4) Ich bin aufmerksam gegenüber Gefahr oder Dingen, vor denen ich Angst habe.
					أشعر بأنني شديد الغضب. أو بالجنون. 4 D2) Ich fühle mich nörglerisch, ärgerlich oder verrückt.

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0	1	2	3	4	
					أفزع بسهولة ، مثلاً عندما أسمع صوت عالي أو عندما يقوم ما احد بمفاجئتي . 12 D5) Ich bin hippelig / zappelig oder erschrecke leicht, z.B. wenn ich ein lautes Geräusch höre oder mich etwas überrascht.
					لدي مشاكل في النوم ، أو استيقظ كثيراً من نومي ليلاً. 13 D1) Ich habe Probleme einzuschlafen oder wache nachts oft auf.
					لدي مشاكل في التركيز والانتباه. 16 D3) Ich habe Probleme mich zu konzentrieren oder aufmerksam zu sein.
					أشعر بأنني أحمّل جزء من المسؤولية عما حدث. 14 AF) Ich denke, dass das was passierte zum Teil meine Schuld war.
					لدي خوف بأن ما حصل سيكرر مرة أخرى. 20 AF) Ich habe Angst, dass diese schlimme Sache noch mal passieren wird.

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CRIS German/Arabic

Ort: _____ Datum: _____

Name / Code: _____ Alter: _____ Geschlecht: M / W

CRIS- Kinder

		gar nicht	selten	manch- mal	nie
1	Denkst Du an das Trauma, auch wenn Du gar nicht daran denken willst?				
2	Versuchst Du das Trauma aus deinem Gedächtnis zu streichen?				
3	Hast Du deswegen plötzlich auftretende starke Gefühle?				
4	Hälst Du Dich fern von Dingen, die dich daran erinnern? (zum Beispiel Orte oder Situationen)				
5	Versuchst Du, nicht darüber zu reden?				
6	Kommen Dir plötzlich Bilder davon in den Kopf?				
7	Lösen andere Dinge solche Gedanken bei Dir aus?				
8	Versuchst Du, nicht daran zu denken?				

CRIES- Kinder

ORT المكان	Manifestation التعبير	Seiten الجهة	ge- schlecht الجنس	Name _____ Alter/Klasse _____ Geschlecht: M W Datum _____ الاسم _____ العمر / الصف _____ الجنس: ل / ر التاريخ: _____	
				Denkst Du an das Trauma, auch wenn Du gar nicht daran denken willst? هل تفكر بالحادثة بل رغم من هم نريدك التفكير بها؟	1
				Versuchst Du das Trauma aus deinem Gedächtnis zu streichen? هل تحاول مسح ما جرى من ذاكرتك؟	2
				Hast Du deswegen plötzlich auftretende starke Gefühle? هل لذلك بسبب الحادثة مشاعر شديدة تأتي بشكل فجائي؟	3
				Hältst Du dich fern von Dingen, die dich daran erinnern? (zum Beispiel Orte oder Situationen) هل تبعد عن الأشياء التي تذكرك بالحادثة؟ (على سبيل المثال أماكن أو مواقف معينة)	4
				Versuchst Du, nicht darüber zu reden? هل تحاول الامتناع عن الحديث عما جرى؟	5
				Kommen dir plötzlich Bilder davon in den Kopf? هل تخطر في ذهنك صورا من الحادثة بشكل فجائي؟	6
				Würden andere Dinge solche Gedanken bei Dir aus? هل توجد أشياء تلهوذا التفكير بما جرى؟	7
				Versuchst Du, nicht daran zu denken? هل تحاول الامتناع عن التفكير بذلك؟	8

CRIES Telugu / English

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.

