BUILDING CAPACITY IN MENTAL HEALTH AND PSYCHOSOCIAL CARE

A training manual for health care workers & community workers in refugee settings in the African Great Lake Area

Developed by HealthNet TPO for UNHCR
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FINAL VERSION AS PRESENTED AT THE END OF PROJECT

(Earlier drafts were distributed in February 2011 and May 2011)

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ENABLING PEOPLE TO HELP THEMSELVES

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FOREWORD

The violent upheavals over the last decades have led to large numbers of refugees living in camps in the African Great Lake area. The United Nations High Commission of Refugees (UNHCR) and the staff of the implementing Non-governmental Organizations (NGOs) are confronted with refugees suffering from mental health problems and severe psychosocial stress. The UNHCR seeks ways to strengthen the competencies of the staff of implementing organizations in the fields of mental health and psychosocial assistance to address the mental health burden in the camps. HealthNet TPO, an international NGO, has been invited to develop, implement and evaluate a model of comprehensive services for mental health and psychosocial support within existing UNHCR-supported care structures for refugees in Burundi, Rwanda and Tanzania.

We would like to draw your attention to characteristic stressors within the refugee experience. From the needs assessment and from what we know of why and how individuals are displaced and migrate, a core theme is violence. High levels of violence are seen before the camps are formed in these populations and for the duration of the refugee experience. Time and time again, violence was cited by community members as a pivotal stressor within the refugee camps and a major determinant of emotional distress. Furthermore, basic human needs and rights such as food, nutrition, healthcare, shelter and education are constrained and exert considerable stress on refugees.

It is our hope that this training program will contribute to the efforts of all stakeholders involved in addressing the large mental health burden conferred to this population.

Although this manual was developed for a specific context in the African Great Lakes Region, we hope that it will be of use for other refugee populations within the African continent. Of course a good local needs assessment, stakeholder mapping and situation analyses should precede the adaptation of this manual for use outside of the Great Lakes region.

This manual is based on research findings found in the international literature and research findings from different projects, including research activities in this UNHCR Project. The manual covers different aspects of complex structures of wellbeing and its diverse manifestations in refugee camps from daily emotional stress to mental distress and disorders. As has become clear, there is no single successful approach to the phenomenon of wellbeing in refugee camps. What is good for whom and why is difficult to address and sometimes 'being sick' is the only possible response to the situation. This manual is written to deal with this broad perspective of wellbeing, covering the broad spectrum of emotional responses in a refugee camp. As such, different mental health issues with corresponding interventions across disciplines are combined in one manual. The reader of this manual should be aware that this multi- modal and multi-disciplinary approach of mental health in refugee camps cannot be streamlined in a recipe with predefined success.

It was our intention to make a manual that provides information from varying perspectives to deal with the wellbeing phenomenon for refugees in refugee camps, their social-cultural networks and for health professionals.

Acknowledgment
We would like to thank UNHCR-Geneva, UNHCR country teams in Rwanda, Burundi and Tanzania and local implementing partners of the refugee camps in Burundi, Tanzania and Rwanda.

Content

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INTRODUCTION TO THE MANUAL

This manual is a facilitator's guide designed to build capacity in mental health and psychosocial care among refugee camps in order to address the complex and pressing needs of this vulnerable population. It was developed in response to a Situation and Needs Assessment of Mental Health and Psychosocial Support among refugee camps in Tanzania, Rwanda and Burundi conducted in 2009 and a strategic planning workshop held in April 2010 in Bujumbura.

This manual uses an integrated approach for both 'mental health' and 'psychosocial support' taking into consideration that mental health interventions must be broad and address issues within a larger socio-political and cultural context. We recognize that to order to address mental health and psychosocial issues, a comprehensive framework that draws from international development, public health, medicine, psychiatry, psychology, social work, psychosocial care, anthropology and community development will result in a better outcome.

The manual is inspired by many sources. We have taken care to ensure that it is in line with recent international consensus documents such as the:
- The IASC Guidelines for Mental health and Psychosocial Support in Emergency Settings.[1]
- The WHO mhGAP Intervention Guide for Mental, Neurological and Substance use Disorders in non-specialist health care settings.[2]
- The Guidelines of Community-based Approach in UNHCR Operations.[3]
- The Sphere Handbook (2011): Humanitarian Charter and Minimum Standards in Humanitarian Response.

This training manual was designed with the following objectives in mind:
1. To build capacity as part of the intervention package for mental health and psychosocial care in refugee settings of the Great Lakes area
2. To establish an integrated knowledge base of mental health and psychosocial issues and strengthen capacity for UNHCR staff and implementing partners
3. To pilot this program and evaluate its impact so that an optimal program can be designed and scaled up in refugee settings
4. To ensure that refugees have appropriate mental health and psychosocial care provided during their tenure in the camps, resettlement and return to country of origin

Specifically with the sections entitled, 'The Local Context' and 'Cultural Idioms of Distress', these were extracted from the Needs Assessment and ecological analysis conducted by Health Net TPO. Although issues may be similar across refugee camps, this should be adjusted for local needs, cultural constructions of mental distress and local understanding of mental health needs.

In the light of advancing integration of mental health and psychosocial support in both community based services and in health care services we strongly advocate to have the trainings for community workers and health workers in the same period and in the same location. Interaction between the different participants is very important to avoid the impression that mental health would be only relevant to health workers and psychosocial support only to psychosocial workers. Different levels of both are relevant respectively. Establishing the idea of working in a multidisciplinary way is one of the major goals of

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[1] IASC (2007). Guidelines for Mental Health and Psychosocial Support in Emergency Settings, Geneva/New York: Inter Agency Standing Committee
[2] WHO (2010) Intervention guide for priority Mental, Neurological and Substance Use Disorders in non Specialised Health Care Settings. Geneva, World Health Organization,
[3] UNHCR. (2008). A Community-based Approach in UNHCR Operations. Geneva: UNHCR.

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this manual.

Trainers
The trainers who use this manual should be competent professionals in mental health and psychosocial support and should be skilled trainers. Within the program that HealthNet TPO has developed for UNHCR a separate program and manual for Training of Trainers has been developed:
- *A guide for training of trainers. Building capacity in mental health and psychosocial care in refugee settings in the African Great Lake Area*. Bujumbura, HealthNet TPO (June 2011, adapted version August 2011)

Monitoring and Evaluation
Included in the manual is the suggestion of a monitoring and evaluation component, e.g. pre-test, post-test study design. We encourage UNHCR and implementing partners to pilot this training program in affected regions and monitor its impact on local staff and knowledge.

Supervision and Refresher Courses
Capacity building is not sustainable unless training is followed up with an integrated and consistent supervision system as part of the longer-term strategy for mental health systems development. Although it is not specifically set out in this manual, we encourage UNHCR and implementing partners to develop supervision strategies, refresher courses and ongoing on-the-job training after implementation of this manual.

Other recommended actions include:
1. Creating linkages with local capacity including but not limited to:
   - Academic medical centers, local hospitals and clinics
   - NGOs, stakeholders and donors already on the ground
   - Existing psychiatrists and psychiatric nurses
   - Ministry of Health
2. Analyzing existing health infrastructure and identifying points of entry to integrate the mental health system.
3. Understanding help-seeking behavior and recruiting those individuals and institutions who are on the frontline of care to attend mental health training, e.g., teachers, healers, shamans, astrologers, priests and religious leaders, community leaders, etc.
4. Identifying individuals with potential for becoming trainers, e.g. those with strength in communication and teaching skills.
5. Identifying community advocates for mental health across sectors including but not limited to media, police and military, legal, criminal justice, etc., to strengthen community-based interventions and to promote inter-sectoral cooperation.

What is different about mental health in the refugee context?
We were asked to create a training manual to build capacity within refugee camps. The critical difference between this manual and those solely designed for low-resource settings is that the experience of the refugee is one that implies grave displacement of the individual from their identity, their families and their community. These dynamics may be constantly shifting based on the socio-political context, causing further instability and dependency on external humanitarian aid. Loss of identity and livelihood, dependency, community deterioration and disorientation, political persecution, exile, torture, shifting gender roles, poverty and social exclusion are just some of the few complicated risk factors which increase vulnerability to mental health morbidity and mortality.

The UNHCR[4] estimates that at the end of 2009, there were approximately 36.5 million refugees identified as needing assistance with only 42.9% (mostly IDPs) of these who

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[4] UNHCR 2009 Global Trends Report: Selected Slides.

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were protected or assisted. Eighteen percent or approximately 6.5 million were stateless at this time.

Due to the unclear status and fate of many of these refugees, psychosocial and mental health issues abound. Distress is omnipresent and mental health issues develop due to the vulnerabilities and lack of appropriate care in these settings.

Who can be trained using this manual?
This manual is intended primarily for two types of staff:
1. Non-specialist health care professionals including but not limited to medical doctors and nurses
2. Community and psychosocial workers, counselors and other relevant staff

Stakeholders, donors, implementing partners, public health experts, community developers, policy makers and other relevant staff may find this helpful as well to enhance their understanding of mental health and psychosocial issues.

How to use this manual
The manual is divided into four parts:
- Part One is an introduction to the concepts of Refugee Mental Health broadly.
- Part Two is a training for health care workers including but not limited to primary care doctors, nurses and other clinicians. It is largely based on the WHO mhGAP Intervention Guide for mental, neurologic and substance use disorders in non specialized health settings
- Part Three is a training in community oriented psychosocial interventions. These modules can be used to train community and psychosocial workers but can also be used to train health workersPart Four contains closing remarks for all participants.

The manual in its entirety will exceed a two week training time. Facilitators can reduce the recommended times specified for each module or can skip various exercises to adapt to a two-week timeframe.

Review process
This final version has been submitted to UNHCR in Geneva in December 2011. An earlier draft had circulated in February 2011, and a partially revised version in May 2011. Based on comments of external reviewers by WHO and UNHCT adaptations were made that led to this final manual.
Reviewers by WHO and UNHCR have commented that some themes were underrepresented. We have tried to adapt this. However we realize that our work remains incomplete. One important suggestion by a reviewer was to create a separate module on Psychological First Aid (PFA). In section 2.12 on psychological trauma PFA is is discussed. We agree that this is an important component of MHPSS in the refugee context and we could have given more attention to it. We have chosen not to add a module on PFA, but refer to the manual that has been published in fall 2011 (in the last months of our project):
- World Health Organization, War Trauma Foundation and World Vision International (2011). *Psychological first aid: Guide for field workers*. Geneva, WHO.
This is an excellent tool for PFA that is downloadable and available in several languages.[5]

Training time specified for each module is a recommendation only and can be altered according to local needs.

The Study Material is for the trainer but can also be used as handouts for the participants.

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[5] http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

Module	Title	Who can use this	Training Time
PART ONE: INTRODUCTION TO REFUGEE MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING All participants 2 days			
1.1	Introduction and Key Concepts		4-6 hours
1.2	Refugee Mental Health		2-4 hours
1.3	The Local Context: The Great Lakes		2 hours
1.4	Cultural Idioms of Distress		1 hour
1.5	Interventions and Inter-Sectoral Cooperation		3 hours
1.6	Introduction to Communication Skills	Optional	1-2 hours
PART TWO: TRAINING FOR HEALTH CARE WORKERS All Health Care Workers (Medical Doctors, Nurses, Clinicians) 7½ days			
2.1	Introduction to Mental Health and Disorders		2 hours
2.2	History Taking and Mental Health Assessment		2 hours
2.3	Use of WHO mhGAP Guidelines		2 hours
2.4	Depression		1 day
2.5	Psychosis		1 day
2.6	Bipolar Disorder		½ day
2.7	Alcohol and Substance Use Disorders		1 day
2.8	Suicide and Self-Harm		½ day
2.9	Epilepsy		½ day
2.10	Delirium		2 hrs
2.11	Developmental Disorders		½ day
2.12	Psychological Trauma		½ day
2.13	Other Emotional and Medically Unexplained Complaints		½ day
2.14	Intervention Guidelines and Community-oriented Strategies		½ day
PART THREE: TRAINING IN COMMUNITY BASED PSYCHOSOCIAL INTERVENTIONS Community health workers, psychosocial workers, counselors, general health workers etc 7½ days			
	THEME 1 PSYCHOSOCIAL SUPPORT: General Understanding and Principles of Psychosocial Support	General community workers and specialized psychosocial workers and health workers	1 days
3.1	Introduction to key concepts of psychosocial support		3 hours
3.2	Principles of psychosocial support		4 hours

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3.3	Personal characteristics of a community and psychosocial worker		2½ hours
	THEME 2: PSYCHOSOCIAL SUPPORT: Foster mutual support and self-help		5 days
3.4	Basic communication skills	General community workers, specialized psychosocial workers and health workers.	4½ - 8 hours
3.5	Introduction to problem solving counseling	Specialized psychosocial workers	3 hours
3.6	Family problem solving counseling	Specialized psychosocial workers	3¼ hours
3.7	Group problem solving counseling	Specialized psychosocial workers	3 hours
3.8	Referral and advocacy	General community workers, specialized psychosocial workers and health workers	1½ hours
3.9	Awareness-raising / sensitization and Psychosocial education	General community workers and specialized psychosocial workers	3½ hours
3.10	Support groups	General community workers and specialized psychosocial workers	3 hours
	THEME 3 PSYCHOSOCIAL SUPPORT: Psychosocial support to people with mental health, neurological and substance use disorders	General community workers, specialized psychosocial workers and health workers	1 day
3.11	Psychosocial support for people with epilepsy and seizure disorders		2-2½ hours
3.12	Psychosocial support for people with severe mental disorders		2 hours
3.13	Psychosocial support for people with common mental disorders and medically unexplained symptoms		2 hours
3.14	Psychosocial support for people with alcohol and substance use disorders		2 hours
	THEME 4 PSYCHOSOCIAL SUPPORT: Specific topics		½ day
3.15	Care for caregivers	General community workers and specialized psychosocial workers	2½ hours
3.16	Psychosocial clinical supervision	Specialized	1½ hours

		psychosocial workers	
3.17	Narrative theatre	General community workers and specialized psychosocial workers	2¼ hours
PART FOUR: CLOSING REMARKS All participants ½ day			

PART ONE: INTRODUCTION TO REFUGEE MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING

Part One is designed as an introduction to concepts in refugee mental health based on the assessment in the Great Lakes Region. It is intended for all participants, both health care workers and community workers.

It has six parts. The last part on communication skills is optional. The expected training time is two full days but can be modified according to local needs.

Module	Title	Who can use this	Training Time
	PART ONE: INTRODUCTION TO REFUGEE MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING	All participants	2 days
1.1	Introduction and Key Concepts	All participants	4-6 hours
1.2	Refugee Mental Health	All participants	2-4 hours
1.3	The Local Context: The Great Lakes	All participants	2 hours
1.4	Cultural Idioms of Distress	All participants	1 hour
1.5	Interventions and Inter-Sectoral Cooperation	All participants	3 hours
1.6	Introduction to Communication Skills	Optional	2 hours

Learning Objectives
At the end of PART ONE, participants will:
- Be able to understand and define "Psychosocial", "Bio-Psycho-Social model", "Mental Health" and "Mental Disorder"
- Be able to understand better the refugee context as it relates to mental health and psychosocial needs
- Understand the local context and cultural idioms of distress
- Become familiar with basic concepts related to mental health and psychosocial issues
- Be introduced to basic concepts related to mental health and psychosocial issues
- Understand interventions and inter-sectoral models of cooperation

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals

Time
2 days

MODULE 1.1: Introduction and Key concepts

Learning Objectives
At the end of this Module participants will:
- Be welcomed and introduced to all participants and facilitators
- Know the defined objectives of the training
- Take a pre-test for monitoring and evaluation purposes
- Understand key concepts related to Refugee Mental Health and Psychosocial issues

Methodology
Introduction exercises, lecture, brainstorming, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals
Printed copies of pre-test for health workers and community workers

Time
4-6 hours

Methodology for the trainer
Participant Introduction and Overview
Welcome and presentation of the trainers and participants
- Facilitator welcomes participants and thanks the organizing agencies
- Each trainer briefly introduces him/herself and working experience
- Materials such as notebooks and pens distributed
- Each participant is invited to share briefly with the other participants:
  o Name
  o Function and organization
  o Prior experiences with mental health and psychosocial support activities or trainings.

Logistics and Practical issues
Discuss the practical and logistic elements of the training such as:
- Transport arrangements
- Times of training
- Per diem and food arrangements
- Time schedule
- Certification
- Create ground rules with the participants, and makes list of these on a flip-chart that is posted in front of the class. For example:
  o Being on time;
  o Let each other finish when talking;
  o Respect all opinions;
  o No side conversations;
  o Mobiles off or mute;
- Language: Find one common language.
  In many African refugee settings there are multiple languages in use, such as French, English, Kiswahili and local languages. The language issue needs to be explicitly discussed and a suitable solution should be found.

Objectives and expectations (30 minutes)
- Participants are asked to share their expectations and hopes for the training
- Exercise:
  o Each participant is given three small colored index cards and invited to write a maximum of 3 things he or she expects to learn during this training, one per card.

- o Cards are collected and pinned on the wall. Facilitators should group similar objectives together and invite participants to take a look.
- o Facilitator explains the objectives of the project and the training

Pre-test
- A written pre test is distributed. Two versions are available: 1) For health workers, 2) For community services workers. Each version is available in French and English.

OPTIONAL EXERCISES
Exercise 1: Ice Breakers
Can use 'ice breakers' and small breaks throughout training if participants are tired and the concentration level goes down. Example: In the beginning, names are read randomly by facilitator and a ball (paper) has to be thrown to that person who in turn has to throw to someone else.

Exercise 2: Secret Friend System
Goal: to promote bonding between participants.
- Small folded papers with the name of each participant on a paper are distributed.
- Each participant is handed a folded paper with a name on it and instructed to read it silently. It should not be his or her own name.
- The participants are given the following instructions:
  'Each person has many qualities. Some of these you may not even realize yourself. You may be a good speaker, you may be a very social person, you may have a very good sense of humor. The person whose name is written on your paper is your secret friend. Each day you make a small note or a gift for your secret friend in which you write some positive reflections about that person for example what you liked about how the person participated in the group sessions yesterday. Write this message in such a way that the person cannot know who wrote it. For example use a different way of writing than you write with your left hand or in a different hand writing.'
- A small box is put somewhere in a corner of the training venue where each person can secretly put messages for the secret friend.
- At the end of the training the secret friend will be disclosed.

Key concepts of Mental Health and Psychosocial Wellbeing
Interactive lecture using flip-chart and participatory methods, clarify the concepts of 'health', 'mental health', 'bio-psychosocial model', 'psychosocial' and 'mental disorder'.

- Health

The trainer asks participants what health is and writes down their suggestions on a flip-chart. Provide and discuss the WHO definition of health: *'health is a state of complete wellbeing, physical, mental and social, and is not merely the absence of disease or handicap.'* Ask participants how the three aspects of health interrelate. Emphasize that 'there is no health without mental health'.

- Mental health

Ask for examples of what 'mental health' is. Write responses on a flip-chart. Provide the WHO definition: "A state of complete physical, mental and social well-being, and not merely the absence of disease". Indicate that mental health refers to a variety of activities directly or indirectly related to:
1. Promotion of well-being,
2. Prevention of mental disorders, and
3. Treatment and rehabilitation of people affected by mental disorders.

Discuss the 3 dimensions of mental health:
- Cognition ('thinking')
- Emotion ('feeling')

- Behavior ('action')

Emphasize that 'good mental health' is a balance between the person and the environment.

A person is called mentally healthy when he/she:
- realizes his or her own abilities
- can cope with the normal stresses of life
- can work productively
- is able to make a contribution to his or her community

Exercise

Facilitator asks participants to provide other examples and indicators of being mentally healthy. See the following list below for examples:
- Self awareness
- Accurate self perception
- Realizing his/her own full potential
- Independence in thought and action
- Accurate perception of reality
- Social and occupation ability to deal with the environment
- Commitment to community and society
- Openness and flexibility

Facilitator asks participants to identify factors that may influence mental health and writes them down on a flip-chart.
- Culture
- Family environment
- Social environment
- Work environment

Bio-psychosocial Model

Use the above exercise to transition into a discussion on the bio-psycho-social model

Definition: the domains of physical, psychological and social well being work jointly in creating a positive health condition of the person. Refer to Figure 1.
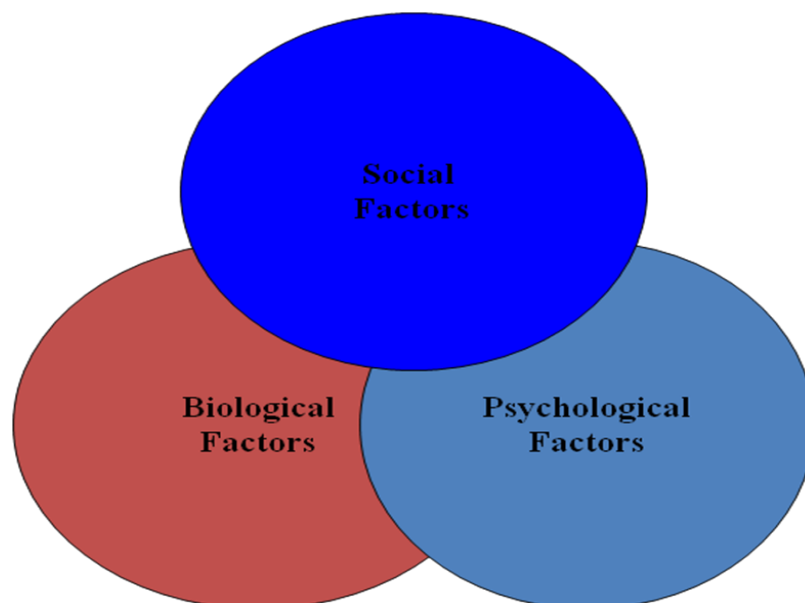

Figure 1. Bio-psychosocial Model

Trainer discusses with participants how bio-psycho-social factors are interrelated. Participants are invited to give examples of how a problem in one domain leads to problems or complaints in another domain.

Psychosocial Issues
Exercise: Ask participants to then define the word psychosocial and identify psychosocial issues within the communities that they work and live. Examples of psychosocial issues:
- Family conflicts
- Unemployment
- Loss of job
- Security problems
- Loss of a loved one
- Financial difficulties
- Disagreement with others
- Homelessness
- A life threatening illness

The word 'psycho-social' underlines the dynamic relationship between psychological and social effects, each continually influencing the other.' **Bio** is the biological or physical aspects of a person and his/her biological needs.
- **Psycho** means **the mind** (ask participants what the word is for *mind* in their own language). The mind refers to a person's thinking, feeling, emotions, understanding, beliefs and attitude.
- **Social** refers to the way a person relates with his or her social environment including: family, friends, neighbors and community and additionally, the influence of what happens in the community. The *social* component may refer to supernatural powers and as such, can be understood as unchangeable or beyond the control of the person.
- **Psychosocial** combines the words **psycho** and **social.** The word *psychosocial* may be new for participants who are not familiar with a related professional field. In general, the psychosocial is used as an adjective in combination with another word, for example: psychosocial problem, psychosocial intervention, psychosocial support.
- **Psychosocial problems** refer to conditions and situations where a negative *psychological state* (feeling sad, feeling stressed, feeling irritable) is strongly related to and influenced by the current *social environment.* The individual may not be fully aware of the relationship of his state of mind with his or her environment. The relation is dynamic: a person who is distressed or upset will interact differently with his environment (for example: due to feeling sad the person may neglect his children, make a mess of finance etc). Psychosocial problem are often related interpersonal problems. For example domestic violence or relationship problem).For example: family conflicts may lead to neglect of children, to alcohol abuse, to domestic violence. This may lead to problems with school, with finance, with neighbours and that will increase the problems of the family. In general physical problems (poverty, homelessness) and general health problems (malaria, HIV) are not considered psychosocial problems by themselves, but they can lead to psychosocial problems if the support mechanisms of the person fall short.
  - **Psychosocial support** usually refers to approaches to support survivors of disasters, violence and other adverse situations by helping the person coping with the situation and by fostering resilience of communities and individuals. Psychosocial support aims at enabling people to restore normal life and empower affected people. Examples of psychosocial support include activities that people do themselves, such as talking to each other or giving practical support, as well as activities facilitated by psychosocial workers, such as: psycho-education, encouragement and support of communal functioning, self-initiative and self-help,

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individual, and family or group counseling. In contrast, handing out medications or food are generally not considered psychosocial support.