వరుస సంఖ్య		Not at all అన్నింటికీ లేదు	Rarely రారే కాదు	Some times అప్పుడప్పుడు	Often ఎప్పుడూ ఉంది	In	Av
1.	Do you think about it even when you don't mean to? అనువదలకుండా ఆలోచనలు మీకు వచ్చేవిలే వస్తున్నాయా/ వాటిని మీరు అర్థం చేసుకోవడం కోరుకున్నారా?	✓					X
2.	Do you try to remove it from your memory అనువదల ఆలోచనలు మీ జ్ఞాపకశక్తిలో నుండి తొలగించుకుంటు ప్రయత్నిస్తున్నారా?				✓	X	
3.	do you have waves of strong feelings about it దీని ఒత్తిడిపట్ల మీకు బలమైన భావన కలుగుతుందా?	✓					X
4.	do you stay away from reminders of it [e.g. places or situations] దీని ఒత్తిడి కలిగించే జ్ఞాపకాలకు దూరంగా ఉంటున్నారా?				✓	X	
5.	Do you try not talk about it? దీని ఒత్తిడి కలిగించే విషయాల గురించి మాట్లాడటానికి జప్తు చేసుకుంటున్నారా?	✓					
6.	do pictures about it pop in to your mind? అనుకోకుండా దీని ఒత్తిడిని కలగజేసే చిత్రాలు గుర్తుకొస్తుంటాయా?	✓					
7.	Do other things keep making you think about it? ఇతర విషయాలు ఒత్తిడిని గూర్చి విషయ ఆలోచన చేస్తున్నాయా?			✓			
8.	Do you try not to think about it? ఒత్తిడి యొక్క ఆలోచనల నుండి నివారించుకు రుచుకుంటు ప్రయత్నిస్తున్నారా?				✓		

Legend: In.= Intrusion; Av. =Avoidance

Depression Self-Rating Scale for Children

الجمال التالية تصف شعورك خلال الشهر الماضي . لا يوجد إجابة صحيحة أو خاطئة ، من الضروري أن تصف كيف شعرت ، الرجاء بصدق قدر استطاعتك .

	أبداً	أحياناً	غالباً	خلال الشهر الماضي	
1	2	1	0	أتطلع بشوق نحو الأمور بقدر ما كنت أفعل سابقاً	1
2	2	1	0	.....أنا جيد جداً	2
3	0	1	2	.....أشعر برغبة في البكاء	3
4	2	1	0	.....أحب أن أخرج وألعب	4
5	0	1	2	.....أشعر برغبة في الهرب	5
6	0	1	2	.....أعاني من أوجاع في المعدة	6
7	2	1	0	.....لدي طاقة كبيرة	7
8	2	1	0	.....أستمتع بتناول الطعام	8
9	2	1	0	.....أستطيع أن أدافع عن نفسي	9
10	0	1	2	.....أعتقد أن الحياة لا تستحق العيش	10
11	2	1	0	.....أجيد ما أقوم به من أعمال	11
12	2	1	0	.....أستمتع بالقيام بالأمور بقدر ما كنت أفعل	12
13	2	1	0	.....أحب التحدث مع أفراد عائلتي	13
14	0	1	2	.....أعاني من الأحلام المرعبة	14
15	0	1	2	.....أشعر بوحدة كبيرة	15
16	2	1	0	.....يسهل إدخال البهجة إلي	16
17	0	1	2	.....أشعر بوحدة شديدة لا أكاد أتحمّلها	17
18	0	1	2	.....أشعر بممل كبير	18

Birleson (1981)

DSRS English

DEPRESSION SELF-RATING SCALE FOR CHILDREN (Birleson 1978)

Instructions:

This self-rating scale was developed for children between the ages of 8 and 14 years of age. Please explain to the child that the scale is a way of getting to know how children really feel about things. Give the scale to the child with the directions below. If children have difficulty in reading any of the items, clinicians may read out the statements in a neutral tone of voice that indicates no preference in what they wish to hear.

Please read these statements and tick the answer that best describes how you have felt during the past week. It is important to answer as honestly as you can. The correct answer is to say how you have really felt.

		Mostly	Sometimes	Never	
1.	I look forward to things as much as I used to..	[0]	[1]	[2]	___
2.	I sleep very well.....	[0]	[1]	[2]	___
3.	I feel like crying.....	[2]	[1]	[0]	___
4.	I like to go out to play.....	[0]	[1]	[2]	___
5.	I feel like running away.....	[2]	[1]	[0]	___
6.	I get tummy aches.....	[2]	[1]	[0]	___
7.	I have lots of energy.....	[0]	[1]	[2]	___
8.	I enjoy my food.....	[0]	[1]	[2]	___
9.	I can stick up for myself.....	[0]	[1]	[2]	___
10.	I think life isn't worth living.....	[2]	[1]	[0]	___
11.	I am good at the things I do.....	[0]	[1]	[2]	___
12.	I enjoy the things I do as much as I used to...	[0]	[1]	[2]	___
13.	I like talking with my family/friends/staff.....	[0]	[1]	[2]	___
14.	I have bad dreams..... [2]	[1]	[0]	___	
15.	I feel very lonely.....	[2]	[1]	[0]	___
16.	I am easily cheered up.....	[0]	[1]	[2]	___
17.	I feel so sad I can hardly stand it.....	[2]	[1]	[0]	___
18.	I feel very bored.....	[2]	[1]	[0]	___
.					Score

ARAMSAMSAM



A - ram sam sam, a - ram sam sam,
gul - li gul - li gul - li gul - li ram sam sam
A - ra - bi, a - ra - bi,
gul - li gul - li gul - li gul - li ram sam sam



(Quelle:
<http://www.skg-forum.de/liederdruck/lied004druck.htm>)

Bewegungen/
Movements:

Wir stehen im Kreis. **We stand in a circle.**

Aramsamsam: Treten auf der Stelle, Hände klopfen über Kreuz auf die Oberarme.

Walk on the place, hands over cross clapping the upper arms.

Gulligulligulligulli: Hände drehen sich vor dem Körper umeinander.
Hands roll around each other.

Arabi: Beide Arme weit nach oben strecken, weiter auf der Stelle treten.
Both arms stretched to the ceiling, walking on the place all the time

Fragebogen zur Sekundären Traumatisierung

(Motta & Joseph, 1998; dt. Maercker, 2000)

Bitte denken Sie an eine schlimme Erfahrung, die Sie im Zusammenhang mit einem traumatischen Erlebnis eines anderen Menschen gemacht haben. Dieser andere Mensch kann ein Patient, eine zu rettende Person, aber auch ein Familienmitglied oder ein Freund gewesen sein.

Was für ein Ereignis war das? _____

In welcher Beziehung standen/steht Sie zu dem damals betroffenen Menschen?

Bitte kreuzen Sie die folgenden Kategorien an, die für die jeweiligen Sätze zutreffend waren.

Aussage	stimmt				
	überhaupt nicht	ein wenig	bin mir nicht sicher	oft	sehr oft
1. Ich zwingen mich selbst, mich nicht an bestimmte Gefühle oder Gedanken zu erinnern, die mit den oben beschriebenen Schwierigkeiten verbunden waren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Ich merke, daß ich bestimmte Aktivitäten vermeide, weil sie mich an diese Probleme erinnern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Ich habe Schwierigkeiten einzuschlafen oder durchzuschlafen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Ich bin leicht erschreckbar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ich habe ungewollt lebhaft Erinnerungen oder Bilder, die mit dem Problem zusammenhängen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Ich bin erschrocken über die Dinge, die er oder sie zu mir sagten oder die sie taten.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Ich habe beunruhigende Träume, die den Ereignissen ähnlich sind.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