The social world which creates the context through the environment, culture, economics, traditions, spirituality, interpersonal relationships with family, community and friends, and life tasks[6]. Ask participants why psychosocial issues are important when thinking about mental health. Explain to participants that identifying psychosocial issues in the refugee camps are of utmost important in order to understand risk factors for mental stress and mental disorders and how interventions can be developed from these.

Mental Disorders.
Discuss with participants what 'mental disorder' is and ask them to provide examples.

Write the definition of a mental disorder:

- Disturbance which affects emotions, thoughts or behaviour
- Which is out of keeping with cultural beliefs and norms.
- Produces negative effects on their lives or the lives of their families

Mental disorders produce <u>symptoms</u> that sufferers or those close to them notice. These may include:

- physical symptoms (e.g. aches and sleep disturbance)
- emotional symptoms (e.g. feeling sad, scared, or anxious)
- cognitive symptoms (e.g. difficulty thinking clearly, abnormal beliefs, memory disturbance)
- behavioural symptoms (e.g. behaving in an aggressive manner, inability to perform routine daily functions, excessive use of substances)
- perceptual symptoms (e.g. seeing or hearing things that others cannot).

This means that someone who has a mental illness may have trouble coping with emotions, stress and anger, and difficulty handling such things as daily activities, family responsibilities, relationships, or work and school responsibilities.

Exercise: Ask participants what is the difference between distress and disorder.
- Duration of symptoms.
- Persistence and severity of symptoms
- Impact of symptoms and impairment on school performance, work, interpersonal relations, home and leisure activities.

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[6] Baron, N., Lessons Learned in Psychosocial Programming World-wide'. Unpublished report. Geneva: UNICEF, 2002

Study Material: Module 1.1

Psychosocial distress[7]
Psychosocial distress usually relates to circumstances in the environment (this can be the natural environment, but also the social environment such as the family situation) that repeatedly induce stressful experiences. The health and well being of an individual is strongly associated with ability to adaptively and successfully cope with the strains and challenges of life. Almost any change in life, either mild or severe, can act as a stressor including changes which brings joy or happiness e.g. marriage, having a new baby etc.

Psychosocial distress has
o   an important role in both the onset and course of mental illness. Exposure to psychosocial stress, such as life events, childhood trauma, or discriminatory experiences may increase the behavioral and biological response to subsequent exposures.
o   Lead to problems that are not a medical *disorder* but a psychosocial *problem*

Psychosocial problems can start suddenly or can be continuous, and can interfere with psychological functioning and daily routines. In most cases such problems will resolve soon and person continue to function normally but it can run a chronic course. Learning skills to cope with psychosocial problem helps reduce the health impact of psychosocial distress.

Therefore psychosocial support interventions are useful to restore mental health and psychosocial well-being.

Biopsychosocial Model[8]
The bio-psycho-social model moves from the original conceptualization by Engel (1977), highlighting the biological or physical aspects of the person and his/her biological needs; denoting the psychological elements which refers to feelings, thoughts, attitudes, emotions and are normally understood as "internal" and linked to the mind; as the relation between the person and the "external" word, such as the interactions in the family, at work and in general in the socio-cultural environment.

This model which refers to a holistic view of the human being and health in opposition to (or better, with the intention to reform) the explanatory meaning of the bio-medical model and its hegemonic position in medical and related sciences.

Being a systemic approach, it assigns the same value to the three different levels of analysis identified and promotes the full integration between the three. It gives the conceptual framework to health workers to identify, assess and intervene for the well-being of a sick person considering the biological, psychological and social (cultural) factors at all stages (prevention; onset; course, treatment).

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[7] Based on: Ager A. 'Responding to the Psychosocial Needs of Refugees'. In M. Loughry and A. Ager, (eds), The Refugee Experience. Psychosocial Training Module, vol. 1. (2nd edn). Oxford: Refugee Studies Centre, 2001.

[8] *Source: UNHCR (2010) 'Psychosocial Counseling and Social Work with Clients and their families in the Somali context*

MODULE 1.2: Refugee Mental Health

Learning Objectives
At the end of this Module participants will:
• Have a better understanding of issues pertinent to the refugee context
• Understand psychosocial factors related to life as a refugee
• Be able to understand the link between community disruption, psychosocial issues and mental health needs
• Describe a real life refugee example of how mental health and psychosocial problems are interrelated
• Explain how interventions need to be interrelated in order to be most effective

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals

Time
2-4 hours

Methodology for the trainer
Introductory Interactive Session: Trainer poses the following questions for discussion to the participants:
1. What is a refugee?
2. What characteristics of refugees that you have worked with put them at risk for increased stress, mental distress and mental health issues?

The Larger Context (present this if trainer feels the context is important – can be brief)
• Per UNHCR number of refugees worldwide totaled 10.3 million with more than half in Asia and approximately 20 percent in Africa.
• Living conditions widely vary in well-established camps, collective centers, makeshift shelters or living in the open.
• Greater than 50% live in urban areas.
• All face three possible situations: repatriation; local integration or resettlement.

Exercise: Can you imagine what the refugee experience must be regarding these 3 possibilities? Put yourself into their shoes and think about what affect this may have.

What do we know about refugees and mental health generally from other contexts?
• Generally, at higher risk for mental distress
• Varies specifically by population and culture
• Migration leads to increased distress
• Long asylum periods lead to more distress
• Levels of psychiatric disorders widely vary

What do we know about refugees in this context which pre-disposes to distress?
High levels of violence within the refugee experience are identified from the needs assessment including:
• Violence as a reason for migration
• Violence within the communities as a result of migration
• Violence in the camps as a result of poverty, marginalization, poor social indicators and all determinants related to social exclusion
• Violence due to shift in gender roles
• Violence behavior and agitation as a result of the above

Identity is a Key Concept in the Wellbeing of Refugees

Exercise: Engage the participants in a discussion of identity and how they have seen refugees struggle with their own identity, how it changed from their home country to life as a refugee now.

Figure 1 demonstrates the layers of identity. The inner circle (red) represents how the refugee views him or herself. The outer two layers change during migration and can be a source of distress.

Who I am to myself
(Individual differences)

The interiorized societal factors: gender
Culture, traditions, traditional roles, etc.

How the others perceive me. Can also
Be a self perception
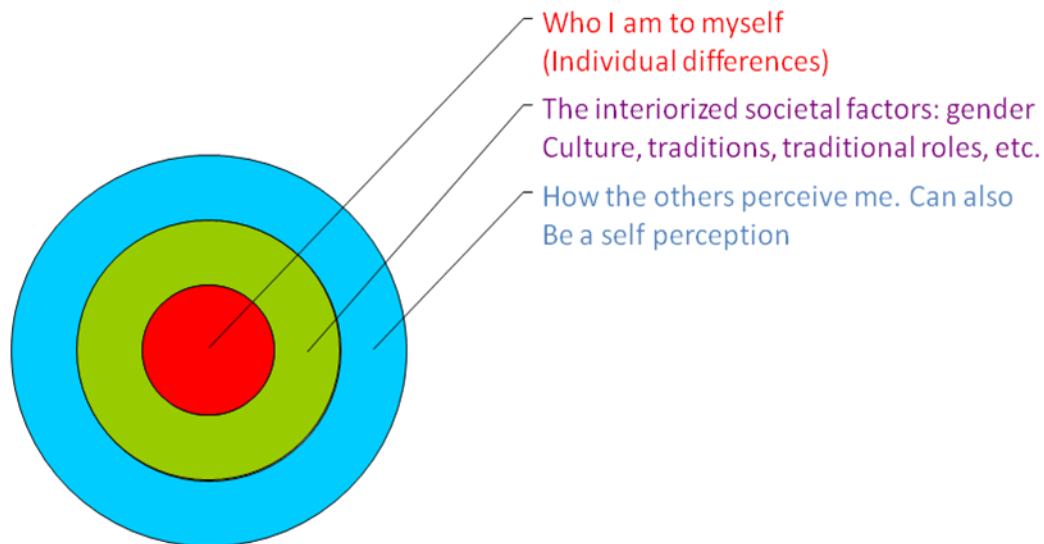
Figure 1. Identity is the Key Concept in the Wellbeing of Refugees
Source: (IOM) International Organization for Migration, Presentation by Guglielmo Schinina, Damak, Nepal, Jan 2011.

KNOWN RISK FACTORS: Can read this to participants.
When refugees arrive in camps….

"…they are also confronted with adverse situations and ongoing stressors, which substantially impact their mental health. For example, the poor quality of accommodations, restricted economic opportunity, and uncertainty over access to food and/or water are major psychological stresses. It is not only traumatic events or experiences that affect the mental health of refugees. Recent work has shown that the daily hassles of living in refugee camps, such as waiting in line at the water tap, also negatively impact mental health. Though the stresses of everyday life at a refugee camp are known to negatively impact health, the good news is that since 'daily hassles seem to be reliable predictors of distress among war-affected populations… they may also be promising targets for interventions.'

'Because refugees have witnessed and experienced many traumatic events, as well as multiple and chronic adversities, they have a high risk of developing mental health problems and have a higher prevalence of psychological disorders, in particular depression and post-traumatic stress disorder. In addition, refugees frequently mention being plagued by feelings of hopelessness, fear, sadness, anger, aggression and worry[9]'

Case Example
A case example (see at end of section in Study Material for Trainers) of a family with multiple problems is presented in the group. The presenter ensures that the participants

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[9] http://www.uniteforsight.org/refugee-health/module2

understand the case and check with them whether the presented issues exist in the camps they work.

Group work (1 hour)
Participants are divided in subgroups that are well balanced with regards to gender, ethnicity and professional background (health services & community services). The groups are given a flip-charts and markers and three questions. Each group assigns a reporter. Each group has 10 minutes to briefly present what they have written on the flip-chart (40 minutes).

The facilitators invite the participants to share and ask questions to each other and then present their own feedback (30 minutes).

Teaching Points of the **Case History** of Bucumi and his family (see description at the end of this module):
The case can be used to demonstrate / illustrate the following key points:

1. Bucumi has an alcohol problem. Is it a mental disorder (an alcohol use disorder)? Is it a social problem? Is there a co-morbid problem that is hidden or 'masked' by the alcohol. There could be a depression (related to the loss of his first wife and the fact that he lost his status and wealth, and is now a dependent refugee.

2. Marie may have a depression. Indications that she may have a depression are:
   - sadness,
   - social withdrawal of activities that used to be pleasurable,
   - tiredness,
   - concentration problems (she makes many mistakes while cooking),
   - sleep problems,
   - suicidal thoughts.

3. The problems are linked to each other and influence each other. For example, the hopeless state of Maria has a direct effect on the wellbeing of the youngest child and it can cause or contribute to the malnutrition of the child. The alcohol problems of Bucumi may affect the behavior of his eldest son Jean.

4. Problems should be seen on several levels:
   - Individual level: several of the persons in the family have individual problems, for example the seizures of Paul, the alcohol problem of Bucumi.
   - Family:
     - Relation problems between Bucumi and his wife Marie. Some factors may make it more difficult to build a health relationship between the partners: the age difference, the death of the first wife of Bucumi for example
     - Family dynamics. The eldest daughter feels very responsible for the wellbeing of the family members and she takes on responsibilities that the parents should take ('parentification')
   - Community:
     - How is the connection of the family with other families in the camp? Are there other relatives? People from their original village or place? How are they connected to the community structures?
   - Society:

- o The problems are related to the socio-historical situation in their home country. Ethnicity plays a role. How does ethnicity play a role in the camp?

5. Solutions should also be sought on different levels.   It can be useful to use the example of Marie:
- Individual level. She feels sad and lost hope.
  - o She may be helped by someone who is attentively listening to her, with empathy. (= individual psychosocial counseling)
  - o If the depression is severe she may need antidepressant medication (= medical intervention by a trained doctor or clinical
- Family level
  - o It can be helpful to look at the problems between the two spouses. Not only does Marie have a problem, but the husband too. The problems are linked. Helping only the wife while not involving the husband may not be a good idea. (= couples counseling)
  - o There may be interventions needed to help the childrearing in the family. The eldest son has a tendency to be delinquent. The eldest daughter is heavily burdened and this may soon be too much (= parent skills training)
  - o The baby may be malnourished because Marie is too depressed to take good care of the baby and she may be not always responsive the needs of the baby due to her illness. She can be helped by activities that promote mother-infant interactions
- Community level;
  - o It can be very helpful to connect Marie to sources of social support. For example 1) encouraging her to take part again in the choir, 2) advise her to be part of a social support group with other women in similar situations

Note: After having discussed the case of Marie it can be useful to indicate that a similar exercise can be done for other family members. For example Bucumi may equally benefit from interventions on individual level (motivational interviewing to encourage him to stop drinking, individual counseling to share his grief about his losses), on family level (couple counseling, child rearing techniques), community level (social groups that he could take part in such as church of recreational activities).

Wrap up and conclusion
Facilitator summarizes main points of what we have learned this afternoon. He/she emphasizes that in the next days, when the community services staff and the health care staff will work in separate groups, we need to keep the example of this case in mind and realize how different problems are interrelated and how thus our interventions also need to be interrelated.

HANDOUT FOR PARTICIPANTS
Module 1.1. <u>Case history</u>

Background: Bucumi and his family became refugees because of ethnic violence. The family is presented because of multiple problems. The family is made up of a father, a mother & seven children.

Here they are:
- Bucumi: In his home country Bucumi was a highly respected person with a successful business. His first wife died from disease when they fled from home. His present wife Maria is from his home village. He is always annoyed with her because he she has changed into a 'lazy woman'. He shouts to her and often beats her, especially when he is drunk. His alcohol drinking has gradually increased.
- Marie: She is 10 years younger than Bucumi. Since last year she has gradually become more and more withdrawn. She often makes mistakes when cooking food, which often results her husband becoming annoyed and beating her up. She worries a lot and feels there is no hope for her. She feels tired and often wishes she was dead. She used to have a cousin in the camp with whom she went to church and sang in the choir. This cousin repatriated home a year ago and she has not received any news from her. Though she has continued attending church Marie no longer sings in the choir.
- Jean: Age 15. He is the son from Bucumi's deceased wife. He has been reported several times to be engaged in fights with other children in the camp. He has also stopped school. He may smoke c hanvre (cannabis) secretly and has once stolen money from the stepmother.
- Anna: Daughter, age 13. She performs well at school. She feels responsible for the younger children and takes good care of them.
- Louisa: Daughter, age 12. Her real father was an elder brother of Bucumi. He died and therefore she lives now with Bucumi, her uncle. There are no problems reported with her. She is doing okay in school. She is a shy girl.
- Paul: Son, 8 years. Everyone likes him. For past one year he has strange attacks in which he falls on the ground and moves with legs and arms. The family is seeking help from different churches, but it has not helped
- Sara: 5 years. No problems reported
- Jeanine: Died last year, age 3 due to malaria, but now the family believes she was poisoned.
- Benjamin: Son, age 8 months. Has malnutrition and is not growing well.

Questions to pose to participants:
1. Describe the psychosocial and mental problems in this family
2. What should be done to help this family?
3. Which groups of helpers should collaborate with each other to be more effective.

Study Material for trainers: Module 1.2

More Information on Mental health of Refugees
A wide variability in the rates of psychiatric conditions, including affective disorder, anxiety disorder, clinical depression, and post traumatic stress among refugees (Fenta 2004). This variability, according to systematic and narrative reviews, depends on (a) research methods (b) past adverse experiences and (c) contextual factors related to the current environment (eg safety, integration etc)(Porter and Hasslma, 2005; Lindert & Brahler 2008; Steel et al 2009).

Resources:

*Porter, M. and N. Haslam (2005). "Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons: a meta-analysis." <u>JAMA</u> **294**(5): 602-12.*

*Fenta, H., Hyman, I., Noh, S. (2004). "Determinants of depression among Ethiopian immigrants and refugees in Toronto." <u>J Nerv Ment Dis</u> **192**(5): 363-72.*

*Lindert, J., E. Brahler, et al. (2008). "[Depression, anxiety and posttraumatic stress disorders in labor migrants, asylum seekers and refugees. A systematic overview]." <u>Psychother Psychosom Med Psychol</u> **58**(3-4): 109-22.*

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MODULE 1.3: The Local Context. The Great Lakes

Learning Objectives
At the end of this Module participants will:
- Have a better understanding of the Situation and Needs Assessment conducted in the Great Lakes Region
- Understand findings and needs within this population
- Identify risk factors and psychosocial issues for mental distress and disorders in these camps

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals
Printed copies of pre-test for health workers and community workers

Time
2 hours

Methodology for the trainer
- Introduction of the risk and protective factors in the camps
  - Brainstorming to explore what the participants already know. Ask participants to come up with risk factors for psychosocial distress and mental disorders and write them down on the flip-chart.
  - Do the same for the protective factors; to prevent psychosocial distress and mental disorders.
- Brief interactive lecture about the finding of the assessment (see Study Material for Trainers for Module 1.3)

Study Material: Module 1.3[10]

To address the needs of the refugees and the care providers, it is critical to look at psychological stress not only from the 'medical' perspective, but to take a broader perspective that includes social and ecological factors. A multidisciplinary approach is required to address the observed problems. The refugees in the camps are vulnerable: on a political, social and cultural level. This vulnerability is caused by their status as a refugee, by the situation in the refugee camps, and it is also related to humanitarian aid. However, not all problems are caused by the refugee situation. Psychosocial and mental problems can be pre-existing for refugees related to disaster, violence, loss of relatives, status, or belongings.

Social risk factors for mental disorders
Social factors are known to be major determinants of mental disorders. Three key social determinants are risk factors for mental disorders: poverty, social exclusion and gender violence. Dependency is a central element in the worldview of the refugees in the Great Lake Area, which results in the feeling that their future is blocked. They seem to develop apathy, but beneath this passivity there is a wish to be active agents in shaping their own future. The refugees the settings of the Great Lake Area often want to work toward self-sufficiency, but care providers often believe that refugees are no longer able to organize their lives.

Changing gender roles
Changing gender roles, due to refugee status and of the structure of the camp (the lack of income-generating activities for men) cause significant stress in marriages. Respondents in all camps mentioned high levels of gender-based violence. Violence is not limited to refugee settings, but the specific dynamics of the refugee setting together with dysfunctional or broken extended family support systems increase the incidence of violence. Regarding sexual violence, refugees most frequently mentioned cases of prostitution, forced sex and unwanted early pregnancies. According to refugees these problems are related to the fact that girls and boys only have education up to grade ten.

Gender violence
Respondents in the refugee camps of the Great Lake Area mentioned high levels of gender-based violence. Violence is not limited to refugee settings, but the specific dynamics of the refugee setting together with dysfunctional or broken extended family support systems increase the incidence of violence.

Worldwide, domestic violence has a significant negative impact on women's mental health. Addressing gender violence requires that agencies work closely *with* refugee communities, rather than setting up parallel systems *for* them. Community-based psychosocial work can have a unifying effect by crossing the boundaries between various services.

Lack of public forum to express
There is limited space for refugees to express themselves and share their feelings in the refugee camps. Lacking a forum for expressing themselves points towards a key strength of group-based interventions. The refugees are very sensitive to the kind of treatment they receive in the camps due to their status. They easily feel disrespected and often expressed negative opinions about NGO's and the UNHCR.

Mental Health of this population

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[10] *Source: HealthNet TPO (2010) Situation and needs assessment of mental health and psychosocial support in refugee camps in Tanzania, Rwanda and Burundi. Unpublished document. Amsterdam April 2010*

Regarding mental health, the stigma of epilepsy and mental disorders is high among refugees and health care providers. In general, only severe mental disorders such as psychosis were, to some extent recognized in the camps. Worldwide the burden of depression and other common mental disorders is significant among refugees, but in this assessment health workers said that they did not often see people with depression. However, detection of depressive symptoms once a refugee seeks help is reasonably easy to elicit.

MODULE 1.4: Cultural Idioms of Distress

Learning Objectives
At the end of this Module participants will:
- Understand the importance of cultural factors in identifying the problems and complains of the refugees
- Understand concepts as disease, illness and sickness, explanatory models and idioms of distress

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip-chat, markers, pen & papers, power point presentation, reference manuals
Printed copies of pre-test for health workers and community workers

Time
1 hour

Methodology for the Trainer
- Interactive lecture: using a flip-chart, explain the following concepts: disease, illness and sickness, explanatory models and idioms of distress (see Study Material: Module 1.4).
- Group work (30 minutes)
    o Ask participants if the understood the concepts. Divide participants in groups and ask each group to create a list with expressions and words people use for distress and mental health problems.
    o In the plenary meeting each group present their list which will be discussed with the other participants.

Study Material for Trainers: Module 1.4: Disease, Illness and Sickness, Explanatory Models and Cultural Idioms of Distress[11]

Disease, Illness and Sickness
In the present and following unit you will explore some key concepts in Medical Anthropology which will provide the participants with theoretical background knowledge useful to better understand relevant aspects of practical psychosocial work with clients.

Medicine as a cultural system
We can view *health care* or *medicine*, as a *cultural system.* [12] The words *cultural system* means that medicine is to be considered as a set of symbolic meanings which shape both the reality that we define as clinic and the reality as experienced by the subject.
Often, people misunderstand *medicine* as something technical which is 'neutral' and 'scientific'. This is not correct. There are many value judgments and cultural factors in the way medicine is shaped.
Understanding medicine as a *cultural system* helps us to better connect the knowledge of scientific medicine with the medical, social, psychological and political implications at various levels.

Explanatory models
The Explanatory Models (EMs) refer to a person's explanations and predictions regarding a particular illness. Patients, as well as families, have direct and informal knowledge about illness, which is dynamically structured when they have to cope with health issues all along the path from perception of the problem, the looking for healing, choice of treatment, course, and outcomes.

Explanatory models are a set of beliefs which "contains any or all of five issues:
- Etiology (*causes of symptoms*);
- Onset of symptoms (*when first signs started);*
- Pathophysiology (*elements that characterize the sickness*);
- Course of sickness (*the evolution, severity of sickness and type of sick role*);
- Treatment".

When people face health issues and perceive themselves to be ill they may ask themselves questions like:
What has happened?   *Why now?*
Why has it happened/ to me?   *What will happen now?*
What should I do about it?   *To whom should I turn?*
How this will affect my?   *How can I cope with this?*
(i.e. work, relations, project)

EMs have often internal contradictory elements, non homogeneous, continuously re-elaborated during personal experiences. Choices as well are modified time to time as per the personal experiences all along the various episodes related to the illness.

Accessing patients/familial perspective (some exemplifying questions):
- How do you call your problem?
- How does it work?
- What do you think caused your problem?
- Why do you think it started when it did?

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[11] Copied with little adaptations from: UNHCR and GRT, Psychosocial counseling and social work with clients and their *families in the Somali context: A facilitator's guide, 2009, pag.17-23.*

[12] Kleinman, A., 1980, "Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine and psychiatry", University of California, Berkeley, p. 131.

- What does your sickness do to you?
- How severe is it?
- How long do you think you will have it?
- Which have been the first signs?
- What has happened before that?
- What are the main problems your sickness has caused you?
- What do you fear most about your illness?
- Anyone else with the same problem?
- What have you done so far to treat your illness?
- Which outcomes?
- What treatments do you think you should receive?
- What resources can you utilize in order to get better?
- What important results do you hope to receive from the treatment?
- Who else can help you?

The following figure shows graphically the interconnections between physician and patient' Ems. In the examples below the professional is a medical doctor but you can consider any other professionals involved (see the examples before). Consider moreover that more than two actors may be involved all over the rehabilitation path of the person at the same time or in different moment, so that the reality is much fluid and dynamic than what could be evinced from the figure below.
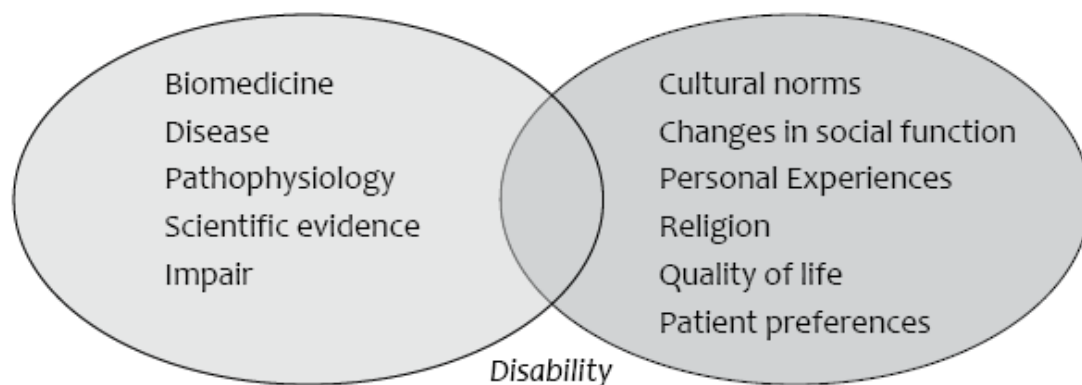
Figure 1. Dominance of Explanatory models (physician and Patient' EMs)[7]

Idioms of distress
It is important to understand how people talk about emotions; *what language they use*. If we want to help people cope with emotional effects of a man made or natural disaster, we have to understand how people communicate their feelings. What different concepts do people use, in different languages, to come to the simple English words as: being/feeling confused, sad, angry, tired, afraid, worried, concerned, troubled, mad, crazy, hopeless, depressed, happy. Which concepts do not exist in English?

To express feelings[13]
How do people *express* these feelings? Do they talk about these feelings, and if so, with whom, and with whom not? If they do not talk, then why not – is it too painful, is it embarrassing, is it not 'correct' to do so? If they can talk, is it easier to talk to people who are close to them (relatives, neighbors) or is it easier to talk to people who are 'far'

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[13] Copied and partly adapted from B. Van Mierlo, *Training manual; A community based psychosocial program*,

HealthNet TPO, 2008, unpublished

from them – perhaps even total strangers?
Can they talk to people who have gone through the same experience, because they share the same emotions, or should they not talk to people with the same experience, because it is too painful and there is nothing they can learn from them?

Do children talk about emotions?
Do they talk among each other, or with their parents, their father or their mother, their grandfather or grandmother, some favorite family member? Or not at all? Do parents talk about the emotions of the children with the children, among each other, or not at all?

What does the community consider to be 'normal' (in other words, when do people think someone has a 'problem')?
- What are 'normal' mourning periods?
- What are 'normal' coping styles, ways of dealing with problems?
- What is acceptable behavior in reaction to loss of children, or of husband or wife, or of parents?
- What is acceptable behavior in reaction to loss of a house or material goods?
- When and where can they cry, or pray, or be angry?
- Can they act in public or only in their own house?
- What does a family do normally when someone dies?
- How is the burial done?
- Where are people buried – in a graveyard? Somewhere else?
- What rituals need to be done?
- What is *not*-acceptable behavior in reaction to these things?

Expressions and idioms refugees in the Great Lake District use in case of mental problems.
Of course, the local terms are by no means synonyms for the medical constructions of mental and neurological disorders. But the local categories and idioms do overlap to some extent with medical terms.

In all settings when asked about 'mental problems' respondents gave examples of people they had seen. The most prominent features that were mentioned were severe behavioral problems ('eating anything one can find on the ground', 'beating children', 'throwing stones to people', 'walking naked'), withdrawal and self-neglect ('they are dirty', they never wash themselves') problems with speech and language ('talking nonsense', 'talking senseless things', and talking a lot', 'saying things that no one can understand'). Specific symptoms of psychosis (delusions and hallucinations) were not frequently mentioned directly but were often acknowledged in an indirect way ('talking to oneself', 'saying things that are not true').

To the question of who assists people with severe mental disorders was often answered by 'no one'. Women in Kiziba said, for example, that some Christians assist people with mental disorders by providing them with material assistance. The health sector was also mentioned but often people were not optimistic about the assistance people with mental disorders could expect from this resource.
In case of epilepsy the notion that epilepsy could be contagious was expressed in various settings. Stigma around epilepsy was considerable: 'There are many people with *igicuri or efuele,* but they do not say it because of the fear to be rejected. Families who have epileptics have serious problems. They are not accepted or nobody to marry in those families because epilepsy is contagious.'

Many people in the camps think epilepsy is caused by poisoning. They find the diagnosis hard to accept particularly in forms of epilepsy that do not have the tonic-clonic manifestations.' Refugees with epilepsy sometimes seek help in the health centre and with traditional healers, but more often 'they are left in the families because epilepsy

does not have a cure and it is contagious.'
People with a depression were described as 'people who cry all the time and there are people who feel that their head is heavy.' Some informants in Rwanda used the word *guta umutwe* ('losing your head'), which has some similarities to depression.

The perception of problems are imbedded in the culture. The refugees in Tanzania (the Burundians and the Congolese) did not mention psychotrauma, and had no words to indicate a specific syndrome related to being traumatized. This was very different in Rwanda and to some extent among the Banyamulenge in Burundi:

Guhahamuka is, for example, when you think about how your children and husband are killed in front of your eyes, when you think about all that you have lost. Someone like that has a fear inside the heart because of all that he has seen. If one thinks about all that you are lost because then you lose your balance and get *guhahamuka*. But of course the difficulties in the camp here make the things worse. The problem comes back when one is in difficult circumstances; for example, when one is in extreme poverty. If you look at a person with *guhahamaka* you may think he has a low intelligence, but this is not true. He is intelligent but because of his problems he is bothered. (*interview traditional birth attendant*)

MODULE 1.5: Interventions and Inter-Sectoral Cooperation

Learning Objectives
At the end of this Module participants will:
- Have a basic understanding about key concepts on mental health and psychosocial interventions
- Have an understanding of the importance of inter-sector cooperation in MHPSS

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, power point presentation, reference manuals

Time
3 hours

This section was obtained from Peter Ventevogel's original training presentation. Please see the Study Material for Trainers at the end of this section for more information.

Methodology for the trainer
a) Introduction to MHPSS in complex emergencies (30 minutes)
Main points that need to be clear to all participants after the lecture:
1. Difference/overlap between psychosocial problems, common mental disorders and severe mental disorders
2. Prevalence of these problems in the general population and in refugee populations
   Importance of a multilayered support system (using the MHPSS intervention pyramid)

b) Group exercise: understanding MHPSS intervention pyramid (60 minutes)
The intervention pyramid is drawn on flip-chart and the different levels are explained in general terms

Intervention pyramid

Examples:	
Mental health care by mental health specialists (psychiatric nurses, psychologists, psychiatrists, etc.)	**Specialised services**
Basic mental health care by PHC doctors **Basic emotional and practical support by community workers**	**Focused non-specialised supports**
Activating social networks **Communal traditional supports** **Supportive age-friendly spaces**	**Strengthening community and family supports**
Advocacy for basic services that are safe, socially appropriate and that protect dignity	**Social considerations in basic services and security**

- Participants are divided in small groups of 4-6 people, from different backgrounds and organizations.
- Each group is given 15 minutes to write on flip-chart for each of the support levels two to three examples of services to support people with mental health and psychosocial problems that already exist in the camp.

- Each group is invited to present in 5-10 minutes what they have written.
- After all groups have given their presentation the facilitator discusses what he/she has seen. He/she corrects misunderstandings and integrates the different contributions and tries to draw lessons/conclusions such as:
  o Much different interventions already exist but there may be a lack of coordination
  o Some levels may be less represented or even be missing completely

Resources for trainer
IASC guidelines MHPSS found at:
http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/

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Study Material: Module 1.5

Some background info from IASC guidelines MHPSS for facilitators
In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity.

The IASC guidelines for Mental Health and Psychosocial Support in Emergency Settings were designed for use by all humanitarian actors, including community-based organizations, government authorities, United Nations organizations, non-government organizations (NGOs) and donors operating in emergency settings at local, national and international levels. Implementation of the MHPSS guidelines requires extensive collaboration among various humanitarian actors: no single community or agency is expected to have the capacity to implement all necessary minimum responses in the midst of an emergency. The MHPSS guidelines are not intended solely for mental health and psychosocial workers but for general workers as well.

IASC MHPSS Core Principles:
1. Human rights and equity
2. Participation: "Humanitarian action should maximize the participation of local affected populations in the humanitarian response. In most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts. Many key mental health and psychosocial supports come from affected communities themselves rather than from outside agencies."
3. Do no harm
4. Building on available resources and capacities
5. Integrated support systems: "Activities and programming should be integrated as far as possible. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma."
6. Multi-layered supports: "In emergencies, people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid. All layers of the pyramid are important and should ideally be implemented concurrently.

MODULE 1.6: Introduction to Communication Skills

This session is optional and has overlaps with Module PS 3.4

Learning objectives
After the session the participants will be able to
- describe the importance of communication skills in MHPSS work and provide examples of different communication techniques for effective communication

Methodology for the trainer
Role play, interactive lecture, demonstrations

Materials
Flip-chart, markers

Time
1-2 hours

Resources to be used
Study Material for trainer (see end of section)

Methodology for the trainer
- Demonstration role play ('example of bad communication skills')
  - Two facilitators do a brief role play of 5 minutes, demonstrating how disruptive bad communication skills can be for a client.
  - After the role-play participants are invited to describe what they saw and how they believe the client felt.
- Interactive lecture on communication skills (60 minutes)
  - Facilitator explains basic principles of effective communication skills when interacting with clients who have MHPSS problems.
  - This is done with the help Study Material for Trainers based on a presentation given in the original training.
- Demonstration role play ('example of good communication skills') (15 minutes)
  - The two facilitator (or two participants) do the role play of a) again but now demonstrating good communication skills such including:

Study Material: Module 1.6 (see also Study Material 3.4)
These are presentation contents from the original training conducted. Importance of Communication Skills:

- Skills are not the helping process itself but are essentials tools for developing relationships and interacting with clients
- They are not ends in themselves but means or instruments to be used in achieving outcomes

1. ATTENDING

Refers to ways in which helpers can be with their clients both physically and psychologically. Effective attending does two things:
a) It tells clients that you are with the client.
b) It puts you in position to listen carefully to their concerns.
The microskills of attending can be summarized in the acronym SOLER:

S: Face the clients squarely: adopt a posture that indicates involvement.
O: Adopt an open posture. Always ask yourself, to what degree does my present posture communicates openness and availability?
L: Lean. Remember that it is possible at times to lean toward the other.
E: Maintain good eye contact.
R: Try to be relaxed or natural.
Try to avoid fidgeting nervously or engaging in distracting facial expression. Become comfortable with using your body as a vehicle of contact and expression

√ Nonverbal communication: Be aware of your body as a source of communication. You should not be preoccupied by your body as a source of communication but you learn to use your body as a means of communication

√ Social- Emotional Presence: Showing a clear cut willingness to work with the client through both your verbal and non-verbal behavior

2. ACTIVE LISTENING

Listen carefully all throughout the helping process to what the client is saying both verbally and nonverbally. Complete listening involves some elements:
1. Observing and reading the client's nonverbal behavior.
2. Listening to and understanding the client's verbal message.
3. Listening to the context, e.g., the whole person in the context of the social setting of his life

3. EMPATHY

Involves listening to clients.
Understanding them and their concerns.
Communicating to them to be able to understand themselves more fully and to act.

Empathy as a communication skill enables helpers to communicate their understanding to the clients. Empathy is directly therapeutic. It contributes to the success of the overall helping process. Through empathy:

- You build a working alliance with the clients
- You can help clients explore themselves and their concerns. When clients feel understood, they tend to move on and to explore issues more widely and deeply.

4. PROBING

Refers to asking questions, encouraging client to speak, responding to their complaints and requesting information to better characterize what is happening with the client.
Importance: This helps clients speak about and clarify missing parts.

PART TWO: TRAINING FOR HEALTH CARE WORKERS

Introduction
This section is specifically designed to train health care workers in mental health and psychosocial care. It is intended for but not limited to:
- Non-specialist Medical Doctors
- Nurses
- Other Clinicians
- Other professionals who wish to obtain more intensive training in mental health may find this useful as well.

Contents

Module	Title	Training Time
2.1	Introduction to Mental Health and Disorders	½ day
2.2	History Taking and Mental Health Assessment	½ day
2.3	Use of WHO mhGAP Guidelines	1 hour
2.4	Depression	½ day
2.5	Psychosis	½ day
2.6	Bipolar Disorder	2 hours
2.7	Alcohol and Substance Use Disorders	4-6 hours
2.8	Suicide and Self-Harm	½ day
2.9	Epilepsy	½ day
2.10	Dementia and Delirium	2 hours
2.11	Disorders of Childhood and Adolescence	½ day
2.12	Somatic Complaints and Anxiety Disorders	½ day
2.13	Psychological Trauma	2 hours
2.14	Intervention Guidelines and Community-oriented Strategies	½ day

Learning Objectives
At the end of this Module participants will:
- Understand the glob-al burden of disease due to mental health.
- Be aware of various classification systems for mental disorders.
- Understand the local context and cultural idioms of distress.
- Become familiar with basic concepts related to mental health and psychosocial issues.
- Be introduced to basic concepts related to mental health and psychosocial issues.
- Understand interventions and inter-sectoral models of cooperation

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers,reference manuals power point presentation. The handouts of the PowerPoint presentation can be found in annexed documents.

Resource List
The following list is a supplement of Study Material for trainers to use as background material for Part Two – Training Health Care Workers. These links can also be distributed to participants for their use in clinical practice.

- Epilepsy: A manual for medical and clinical officers in Africa (WHO)
  http://www.who.int/mental_health/media/en/639.pdf

- Pharmacologic treatment of mental disorders in primary health care (WHO)
  http://www.who.int/mental_health/management/psychotropic/en/index.html

- Preventing Suicide: a resource series (WHO)
  http://www.who.int/mental_health/resources/preventingsuicide/en/index.html

- ICD-10: International Classification of Disease
  http://www.who.int/classifications/icd/en/

- DSM-IV: Diagnostic and Statistical Manual of Disorders
  http://www.psych.org/mainmenu/research/dsmiv.aspx
- WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings ((mhGAP-IG).
  http://www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/index.html

- Psychosocial Counseling and Social Work with Clients and Their Families in the Somali Context (UNHCR), www.grtitalia.org/PCSWEnglish.pdf

MODULE 2.1: Introduction to Mental Health and Mental Disorders

Learning Objectives
At the end of this Module participants will:
- Understand the global burden of disease due to mental health.
- Be aware of various classification systems for mental disorders.
- Be introduced to mental disorders at large.
- Be able to discuss risk factors and protective factors for mental illness.
- Understand the rights of patients with regard to mental health.

Materials
Flip chat, markers, pen & papers, reference manuals

Methodology for the trainer
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises

Introduction to Global Burden of Disease
- Facilitator chooses to present various WHO global statistics on Mental Health relevant for participants. For example:
  - 14% of global burden of disease due to mental, neurological and substance use disorders
  - Depression is the 4th leading cause of disease burden globally
  - Suicide is the 3rd leading cause of death in young people
  - Alcohol is the 5th leading risk factor for death and disability
- Review again what is mental illness (from Part One)

Exercise: Ask participants what major mental disorders they have seen in the communities in which they work.

There are professional classification made for mental health professionals. These are often quite comprehensive and complicated.
Therefore WHO has made an Intervention Guide for Mental, Neurological and Substance Use Disorders in non specialized health settings.
mhGAP will be discussed fully in a subsequent section. It identifies priority areas based on burden of disease, cost to society and/or human rights violations. There is a high economic burden due to these disorders attributable to loss of employment and income, care giving need, cost of medications, and need for interventions and services.

Another good resource for practitioners in non-specialized health settings is the book by Vikram Patel: Where there is no psychiatrist.
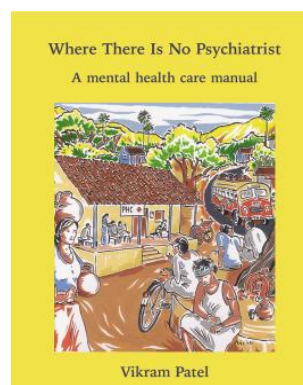

Figure 1. Where there is no Psychiatrist? By Vikram Patel

Stigma

Exercise: Ask participants to describe how mental health is stigmatized in the populations in which they work. Discuss how mental disorders are stigmatized in many settings and have resulted in discrimination, poor access to care and abuse/neglect.

Risk Factors and Protective Factors

Exercise: Ask participants to identify both in their community. Think about risk factors on the individual, family and community level for refugees.

Known Risk Factors for Mental Disorders:
• Alcohol and Substance Abuse
• Men more likely to abuse alcohol
• Low socioeconomic status/poverty
• Past traumatic life events
• Past history of mental illness
• Family History of mental illness

Exercise: Ask participants to think about risk factors for mental illness among the refugees they work with.

Protective Factors

Exercise: Think of protective factors in your community. How do these differ across cultures?

Resilience

What is resilience? It is the ability for individuals to 'bounce back' after adverse events. Discuss how most people are resilient and will not develop a mental illness even during times of severe stress.

Rights of People with mental disorders (½ hr)

The trainer gives an interactive lecture using a flip-chart. It is important here to realize that the goal of this part of the session is not so much transfer of knowledge or building skills, but mostly change of attitude. Just as many other members of the community health workers may have strong prejudices about people with mental disorders.

It is important to discuss this and to relate to positive experiences that participants may have with people who have mental disorders.

• Rights of Mental Patients: All mental patients have the same rights as non-mental patients. Health workers have a responsibility to respect and to advocate for the rights of mental patients.

• These are some of the following rights:
  o Right to privacy
  o Right to confidentiality
  o Right to informed consent
  o Right to refuse treatment
  o Right to quality treatment and rehabilitation

Key message: Mental patients have the same rights as other patients. These include among others the right to respect, privacy, confidentiality, informed consent, refuse treatment, quality treatment and rehabilitation.

Resource materials
• ICD-10: International Classification of Disease
  http://www.who.int/classifications/icd/en/

• DSM-IV: Diagnostic and Statistical Manual of Disorders

http://www.psych.org/mainmenu/research/dsmiv.aspx

- mhGAP-IG: WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings
http://www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/index.html

Study Material for Trainers: Module 2.1

Classification Systems: Key Points
- 1970s: psychiatrists working in psycho-pharmacological research developed Research Diagnostic Criteria
- Method adopted and refined in the development of ICD (WHO) and DSM (APA) systems of classification
- 10th revision of the ICD: Published in 1993 after 10 years of consensus and field work, Aimed to be a universal, culturally appropriate classification system
- ICD-10: International Classification of Disease (WHO) http://www.who.int/classifications/icd/en/
- DSM-IV: Diagnostic and Statistical Manual of Disorders (APA in U.S.) http://www.psych.org/mainmenu/research/dsmiv.aspx

Advantages of International Classification
- Criteria for research on health problems that do not have 'gold standard' diagnostic tests
- Common global language for mental & public health professionals
- Has led to development of standardized interview based diagnostic measures for research
- Enables comparisons of research findings and clinical experiences across nations

Limitations
- Culturally insensitive: local idioms and categories are ignored (e.g. depression rarely presents with depression)
- Over-complicated: Too many categories; only a few diagnoses used in clinical practice
- Reclassification and reviews of illness cause definitions to constantly change. Some conditions stop being mental disorders (Ask participants if they know of any e.g. neurosis, homosexuality etc)

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Disadvantages
- Culturally insensitive: local idioms and categories are ignored (e.g. depression rarely presents with depression)
- Over-complicated: Too many categories; only a few diagnoses used in clinical practice
- Reclassification and reviews of illness cause definitions to constantly change. Some conditions stop being mental disorders (Ask participants if they know of any e.g. neurosis, homosexuality etc)

MODULE 2.2: History Taking and Mental Health Assessment

Learning Objectives
At the end of this Module participants will:
- Understand the basic principles of communication skills required when carrying out a mental health assessment
- Conduct a basic mental health assessment, as a general health worker
- Use the WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, power reference manuals

Time
3-4 hours

Methodology for trainers
Basic principles of Communication Skills (1 hr)
- This part of the session builds on an earlier session that was done in Part One
- The trainer outlines the basic principles of basic counseling and communication skills.
- Then in small groups of three, participants practice basic communication skills. In each group, one participant is a patient, another is a health worker and the other is an observer.
- The session consists of the 'patient' relating to the 'health worker' a difficult life experience.
- In plenary, the participants who have been observers present a critique of the performance of the 'health workers.'

Taking History (2 hrs)
- Methods: Interactive lecture, 2 role-plays
- It is important here to realize that the goal is partially knowledge acquisition, but also skills building.
- The trainer outlines the key areas to be covered when taking a mental health history.
- Exercise: Conduct a role-play depicting the technique of taking history (30 minutes).
- In this first role-play, all the participants observe the trainer taking history from a co-facilitator.
- In the second role-play, one of the participants takes history from one of the trainers. The other participants observe and critique

Mental State Examination
Methods: Interactive Lecture, 2 Role Plays

Assessment, Diagnosis and Formulation
Based on the symptoms elicited, health care workers should come up with a differential diagnosis

Treatment Plan
Once a diagnosis has been established, a treatment plan should be developed and should be focused on the biological, psychological and social domains of functioning.

For example,
- Biological could include laboratory tests and medications
- Psychological could include attempts by clinicians to help a person cope with multiple losses, or with negative thoughts and poor self-esteem.

o   Social can include employment and vocational training and peer support programmes

Further information on treatment strategies will be presented in each section and at the end of Part Two, and is also available through the mhGAP-IG.

Key messages
- Health workers should apply basic principles of communication skills when carrying out mental health assessment of patients.
- Taking a history should include basic screening of the patient
- History and screening is not solely a focus on symptoms – it is a sketch of stressors, psychosocial factors, relationships, occupational function and all domains that are important to daily life - biological, psychological and social.
- The mental status exam is the equivalent of the physical exam for a general practitioner in medicine
- Mental state assessments may require more than one session with the patient.

Evaluation
Ask the participants at the end of the session what they have learned.

Study Material for Trainers: Module 2.2

The assessment of a patient for potential mental disorders consists of different elements:
1. Psychiatric history taking,
2. Mental state examination,
3. Physical examination, and
4. Additional investigations such as lab-tests.

1. Psychiatric History Taking
The psychiatric history is the patient's story told to the health worker in the patient's own words and from his or her own point of view. The history can also include information about the patient obtained from other sources, such as another member of the household.

A psychiatric history differs somewhat from histories taken in other fields of health care In addition to gathering the facts a psychiatric history should also to provide a picture of a patient's personality, including both strengths and weaknesses.

The standard format for psychiatric history is presented below.

Identification
Patient's name, age, gender, marital state, occupation, current living situation, language, and ethnic background.

Main complaint
Provide the reason that the patient is seeking care using the patient's own words in quotation marks if that information does not come from the, note who supplied it.

History of Present illness
Document current symptoms as described by the patient's; date of onset, duration and course of symptoms. Obtain a chronological description of recent events leading up to the presentation, precipitating events, and any other psychosocial stressors. This section should include a psychiatric review of symptoms that assesses the presence of affective or mood, psychotic, and anxiety disorders.

Past psychiatric history
Past and current diagnoses
Detailed descriptions of past illness including symptoms of illness
Number of hospitalizations, dates, and treatments.
Past history of suicide attempts and suicidal ideation; Self-injurious behavior
History of psychiatric medications and response to medications, side effects
Current treatment, if any

Substance abuse history
Inventory of past history of alcohol and illicit substance abuse including but not limited to: alcohol, cannabis, prescription medications (pain medications, benzodiazepines), opiates, heroin, cocaine and other stimulants. Document the extent of use, amount of substance use, money spent daily, weekly or monthly. Ask about method of use, such as inhaled, intranasal, or intravenous. If alcohol use is present, screen for abuse or dependence with questions about attempts to cut down, anger, guilt, eye-openers, history of blackouts, shakes, seizure, or delirium. Ask about detox history or other treatment history.

Past medical history
Past and current medical problems and treatments. Medication used by the patient. Specifically screen for HIV, thyroid issues, central nervous system problems,

seizures/epilepsy and metabolic disturbances.