8. Ich habe wiederkehrende, ungewollte Gedanken über das Problem.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Ich habe Schlafprobleme durch diese Ereignisse bekommen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Ich denke, dass ich durch diese Erfahrungen in Mitleidenschaft gezogen sein könnte	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Ich fühle mich wie "auf der Kippe" und sehr belastet und das wird mit den Gedanken an diese Probleme zusammenhängen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Ich hätte mir gewünscht, dass ich den oben genannten Problemen aus dem Wege hätte gehen können.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Es fällt mir schwer, mich an bestimmte Einzelheiten der genannten Probleme zu erinnern	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Ich merke, dass ich das Interesse an Tätigkeiten verloren habe, die mir Freude bereiten	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Ich finde es zunehmend schwer, warmherzige und positive Gefühle Anderen gegenüber zu haben.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Meine eigene Zukunft ist mir weniger klar und ich sehe sie weniger optimistisch als ich sie früher gesehen habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Ich habe Schwierigkeiten, mich zu konzentrieren	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Ich würde mich bedroht und verletzbar fühlen, wenn ich das erlebt hätte, was der oben genannten Person zugestossen ist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Ich hätte starke Schrecken und intensive Furcht erlebt, wenn ich ihr oder sein Problem gehabt hätte	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Ich habe belastende Erinnerungen und störende Gedanken durch die Erlebnisse der anderen Person.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Fragebogen zur Erfassung der aktuellen Ressourcenrealisierung (RES)

Dieser Fragebogen enthält Aussagen zu verschiedenen Bereichen, die allgemein in einem engen Zusammenhang stehen zu dem Wohlbefinden und der Lebenszufriedenheit von Menschen. All diese Aussagen beinhalten Verhaltensweisen oder Situationen, die Sie von *nie* über *zeitweise* bis hin zu *sehr häufig* erleben können.

Um anzugeben, wie häufig Sie dies jeweils erleben, kreuzen Sie bitte jeweils rechts eine der vorgegebenen Antwortmöglichkeiten an. Für jeden Bereich ist durch "___" gekennzeichnet, wo die Häufigkeitsangabe ausgelassen worden ist. Bitte vervollständigen Sie an dieser Stelle in Gedanken die Aussage durch eine der Häufigkeitsaussagen.

Hier ist ein Beispiel für den Bereich "Wohlbefinden":

Beispiel: Während der letzten 4 Wochen habe ich mich zeitweise (3) wohl gefühlt, weil ich bei jemandem Geborgenheit und Sicherheit gefunden habe.

	nie		zeitweise		sehr häufig	
	0	1	2	3	4	5
Während der letzten 4 Wochen habe ich mich ___ wohl gefühlt, weil ... ich bei jemandem Geborgenheit und Sicherheit gefunden habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	X	<input type="checkbox"/>	<input type="checkbox"/>

Grundsätzlich gibt es hierbei keine "guten" oder "richtigen" Aussagen. Wichtig ist vielmehr, welche persönlichen Erfahrungen Sie in der letzten Zeit gemacht haben. Bitte überlegen Sie daher auch nicht, welche Antwort den "besten" Eindruck machen könnte. Sie können sich darauf verlassen, daß alle Ihre Antworten vertraulich behandelt werden.

Bitte überlegen Sie bei der Beantwortung der Fragen nicht zu lange. Im Zweifelsfall entscheiden Sie sich einfach für eine der Antwortmöglichkeiten. Vielleicht haben Sie zwischendurch den Eindruck, eine der Fragen in diesem oder in einem anderen Zusammenhang schon einmal beantwortet zu haben. Bitte beantworten Sie dennoch der Reihe nach alle Fragen und lassen Sie keine aus.

Vielen Dank!

I. Wohlbefinden

Bitte schätzen Sie ein, wie sehr die folgenden Situationen *während der letzten 4 Wochen* dazu beigetragen haben, daß Sie sich wohl gefühlt haben.

Während der letzten 4 Wochen habe ich mich ____ wohl gefühlt, weil ...		<i>nie</i>		<i>zeit weise</i>		<i>sehr häufig</i>		
		0	1	2	3	4	5	6
1	... ich bei jemandem Geborgenheit und Sicherheit gefunden habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	... ich mit Freunden oder Bekannten zusammen gewesen bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... ich mit meiner/m PartnerIn oder meiner Familie zusammen gewesen bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... ich meinem Hobby nachgegangen bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... ich anregende und interessante Erlebnisse gehabt habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... ich etwas für meine Gesundheit und Fitneß getan habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... ich mir Zeit genommen habe, mich auf mich selbst zu besinnen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... ich religiöse oder spirituelle Erlebnisse gehabt habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... ich mich bewusst entspannt habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... ich etwas erledigt habe, was schon seit einiger Zeit angestanden hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	... ich etwas geleistet habe, auf das ich stolz sein kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	... ich etwas besonders Schönes unternommen habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

II. Bewältigung von alltäglichem Stress

Die folgenden Fragen beziehen sich auf verschiedene Möglichkeiten, im Alltag (z.B. während der Arbeit, im Haushalt usw.) mit stressigen Situationen fertig zu werden. Bitte beziehen Sie Ihre Antworten nur auf Ihre Erfahrungen während der letzten 4 Wochen.

Wenn ich während der letzten 4 Wochen Stress im Alltag erlebt habe, dann hat es mir ____ geholfen, ...		nie		zeit weise		sehr häufig		
		0	1	2	3	4	5	6
1	... mir einen Überblick über die Situation zu verschaffen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	... mich zu motivieren, indem ich mir meine Ziele oder Fortschritte vor Augen geführt habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... Gespräche zu suchen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... von anderen akzeptiert zu werden.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... mich zu entspannen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... Dampf abzulassen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... meinem Hobby oder meinen Interessen nachzugehen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... meine Vorstellungen einzubringen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... mich abzugrenzen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... mir etwas zu gönnen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	... zu wissen, daß ich die Situation meistern kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	... mich zurückzuziehen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	... zu wissen, daß die Belastung nur vorübergehend ist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	... mich mit der Situation abzufinden.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

III. Unterstützung im Alltag

Bitte beurteilen Sie bei den folgenden Fragen, auf welche Weise Sie während der letzten 4 Wochen im Alltag von anderen Menschen unterstützt worden sind.

<u>Während der letzten 4 Wochen</u> habe ich im Alltag ____ Unterstützung erfahren, indem ...		nie			zeit weise		sehr häufig	
		0	1	2	3	4	5	6
1	... jemand etwas mit mir zusammen unternommen hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	... mir jemand hilfreiche Kritik gegeben hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... mir jemand konkrete Perspektiven aufgezeigt hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... mir jemand konkrete Hilfe angeboten hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... mir jemand Vertrauen entgegen gebracht hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... jemand Rücksicht auf mich genommen hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... Personen um mich herum gut miteinander ausgekommen sind.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... mir jemand mitfühlend zugehört hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... mir jemand eine kleine Aufmerksamkeit erwiesen hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... mich jemand ermutigt hat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	... ich bei jemandem Dampf ablassen konnte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

IV. Bewältigung früherer Krisen

Die folgenden Fragen beziehen sich auf eine frühere Krise in Ihrem Leben, die Sie heute nicht mehr oder kaum noch belastet. *Beispiele* für solche Krisen können sein: Verlusterlebnisse (Trennungen von Partnern, Tod naher Angehöriger u.a.), einschneidende Lebensereignisse durch Unfälle, ernsthafte Erkrankungen (auch naher Angehöriger), einschneidende Erfahrungen im Berufsleben (Kündigung, Arbeitslosigkeit, örtliche Versetzungen u.a.). Bitte beurteilen Sie im folgenden, was Ihnen *in dieser Zeit aus heutiger Sicht* geholfen hat, mit der belastenden Situation umzugehen.

In einer <u>früheren</u> Krise hat es mir ____ geholfen, ...	nie			zeit weise		sehr häufig	
	0	1	2	3	4	5	6
1 ... meinen Alltag zu strukturieren.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2 ... mir über meine Ziele klar zu werden.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3 ... mir etwas zu gönnen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4 ... mir Zeit für mich zu nehmen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5 ... so sehr unter Druck zu kommen, daß ich etwas unternehmen musste.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6 ... die Situation zu akzeptieren.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7 ... meine Schwierigkeiten als Chance zu sehen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8 ... der Situation mit Humor zu begegnen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9 ... Geduld zu haben.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 ... Kraft aus meinem Glauben oder meiner Spiritualität zu schöpfen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11 ... zeitweise bewusst an etwas anderes zu denken.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12 ... mich mit Aktivitäten abzulenken.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13 ... professionelle Hilfe in Anspruch zu nehmen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14 ...zu erleben, wie jemand anderes mit einer ähnlichen Situation umgegangen ist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15 ... meine Einstellung zu überdenken.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In einer <u>früheren</u> Krise hat es mir ____ geholfen, ...		nie		zeit weise		sehr häufig		
		0	1	2	3	4	5	6
16	... zu denken, daß es mir im Vergleich zu anderen Menschen immer noch gut geht.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	... zu weinen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	... von anderen Menschen unterstützt zu werden.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