Psychiatric family history
Ask about psychiatric illnesses, suicide or suicide attempts in the family.

Social history
This section should cover the major domains of the patient's life, including work, marriage, family situation and recreation. Ask about level of education, the family of origin, marital history, religion, occupational history. For refugees also ask about the history with violence and persecution and how they ended up in the refugee camp. Get information on details of past traumatic events; physical abuse or sexual abuse where relevant.

2. Mental Status Examination

The 'mental state examination' is the examination of the different mental functions of the patient at the time of the consult. It is based on observation, listening and communication with the patient. This is the psychiatric variant of the 'physical examination' that is done by a doctor.

Appearance
The doctor tries to observe and describe different elements of the patients general appearance and can include:
o *General description:* How does the patient look? How is he/she clothed (dirty, clean?), how is the self care (grooming, hair, nails', smelling?) Does he she look healthy, sickly, angry, frightened, apathetic, perplexed, old looking, young looking, effeminate, masculine; Are there signs of anxiety? (moist hands, perspiring forehead, restlessness, tense posture, strained voice, wide eyes etc? Are there shifts in level of anxiety during interview or with a particular topic?
o *Attitude toward examiner*: For example describe if the patient is cooperative, attentive, interested, frank, seductive, defensive, hostile, playful, etc.
o *Behaviour and psychomotor activity*: For example describe how the patient moves and how he behaves. Is he/she very sitting motionless? Is he/she moving a lot (hyperactive)? Is he/she agitated? Does he/she show stereotypic movements or gestures?

Speech
Describe how the patient is speaking? Look for elements such as: rapid, slow, pressured, hesitant, emotional, monotonous, loud, whispered, slurred, mumbled, stuttering, echolalia, intensity, pitch, ease, spontaneity, productivity, manner, reaction time, vocabulary, prosody.

Mood and affect
In psychiatry we make a difference between 'mood' which is how the person in general is feeling inside his heart and 'affect' which are the directly shown emotions that are expressed. through facial expression, and talking.
o *Mood* is in terms of psychiatry 'a pervasive and sustained emotion that colours the person's perception of the world'. The examiner checks the mood though communication with the patient and asking how he or she says he or she feels. Ask about depth of emotions, intensity, duration, and fluctuations of mood- depressed, despairing, irritable, anxious, terrified, angry, expansive, euphoric, empty, guilty, awed, self-contemptuous, anhedonic (not being able to feel pleasure)
o *Affect* is 'the outward expression of the patient's inner experiences'. The examiner evaluates patient's affects by observing the emotions that are visible in the patient: broad, restricted, blunted or flat, shallow, amount and range of expression; difficulty in initiating, sustaining or terminating an emotional response; is the emotional expression appropriate to the thought content, culture, and setting of the

examination; give examples if emotional expression appropriate.

Thinking

Form of thinking
- productivity: overabundance of ideas, flight of ideas, rapid thinking, hesitant thinking; does patient speak spontaneously or only when questions are asked, stream of thought, quotations from patient.
- Continuity of thought: whether patient's replies really answer questions and are goal directed, relevant, or irrelevant; loose associations; lack of causal relations in patient's explanations; illogical, tangential, circumstantial, rambling, evasive, perseverative statements, blocking or distractibility
- Language impairments: incoherent or incomprehensible speech (word salad), clang associations, neologisms

Content of thinking
- preoccupations: elements in the mind of the patient that bother him: for example thinking all the time about the illness, thinking about a specific problem etc

Thought disturbance
- delusions: delusion = a false belief that is not shared by others in the group to which the patient belongs and that is not changeable.
- Ideas of reference and ideas of influence: how ideas began, their content, and the meaning the patient attributes to them.

Perception

Check for disturbances in perception (the way the world sees, hears, smells etc)
- Hallucinations and illusions: whether patient hears voice or sees visions; content, sensory system involvement, circumstances of the occurrence; thought broadcasting.
- Depersonalization and derealization: extreme feelings of detachment from self or from the environment.

Sensorium

Alertness
awareness of environment, attention span, clouding of consciousness, fluctuations in levels of awareness, somnolence, stupor, lethargy, fugue state coma
Orientation
- *Time:* whether patient identifies the day correctly; or approximate date, time of day; if in a hospital, knows how long he or somnolence, stupor, lethargy, fugue state, come
- *Place*: whether patient knows where he or she is
- *Person*: whether patient knows who the examiners are, and the roles or names of the persons with whom he or she is in contact

Concentration and calculation

Check the concentration by asking questions that require a good concentration. For example, a patient can be asked to subtracting 7 from 100 and keep subtracting 7s. If patient can not calculate well, then one can ask other question that require concentration.

Memory

Look for impaired memories. Ask if the patient has trouble with memories, and what efforts he makes to cope with impairment (for example denial or confabulation). To check the different levels of memory ask different questions:
Remote memory: childhood data, important events known to have occurred when the patient was younger or free of illness, personal matters, neutral material
Recent memory: ask about events in the past few months
Recent memory: Ask about the past few days, what did patient do yesterday, the day before, what did he have for breakfast, lunch, dinner?
Immediate retention and recall: Check the patients ability to repeat six figures after

examiner dictates them-first forward, then backward, then after few minutes' interruption; other test question; did same questions, if repeated, call forth different answers at different times.

Intelligence
Ask the level of formal education and self-education; Estimate the patient's intellectual capability. Is the intelligence different from other family members? Ask only questions that have relevance to the patient's educational and cultural background.
Check the level of abstract thinking: can the patient detect similarities (e.g. between apples and mango: both are fruit. Or between a cat and a dog: both are animals), does the patient understand the meaning of simple proverbs? Answers may be too concrete (giving specific examples to illustrate the meaning) or overly abstract (giving generalized explanation).

Insight
Degree if personal awareness and understanding of illness. There can be:
o *complete denial* of illness: patient does not accept in any way that he has a mental illness
o *Slight awareness* of being sick and needing help but denying it at the same time
o *Awareness of being sick but blaming it on others*, on external factors, on medical or unknown organic factors
o *Insight*: Patient admits that he or she has a mental illness, and recognizes that symptoms or failures in social adjustment are due to *mental* problems.

Judgment
Check for subtle manifestations of behaviour that are harmful to the patient and contrary to acceptable behaviour in the culture; does the patient understand the likely outcome of personal behaviour and is patient influenced by that understanding examples of impairment?

3 & 4. Physical examination and lab examinations
It is important that a patient who is assessed for a mental disorder is also physically examined because 1) a patient with a mental disorder can have an undetected physical problem, such as a neglected infectious disease or malnutrition, 2) the mental disorder of a patient can be caused by physical disorder and the physical examination may reveal useful signs such as a goitre, 3) psychotropic drugs can produce side effects such as hypertension and parkinsonism.

General physical examination
The general physical examination consists of:
o Basic observations, such as the person's walk, skin tone, voice intonation and ability to hold a normal conversation.
o Taking the blood pressure and checking for basic signs of disease such as anaemia or swelling of the legs.
o Examining the various organ systems of the body; the heart, lungs, bowels, etc.

Neurological examination
For a person with a psychiatric disorder, it is also important that a neurological examination is performed. This examination gives an understanding of the wellbeing of the person's brain, mental function, nerves and muscles. It is the tool that physicians use to identify
structural and psychiatric abnormality.

Lab examinations
The lab investigations vary per diagnosis and the available resources. Usually, when a patient is admitted in a hospital full blood count, electrolytes, liver and thyroid function are advised.

MODULE 2.3: Using the WHO mhGAP Guidelines

Learning Objectives
At the end of this Module participants will:
- Understand the basic principles behind the WHO mhGAP Guidelines for mental, neurological and substance use disorders in non-specialized health settings
- Use the Guidelines in the choice of interventions for people with priority mental, neurological and substance use disorders presenting in primary care
- Use the Guidelines as a tool for advocacy to adapt clinical practices in health care for refugees

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals.

Time
2 hours

Methodology for the Trainer
Introduction to mhGAP
- The trainer gives an interactive lecture using a flip-chart. Mental Health Gap Action Program (WHO)
  - Launched in 2008 by the WHO
  - A comprehensive action plan for low and middle income countries to scale up services and treatment for the high burden of mental, neurological and substance use disorders globally
  - Available on the internet
  - Based on the idea that treatment is feasible
  - Interventions possible by non-specialist health providers and low-cost strategies.
  - Can be used for the refugee context but must be adapted

- The mhGAP Intervention Guide for mental, neurological and substance use disorders for non-specialist health settings (mhGAP-IG) is a *technical tool* developed by WHO to assist general health workers to choose appropriate treatment and management options for people with MNS disorders presenting in general health care.

- The mhGAP-IG presents integrated management of *priority conditions* using protocols for clinical decision-making. The priority conditions included are:
  - depression,
  - psychosis,
  - bipolar disorders,
  - epilepsy,
  - developmental and behavioral disorders in children and adolescents,
  - dementia,
  - alcohol use disorders, drug use disorders,
  - self-harm/suicide
  - and other significant emotional or medically unexplained complaints.

  In this course we will address all the priority condition except dementia and behavioural disorders in children. We add *delirium* because dementia is fortunately not frequently seen in refugee settings, while *delirium* is important in this setting.
- On its own, the mhGAP intervention guide cannot be expected to bring substantive improvements in mental health. Much work remains in *adapting the guide* to local languages, culture, and health-system capabilities. The Intervention Guide should be

embedded in a larger program for improvement of mental health care. WHO pilots such program in several countries. This program to minimize the treatment gap for mental health problems is called mhGAP.

- The Intervention Guide is *brief* so as to facilitate interventions by busy non-specialists in low- and middle-income countries. The Guide includes a *Master Chart* which provides information on common presentations of the priority conditions to guide the clinician to the relevant modules. The modules provide information on assessment and management for the priority conditions in form of simple flow charts.

Using the Intervention Guide
The facilitator distributes hard copies of the Intervention Guide and gives the participants few minutes to explore it. He/she then leads them through the document explaining the different sections:

General Principles of Care
The mhGAP-IG starts with a section on *General Principles of Care*. It provides good clinical practices for the interactions of healthcare providers with people seeking mental health care. Many of the elements in this section are not specific for people with *mental disorder* but are important to people with *any medical disorder*. It covers tips for:
1. Good communication
2. Assessment (including a physical assessment. For people with mental disorders this is often neglected
3. Informed consent
4. Mobilizing and providing social support
5. Protection of human rights.

Master Chart
The Intervention Guide includes a *Master Chart,* which provides information on common presentations of the priority conditions. This should guide the clinician to the relevant modules.
→ Facilitator goes through the master chart to show main themes.

In the event of potential co-morbidity (two disorders present at the same time), it is important for the clinician to confirm the co-morbidity and then make an overall management plan for treatment. The most serious conditions should be managed first.

Modules for each priority condition
Each module is in a different color to allow easy differentiation. There is an *introduction* at the beginning of each module that explains which condition(s) the module covers. Each of the modules consists of two sections.

Section 1:
The first section is the *assessment and management section*. In this section, the contents are presented in a framework of *flowcharts* with multiple decision points. Each decision point is identified by a number and is in the form of a question. Each decision point has information organized in the form of three columns – *assess, decide and manage.*
- The left-hand column includes the details for *assessment* of the person. It is the assess column, which guides users how to assess the clinical condition of a person. Users need to consider all elements of this column before moving to the next column.
- The middle column specifies the different scenarios the health-care provider might be facing. This is the *decide* column.
- The right-hand column describes suggestions on *how to manage* the problem. It provides information and advice, related to particular decision points, on psychosocial and pharmacological interventions. The relevant intervention details are identified with *codes.* For example PSY 3 means the intervention detail number three for the Psychosis Module.

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Section 2:
The *second section* of each module consists of intervention details which provides more information on follow-up, referral, relapse prevention, and more technical details of psychosocial / non-pharmacological and pharmacological treatments, and important side-effects or interactions.

In the end of the guide is a section covering *advanced psychosocial interventions* that take more than a few hours of a health-care provider's time to learn and typically more than a few hours to implement. Such interventions can be implemented in non-specialized care settings but only when sufficient human resource time is made available. Within the flowcharts in the modules, such interventions are marked by the abbreviation INT indicating that these require a relatively more intensive use of human resources.

Key messages
- The WHO mhGAP Intervention Guide is a technical tool to assist non-specialist general health workers in management of people with mental, neurological or substance use disorders.
- It can only be implemented in a supportive health care system with adaptations in drug supply, health management information systems (HMIS) and good cooperation with those who provide non health interventions (staff from the community services and refugee themselves).

Evaluation
Ask the participants at the end of the session what they have learned.

Resources
- Study Material for Trainers (see end of section)
- Hand-out for Participants (see end of section)
- WHO mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings ((mhGAP-IG). Can be ordered through WHO and can be downloaded from: http://www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/index.html

Study Material for Trainers: Module 2.3

mhGAP and the Intervention Guide
About four out of five people in low- and middle-income countries who need services for mental, neurological and substance use conditions do not receive them. This is referred to as the 'treatment gap'. Even when available, the interventions often are neither evidence-based nor of high quality. WHO recently launched the mental health Gap Action Program (mhGAP) for low- and middle-income countries with the objective of scaling up care for mental, neurological and substance use disorders. This mhGAP Intervention Guide (mhGAP-IG) has been developed to facilitate mhGAP-related delivery of evidence-based interventions in non-specialized health-care settings.

There is a widely shared but mistaken idea that all mental health interventions are sophisticated and can only be delivered by highly specialized staff. Research in recent years has demonstrated the feasibility of delivery of pharmacological and psychosocial interventions in non-specialized health-care settings. The present model guide is based on a review of all the science available in this area and presents the interventions recommended for use in low- and middle-income countries. The mhGAP-IG includes guidance on evidence-based interventions to identify and manage a number of priority conditions.

The priority conditions included are
1. depression,
2. psychosis,
3. bipolar disorders,
4. epilepsy,
5. developmental disorders in children and adolescents
6. behavioral disorders in children and adolescents,
7. dementia,
8. alcohol use disorders,
9. drug use disorders,
10. self-harm / suicide
11. Other significant emotional or medically unexplained complaints.

These priority conditions were selected because they represent a large burden in terms of mortality, morbidity or disability, have high economic costs, and are associated with violations of human rights.

Development of the mhGAP Intervention Guide (mhGAP-IG)
The mhGAP-IG has been developed through an intensive process of evidence review. Systematic reviews were conducted to develop evidence-based recommendations. The process involved a WHO Guideline Development Group of international experts, who collaborated closely with the WHO Secretariat. The recommendations were then converted into clearly presented stepwise interventions, again with the collaboration of an international group of experts. The mhGAP-IG was then circulated among a wider range of reviewers across the world to include all the diverse contributions.

The mhGAP-IG is based on the mhGAP Guidelines on interventions for mental, neurological and substance use disorders (http://www.who.int/mental_health/mhgap/evidence/en/). The mhGAP Guidelines and the mhGAP-IG will be reviewed and updated in 5 years. Any revision and update before that will be made to the online version of the document.

Purpose of the mhGAP Intervention Guide
The mhGAP-IG has been developed for use in non-specialized health-care settings. It is aimed at health-care providers working at first- and second-level facilities. These health-care providers may be working in a health centre or as part of the clinical team at a

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district-level hospital or clinic. They include general physicians, family physicians, nurses and clinical officers. Other non-specialist health-care providers can use the mhGAP-IG with necessary adaptation. The first-level facilities include the health-care centers that serve as first point of contact with a health professional and provide outpatient medical and nursing care. Services are provided by general practitioners or physicians, dentists, clinical officers, community nurses, pharmacists and midwives, among others. Second-level facilities include the hospital at the first referral level responsible for a district or a defined geographical area containing a defined population and governed by a politico-administrative organization, such as a district health management team. The district clinician or mental health specialist supports the first level health-care team for mentoring and referral.

The mhGAP-IG is brief so as to facilitate interventions by busy non-specialists in low- and middle-income countries. It describes in detail *what to do* but does not go into descriptions of *how to do*. It is important that the non-specialist health-care providers are trained and then supervised and supported in using the mhGAP-IG in assessing and managing people with mental, neurological and substance use disorders.

Service development is described elsewhere
It is not the intention of the mhGAP-IG to cover service development. WHO has existing documents that guide service development. These include a tool to assess mental health systems, a Mental Health Policy and Services Guidance Package, and specific material on integration of mental health into primary care. Information on mhGAP implementation is provided in *mental health Gap Action Program: Scaling up care for mental, neurological and substance use disorders*. Useful WHO documents and their website links are given at the end of the introduction.

Role of specialists
Although the mhGAP-IG is to be implemented primarily by non-specialists, specialists may also find it useful in their work. In addition, specialists have an essential and substantial role in training, support and supervision. The mhGAP-IG indicates where access to specialists is required for consultation or referral. Creative solutions need to be found when specialists are not available in the district. For example, if resources are scarce, additional mental health training for non-specialist health-care providers may be organized, so that they can perform some of these functions in the absence of specialists. Specialists would also benefit from training on public health aspects of the program and service organization. Implementation of the mhGAP-IG ideally requires coordinated action by public health experts and managers, and dedicated specialists with a public health orientation.

Adaptation of the mhGAP-IG
The mhGAP-IG is a model guide and it is essential that it is adapted to national and local situations. Users may select a subset of the priority conditions or interventions to adapt and implement, depending on the contextual differences in prevalence and availability of resources. Adaptation is necessary to ensure that the conditions that contribute most to burden in a specific country are covered and that the mhGAP-IG is appropriate for the local conditions that affect the care of people with mental, neurological and substance use disorders in the health facility. The adaptation process should be used as an opportunity to develop a consensus on technical issues across disease conditions; this requires involvement of key national stakeholders. Adaptation will include language translation and ensuring that the interventions are acceptable in the sociocultural context and suitable for the local health system.

mhGAP implementation – key issues
Implementation at the country level should start from organizing a national stakeholder's meeting, needs assessment and identification of barriers to scaling-up. This should lead to preparing an action plan for scaling up, advocacy, human resources development and

task shifting of human resources, financing and budgeting issues, information system development for the priority conditions, and monitoring and evaluation. District-level implementation will be much easier after national-level decisions have been put into operation. A series of coordination meetings is initially required at the district level. All district health officers need to be briefed, especially if mental health is a new area to be integrated into their responsibilities. Presenting the mhGAP-IG could make them feel more comfortable when they learn that it is simple, applicable to their context, and could be integrated within the health system. Capacity building for mental health care requires initial training and continued support and supervision. However, training for delivery of the mhGAP-IG should be coordinated in such a way as not to interrupt ongoing service delivery

MODULE 2.4: Depression

Learning Objectives
At the end of this Module participants will be able to
- Define the concept of a depression
- Do a structured assessment of a person with a probable depression according to the mhGAP intervention guide
- Outline the differences and similarities between severe depression, mild to moderate depression and bipolar disorder
- Make a management plan for people with depression in line with the WHO mhGAP Intervention Guide
- Demonstrate key interpersonal skills in working with people who have depression

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals.

Time
3-4 hours

Methodology for the Trainer
Exercise: Introduction
- Facilitator introduces the topic of *sadness* by asking the participants why people feel sad or lose interest?
    o It will become clear that from time to time every person feels sad or unhappy; this is a normal part of life. In particular when a person is in difficult circumstances with little prospects for the future or experiences an important loss (for example the death of a loved one)
- Ask the participants when a condition of sadness and loss of interest can become a condition to worry about? When will it become an illness?
    o The facilitator organizes the discussion by emphasizing that 'normal sadness' may become a condition for concern if
        ▪ The reaction of the person is <u>too strong</u> in relation to the circumstances
        ▪ The reaction of the person takes <u>too long</u>
        ▪ The person is <u>not able to carry out his usual tasks</u> (domestic chores, work, social responsibilities)
        ▪ The person has <u>additional symptoms</u> (does not eat, does not sleep etc)
        ▪ The person may endanger him, her self or others (for example kill him/herself)
- What kind of words do refugees use to indicate people who are very sad and isolate themselves? (write these words on a flipchart)
    o Here it is important to encourage the participants to mention local expressions and ask them to describe them briefly. Be aware that these local concepts are not identical to depression, but people may use them to indicate they are not well. Ask them to keep this in mind when we are discussing the medical definition of depression later in this module. Examples:
        ▪ *Ibonge* or *Akabonge* (Kirundi)
        ▪ *Agahinda* (Kinyarwanda)
        ▪ *Mwaci wa malenga* ('disease of thinking') (Kibembe)
        ▪ *Magonjwaya roho* ('heart lllness') *(Kiswahili)*
        ▪ *Moyo wangu haupige* ('heart is not beating')(Kiswahili)
        ▪ *Numva ata buzima mfise (*'I feel I do not have a life') (*Kinyarwanda*)

- o What do people with such conditions do to improve? Do the refugees see this as a medical illness? (inventarize *local coping mechanisms* and *local resources*, such as pastors, community leaders, healers)

What is depression?
(Use PowerPoint Presentation Module 2.4 slide 1-20)
- Interactive presentation covering a description of the symptoms of depression. It is important to relate to the way people with depression present in clinical practice. The symptoms are often not mentioned spontaneously but need to be elicited by the health worker in an active way.
- Facilitator can ask the participants to provide examples of symptoms they have seen in patient, or he/she can demonstrate the symptom by 'acting it'.

Assessment of depression
- Two of the trainers (or participants with much experience, such as a psychiatric nurse) play a depressed patient with an accompanying family member. It could for example be a refugee woman who is socially isolated after her cousin resettled in a third country and who has lost much in her life and has an unsupportive husband.
- During the role play (15 minutes) the typical manifestations of depression are demonstrated such as:
  - o Limited movement and expressionless face (not necessarily sad)
  - o Many physical complaints that bother the patient
  - o Feelings of guilt and uselessness
  - o Social dysfunction
  - o Hidden ideas that it would be better to be dead.
- After the role play the participants split into smaller groups and are invited to describe the symptoms they have noticed in the patient (15 minutes)
- Plenary session to discuss what the groups have found (15 minutes).
(Use PowerPoint Presentation Module 2.4 slide 21-26 and then the mhGAP Intervention Guide)

Causes and management of depression
Use PowerPoint Presentation Module 2.4. slides 27-51 and refer to the mhGAP Intervention Guide)

- Interactive presentation covering management of depression. It is important to take a good deal of time for a discussion of the non-pharmacological management of depression and how this could be done in the setting of a refugee camp. (and who should be involved, with a particular reference to the staff of the community services and local resources such as churches, women's groups etc)

  - o If times allows (additional 30 minutes needs) it will be good to do a role play in which a participant is asked to explain to a patient and family member (of the role play that we played earlier) what the diagnosis is and how the management will be.

- *Treatment Strategies* (see Study Material for Trainers at end of section)
- Mild depression: Non-pharmacologic treatment including group sessions, therapy, community-based interventions, address psychosocial needs and stressors, encourage social support.
- Moderate-Severe depression: Pharmacological interventions with supportive psychosocial and psychotherapeutic care where possible, address psychosocial needs, encourage social support.
- Optional Exercise: (30 minutes) Role play in which a participant is asked to explain to a patient and family member (of the role play that we played earlier) what the diagnosis is and how the management will be.

Postnatal depression
- If the group of participant works often in reproductive health and additional topic can be post natal depression

Key messages
- Depressive feelings are not the same as having a depression!
- Moderate and severe depression should be managed with a combination of medication, psychotherapeutic and psychosocial care
- Mild forms of depression should not be managed with medication
- Depression is often missed by health workers and patients with depression are given unnecessary medication of physical disorders
- Always ask about suicidal thoughts in a person who is depressed and family history of suicide!!

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
- *PowerPoint Slides for Module 2.4. (Handout for participants)*
- *Study Material for Trainers for module 2.4.* (see end of this session)

Study Material for Trainers: Module 2.4

Depression
From time to time every person feels sad or unhappy, particularly when a person experiences an important loss (e.g., the death of a loved one). This is a normal part of life. Sometimes a person can develop an illness that is characterized by sadness and loss of pleasure. This is called depression. A depression is a mental illness that involves the body, mood, and thoughts. It affects the way the person eats and sleeps, the way one feels about oneself, and the way one thinks about oneself and things. A depression is not the same as feeling unhappy or sad. It is a real disease, which can make the person suffer, just as any other disease. It is not a sign of personal weakness. Depression is the most common mental disorder encountered by primary care doctors. This disease often becomes chronic and interferes with normal functioning and causes pain and suffering to patients and the family as well.