V. Situationen, die mit einem hohen Selbstwerterleben verbunden sind

Es gibt Zeiten, in denen man sich ausgesprochen unausgeglichen fühlt, an sich selbst zweifelt. Manche Situationen wiederum führen dazu, daß man *regelrecht stolz auf sich selbst* sein kann: man hat etwas geschafft, was einem zu Recht viel bedeuten kann. Im folgenden sind eine Reihe von Situationen aufgeführt, die bei vielen Menschen damit verbunden sind, daß sie stolz auf sich selbst sein können. Bitte beurteilen Sie jeweils, wie häufig Sie *während der letzten 4 Wochen* aufgrund dieser Situationen stolz auf sich selbst sein konnten.

<u>Während der letzten 4 Wochen bin ich ____ stolz auf mich gewesen, weil</u>		nie		zeit weise		sehr häufig		
		0	1	2	3	4	5	6
1	... ich für andere da gewesen bin, wenn sie mich brauchten.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	... ich von anderen Anerkennung bekommen habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... ich eine gute Leistung erbracht habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... ich eigene Ängste überwinden konnte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... ich mir etwas gönnen konnte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... ich etwas für mein Wohlbefinden getan habe (Hobby, Sport...).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... ich mutig gewesen bin..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... ich alles ruhiger und gelassener als sonst genommen habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... ich mich auf eine wichtige Situation gut vorbereitet habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... ich meine Meinung gut vertreten konnte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Während der letzten 4 Wochen bin ich ____ stolz auf mich gewesen, weil		nie		zeit weise		sehr häufig		
		0	1	2	3	4	5	6
11	... ich etwas Unangenehmes oder Aufgeschobenes erledigt habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	... ich kreativ gewesen bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	... ich mich gut konzentrieren konnte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VI. Persönliche Stärken und Fähigkeiten

Insgesamt nehmen Menschen viele und ganz unterschiedliche Seiten an sich wahr - und sind unterschiedlich zufrieden mit diesen Seiten. Die folgenden Fragen beziehen sich ausschließlich auf *Aspekte, die Sie als eine Stärke von sich selbst erleben*: etwas, was Sie an sich besonders schätzen oder was Sie besonders gut können.

Es ist ____ eine Stärke von mir, daß...		nie			zeit weise		sehr häufig	
		0	1	2	3	4	5	6
1	... ich ein Hobby oder besondere Interessen habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	... ich geradlinig bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... ich offen für neue Erfahrungen bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... ich anderen Menschen Mitgefühl entgegenbringe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... ich zuversichtlich in die Zukunft schaue.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... ich viele schöne Sachen erleben kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... ich geduldig bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... ich temperamentvoll bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... ich Phantasie habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... ich gut mit Menschen umgehen kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	... ich gut Probleme lösen kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Es ist ____ eine Stärke von mir, daß...		nie		zeit weise		sehr häufig		
		0	1	2	3	4	5	6
12	... ich selbstbewusst auftrete.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	... ich den Dingen kritisch auf den Grund gehe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	... ich eine rasche Auffassungsgabe habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	... ich körperlich fit bin.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	... ich mich attraktiv kleide.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17	... ich selbstständig für mich sorgen kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18	... ich einen guten Geschmack habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19	... ich zu meinen Schwächen stehen kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20	... ich Humor habe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21	... ich zielstrebig handle.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. Gegenwärtige Beziehungen

Bitte beziehen Sie die folgenden Fragen auf Ihre *derzeitige Beziehung zu Ihrer/m festen PartnerIn*. Sollten Sie zur Zeit nicht in einer festen Beziehung leben, so beziehen Sie die folgenden Fragen bitte auf eine Ihnen sehr nahestehende Person.