Clinical features of depression
Usually patient presents with physical symptoms; commonly tiredness, headaches and body pain in health facility. Remember depression cannot be diagnosed on the basis of physical symptoms. People use a variety of words to describe depression in Afghanistan so doctors must be familiar with them in the area they work. Common symptoms in depression according to importance are as follow:

Core symptoms (at least 2 present for 2 weeks, most of the days)
- *Sadness and depressed mood*
  - This may not always be very clear at first impression, one needs to ask the patient and to observe carefully. Some depressed people will deny that they are sad or hopeless. They may say they are all right even if something bad has just happened. Often these people complain about physical problems instead. Other patients may be so depressed that they have few complaints and they stay quiet. They are seriously in great danger of killing themselves at some time.
- *Lack of interest or pleasure in all, or almost, all activities*
  - Ask the patient if he or she had activities that used to be pleasurable but are not so anymore
- Fatigue or loss of energy
  - Compare with the situation before the disease started, do not include fatigue due to hard labour

Additional symptoms (at least 3 should be present to diagnose depression)
- *Reduced concentration and attention*
  - Ask the patient if s/he makes many mistakes during tasks that require good concentration such as cooking, reading, (Islamic) prayers etc)
- *Reduced self esteem/ self confidence*
  - Ask the person if s/he feels she is not able to do what is expected from him/her as a family member, community member. The symptom refers to what the person thinks about him/herself, not what others really think about him/her.
- *Ideas of unworthiness, uselessness or guilt*
  - Ask if the person feels guilty about things that have happened. The health worker should try to establish whether the ideas of guilt and unworthiness are exaggerated.
  - Ask the person if s/he feels she has no value to others or to her/himself. This symptom means that the person himself thinks bad about him/herself. When a person tells you that others do not respect him/her and think s/he has no value, but that s/he thinks she has value, this is NOT reduced self esteem.
- <u>Hopelessness/ pessimistic views on the future</u>
  - Ask what would happen if the person's life situation would improve. A person

     with depression will often answer that this will never happen
- Ideas or acts of self-harm of suicide
    - *suicidal thought*
    - *suicidal intention*
    - *suicidal attempts*
- Sleep disturbance
    - Usually less sleep: the person feels tired, but still is not able to sleep.
    - Sometimes the person has the opposite and sleeps too much, and feels sleepy in daytime as well)
- Diminished appetite / weight loss
    - Check if weight loss is not due to malnutrition or a physical illness.
    - The opposite can also be true: weight gain and increased appetite

Other common symptoms
- Psychomotor retardation or agitation
    - One can ask the patient, and the health worker can also observe during the interview.
- Pain and aches all over the body
- Diminished sexual drive

A person does *not* have a depression if the symptoms:
- happen for only a short time (less than two weeks)
- Are parts of normal bereavement after the death of a loved one a person can have many of the symptoms mentioned above but this is not a depression. It can become a depression when the symptoms last too long.
- Are reactions to a new stressful situation. When a person becomes a refugee, s/he can have temporary symptoms like the ones mentioned above. When the stressful factor is not present anymore the symptoms disappear.

About two thirds of depressed patients present to their doctor with somatic symptoms. Only of the doctor does a careful history taking the depressive symptoms become clear. Physical examination must be performed for all patients with specific attention for physical illness such as chronic headaches, hypothyroidism, anaemia etc

Treatment
Most of the patients can be managed in primary care setting. Patients can benefit from non pharmacological (psychosocial) interventions and from medication.
As a rule:
- For mild forms of depression provide non-pharmacological interventions.
- For moderate and severe depression combine non pharmacological interventions with medication.

Doctors should always make sure that the patient his family are educated about depression symptoms, causes, diagnosis, treatment, relapse prevention, importance of follow up.

Non pharmacological treatment of depression
Psychosocial interventions and other non-pharmacological interventions are effective in many cases. Psychosocial interventions are the treatment of choice in mild and moderate cases of depression. In difficult cases it is best to combine psychosocial interventions and pharmacological interventions. It is important for all medical staff to realize that their attitude and way of talking has an important influence on the patient. The person who is depressed thinks that her/his mood and situation will never change. It is important to remember that this belief of the person with depression is one of the symptoms of the illness.

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Talking with depressed patients

Depressed people often feel very lonely, even when there are other people around. It is important to lessen the isolation of a depressed person. A doctor and any other health worker can use the following tips when talking with a depressed person:

- Make the person feel comfortable to talk about her/his feelings.
- Emphasize that you will keep secret what s/he tells you.
- Listen attentively and sympathetically.
- Explain that the person has a depression, and tell her/him something about the treatment.
- Give the person hope that this condition will change.

Some things should be avoided when talking to a depressed patient:

- Do not judge, such as saying that s/he is not a good husband/wife/parent.
- Do not 'order' the person to be happy.
- Do not remind her/him all the time how wonderful life is.
- Do not tell the person that the depression is caused by her/his own failures.
- Do not immediately give advice to the person but listen first and see what the person comes up with.

Psycho education and advice

A doctor can provide useful advise to the patient:

- Psycho-education about the disorder (explain the symptoms and that these are part of a medical disorder called 'depression'. Educating patient and the family duration and its changes over time, possible risk factors, psychosocial stressors, consequences, suicide risk, treatment issues, follow up, relapse and its prevention.
- The importance of continuing to do activities that used to be interesting or give pleasure
- The importance of maintaining a regular sleep cycle
- The benefit of regular physical activity
- The benefit of regular social activity, including participation in communal social activities
- The depressive effects of alcohol and the importance to avoid it.
- Recognizing thoughts of self-harm or suicide and what to do when these occur.

Important: what to tell the patient and family about medication:

- It usually takes a few weeks before the medication has its effect on the depression. If the patient's condition has not improved after a few weeks, the doctor can increase the dose.
- Side effects may appear before antidepressant activity does. It is important to be aware that initially
- The patient feels only effects in the body, while the mood is unchanged. The health worker should inform the family that these effects on the body are not harmful. They are a sign that the medication is working in the person. It should not be a reason to stop taking the medication. Side effects are usually mild and temporary: the effects on the body become less after time, but some of them remain as long as the persons use the medication. When the person stops the medication, these effects will also stop.
- The medication should be taken for a long period of time, often for six months or longer. Patients often try to stop medication soon. They may feel better and think they no longer need the treatment.
- Remember that there are no instant solutions to problems in life.
- Discuss treatment plan with patient
- Antidepressants do not cause dependence
- Always assess the patient for suicidality before starting an antidepressant.

Reactivate social networks and address current psychosocial stressors

Try to identify the person's prior social activities that, if re-initiated, would have the potential for providing direct or indirect psychosocial support (e.g., family gatherings, outings with friends, visiting neighbours, social activities at work sites, sports, community activities). Actively encourage the person to resume these social activities and advise family members about this. Community based psychosocial workers or community health workers can play an important role here.

Problem-solving counselling

Psychosocial counselling is helpful if the case is mild or moderate and psychosocial stressor is present. When or psychosocial counsellors are available patients can be referred. If these resources are not available a health worker should offer the opportunity to talk, preferably in a private space. Ask for the person's explanation of the symptoms. Ask for current psychosocial stressors and to the extent possible, address pertinent social issues and problem-solve for psychosocial stressors or relationship difficulties with help of community services/resources. It is helpful for a depressed person to have signs that people are supportive. This means that it is necessary to involve the family.

Referral for psychosocial counselling should be considered if any of the following conditions exist:
- Depression is not severe and psychotic symptoms are absent;
- A clear psycho-social stressor/stressors exist or there are complicated psychosocial circumstances
- Previous response to psychosocial interventions was positive;
- A medical contraindication to medication exists;
- Recovery has not been achieved with medication alone;

Structured physical activity program

It can be very helpful for a depression patient to do physical activity of moderate duration (at least 45 minutes) 3 times per week. Running is very effective in people with depression.

Relaxation training

A psychosocial worker or a trained health worker can train the person in a technique such as breathing exercises and progressive relaxation. to elicit the relaxation response. Progressive relaxation teaches how to identify and relax specific muscle groups. Usually treatment consists of daily relaxation exercises for at least 1-2 months.

Tips on suicidality

Important point is the patient always should be assessed for suicidality before starting an antidepressant. In the first two weeks of treatment the suicide risk is increased. In case the patient is suicidal ask a family member to administer the medication. The family needs to know about this risk and watch the patient carefully until he/she is clearly better. Follow up visits need to be frequent in the beginning in case the patient is suicidal. To find out if the person is suicidal ask some questions directly, as follows:
- Do you think life is not worth living?
- Would you prefer to be dead?
- Have you thought of killing yourself?
- Have you tried to kill yourself or do you have plans to kill yourself?
- Also, ask about previous suicide attempts (previous attempts increase the risk of further suicidal behavior and will give you an idea of what they will do).

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Pharmacological treatment

Antidepressants are effective medications for moderate -*severe depression*. They should be avoided in people with a mild depression because in these cases medication is less effective than psychosocial treatment.

Overall, there is little difference in efficacy among antidepressants in treating depression. Fluoxetine and amitriptylline are listed in the WHO formulary.

If a person has had a *mania* in the history (see module 2.6) be careful with prescribing antidepressant medication, and in principle only do this simultaneously with a mood stabilizer.

If there are *psychotic symptoms*, antipsychotic medication should be added. When physical illness is a likely cause, management must be directed at the underlying condition rather than the depressive symptoms.

Many *physical illnesses* occur with depression; in such cases treatment must be directed at the depression as well as the physical illness. When depression is considered the primary diagnosis then it requires treatment first.

Follow the mhGAP guidelines here for prescribing practices. TCAs should be avoided if possible due to side effects in the elderly and people with cardiovascular disease.

Fluoxetine

Fluoxetine is a SSRI (Selective Serotonin Reuptake Inhibitor) and has fewer and milder side effects. Due to insomnia as one of side effects, preferably give in the morning as single dose.

Side effects: The adverse effects of fluoxetine and other SSRIs differ significantly form those of tricyclic antidepressants. A major difference of that SSRIs are less cardio-toxic than tricyclic antidepressants and are safer in overdose. SSRIs also lack anti-cholinergic effects and are not sedating. Common side effects of fluoxetine are:

- Insomnia
- Nausea
- Vomiting
- Feeling anxious
- Sexual dysfunction
- Headaches
- Diarrhea

Guideline: Treatment of Depression with fluoxetine

Step 1: Give fluoxetine capsules 20mg/day.
Step 2: If the dose in step 1 does not work after three weeks, increase dose to 40mg.

Amitriptyline

Amitriptyline (10 & 25 tab) is a tricyclic antidepressant (TCA). Common side effects are seen in the beginning and usually disappear after few days. Side effects should be explained to patient and the family

Guideline:
Treatment of depression with amitriptyline
- Start with 50 mg at bedtime.
- Increase by 25 or 50 mg every 1-2 weeks
- Aim for 100 – 150 mg by 4 – 6 weeks
- If no response in 4 – 6 weeks or partial response in 6 weeks, increase dose gradually in divided doses.
- Maximum dose 200 mg, but usually high dosis is not needed

- Medication to be taken for minimum 6 months

Switch to fluoxetine if this is available:
- Amitriptyline did not work after 8 weeks

Preferably do not use amitriptiyline (but fluoxetine) of
- The patient has cardiac disease (e.g., irregular heartbeat or a murmur)
- The patient is older than 65 years
- The patient may be pregnant or is breastfeeding
- The patient is an adolescent or child.

Side effects: Side effects of amitriptyline (and other TCAs) include:
- Tiredness
- Dry mouth
- Dizziness when the person changes position from lying or sitting to standing, will feel dizzy due to a drop in blood pressure
- Constipation
- Blurring of vision

Benzodiazepines
When anxiety is prominent and insomnia is problematic a benzodiazepine e.g. diazepam 5-10 mg or alprazolam (0.25-0.5 mg, not in essential medicine list) can be given for few days.

However it is very important for doctors to realize that diazepam and alprazolam are not indicated for depression as depression requires long-term medication and there is an important risk that the patient gets addicted to alprazolam and diazepam. It is the responsibility of the health worker not to create addiction!!!

Follow up
Follow up is very important in early weeks of treatment. It can be for assessing compliance, symptoms improvement, counselling, monitoring side effects of medication, evaluation of psychosocial stresses and family support.

Criteria for admission of a depressed patient
Usually a patient with depression should not be admitted in IPD. Hospitalization and the associated passivity and being treated as a 'mental patient' can often worsen the patients situation. Outpatient treatment is the preferred option. However in some case admission is needed:
- Severe depression with suicidal ideation and or behaviour
- Patients with depression plus psychotic features that cannot be handled in the community

Did you discuss the risk of developing mania in reaction to antidepressants? Perhaps I missed it?

MODULE 2.5: Psychosis

Learning Objectives
At the end of this Module participants will be able to:
- Define the concept of a psychotic disorder and describe symptoms
- Identify people with schizophrenia and other psychotic disorders who present to general health services
- Make a treatment plan for people with psychosis, in line with the WHO mhGAP Intervention Guide
- Demonstrate key interpersonal skills in working with people who have psychosis or other severe mental illness

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises. (see the ANNEX for the handout of the PowerPoint).

Materials
Flip chat, markers, pen & papers, power point presentation, reference manuals

Time
3-4 hours

Methodology for the Trainer
Introduction
- Facilitator introduces the topic by explaining that psychosis is one of the most severe mental disorders.
- Participants are asked what local terms for severe mental disorders are in use by the refugees they work with. The concept of severe mental disorder often overlaps with local terms such as *umusazi* (Kirundi/ Kinyarwanda), *mshile* or *mwenye kuchanganyikiwa* (Kibembe), *Kicha* or *payu* (kiSwahili).
- The trainer invites the participants to elicit a list with local symptoms for severe mental disorders (facilitator writes the symptoms on a flip-chart, already ordering the symptoms according to
    - behaviour,
    - cognition,
    - emotions and
    - perception

What is psychosis?
- Trainer gives an interactive presentation covering a description of the symptoms of psychosis, using the PowerPoint Slides for Module 2.5. (slides 1-18)
- It is important for the trainer to use context appropriate examples when presenting the different symptoms. The facilitator can ask the participants to provide examples of symptoms they have seen in patients, or he/she can demonstrate the symptom by 'acting it'.

Assessment of psychosis
- Two of the trainers (or participants with much experience, such as a psychiatric nurse) play a psychotic patient with an accompanying family member. They consult a doctor 'because they have heard that now the health centre can also cure mental disorders.
- During the role play the typical manifestations of psychosis are demonstrated such as
    - Strange appearance (with inappropriate way of dressing) and bizarre behaviour:
    - Talkative speech (or the opposite: keeping silent)
    - Increased psychomotor activities (or the opposite: making no body movements)
    - Thoughts: paranoid delusions (or other types of delusions)
    - Visual and auditory hallucinations (often these symptoms will not be

spontaneously mentioned by the patient, unless asked in a non-judgemental way. The trainer who plays the patient can show behaviour that indicates that the patient may have hallucinations: for example: having suspicious looks into one direction, as if s/he sees or hear something there)
  o Lack of insight in the disorder. (the person can flatly deny that anything is wrong with him or her)
- After the role play the participants split into smaller groups and are invited to describe the symptoms they have observed (15 minutes).
- This is then discussed in plenary session (15 minutes)
  o The trainer needs to take an active approach, and correct potential misconceptions among participants. Health workers who have limited experience in the assessment of mental disorders often tend to:
    ▪ Confuse the concepts of 'hallucination' and 'delusion'
    ▪ Overlook 'negative symptoms' (this is for example: limited body movements, limited facial expression)
  o The trainer needs to raise attention to the way the trainer who role-played the doctor approached the patient. Discuss with the group and with the participants in the role play what was helpful the assessment. Elements that are important:
    ▪ A respectful attitude to the patient, taking him/her serious as a person, not laughing at the patient when s/he says something strange. It is important to convey to the participants that this is very important!)
    ▪ A sensitive way of asking questions, that facilitates the patient to share experiences that s/he may not easily talk about.

Causes and management of psychosis
- Trainer gives an interactive presentation covering causes and management of psychosis. It is important not to take too much time for the aetiology, and to take a good deal of time for a discussion of the medication and their side effects. The facilitator can ask the participants to provide examples of side effects or he/she can demonstrate the symptom by 'acting it'.
- Assessment: Questions to consider (see mhGAP)
  o Does the person have acute psychosis?
  o Does the person have chronic psychosis?
  o Is the person having an acute manic episode?
  o Are there concurrent conditions such as alcohol, drugs, suicidal ideation, dementia or a medical illness?
- Presentation on Acute psychosis and management
- Treatment strategies (see mhGAP)
  o Psycho education
  o Community Rehabilitation
  o Follow-up
  o Pharmacologic Intervention
- Key Points: Pharmacologic treatment is often necessary and community-based psychosocial care is important in rehabilitation and treatment for psychosis.
- If times allows (additional 30 minutes needs) it will be good to do a role play in which a participant is asked to explain to a patient and family member (of the role play that we played earlier) what the diagnosis is and how the management will be. Important elements in the role play are:
  o Explain the importance of long term treatment
  o Explain that the medication has side effects
  o Ensure that the patient and family member have understood what the treatment entails

Key messages
- Psychosis is one of the most severe mental disorders.
- Psychosis can be managed with a combination of medication and community

rehabilitation strategies.
- It is important to address the stigma around mental disorders
- Medication for schizophrenia needs to be taken long term and must be monitored due to side effects.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
o *PowerPoint Slides for Module 2.5. (Handout for participants)*
o *Study Material for Trainers for module 2.5.* (see end of this session)

Study Material for Trainers: Module 2.5

The text below is meant for trainers to use in preparing their sessions.

Introduction to psychotic disorders

Psychosis is a mental state characterized by loss of contact with reality. During the psychotic state the consciousness is not changed. The symptoms include 'positive symptoms' (phenomena that are present in the person with a psychosis while they are absent in a normal person) such as delusions, hallucinations and thought disorder and 'negative symptoms' (phenomena that are absent in the person with psychosis but are present in normal person). There are usually a number of 'other symptoms' that are often present but are not specific for psychotic disorders: sleep disturbance, agitation, behaviour changes, social withdrawal and impaired role functioning.

Incoherent, irrelevant or disorganized speech

When a person's thinking is disturbed, s/he may talk in such a way that other people cannot understand what s/he is saying, or cannot follow her/his line of reasoning. There seems to be no logic behind her/his words. Sometimes the person may even talk pure nonsense, using made-up words or incomplete sentences.

This symptom does not refer to the *content* of the thinking but to the *form*. In other words the symptom 'incoherent, irrelevant or disorganized speech' does refer to *how* a person is thinking and not so much to *what s/*he is thinking.

Examples:
- Connecting things that are not usually connected. See for example the speech of this man in the following conversation who is jumping from one thing to another:
    - Doctor: 'Can you tell me your name?'
    - Patient: 'My name? My name is John. John is the Baptist. Are you baptized? Baptizing is good because it is with water. Do you have a glass of water for me?'
    In this example each of the sentences is correct but they are not logically connected.
- Starting a sentence that goes in a certain direction, but even before the sentence is finished the person is already going into another direction and
    - Doctor: "Where do you live?'
    - Patient: "I live in the village of Friday. Friday. Friday is blue.
    In this example the sentence is nonsense.
- Making words that are not existing:
    - Doctor: "What is your name?"
    - Patient: "Kra. Bu bu bu. Di do du'
    In this example the patient uses words that he makes up himself. The words have no meaning for anyone who listens to it.
- Not talking at all or very little. For example the patients keeps quiet and does not say a word.

Delusions

Delusions are false thoughts that are not shared by anyone else in the affected person's environment. The person with delusions is convinced that her/his ideas are the truth, even if there are signs that prove that s/he is mistaken. The person persists with these ideas.

This symptom refers to the content of the thoughts (*what* the person is thinking)

Examples:
- Believing that people are trying to poison or kill him/her, even when there is no evidence in support of this notion
- Suspecting that everyone is talking about him/her on the streets or on the radio

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- Being convinced that persons have implanted radio equipment in her/his body so that someone else can keep track of her/his actions
- Being certain that s/he has a lethal disease such as cancer or AIDS, while all medical tests show that s/he does not have one
- Thinking that s/he is very famous or rich, when this is known not to be true.

Hallucinations

When a person hallucinates, s/he is seeing or hearing things that are not real, and is convinced that they are real. Examples:
- Hearing things that no one else can hear
- Voices talking to him/her, commenting on him/her
- Voices in her/his head
- Strange sounds or music coming from unknown places
- Seeing things or persons that no one else can see

The person sometimes keeps silent about these things because s/he realizes that other people do not believe him. Often, however, s/he reacts to the hallucinations as if they are real. For example, s/he may talk or shout in response to someone that is not actually there.

Withdrawal, agitation, disorganized behaviour

A psychotic person may also display chaotic behaviour, or behaviour that is disorganized. When s/he starts an activity, it become a mess or is not completed. Examples:
- Wearing clothes in a strange or inappropriate way
- Collecting or keeping things that have no value
- Destroying things without realizing what is happening
- Sitting motionless, without moving, for a very long time
- Laughing suddenly when nothing funny has happened or smiling when recounting sad events (this is called: inappropriate affect)
- Crying without a clear reason
- Showing no emotion when something happens that usually will provoke strong emotions (for example: getting a present, getting a bad message)
- Showing indifference toward things that are generally relevant (for example, food, clothing, money).

Beliefs that thoughts are being inserted or broadcast from one's mind

Some patients with psychosis have the belief that their thoughts are not from themselves, but are from other people and that these thoughts are literally 'put in the their head'. Or they think that their thoughts are 'stolen' by other people and taken out of their head to be broadcast in the radio for example or to be read by other people. These experiences are a kind of delusions and they are rare. But they are so typical that if they occur one can be almost sure that the patient has a severe psychosis (called schizophrenia)

Social withdrawal and neglect of usual responsibilities related to work, school, domestic or social activities.

A person with psychosis often isolate him or herself. He or she prefers to be alone ad cannot participate in usual social gatherings such as marriages, community events etc. When he has a job s/he is usually not able to fulfil the obligations as s/he did before.

Sometimes we talk about "negative symptoms,". This are 'symptoms' that refer to the absence of certain normal or characteristic behaviours. For example:
- Absence of emotions: the person feels indifferent; nothing seems to make him/her happy, sad or angry
- Absence of initiative: the person does not feel inclined to take action; s/he is not motivated to accomplish anything
- Absence of interest: the things that interested the person before s/he became sick do

not interest him/her anymore, such as listening to the radio, hearing news about relatives, discussing politics or economics
- Absence of movement: the person can sit quietly and motionless for a long time

As a general guideline: when a person has more than two of the above mentioned symptoms, a doctor can make a diagnosis of psychosis. This diagnosis may be further supported by observations of the patient's behaviour or reports made by the patient's family. Note: only one symptom is required if delusions are bizarre or hallucinations consist of a voices conversing with each other.

Types of psychosis
We classify psychosis into different groups:
1. *Acute psychosis*, such as acute psychosis that is induced by cannabis, or acute psychosis after child birth (post partum psychosis)
2. *Chronic psychosis* of which schizophrenia is the best example.
o *Mania:* this is a psychosis with strong emotional symptoms. It will be discussed in a separate module 2.6)

Acute Psychosis: clinical features
- In acute psychosis one may observe all symptoms that were described above. Common symptoms of acute psychosis are:
  - o *Incoherent, irrelevant or disorganized speech,*
  - o *Delusions,*
  - o *Hallucinations:* in acute psychosis all kinds of hallucinations can be present. Most often these are auditory (hearing voices) but in acute psychosis one can also have visual hallucinations (seeing things others cannot see) and tactile hallucinations (for example feeling crawling under the skin)
  - o Severe *behavioural disturbances:* Agitation is common. The patient is often fearful emotional state or may have rapidly changing emotions. S/he may be aggressive.

Acute psychosis is sometimes linked to an external provoking factors such as:

- Use of alcohol or drugs, or the withdrawal from it. This is known as 'drug-induced psychosis.
- Period immediately after a woman has given birth (this is called post partum psychosis)
- Response to a major stress in the person's life.

Acute psychosis is a common psychiatric emergency that may present to health services. It is confusing, distressing and disruptive for the person and their family.

Clinical features of chronic psychosis
Chronic psychosis often starts with gradual changes in the person's behaviour. Family members may attribute it to others issues such as work problems, study problems etc. Usually such changes go unnoticed by family members for weeks or months. Gradually typical symptoms such as delusions, hallucinations, agitation, etc appear. When the symptoms trouble the person for longer than three months and s/he is unable to function normally, it is a chronic psychosis. In the beginning, the symptoms may not reach a psychotic state. Both positive and negative symptoms can be present in schizophrenia with fluctuating severity. In the acute phase positive symptoms are prominent while in chronic cases negative symptoms

Among the typical *positive symptoms* of chronic psychosis are:
- Paranoid delusion: Any delusion that refers back to the self, also called persecutory delusions such being poisoned, plotted for killing, spying etc
- Grandiose delusions such as having special powers or missions
- Delusions of thought interference: that others can hear, read, insert, or steal the patient's thoughts
- Bodily sensations being imposed by some outside agency
- Passivity phenomena: these are delusional beliefs or perceptions that others can control the patient's will, limb movements, bodily functions, or feelings
- Thought echo: The patient hears his/her own thoughts spoken aloud
- Auditory hallucinations as voices speaking about the patient may include a running commentary on the patient's actions.
- Thought disorder: Breaks in the train of thought e.g. thought block and difficulties in abstract thinking for example, cannot explain proverbs or common sayings

The following *negative symptoms* are common in chronic psychosis:
- Apathy or blunted or flat affect
- Inappropriate affect e.g. patient smiles when recounting sad events.
- Anhedonia or lack of pleasure in everyday life
- Lack of energy
- Lack of motivation
- Lack of self care skills
- Reduced verbal and non-verbal communication e.g. no eye contact.
- Lack of spontaneity and flow of conversation
- Diminished ability to initiate and sustain planned activity

Other symptoms can also be present like:
- wandering around
- collecting trash,
- talking and laughing to self,
- unusual physical complaints such as having a snake inside the brain, or an animal in the body, absence of body organs,
- denying recognizing relatives

Course and outcome of chronic psychosis (schizophrenia):
- About 45 per cent recover after one or more episodes.
- About 20 per cent show constant symptoms and increasing disability.
- About 35 per cent display a mixed pattern, with varying degrees deterioration.

The causes for psychosis are not known, but there are many risk factors for developing psychosis. Some risk factors are:

Biological
- Genetic vulnerability
- Use of substances e.g. cannabis
- Complications during pregnancy
- Brain damage and infections
- Neurodevelopment problems

Psychological
- Stressful life events,
- Disturbed family environment,
- Traumatic experiences,
- Having been sexually abused

Social

- Bereavement,
- Displacement,
- Migration,
- Witnessing a violence,
- Being subject to violence

None of those factors is however sufficient to explain why a person develops a psychosis. Most likely multiple factors are involved.

Assessment of psychosis

Diagnosis of psychosis is based on clinical findings. No confirmatory laboratory or radiological tests are available, although investigations may be needed to rule out organic illnesses.

During the assessment ask questions about
- Start of the episode
- Whether previous episodes with similar symptoms have occurred
- Whether the person has received treatment before

During the interview with the patient and the caretaker check for the typical symptoms of psychosis:
- Incoherent, irrelevant or disorganized speech
- Delusions
- Hallucinations
- Withdrawal, agitation, disorganized behaviour
- Beliefs that thoughts are being inserted or broadcast from one's mind
- Social withdrawal and neglect of usual responsibilities

If multiple symptoms are present psychosis is likely

However, it is important to check whether the psychosis is caused by:
- Intoxication of alcohol and drugs, or withdrawal from these substances (see module 2.7)
- Acute medical conditions such as:
  - Cerebral malaria
  - Systemic infections, with fever
  - Sepsis
  - Head injury

  This type of acute psychosis is called: delirium (see Module 2.10)

Management of psychosis
Success in management of psychosis depends on first establishing a good relationship with the patient and the family. This can be difficult because of the nature of the illness, but with skill and patience progress can usually be made. It is important to make plans that are realistic, especially for the more disabled patient, and acceptable to the patient and their careers. Explaining the benefits of medication, but also discussion and limitation of its side-effects, are important.
Although antipsychotic medications are very important in the treatment of psychosis psychosocial interventions are important too. Patients with psychosis benefit more from the combined use of anti-psychotic drugs and psychosocial treatment than from either treatment used alone.

Management of psychosis requires pharmacological, psychosocial, and social approaches, depending on the stage of the illness. The first approach is pharmacologic to control symptoms with antipsychotic medication.
Psychosocial interventions minimize distress and reduce frequency of relapse and help developing social skills as well. If the symptoms have subsided it important to guide the patient and the careers to continue the medication to prevent relapses

Specific treatment goals in psychosis are the following:
- Ensuring the safety of the patient and family.
- Evaluating and treating precipitating factors.
- Rapidly resolving the patient's psychotic symptoms.
- Establishing an effective and well-tolerated medication regimen.
- Beginning transitional phase to maintenance treatment.

Psychosocial interventions for psychosis include: psycho education of the affected individual and for families, community rehabilitation and follow-up. It is important for providers to refer patients to relevant services and support in the community.

Medication for psychosis
The same medication is used for acute psychosis and for chronic psychosis.
Antipsychotic medication is the most important element of the treatment of psychosis. It will usually be initiated soon after the diagnosis is made. Decisions about use of medication and appropriate involvement of the patient and the career are a key aspect of management. In the acute phase, the priority is to suppress the positive symptoms and control agitation or excitement, without producing unnecessary side-effects, such as acute dystonia. To achieve this, a combination of a moderate dose of an antipsychotic (e.g. haloperidol 2-10 mg/day) with a benzodiazepine is useful. Alternatively, a more sedative antipsychotic, such as chlorpromazine can be used. Oral medication is always preferable, although occasional intramuscular doses may be needed for patients who exhibit acutely disturbed behaviour and are unwilling to comply with oral treatment. If there are doubts about whether the patient is swallowing tablets, the drug can be given as syrup or orally dispersible tablet. Ant-cholinergic drugs should be prescribed if parkinsonian side-effects are sustained periods.

There are several types of anti-psychotic medications available in the WHO formulary:
- Chlorpromazine
- Haloperidol
- Fluphenazine depot/long acting

To combat the side effects of the antipsychotic treatment one can add:
- Biperiden
- Trihexyphenidyl

Medication in acutely agitated psychotic patients
Rapid control of agitation is essential before if the patient is severely agitated, aggressive and or endangers himself or others. If the patient refuses oral medication give injectable antipsychotic medication, either:
- chlorpromazine 50mg IM or
- Haloperidol 5mg IM
These injections can be repeated, however when patient is cooperative switch to oral preparations Usually one or two injection improves aggressive behaviour, after that switch to oral antipsychotic. There is no evidence that high doses lead to a more rapid response or to improved efficacy but there is always risk of severe side effects with high doses. Chlorpromazine and haloperidol are listed in the essential medicine list of WHO and most African countries for treating psychosis.

Oral antipsychotics
- Chlorpromazine 75 mg at the beginning in divided doses, increase 50 mg every 2-3 days. Typical effective dose is 75-300 mg (but can go up to 600 mg)
- Haloperidol 1.5-3 mg as a starting dose. If tablets of 1 mg are available one can start with 2-3 tablets per day. If only 5 mg tablet are available start with half tablet. Increase gradually every 2-3 days. The typical effective dose is 3-15 mg.

If these do not work properly given in an appropriate dosage for an appropriate duration, it is important find out why. If the treatment does not work because the patient refuses to take tablets by mouth, then switch to injections of fluphenazine.

Long acting antipsychotics
When a patient is unable to take the medication orally one can prescribe long acting injections with antipsychotics. Fluphenazine decanoate (25 mg/ml). Start with 12.5 mg injections in the region of the buttocks.

Duration of treatment
Anti-psychotic medication works gradually. It may take weeks before it shows its full effect.
- Within hours: A patient who is very agitated becomes less aggressive. S/he feels more relaxed and sleepy.
- Within days to weeks: The patient sleeps better and hallucinations (voices/sounds) occur less frequently or are not as loud.
- After weeks: The delusions decrease. The patient may seem less convinced that her/his ideas are the truth, or even doubt about her/his delusions.
- In chronic psychosis, the medication has to be taken for a long time—usually for more than a year. The patient should continue even when the symptoms of psychosis seem to have disappeared. Complete instructions should be given to patients and their family members

Side effects of antipsychotics
 Chlorpromazine, haloperidol and fluphenazine can all cause side effects. The most important side effects of antipsychotic are:
- Parkinsonism: stiffness, tremor, slow movements, can he managed with oral ant Parkinson medication e. g., trihexyphenidyl 2-4 mg/day or biperiden 2-6mg/day.
- Acute dystonia: acute muscle spasms. Usually of the muscles of the neck or the face (jaw,tongue). It can be managed with inject able benzodiazepines or antiparkinson medication
- Akathisia: severe motor restlessness. It can be managed with dosage reduction of antipsychotic or a beta-blocker such as propranolol 20-40m/3times)
- Tardive dyskinesia: a rare complication of antipsychotics which appears after a prolong treatment. It is characterized by abnormal repetitive movements in face, lips, trunk etc. Early recognition and discontinuation of treatment is necessary.

Important tips for psychopharmacology for psychosis
- Discuss treatment plan with patient
- Antipsychotic drugs should be chosen after considering their relative side effects
- Use only one antipsychotic drug at a time
- Start low - go slow
- Use minimum dose required to maintain remission and avoid side effects
- Monitor symptoms and side effects
- Switch to another anti psychotic if symptoms do not respond to adequate dose in 4 weeks
- For long term treatment in non compliance, depot injections can be used

Extra info for trainers: Atypical antipsychotics
There is a range of newer anti-psychotic medications. These are called atypical antipsychotics. Examples are risperidone and olanzapine. They are usually better tolerated by the patient because they give less side effects. There are few extra pyramidal side effects. Other side effects are common such as considerable weight gain in olanzapine and a risk of developing hyperglycaemia and diabetes. The atypical antipsychotics are not part of the essential drug list of WHO.

Psychosocial interventions
Psychosocial interventions in psychosis are important and will help the patient to:
- Improve social skills
- Increase self esteem
- Reduce stigma
- Restore order to life
- Integrate the person into community

Psycho education to the patient
It is important that the patient realizes that s/he has a disease. Often patients with psychosis do not accept this. The health worker should realize that the patient is often extremely fearful and perceives the world as hostile and dangerous. A health worker has to adopt a friendly approach, and explain things in a kind and understanding manner. Try to motivate the patient to go back to work and think of himself/herself as part of the community.

Psycho education to the family
- Advise the family that the strange behaviour and the agitation of the patient are caused by the disease.
- Discuss the importance of medication.
- Inform them about the importance of minimizing stress:
- Do not argue with the patient about her/his psychotic beliefs. Do not say that you agree with her/his ideas, either, but respect them.
- Avoid confrontation or criticism.
- When the symptoms are severe, rest and withdrawal can be helpful.
- Recommend a structured daily life: the same pattern every day helps the patient feel safe.
- Advice those to find activities that help distract the person from her/his thinking, and make him/her feel valuable.
- Encourage them to find suitable work for the person. Occupational or vocational training and employment in a protected environment will help.
- Discourage the use of cannabis (*bhangi*)

Facilitate reintegration in the community
Basic information about the disease can be helpful for neighbours and community leaders. Community health worker or the community based psychosocial worker can provide this information. When there are major problems with the patient in the community, a social worker could make a home visit and provide information and do conflict mediation.

MODULE 2.6: Bipolar Disorder

Learning Objectives
At the end of this Module participants will:
• Define the concept of bipolar disorder
• Assess and identify probable cases of bipolar disorder who present to health services
• Outline the differences and similarities between depression and bipolar disorder; and understand the importance to screen for bipolar symptoms among people with depression
• Make a multi-disciplinary treatment plan in line with WHO mhGAP Intervention Guide - for people with bipolar disorder
• Demonstrate key interpersonal skills in working with people who have bipolar disorder

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises. (see the ANNEX for the handout of the PowerPoint).

Materials
Flip chat, markers, pen & papers, power point presentation, reference manuals

Time
2-4 hours

Methodology for trainer
What is bipolar disorder?
• Trainer gives an interactive presentation covering a description of bipolar disorder and its symptoms, using the PowerPoint Slides for Module 2.6. (slides 1-20)
• Use examples from clinical practice and invite participants if they have seen patients with mania. The facilitator can ask the participants to provide examples of symptoms they have seen in a patient, or he/she can demonstrate the symptom by 'acting it'.

Assessment of bipolar disorder
Two of the trainers (or participants with much experience, such as a psychiatric nurse) play a manic patient with an accompanying family member. The consult a doctor 'because they have heard that now the health centre can also cure mental disorders). The participants of the training are invited to note down what they observe during the mental state examination. During the role play the typical manifestations of mania are demonstrated such as
• Strange appearance (with exuberant way of dressing) and behavior that too intimate (asking personal questions to the interviewer for example):
• Increased talkativeness
• Extreme happiness and joy that is clearly inappropriate
• Increased psychomotor activities
• Thoughts: grandiose delusions
• Absent insight in the disorder.
You can use the 'scenario to play a manic patient' in the annex.

After the role play the participants split into smaller groups and are invited to describe the mental state examination of the patient. This is then discussed in plenary session

Management of bipolar disorder
Trainer gives an interactive presentation covering management of bipolar disorder using the PowerPoint Slides for Module 2.6. (slides 22-29). It is important to take a good deal of time for a discussion of the medication and their side effects.

Role Play: Participant is asked to explain to a patient and family member (of the role play that we played earlier) what the diagnosis is and how the management will be. Important elements in the role play are:
• Explain the importance of long term treatment
• Explain that the medication has side effects
• Ensure that the patient and family member have understood what the treatment entails.

Key messages
• Mania should be distinguished from ordinary psychosis because the treatment is different due to the need to add mood stabilizers
• In case of depression it is important to verify that this is not a depression as part of a bipolar disorder: the treatment will be different
• Mania can occur as part of bipolar disorder, but it can also be secondary to other medical disorders, particularly HIV-AIDS, of which it can be the first clinical manifestation.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
o *Scenario for a simulated patient with Bipolar Disorder and his caretaker*
o *PowerPoint Slides for Module 2.6. (Handout for participants)*
o *Study Material for Trainers for module 2.6.*

Annex for Module 2.6.

Scenario for a simulated patient with Bipolar Disorder and his caretaker

Name:
- Jean, 30 years old man (patient)
- Pierre, 55 year old man (his father)

Background data

o   You are married, two children.
o   Refugee since 5 years.
o   Working as a volunteer with one of the NGOs, cleaning the compound.
o   Active in church

Attitude and appearance
NB: It is important to act the symptoms of mania, but not go too far and doing it in such an exaggerated way that the participants do not learn much but are only amused by the play!. So: do not exaggerate!!)

o   Dressed with some exaggerated colours (for example using shawls and many rings/bracelets)
o   Cannot keep attention, is very easily distracted (for example by objects in the room, or by sounds that come from outside the room)
o   Inappropriate behaviour:
   ▪   When the interviewer ask for example something about his life ("Are you married?" 'Where do you come from?', he starts asking the same kind of questions to the interviewer)
   ▪   When you see something in the audience (like a mobile phone) you take it, and say that you own it.
o   When asked: you say that you are very special because you are actually the director of the NGO. This has been told to you in a dream.

Actual symptoms

According to Jean:
o   No problems at all. It is going very well.
o   No need to sleep because you have many plans to realize

According to Pierre, the father:
o   It started a week ago
o   He does not sleep, only a few hours
o   He never drunk alcohol, but since a few days he started drinking
o   He abandoned his wife for a few nights and was reported to be with a prostitute. He stole money from his father and gave it to the prostitute
o   He has had a similar episode 6 years ago, in Congo
o   The brother of the father also had a mental illness. He thought he was God and run in the bush and was later found dead.

Medical record
No medical problems
Tested for HIV six months ago. Was negative

Study Material for Trainers: Module 2.6.

Bipolar disorder
Bipolar means 'two extremes': People with bipolar disorder have recurrent episodes of low mood (depression) and of increased mood (mania or hypomania). Bipolar disorder is disorder with episodes of mania or hypomania alternating with episodes of depression. Bipolar disorder is the same as *manic-depressive illness*.

Symptoms of bipolar disorder are severe. They are different from the normal ups and downs that everyone goes through from time to time. Bipolar disorder symptoms can result in damaged relationships, poor job or school performance, and even suicide. Bipolar disorder can be treated, and people with this illness can lead full and productive lives. The symptoms of depression in a patient with bipolar disorder are the same as in a patient with a 'unipolar' depression. See the section on 'depression' for the description of symptoms.

Clinical features
The clinical features of mania are generally the opposite of those of depression. Thus, instead of lowered mood, thinking, activity, and self-esteem, there is elevated mood, a rush of ideas, psychomotor acceleration, and grandiosity. Despite those contrasts, the two conditions share such symptoms as irritability, anger, insomnia, and agitation. Signs and symptoms of mania (also called 'manic episode') include:

Mood symptoms (feeling)
- Excessively high mood, euphoria
- Increased energy, activity, and restlessness
- Extreme irritability

Cognitive symptoms (thinking)
- Racing thoughts jumping from one idea to another
- Talking very fast
- Distractibility
- Difficulty in concentration
- In severe cases: delusions. Typical are the *grandiose* delusions: a person has unrealistic beliefs in one's abilities and powers
- Poor judgment (a person may for example believe he or she is able to drive a car even when he has never done this before)
- Denial that anything is wrong (the person does not at all accept that he is sick, on the contrary he or she feels that everything goes very well)

Behavioral symptoms
- Risk taking behavior e.g. spending too much, starting new business
- Increased sexual drive, risk of HIV/AIDS
- Abuse of substances or alcohol, and sleeping medications
- Provocative, intrusive, or aggressive behavior

Other symptoms
- Decreased need for sleep: patients not sleep anymore and are there is danger of physical exhaustion. In contrast with the sleep problems in depression a patient with mania is usually happy with the decreased sleep and he/she feels she does not need more sleep.

In some patient we can find element of depression and mania at the same time: this is called 'mixed episode'.

A less severe state is called *hypomania*. In hypomania the person does not have psychotic symptoms such as delusions, and the person is still able to function to some

extent. A person with hypomania often does not need to be hospitalized. Bipolar disorder often develops in a person's late teens or early adult years.

There are different types of bipolar disorder:
1. *Bipolar I Disorder* is mainly defined by manic or mixed episodes that last at least seven days, or by manic symptoms that are so severe that the person needs immediate hospital care. Usually, the person also has depressive episodes, typically lasting at least two weeks. The symptoms of mania or depression must be a major change from the person's normal behavior.
2. *Bipolar II Disorder* is defined by a pattern of depressive episodes shifting back and forth with hypomanic episodes, but no full-blown manic or mixed episodes.

See the figure below to see the differences between bipolar I disorder, bipolar II disorder and 'unipolar depression'.
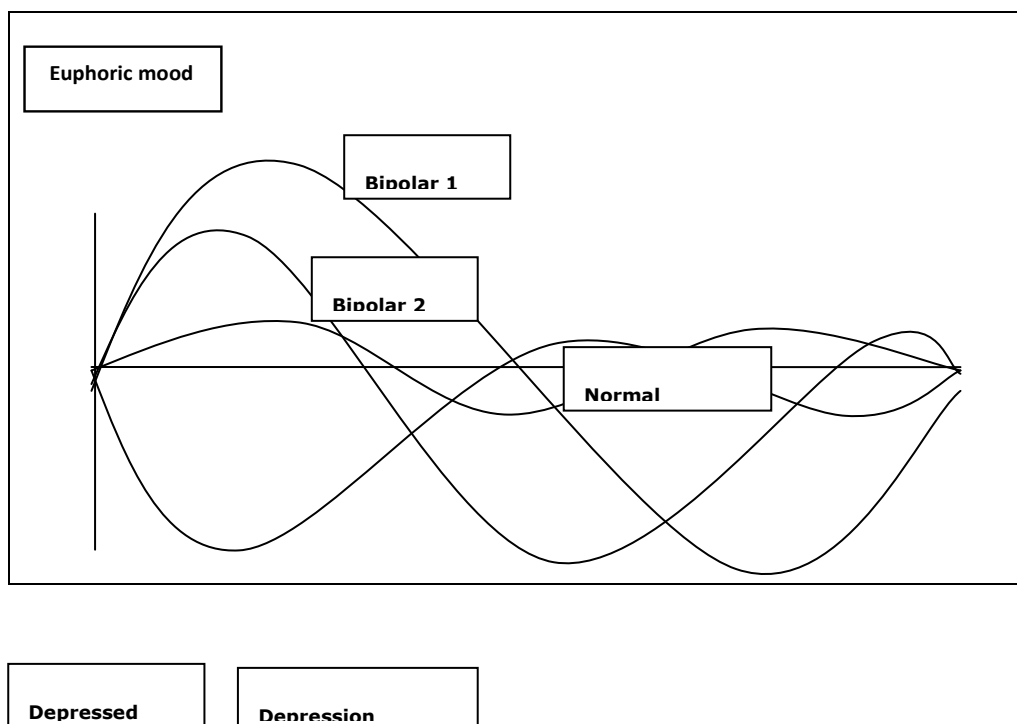
Figure: patterns of different mood disorders

Possible risks of mania
- Abuse of substances or alcohol
- Accidents
- Long lasting disturbances of family relations and friendships (the people around the person do not understand the behavior of the patient and can become angry or disappointed with him or her)
- Suicide attempts
- Problems with police and justice system
- Person can get infectious diseases due to reckless behavior, for example HIV/AIDS

Mental Status Examination
Main changes that can be observed in mania
- Restless or agitated person (increased psychomotor activity), anger outburst can be seen, talkative (starts without asking a question), cooperative, well dressed, greets, high self esteem, sarcastic.

- Speech: talkativeness, flight of idea and racing thoughts, frequent change of topics
- Thought: Inflated ideas and grandiosity can have persecution related to grandiosity of being influential
- Perception: hallucinations such as voices telling patient is an influential
- Affect; euphoria (abnormal happiness), irritability
- Distractibility and poor attention
- Poor judgment (not accepting illness)

Diagnosis

The diagnosis of bipolar disorder is made on the basis of symptoms and the course of illness. There are no lab tests or other tests to establish the diagnosis. If a patient is visiting doctor again and again for his depression without any obvious reasons for becoming depressed, he might suffer from bipolar disorder. To confirm the diagnosis the doctor has to investigate if the patient has had at least one manic episode in his past history.

Causes

The cause of bipolar disorder is not known but genetic and environmental factors both play a role. Bipolar disorder tends to be familial, meaning that it "runs in families." About half the people with bipolar disorder have a family member with a mood disorder, such as depression. The current thinking is that bipolar disorder is a predominantly biological disorder that lies dormant and may be activated spontaneously or it may be triggered by stressors in life.

A person who has one parent with bipolar disorder has a 15 to 25 percent chance of having the condition.

Secondary mania

Above we presented the typical description of mania as part of a bipolar disorder. This type of mania is also called 'primary mania'. However, mania can also present itself secondary to another condition.

Medication

Medications such as antidepressants can trigger a manic episode in people who are susceptible to bipolar disorder. Therefore, a depressive episode must be treated carefully in those people who have had manic episodes.
Some drugs and medication can cause a manic-like symptoms such as medication for thyroid problems and corticosteroids like prednisone.

Neurological conditions

For example neurological disorders such stroke (if this occurs in a particular part of the brain), brain tumors, head trauma, dementia or neurosyphilis can provoke mania.

HIV and mania

An important cause for secondary mania in Sub-Saharan Africa is untreated HIV infection. The massive introduction of highly active anti-retroviral therapy (HAART) has resulted in decrease of all kinds of complications (including mania) in HIV infected patients. However in many areas of African the availability of HAART is limited or unreliable and people with HIV infection often remain without adequate treatment.
Patients with secondary mania due to HIV-AIDS tend to have more severe manic symptoms (Nakimuli-Mpungu, 2006). In Africa, for patient presenting with mania, but without a history of bipolar disorder, it is important to consider HIV as a possible cause. Mania can be the first revealing symptom of HIV infection (Nakimuli-Mpungu, 2009).