Welche Person steht Ihnen zur Zeit am nächsten?

<input type="checkbox"/> PartnerIn	<input type="checkbox"/> FreundIn	<input type="checkbox"/> Mutter	<input type="checkbox"/> Vater	<input type="checkbox"/> Schwester	<input type="checkbox"/> Bruder
<input type="checkbox"/> eigenes Kind	<input type="checkbox"/> andere _____				

Meine Beziehungen zu _____ ist <u>zur Zeit</u> _____ dadurch gekennzeichnet, daß...		nie		teil- weise		sehr häufig		
		0	1	2	3	4	5	6
1	... wir Verständnis für einander haben.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Meine Beziehungen zu _____ ist <u>zur Zeit</u> _____ dadurch gekennzeichnet, daß...		nie			teil- weise		sehr häufig	
		0	1	2	3	4	5	6
2	... wir uns vertrauen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... wir gerne miteinander Gespräche führen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... wir den Kontakt zueinander aufrecht erhalten.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... wir uns durch unsere Unterschiede gegenseitig anregen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... wir einen ähnlichen Humor haben.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... wir ähnliche Ansichten oder Interessen haben.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... wir ähnliche Erfahrungen in der Vergangenheit gemacht haben.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... sie/ er ein Vorbild für mich ist.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... ich ihr/ ihm gegenüber offen und ehrlich sein kann.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	... ich für sie/ ihn Zärtlichkeit empfinde.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	... wir Erotik und Sexualität teilen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13	... wir für einander da sind, wenn wir einander brauchen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14	... wir viel Zeit miteinander verbringen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15	... ich mich ihr/ ihm sehr vertraut fühle.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16	... wir Schwierigkeiten gemeinsam überwinden können.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIII. Sinnerleben

Über verschieden Lebensphasen hinweg finden Menschen durch sehr unterschiedliche Tätigkeiten und Interessen Sinn in ihrem Leben. Bitte schätzen Sie im folgenden ein, wie häufig die folgenden Tätigkeiten Ihnen zur Zeit ein Gefühl von Sinnhaftigkeit vermitteln.

Zur Zeit finde ich ____ Sinn in meinem Leben, indem ...		nie			zeit- weise		sehr häufig	
		0	1	2	3	4	5	6
1	...ich Einfluss - z.B. auf wichtige Entscheidungen - nehme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2	... ich gute Leistungen erbringe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3	... ich mich bemühe, mit anderen Menschen gut auszukommen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4	... ich für andere da bin, wenn sie mich brauchen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5	... ich auf meine Gesundheit achte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6	... ich mich mit meinem Glauben oder Spiritualität auseinandersetze.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7	... ich selbstständig mein Leben meistere.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8	... ich mir konkrete Ziele setze, die ich erreichen möchte.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9	... ich mir für nahestehende Personen (PartnerIn, Familie, Freunde) viel Zeit nehme.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10	... ich mein Hobby ausübe.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11	... ich mich vielfältig interessiere.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12	... ich mich für die Entwicklung meiner Persönlichkeit engagiere.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

EIGENSTÄNDIGKEITSERKLÄRUNG

Ehrenwörtliche Versicherung gemäß §10 Abs. 1c,d,e der Promotionsordnung

Mit Verweis auf die Richtlinie zur Sicherung guter wissenschaftlicher Praxis und zur Vermeidung wissenschaftlichen Fehlverhaltens versichere ich an Eides statt, dass ich die Abhandlung selbst verfasst habe, ich mich keiner unzulässigen fremden Hilfe vor oder während der Abfassung der Dissertation bedient habe, ich keine anderen als die im Schriftenverzeichnis der Abhandlung angeführten Schriften benutzt habe und ich alle wörtlich oder sinngemäß den Schriften anderer Autoren entnommenen Stellen kenntlich gemacht habe.

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Datum: 09.07.2017

Unterschrift:



Beate Leinberger