Treatment

The treatment of mania is often challenging and it requires good management skills and coordination. Ideal treatment involves: psychosocial interventions, pharmacologic

treatment of acute mania, and maintenance treatment. Discuss treatment plan with patient (although this is often very difficult) and family members. Medication is the key to stabilizing bipolar disorder.

The role of the nurses in the psychiatric ward is very important. Their role is to prevent that the patient will harm himself or others, will take the medication. The nurse can help to decrease the stimuli around the patient (sometimes other patients and visitors encourage the manic patient in his manic behavior and it is the task of the nurse to prevent this). Psychosocial interventions are helpful when patient is stable after taking medication.

Initial treatment of acute mania consists of valproic acid, carbamazepine, lithium or anti-psychotics. Benzodiazepines may also be used for agitation.

Anti-depressant as monotherapy for bipolar patients is not recommended due to the risk of inducing mania. If patients develop mania while on anti-depressants alone, anti-depressants should be stopped as soon as possible. For patients with bipolar depression, anti-depressants are less likely to induce mania when added to lithium, anti-psychotics and valproate. Treatment should be closely monitored.

Treatment of Acute Mania
Consult mhGAP-IG for specific prescribing guidelines

Treatment of hypomania
- In hypomania the symptoms are not yet extreme and in many cases it is not needed to give antipsychotics
- It is often sufficient to give a mood stabilizer and benzodiazepines.

Treatment of bipolar depression
If the patient has a depression but in the past had mania or hypomania, the drug of choice is mood stabilizer and can be treated with anti depressants but be careful and use low dosage because higher doses can easily push him/ her to manic episode.

Prophylactic treatment with mood stabilizers
After the acute symptoms have disappeared the use of antipsychotics and benzodiazepines can be stopped. However, the patient needs to take mood stabilizing medication for a long period, at least six months. If the patient has recurrent episodes the mood stabilizers need to be take for years or even lifelong.

Mood stabilizers
Some medications that are used to treat patients with epilepsy are also effective to treat bipolar disorder. For detailed information on dosage and side effects see the chapter on epilepsy. These mood stabilizing medications are the first choice to treat bipolar disorder. In general, people with bipolar disorder continue treatment with mood stabilizers for years.
- Valproic acid (or sodium valproate, or divalproex sodium): 500 to 750 mg daily; lower dosages may be used in hypomania. Sometimes it is appropriate to give as a single bedtime dose; otherwise twice-daily dosing.
- Carbamazepine: 200 to 600 per day; Starting with small doses increase by 200 mg daily every 2 to 4 days , it is appropriate to give a single bedtime dose; otherwise, twice-daily dosing.

Treatment with mood stabilizers required periodic laboratory tests, initially to monitor the patients' response to the drugs.

Other medication
Some medications, such as lithium are often used for treatment of bipolar disorder, but are not available in the health care system of many African countries.

Lithium is mentioned on the international list if essential drugs by WHO, but not yet on the African drug lists. Lithium is often very effective in controlling symptoms of mania and preventing the recurrence of manic and depressive episodes. It is not used the EPHS because it needs close monitoring of the side effects. Lithium concentration in the blood can easily reach toxic levels and the plasma concentrations need to be monitored though blood tests. Lithium excretion from the body is through the kidneys. Toxic levels of lithium can cause kidney failure and neurological symptoms such as partial paralysis. Less severe side effects that are often seen in patients using lithium include tremor in the hands and tendency to drink much water (polydipsy) and polyury. Lithium treatment may also cause low thyroid levels in some people. Because too much or too little thyroid hormone can lead to mood and energy changes, it is important to check thyroid levels carefully. A person with bipolar disorder may need to take thyroid medication, in addition to medications for bipolar disorder, to keep thyroid levels balanced.

Important:
- Changes in mood and behavior are symptoms of an illness
- Avoid confrontation with patient, unless to prevent harmful or dangerous acts
- Effective treatments are available
- Admission in the hospital is for the safety of patient and family members
- Long-term treatment can prevent future episodes.
- Without treatment, patient may become disruptive or dangerous.
- Mania can lead to loss of job, financial problems or high-risk sexual behavior etc.
- Close observation by family members is often needed
- Treatment is more successful with strong support from family
- Stress can exacerbate maniac episode in those people whom had bipolar disorder.
- Signs of relapse can be identified by family members
- In some patients it can be helpful to ask them or the family to keeping a chart of daily mood symptoms, treatments, sleep patterns, and life events. This can help the doctor track and treat the illness more effectively.
- Regular appointments for follow up are very important
- Stigma and discrimination is common

Psychosocial education:
- Educating patient and the family on the nature of symptoms, duration of episodes and changes over time, risk taking-behavior, psychosocial stressors, consequences including suicide, treatment, follow up, relapse and its prevention.
- Psychosocial interventions depends on the psychosocial stressors and enhanced family support.
- Psychosocial interventions are an addition to the medication and not a replacement!

Criteria for hospital admission:
- suicidal ideation and or behaviour
- Manic patients with behavior that cannot be handled in the community level
- Patients don't sleep anymore and there is a danger of physical exhaustion

Follow up
During follow-up, the health worker should monitor the patient for signs of mood swings and violence. When the patient's condition has become stable, the doctor may not need to see the patient as often, although the frequency of follow-up visits depends on the course of the illness, the patient's adherence to treatment, medication requirements.

Important tips:
- Monitoring suicidality, change in mood, substance use, sleep patterns and medication compliance.
- Educating patient and family members about features and nature of the illness and the importance of compliance with therapy.

Setting limits on impulsive behavior in patients with mania which can be discussed in family meetings.

MODULE 2.7: Alcohol and Substance Use Disorders

This module consists of two topics:
1. Alcohol
2. Drugs (optional)

Learning Objectives
At the end of this Module participants will be able to:
- Describe why and how alcohol and drug use can be problematic and be both a health problem and a social problem
- Identify people with alcohol and drug use disorders who present to the health services
- Become familiar with the concepts of abuse, dependence, withdrawal and tolerance
- Make a treatment plan - in line with the WHO mhGAP Intervention Guide - for people with alcohol and drug use disorders presenting to the general health services
- Formulate ways to cooperate effectively with community services in providing interventions to combat alcohol and drug use among refugees.

Methodology
Lecture, brainstorming, case studies, discussions, group exercises. (see the ANNEX for the handout of the PowerPoint)

Materials
Flip chat, markers, pen & papers, power point presentation, reference manuals

Time
3-4 hours

Methodology for trainer
- Introduce the terms abuse, dependence, tolerance and withdrawal
- Ask for examples of substance abuse issues in the refugee camps

Topic 1. Alcohol Use Disorders

a) Exercise: Ask participants if they view alcohol as a problem within the refugee camps? And if so, how? Ask them to discuss examples in the community where it has done harm.

b) Definition of Harmful Alcohol Use
The facilitator uses an interactive lecture using PowerPoint presentation 2.7 (slide 1 to slide 12) to cover the following areas:
- Social use of alcohol
- Safe levels of drinking
- Excessive drinking

c) Exercise Factors contributing to Excessive Consumption of Alcohol (½ hr)
Participants have small group discussions and then make presentations in Plenary. Then the facilitator summarizes on a overhead sheet and in slide 13/14

d) Effects of Harmful Use of Alcohol
The facilitator uses an interactive lecture using PowerPoint presentation 2.7. (slide 15 to slide 23) to cover the following areas:
o   Health effects (physical, mental)
o   Social effects

e) Assessment of alcohol use
Using an interactive lecture PowerPoint presentation 2.7. (Slide 24-30), the facilitator

introduces how to do an assessment of alcohol problems.

Then role play is done in small groups. Aim of the role play is to assess alcohol problems in a non-judgmental way with clear question.

f) Management of Alcohol Use Disorders (1¼ hr)
Using an interactive lecture PowerPoint presentation 2.7. (Slide 31- 42), the facilitator covers the following areas:
o   Brief Interventions (Motivational interviewing)
o   Controlled Drinking
o   Abstinence
o   Support to the Family
o   Psychosocial Interventions
This includes small role plays in which the participants to motivational interviewing with each other.

i) Emergencies
Using an interactive lecture PowerPoint presentation 2.7. (Slide 43-55), the facilitator covers the following areas:
o   Acute intoxication
o   Acute withdrawal
o   Wernicke's syndrome

h) Group work: 1 hr **(optional)**
What can we as health workers and community services workers do to improve the situation with problematic drinking in the refugee population?

• Brainstorm: What can we as health workers and community services workers do to improve the situation with problematic drinking in the refugee population?
• How can we use existing structures within the camps to address the alcohol issue?
• Rather than create a separate alcohol treatment program, how can we identify and provide treatment to those in need in the camps?

Topic 2. Substance Use Disorders (optional)
Due to the predominance of harmful alcohol use in the camps rather than substance abuse, this section was not presented in the original training and is optional. It should be tailored to the context at hand.

Exercise:
• Ask participants what illicit substances are abused in the camps where they work. Ask them to discuss examples in the community where it has done harm.
• If there are issues identified of drug overdose, drug intoxication, drug withdrawal, drug dependence within the community, then trainer can further expand upon topics in this section.

Clinical Questions to Consider in Emergencies
• Is the person suffering from a sedative overdose?
• Is the person in a state of acute stimulant intoxication or overdose?
• Is the person suffering from acute withdrawal?

Clinical Questions to Consider in the Primary Care setting
• Does the person use illicit drugs in a harmful way?
• Is he or she drug dependent?

Interventions:
- Psychosocial interventions
  - o Brief intervention techniques
  - o Self-help groups
  - o Housing and employment needs
  - o Care to families and care givers
  - o Harm-reduction strategies
  - o Breastfeeding and Pregnancy
- Pharmacotherapy: managing withdrawal, detoxification and continued treatment (see mhGAP)

Key messages
- Many people who drink alcohol consume moderate amounts that are not likely to harm their health or social lives.
- Majority of those who drink too much do not seek help until their health effects are severe. Yet early detection of harmful use of alcohol is an important part of health promotion and prevention of alcohol related illnesses.
- Health workers have an important role to play in identifying patients who have alcohol problems and motivating them to reduce drinking (controlled drinking) or stop drinking (abstinence).
- Interventions include psychosocial and pharmacologic depending on the individual case at hand

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
- o *PowerPoint Slides for Module 2.7. (Handout for participants)*
- o *Study Material for Trainers for module 2.7.*
- Suggested reading:
  - o Emmanuel Streel & Marian Schilperoord (2010) Community oriented interventions for alcohol and psychoactive substance abuse in refugee settings: Lessons from the field. Intervention 8 (3): 268-275.
  - o WHO Global Status Report on Alcohol and Health 2011 http://www.who.int/substance_abuse/publications/global_alcohol_report/en/index.html

Study Material for Trainers: Module 2.7

1) Refer to Chapter on Alcohol from Vikram Patel, <u>Where there is no psychiatrist</u>

2) Consequences of Alcohol Use
 "Alcohol can both be an additional stressor and a consequence of stressors" (Streel, Schilperoord 2010)

Break-out into groups and discuss how alcohol can impact the following domains: medical, psychological, socio-economical and behavioral.

<u>Table 1. Direct and indirect alcohol and psychoactive substances consequences</u>
(taken from Steel & Schilperoord 2010)

Area of Burden	Commonly Described Consequences
Medical	Physical problems related to intoxication and regular excessive consumption, such as accidental injuries and liver cirrhosis. Unplanned pregnancy risks. Individuals with chronic disease, who also are heavy drinkers, frequently forget to take their medicines or are otherwise not consistent in taking it. Physical injuries caused to other by intoxicated persons.
Psychological	Incapacity to reason properly, with some developing mental health conditions. Exacerbation of underlying mental health problems. Suicides attempts in those engaged in heavy alcohol use.
Socio-economical	Undermining of community values, loss of culture, dignity and respect. Financial problems commonly result from indebtedness and trading family ration for alcohol. Household impoverishment. Personal and security issues (such as theft). Incapacity to get involved in any physically demanding labor.
Behavioral	Sexual and gender based violence, including wife and child abuse, sexual harassment, rape. Other violent sexual behavior that constitutes a high risk for unprotected sex and the transmission of HIV and sexually transmitted infections. Public disturbance, interpersonal violence and other criminal (e.g. theft) and antisocial behaviors. Slipping drugs (e.g. benzodiazepine) into drinks of unsuspecting women leading to rape. Risk-taking behaviors, including unsafe sex and commercial sex near bars.

3) Why do some people drink so much?

- Peer pressure
- Availability (prices, absence of laws on drinking hours, sale of alcohol-places, young people)
- In some cultures maleness is measured by how much alcohol you can drink.
- Lack of awareness about dangers of overdrinking and the benefits from responsible drinking.
- Irresponsible advertising by the media
- Poor coping
- Redundancy
- Mental health problems (poor coping skills, depression, anxiety)
- Gender Issues:
- Because of shame associated with drinking, women tend to drink at home. They are less likely to discuss it with a health worker and so less likely to receive help.
- Women are more vulnerable to the dangerous effects of alcohol that is why safe levels are lower for women.
- During pregnancy can cause harm to unborn baby leading to birth defects or mental retardation.
- Women who have male partners who drink heavily may suffer physical or emotional violence from them.
- Women often suffer gender-related problems and so are vulnerable to starting drinking as a way of coping.
-

MODULE 2.8: Self-Harm and Suicide

Learning Objectives
After this module the participants will be able to:
- Identify people early with suicide risk factors
- Conduct a suicide assessment
- Make a treatment plan – based on the WHO mhGAP Intervention Guide - for people with suicidal thoughts or past history of suicide attempts presenting to the general health services

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises

Materials
Flip-chat, markers, pen & papers, reference manuals
MhGAP Intervention Guide

Time
1-2 hours

Methodology for trainer

What is suicidality and self harm
- Trainer gives an interactive presentation covering definitions, using the PowerPoint Slides for Module 2.8. (slides 1-5)

- Brainstorm: Ask participants to discuss the following questions

  - What are risk factors for suicide among refugees?

  - Have you witnesses / heard of cases of suicide or self harm among the refugees?

  - What was the involvement of the health care sector?

Assessment of suicidality and self harm

- Trainer gives an interactive presentation covering *assessment* using the PowerPoint Slides for Module 2.8. (slides 6-15)
- Do a role play of an assessment of a person who may be suicidal. One of the trainers can play the role of a person who has suicidal ideas but feels ashamed of it and fears to be rejected
- In the discussion of the role play let all persons (person who was suicidal, the care taker and the health worker) share their feelings and how they believe the health worker reacted. Ensure the discussion is done in a positive and encouraging way , without badly criticizing the person who played the health worker.

Management of suicidality and self harm

- Trainer gives an interactive presentation covering *assessment* using the PowerPoint Slides for Module 2.8. (slides 16-21)

- Do a role play of an assessment of a person who may be suicidal. One of the trainers can play the role of a person who has attempted suicide. Two or three others can

play the family and bystanders. It is important that the bystanders are sent away if they are distracting or having negative comments (and for example make negative comments on the person who has done a suicide attempt, for example when they threaten him that s/he will go to hell if he does it again, and that s/he is a shame for the family, and not a good Christian/Muslim etc.

- In the discussion of the role play let all actors share their feelings and how they believe the health worker reacted.

- Discuss how the health sector can work with the colleagues from the community services projects and with community resources such as religious leaders.

Key messages
- Suicide can result from depression and many other disorders and forms of distress.
- Suicide screening is important for depressed individuals and those who have established risk factors
- Active suicidal ideation is a reason to hospitalize!!
- Early identification, prevention and multi-sectoral community strategies are important.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
o *PowerPoint Slides for Module 2.8. (Handout for participants)*
o *Study Material for Trainers for module 2.8.*
o Suggested reading:
  Preventing Suicide: a resource series (WHO)
  http://www.who.int/mental_health/resources/preventingsuicide/en/index.html

Study Materials for Trainers: Module 2.8.

- Clinical Assessment: Primary Care Setting
  - o If depression or risk factors for suicide are present, conduct a suicide assessment focusing on the nature of the thoughts (active or passive), if a plan has been formulated, and level of intent to act on thoughts.
  - o In summary, ask about:
    - ▪ Current thoughts or plan to commit suicide/self-harm
    - ▪ Intent to harm self and if suicidal ideation is active or passive
    - ▪ Access to means of harm (weapons, knives etc)
    - ▪ History of suicidal attempts and lethality, suicidal ideation including thoughts or plan and past history of self-harm and mutilation
    - ▪ Family history of suicide

- Clinical Assessment after suicide attempt
  If suicide attempt already occurred and patient is in your office and able to communicate, ask about
  1. How it happened? E.g. lethality, means
  2. What happened immediately preceding the suicide both in terms of psychological and social factors?
  3. Symptoms preceding the attempt in recent past
  4. Social stressors in recent past
  5. Ask the person to walk you through that day
  6. Was it impulsive or planned?
  7. Suicidality: active vs. Passive?
  8. Risk Factors for suicide

- Suicide Prevention Strategies: Present on general strategy for targeting suicide. Note that strategy is often comprehensive and multi-sectoral. See WHO guidelines for more information here.
  - o Early identification, assessment and elimination of risk factors
  - o Increasing awareness about suicide
  - o Restricting access to common methods such as pesticides, firearms and toxic substances
  - o Prevention and treatment of Depression, Alcohol and Substance Abuse
  - o Follow-up contact with those who have attempted suicide
  - o Early identification and detection through training frontline professionals
  - o Multi-sectoral responses
  - o Community-based prevention program
  - o Guidelines for media reporting
  - o Psychosocial support for affected families and friends, and those who have attempted suicide.

MODULE 2.9: Epilepsy and Seizures

Learning objectives
After this module the participants will be able to:
- Identify people with epilepsy and seizure disorders
- Outline the differences and similarities between different forms of epilepsy and non-epileptic seizures
- Make a treatment plan – based on the WHO mhGAP Intervention Guide - for people with epilepsy or seizure disorders presenting to the general health services

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises

Materials
Flip chat, markers, pen & papers, power point presentation, reference manuals MhGAP Intervention Guide

Time
4 hours

Methodology for trainer
Introduction
The facilitator introduces the topic by explaining that epilepsy is quite common disorder. Ask which local names refugees use for it. What do they consider the cause? How is their help seeking behavior? Where do they go for treatment? Why is that?

What is epilepsy?
Facilitator asks participants what the key symptoms are and writes them on a flip-chart. Trainer gives an interactive presentation covering a description of the symptoms of epilepsy, using the PowerPoint Slides for Module 2.10. (slides 1-17)

Causes of epilepsy
Ask the participant to mention causes of epilepsy they know.
The trainer writes the good responses on a flip-chart, already ordering them into
- Prenatal
- Perinatal
- Postnatal
It is important to emphasize that in most case the cause of epilepsy is not known. This is also called idiopathic epilepsy.
Using the PowerPoint Slides for Module 2.10. (slides 18-21) to summarize.

Management of epilepsy
- Trainer gives an interactive presentation using the PowerPoint Slides for Module 2.10. (slides 22-50)
- Role Play: Participant is asked to explain to a patient with epilepsy and family member what the diagnosis is and how the management will be. Important elements in the role play are:
  o Explain the importance of long term treatment
  o Explain that the medication has side effects
  o Ensure that the patient and family member have understood what the treatment entails

Living with epilepsy
- If possible invite a person living with epilepsy to explain his or her story and how he or she copes with epilepsy. The trainer can do the interview, focusing on:
  o How did it start?
  o What kind of explanations did the patient and family use to explain the symptoms

o What is the treatment for epilepsy in this patient?
o How does the disorder affect his/her life? Faces the person difficulties due to his/her epilepsy. What are his or her limitations?

Key messages
- There are many different types of epileptic seizures, some or difficult to identify as epilepsy
- Epilepsy can be managed with a combination of medication and psychosocial care
- Medication can have side effects, that are sometimes severe
- Status epilepticus is a medical emergency

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
- Study Material for trainers (see end of this session)

Resource materials to use in this module
o *PowerPoint Slides for Module 2.9. (Handout for participants)*
o *Study Material for Trainers for module 2.9.*
o If available: use demonstration video of different types of seizures: video from for example: How To Recognize and Classify Seizures – DVD (Epilepsy Foundation)

Study Material for Trainers: Module 2.9

Epilepsy: Introduction

Seizures or fits
The normal brain gives electric signals all the time. Through the signals of the brain we can move our muscles, our intestines and stomach can work. During a seizure this normal pattern of neuronal activity in the brain becomes disturbed and neurons within the central nervous system discharge in an uncontrolled way, causing muscle spasms, strange sensations, and behavior, loss of consciousness.

What happens during a seizure?
During a seizure the normal activity of nerve cells in the brain becomes disturbed. Electrical signals in the brain increase in frequency. This results in abnormal functioning of the body during a short period, causing seizure. This can lead to:
• muscle spasms,
• strange sensations,
• strange behavior,
• loss of consciousness
The clinical signs or symptoms of seizures depend on the location of the seizure discharges and the extent and pattern of the spread of the seizure discharge in the brain.

When seizures are called epilepsy?
Epilepsy is not a mental disorder, but a neurological disorder. It is a brain disorder characterized by repeated spontaneous seizures. To diagnose epilepsy in a person he/she needs to have at least two unprovoked seizures. Epilepsy is a life-long tendency. The seizures may occur only sporadically, but the a vulnerability remains.
Epilepsy can develop after a particular identifiable event (e.g., asphyxia, head injury, meningitis), in which case it is called *symptomatic epilepsy*, or it may develop without any identifiable cause, and then it is called *idiopathic epilepsy*.

Types of seizures
International classification of epileptic seizures divides seizures into 2 major classes: *partial seizures* and *generalized seizures.* In the *partial seizures* the abnormal electrical discharges start in a localized area of the brain. The symptoms/signs are dependent on which part of the brain is affected. These discharges may remain localized, or they may spread to other parts of the brain and then the seizures become generalized (*secondary generalized seizures*). About half of the people with epilepsy have partial seizures. The partial seizures include:
• simple partial seizure
• complex partial seizures (for example temporal lobe epilepsy and frontal lobe epilepsy)
• Seizure with secondary generalization.

In *generalized seizures*, the seizure is generalized from the onset (*primary generalized seizures*), starting in both halves of the brain simultaneously. We often do not have an EEG to help in making this division, and we are thus dependent on the clinical expression: the history, and the ability of the observer to describe the seizure. The patient himself has no memory of the seizure, except in simple partial seizures and only of the aura of other seizures. The generalized seizures include:
• Absences seizure (petit mal)
• Myoclonic seizures
• Tonic/clonic seizures (grand mal)
• Clonic seizures
• Tonic seizures
• Atonic seizures

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Partial seizures

Simple partial seizure

In a simple partial seizure, the person will remain conscious. In motor seizures the epileptic symptoms occur only in one part of the body: brief twitching of groups of muscles, often in the distal part of the arm or in the face. The twitching may remain there, or spread up the whole extremity and even become completely generalized (See: partial seizure, secondary generalized). A simple partial seizure can also manifest itself in sensory symptoms, for example seeing flashes or bright colored light, or hearing or smelling sensations. There might be feelings of tingling, pins and needles, cold or heat, or numbness of a limb. The autonomic seizures are associated with foci in the temporal lobe. There maybe: a sensation rising from the epigastrium to the throat, palpitations, sweating or flushing. The psychic symptoms may consist of changes in mood, memory, or thought (thinking). There may be distorted perceptions (time, space, or person) or problems with language. Complex structured hallucinations could occur (hearing music, seeing vivid scenes). These simple partial seizures are difficult to diagnose and are often missed by doctors. They are usually only recognized as epileptic seizures when they develop into generalized seizures.

Partial seizure, secondary generalized

A partial seizure can become generalized, and develop into a full tonic clonic seizure. This is called 'partial seizure, secondary generalized'.

Aura

Some people with epilepsy may experience *auras:* unusual sensations that warn of an impending seizure. The feelings of an aura are often vague, such as strange sensations in the stomach, unpleasant smells, or a dreamlike feeling. These auras are actually simple partial seizures in which the person maintains consciousness.

Complex partial seizure

In a complex partial seizure, the person has a changed consciousness, but the consciousness is not impaired completely. During the period of the attack s/he does not react to normal talking and might look as if s/he is in a dreamlike state. People having a complex partial seizure may display strange, repetitious behaviors such as blinks, twitches, or mouth movements. These repetitious movements are called automatisms. During a complex partial seizure, some patients may make simple verbal responses, follow simple commands, or continue to perform simple gestures. Complex partial seizures typically arise from the temporal lobe but may arise from any region in the brain such as the frontal lobe. These seizures usually are brief, from a few seconds to max two minutes. Complex partial seizure often lasts up to 2 minutes.

Generalized seizures

Absence seizure (petit mal)

Absence seizures are a special form of generalized seizures. Onset usually in childhood (between 4 to 12 years of age), they are often overlooked. Absences consist of short periods of loss of consciousness lasting only a few seconds (5-15 second not more than 30 seconds). They often occur many times a day. The person often shows a blank stare and a brief upward rotation of the eyes. The person does not respond when spoken to. The absence starts suddenly and then is suddenly over. After the absence the person continues what s/he was doing before the seizure. S/he has no memory of the seizure. The parents or teachers think that the child is inattentive and does not want to listen. During such an absence seizure the child does not hear what the teacher is saying, and as they occur so often the child cannot follow the lessons any more. Unless the teacher is aware of this condition, s/he will scold the child for daydreaming and inattentiveness. Most parents are unaware of these small seizures, and even when they observe them, do not think them important and will not mention them to the doctor.

Unless these children also suffer from generalized tonic-clonic seizures they are not brought to a clinic, and especially not to an epilepsy clinic, as people are unaware that these absences are epileptic seizures.

Tonic clonic seizures
These seizures are the most common form of generalized seizure. Typically the patient loses consciousness, falls down, sometimes with a scream, and develops a generalized stiffness (the tonic phase). Breathing stops, as all the muscles of the trunk are in spasm, and the patient becomes cyanotic, the head is retracted, the arms flexed and the legs extended. After a while, this tonic phase is followed by the clonic phase, when the muscles alternately contract and relax, resulting in clonic movements. With this jerking the patient might bite his tongue, pass urine, or sometimes stool. The clonic phase may last several minutes. When all the jerking stops and the patient regains consciousness, he may feel very tired with a headache and confusion. He has no memory of what happened, and may find himself on the floor in a strange position. Often he falls into a deep sleep.

The main characteristics of a generalized seizure (tonic/clonic) are:
• Sudden fall with injury, tongue bite, frothing from mouth
• Jerky movements of limbs
• Blank stares during attack
• Incontinence of urine and feces
• Impaired consciousness during attack

The person may have a seizure when asleep or alone, and their body may show signs of old injuries, burns, etc. Generalized seizures have three phases: tonic, clonic and postictal.

1. Tonic phase
• The tonic phase begins with flexion of the trunk, elevation and abduction of the elbows with extension of the back and neck is followed by extension of arms and legs.
• Autonomic signs are common during this phase and include increase in pulse rate and blood pressure, sweating, etc
• This stage lasts for 10-20 seconds.

2. Clonic phase
• The tonic stage gives way to clonic movements, in which the tonic muscles relax intermittently, lasting for a variable period of time.
• During the clonic stage, a generalized tremor occurs. This is because phases of atonia (muscle relaxation) alternate with repeated spasms (muscle contraction
• The atonic periods gradually become longer until the last spasm. Incontinence may occur at the end of the clonic phase as sphincter muscles relax. The atonic period lasts about 30 seconds and during the atonic period it can happen that the breathing temporarily stops.
The convulsion, including tonic and clonic phases, lasts for 1-2 minutes.

3. Postictal state
The postictal period includes a period of unconsciousness during which the patient becomes quiet and breathing resumes. Patient gradually awakens, often after a period of sleep, and is confused. Headache and muscular pain are common. The patient does not have memories about what happened during the seizure.

When are seizures not epilepsy?
While any seizure is cause for concern, having a seizure does not by itself mean a person has epilepsy.

First seizures: Many people have a single seizure at some point in their lives. Often these seizures occur in reaction to anaesthesia or a strong drug, but they also may be unprovoked, meaning that they occur without any obvious triggering factor. These single seizures usually are not followed by additional seizures. It may be beneficial to begin anticonvulsant medication once a person has had a second seizure, as the chance of future seizures increases significantly after this occurs.

Febrile seizures: Sometimes a child will have a seizure during the course of an illness with a high fever. These seizures are called *febrile seizure* and can be very alarming to the parents and other care givers. In the past, doctors usually prescribed a course of anticonvulsant drugs following a febrile seizure in the hope of preventing epilepsy. However, most children who have a febrile seizure do not develop epilepsy, and long-term use of anticonvulsant drugs in children may damage the developing brain or cause other detrimental side effects. Preventive treatment after a febrile seizure is generally not warranted unless certain other conditions are present: a family history of epilepsy, or a relatively prolonged or complicated seizure. The risk of subsequent non-febrile seizures is only two to three percent unless one of these factors is present.

Eclampsia: Eclampsia is a life-threatening condition that can develop in pregnant women. Its symptoms include sudden elevations of blood pressure and seizures. Pregnant women who develop unexpected seizures should be rushed to a hospital immediately. Eclampsia can be treated in a hospital setting and usually does not result in additional seizures or epilepsy once the pregnancy is over.

Non-epileptic seizures or psychogenic seizures: Sometimes people appear to have seizures, even though their brains show no seizure activity. This type of phenomenon has various names, including non-epileptic seizures. The attack may look like epilepsy but is not epilepsy. These attacks are called non-epileptic seizures or psychogenic seizures. "Psychogenic" means "beginning in the mind." These are episodes in which the behavior and consciousness of the person is briefly changed. Non-epileptic seizures are not caused by electrical disruptions in the brain, like in epilepsy, but are often caused by stressful psychological experiences. Non-epileptic seizures are a way that the body indicates excessive stress. The stress that can result in people having non-epileptic seizures varies with each individual. For some people it may result from experiences of abuse (sexual or physical) in the past, especially in their childhood. Others may have experienced a major life event such as the death of someone close to them or a difficult family situation. Careful history taking makes it often possible to differentiate between psychogenic seizures and epileptic seizures. It is important to recognize that these seizures are real events, although they are different from epileptic seizures. In the past, they were sometimes called "hysterical seizures" and people having them were thought to be faking them or trying to get attention. There is nothing false or insincere about these seizures. It is important to diagnose them correctly so that people who have non-epileptic seizures can get appropriate treatment, and they will be prevented from getting the wrong treatment. Many Africans consider non-epileptic attacks as possessions by spiritual entities, bad spirits or souls of ancestors.

Differences between epileptic seizures and non-epileptic seizures are shown in the table below. In epileptic seizures consciousness is lost, while in non-epileptic attacks the consciousness is often not completely lost. In non-epileptic seizures often the person is able to hear the relatives talking or is able to see the environment. In epileptic seizures often (but not always) tongue bite and urine incontinence is seen. In non-epileptic seizures this is rare. Epileptic seizures can happen everywhere, at any time, and in any social setting. They can also happen when the person is alone or when in dangerous circumstances. A person with epilepsy often has the scars of injuries and burns. Non-epileptic seizures mostly always happen in social situations in which tension occurs. They rarely happen when the person is alone. During a seizure one can do the flailing hand

test while the patient is lying on her/his back on the floor. The investigator brings the hand about 40–50 cm above the head of the patient and lets it drop. In epilepsy the hand will fall vertically and hit the face. In non-epileptic seizures the patient is able to control the movement of the hand so that it does not hit the face.

Epileptic seizures often have a short duration (usually less than 15 minutes) after which the person wakes up in a state of confusion. Non-epileptic attacks can have a duration of several hours.

	Epileptic Seizure	Non-Epileptic Seizure
Precipitating factor before attack	Rare	Often (emotion)
Circumstances	Can be everywhere, while asleep, or when alone	In social situations
Motor signs	Stereotyped	Variable
Consciousness	Lost	Not lost
Injury or burns	Present	Not present
Tongue bite	Common	Rare
Incontinence	Common	Rare
Time	1–10 minutes	Many minutes (up to hours)
Confusion after seizure	Present	Not present
Flailing of hand test	Positive	Negative

Psychogenic seizures should not be treated in the same way as epileptic seizures. Anti-epileptic medication is not useful for them and can harm the patient due the side effects! Psychogenic seizure may indicate dependence, a need for attention, avoidance of stressful situation, or specific psychiatric condition. It often occurs in women who are in very stressful circumstances, often family problems. More about the treatment of psychogenic seizures can be found in the chapter on somatoform disorders.

Provoking factors of epileptic seizures
Seizures can be provoked by
- Sleep deprivation,
- Tiredness
- Stress,
- Extreme alcohol consumption,
- Some drugs (anti psychotic, anti-depressants, antihistamines, beta-adrenergic)
- Flickering of light (e.g. in water or fire)

Diagnosis of epilepsy
The diagnosis of seizures is based on clinical recognition of one of the seizure types described above. A detailed history is likely to lead to an accurate diagnosis in up to 90% of patients. Diagnosing epilepsy is a multi-step process, usually involves the following evaluations:
- Confirmation through patient history, neurological exam, and supporting blood and other clinical tests if needed.
- Identification of the type of seizure involved, through careful history taking
- A clinical evaluation in search of the cause of the epilepsy. The main tool in diagnosing epilepsy is careful medical history
- In some rare cases electroencephalography (EEG) can help to confirm the diagnosis. However, the absence of abnormality in the EEG does not prove anything: a normal

or non specifically abnormal EEG never excludes epilepsy! The interpretation of EEG results is a specialized task that requires extensive specialized training.

Treatment of epilepsy

For about 80 percent of those diagnosed with epilepsy, seizures can be controlled with medicines. However, about 20 percent of people with epilepsy will continue to have seizures even with the best available treatment. Once epilepsy is diagnosed, it is important to begin treatment as soon as possible because treatment may be less successful once seizures and their consequences become established.

Pharmacotherapy is the first treatment approach for controlling seizure attacks. The pharmacological approach consists of the following steps
• Decide on the need for treatment on the basis of prognosis
• Select a single drug and increase the dosage slowly
• Give the family clear information on how to manage status epilepticus
• Maximize the drug dosage if seizures continue
• Add a second drug if epilepsy is not controlled, with combined treatment lasting for sufficient time to assess the second drug as a possible line of treatment before withdrawal of the first
• Try further drugs and instigate detailed investigations if the epilepsy proves intractable to two drugs. If adverse factors are absent the diagnosis of epilepsy should be questioned

The following anti-convulsant drugs are on WHO's essential drug list
• Phenobarbital
• Carbamazepine
• Valproic acid
• Phenytoin

One anti-epileptic drug or more than one?

Monotherapy or choosing a single drug is a first method in the pharmacotherapy of epilepsy. 70–80 percent of patients can be controlled on monotherapy. The advantages of using only one drug are:
• Fewer side effects
• Reduced risk of the fetus when a women with epilepsy gets pregnant
• Less chance for drug – drug interactions
• Easier dosing, greater compliance
• Lower cost

Valproic acid

Valproic acid is considered by many the drug of first choice since it treats a broad spectrum of seizure types.
Adults
• 400 mg/ day (divided in 2 doses of 200 mg)
• Increase to 1000 or 2000 mg a day (divided in 2 doses) if needed
Children
• 15 mg / kg/ day (divided in 2 doses per day)
• Increase to 30 mg/kg/day

The dose of valproic acid is, 400-750mg/day, in two or three doses per day. Maximum dose 2000 mg/day.

Common side effects (usually not too severe) are:
• Sedation
• Tremor
• Hair loss (in 5% to 10% of patients. This is temporary, hair starts to grow again

within a few months)
- Weight gain (in 30% to 50% of patients)
- Tiredness
- Dizziness
- Nausea (common when therapy begins. Advise the patient to take the medicine on a full stomach to reduce nausea)

Serious side effects are fortunately very rare but can occur
- Liver damage. The risk of liver failure is very low: 1 in 50,000 in older children and adults, but higher in children under 2 years of age. Valproic acid should be terminated if symptoms of liver damage occur, such as jaundice in combination with nausea, vomiting, anorexia.

Carbamazepine
Carbamazepine is often used for partial seizures.

Children:
- 5 mg / kg day (divided in 2 doses)
- Increase to 10-30 mg/kg/ day

Adults:
- 100 – 200 mg/ day (divided in 2 doses)
- Increase to 400 – 1000 mg (divided in 2 doses)

The most common side effects are dose-related. They include:
- Drowsiness
- Nausea (at the start of treatment)
- Nausea
- Ataxia (staggering gait, with uncoordinated movement, 'like a drunk man')
- Blurred vision

These side effects tend to occur within a week of initiation or dosage increase. They can be lessened by:
- Reducing the total daily dosage
- Splitting the total daily dosage into more frequent doses

Shifting more of the total daily dosage to bedtime, especially for patients with nocturnal or early-morning seizures

More serious side effects
- Skin rash. About 5% to 10% of people who take carbamazepine have an allergic reaction consisting of a red rash. This happens within the first month of taking the drugs. If a rash develops stop carbamazepine and choose another drug More serious rashes, such as Stevens-Johnson syndrome can occur but are very rare.
- Hematological changes (blood disorder). Rare. Carbamazepine should be discontinued if the total neutrophil count falls below 1500/ml First signs in the patient can be
  o fever
  o sore throat
  o sores in the mouth
  o nosebleeds or other unusual bleeding or bruising
  o tiny red spots on the skin
- Liver damage. Carbamazepine can lead to hepatic toxicity.

A complete blood count and liver function tests should be obtained before initiating administration of carbamazepine and at intervals during the course of treatment.

Phenobarbital

Phenobarbital is commonly used for epilepsy, though its adverse effects have led to a decline in its use. It is recommended by the World Health Organization as first-line for epilepsy in developing countries.

Some doctors hesitate to prescribe phenobarbital because it has a reputation for causing unwanted side effects, especially drowsiness in adults and behavioral or learning problems in children. Some studies have found greater problems with behaviour and thinking in children taking phenobarbital than in children taking other seizure medicines. Side effects are much more likely to be troublesome if high doses are given.

Dosage:
Children
- 2 mg/kg/day (give at bedtime)
- Increase dosage to 2-6 mg/kg/day)
Adults:
- 60 mg/day (in one dose)
- Increase to max 180 mg/day

Common side effects of phenobarbital
- Sleepiness or fatigue. (Warn patient to be careful with driving, operating machinery, or any other dangerous activity)
- Hyperactivity (in children)
- Trouble paying attention (in children and adults)
- ataxia
Rare adverse affects:
- Skin rash

Phenytoin

Common side effects of phenytoin
- Drowsiness
Less common
- Ataxia (lack of coordination of muscle movements: for example walking like a drunk man)
- Slurred speech
- Enlargement of the gums in the mouth
Rare
- Allergic skin reactions

Dosage
Children
- 3-4 mg/kg/day (in 2 doses)
- Increase to 3-8 mg/kg/ day (max 300 mg daily)
Adults:
- 150 -200 mg/day (in one dose)
- Increase to max 400 mg/day

Stopping medication
Some doctors will advise people with epilepsy to discontinue their antiepileptic drugs after two years have passed without a seizure. Others feel it is better to wait for four to five years. Discontinuing medication should *only* be done with a doctor's advice and supervision. It is very important to continue taking epilepsy medication for as long as the doctor prescribes it.

Discontinuing medication without a doctor's advice is one of the major reasons people who have been seizure-free beginning having new seizures. Seizures that result from

suddenly stopping medication can be very serious and can lead to status epilepticus.
The chance that a person will eventually be able to discontinue medication varies depending on the person's age and his or her type of epilepsy. More than half of children who go into remission with medication can eventually stop their medication without having new seizures.

Social and psychological elements of treatment

Most people with epilepsy lead outwardly normal lives. Approximately 80 percent can be significantly helped by modern therapies, and some may go months or years between seizures. However, epilepsy can affect daily life for people with epilepsy, their families, and their friends. People with severe seizures have an increased risk of cognitive impairment, particularly if the seizures developed in early childhood.

Society's lack of understanding about the many different types of seizures is one of the biggest problems for people with epilepsy. People who witness a non-convulsive seizure often find it difficult to understand that behavior which looks deliberate is not under the person's control. In some cases, this has led to the affected person being arrested, or placed in a mental institution. To combat these problems, people need to understand the different types of seizures and how they may appear.

Educating patient and the family on the nature of symptoms, duration and frequency of attacks, changes over time, possible risk factors for attacks, psychosocial stressors, consequences, treatment issues, follow up, and prevention of new attacks.

Epilepsy & Pregnancy and motherhood

Women with epilepsy are often concerned about whether they can become pregnant and have a healthy child. Most women with epilepsy can become pregnant and deliver a normal baby. Women with epilepsy have more than a 90% chance of having a normal, healthy baby. There are several precautions women can take before and during pregnancy to reduce the risks associated with pregnancy and delivery. Women with epilepsy who want to become pregnant should talk with their doctors about their medications. Some anti-epileptic medications, particularly sodium valproate and phenytoin, are known to increase the risk of having a child with birth defects such as cleft palate, heart problems, or finger and toe defects and neuronal tube defects. Do not prescribe them to pregnant women!!

Generally, the woman should continue taking anti-epileptic medication as prescribed to avoid preventable seizures. Seizures during pregnancy can harm the developing baby or lead to miscarriage, particularly if the seizures are severe. Labor and delivery usually proceed normally for women with epilepsy. Woman using epilepsy medications can breastfeed her baby. Only minor amounts of epilepsy medications are secreted in breast milk; usually not enough to harm the baby.

Women with epilepsy sometimes experience a change in their seizure frequency during pregnancy, even if they do not change medications. About 25 to 40 percent of women have an increase in their seizure frequency while they are pregnant, while other women may have fewer seizures during pregnancy. The frequency of seizures during pregnancy may be influenced by a variety of factors, including the woman's increased blood volume during pregnancy, which can dilute the effect of medication.

Advises to pregnant women with epilepsy
- Take prenatal vitamins and folic acid
- Get plenty of sleep to avoid seizures caused by sleep deprivation.
- Go for prenatal care
- Do not use heroine or other illegal drugs
- Try to avoid stress.

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- Regular check up with the doctor who treats the epilepsy

Prognosis
Good and adverse prognostic features for outcome of epilepsy:

Good outcome	Adverse outcome
Single seizure type	Good response to antiepileptic drugs
No additional impairment	Multiple seizure types
Late age of onset	Additional neurological impairment (especially in cognitive function)
Episode is related to illness with full recovery or was provoked	Early age of onset (for the syndrome)
Episode is related to illness with full recovery or was provoked	Spontaneous seizures
Low rate of seizures	Status epilepticus
Short seizures	High rate of seizures

Prevention of epilepsy
Many cases of epilepsy can be prevented. Health workers can contribute to prevention of epilepsy by promoting the following:
- Adequate antenatal care (control of high blood pressure and infections during pregnancy can prevent brain damage in the developing baby that may lead to epilepsy and other neurological problems later).
- Safe delivery in the presence of a skilled provider to respond to problems during labor or the birth.
- Control of fever in children.
- Prevention of brain injury.
- Control of parasitic and infectious diseases.
- Wearing seat belts in cars and using helmets when riding a motorcycle.

Important tips:
- Epilepsy is not a mental illness
- Epilepsy patient can get mental illness
- Most cases start at childhood
- Discuss treatment plan with patient
- Medication controls attacks
- Coping with stress reduces number of attacks
- Counseling can improve anxiety or depression
- Attacks occur any time including during sleep
- Stigma and discrimination is high
- Treatment duration is about three years
- Focuses on family support, psychosocial stressors and mental illness if present with epilepsy.

Follow up:
Epilepsy patients need a regular follow up till seizures are adequately controlled. The follow up will focus on improvement in seizure control, side effects of medication, compliance, psychosocial problems, and family support.

Status Epilepticus
Most seizures end after a few moments or a few minutes. Sometimes a seizure can continue. Status epilepticus is usually defined as 30 minutes of uninterrupted seizure activity or if the person does not fully regain consciousness between seizure episodes. The term 'status epilepticus' literally means a continuous state of seizure. Status epilepticus is a medical emergency. Status epilepticus is a medical emergency because it can lead to permanent brain damage if untreated. Someone with a prolonged seizure lasting more than 10 minutes should be taken to a doctor immediately.

Status epilepticus may occur after head injury, on reducing drug therapy (especially phenobarbitone), with alcohol or other sedation withdrawal, drug intoxications (tricyclic antidepressants), infections, metabolic disturbances (hyponatraemia) or pregnancy.

Management of status epilepticus

The doctor who is responsible for the management of status epilepticus should act quickly to prevent seizure activity to do chronic damage. Below are more detailed guidelines, but in essence the treatment consists of injecting a benzodiazepine in the blood circulation (lorazepam or diazepam), followed by iv administration of an anti-epileptic drug such as phenytoin, valproate or Phenobarbital.

Early management

- The immediate goal is to stop status epilepticus; the appropriate special investigations can be done later once the seizures have been stopped.
- Immediate attention should be given to ensuring that the airway is free and the patient positioned to prevent aspiration of stomach contents.
- Start monitoring pulse, respiration and blood pressure. Prevent aspiration, maintain clear airway.
- While making arrangements to set up an i.v. line, a few questions must be asked of the accompanying persons (a detailed history can be taken later). Questions can include:
  o Is the patient known to suffer from epilepsy? Did he take anticonvulsants? Did he discontinue the intake? If so, when?
  o Is the patient known to use drugs? Did he discontinue to use this recently?
  o Have any symptoms been noticed that might indicate a disorder apt to cause convulsions?
  o When was the last meal taken? (The answers to the last questions could indicate a hypoglycaemic state.
- Send blood for lab investigation to find a somatic cause. Diagnostic procedures can include:
  o blood glucose
  o calcium,
  o electrolytes
  o urea
- If fever or meningeal signs are present, immediate lumbar puncture to be done. Other investigations to be done after the seizures are under control.
- Management of hyperthermia: Hyperthermia can increase the risk of brain damage from status epilepticus and requires specific attention. Severe hyperthermia must be treated with a cold sponging.
- Start i.v. line with 5% glucose solution.
- Medicines (Inject into the i.v. line)
  o Glucose solution: 50 ml of 50% glucose with 100 mg thiamine.
  o Inject anti-epileptic drugs in the iv line or give by iv injection

Drug therapy for status epilepticus

When a seizure lasts more than 10 minutes patient should be seen by a doctor. Intravenous (IV) injections with diazepam can be given. Give this slowly, over the course of a few minutes.
- 5 mg diazepam in children under 5 years
- 10 mg diazepam in children 5–10 years
- 20 mg diazepam in adults

Repeat this dose after half an hour if the seizure still has not stopped. If it is not possible to give diazepam IV, it can also be administered rectally via a plastic syringe. Diazepam can interrupt status epilepticus rapidly, but its effect is short-lived. As soon as the status epileptic is under control, give phenobarbital by intramuscular (IM) injection (3 mg/kg).

Diazepam

- The effects of diazepam can wear off in 20 minutes later in spite of its 30-hour half life (due to extensive redistribution of diazepam outside the vascular compartment as diazepam is highly lipid soluble).
- Dosage i.v is 0.3 mg/kg (up to 10 mg max). Rate of administration: 1 mg/min until seizures stop *or*
- If iv line is not available give intravenous injection.
  o As rough guide:
    ▪ up to 5 mg in children under 5 years;
    ▪ 10 mg in children 5–10 years;
    ▪ 15 mg in older children and 20 mg in adults.
  o Repeat after 5 minutes if seizure persists and then twice more if necessary
  o May be repeated after 20–30 min, and once again 30 min later.
- If not successful in finding a vein: the same solution in the same dosages can be given rectally via a catheter or syringe. This can be very useful for small children.
- Do not give diazepam i.m.
- Watch for hypotension and respiratory depression and be ready to support the respiration because a respiratory arrest may occur.

Lorazepam
- The anticonvulsant effect of lorazepam is much longer (6 hours). The risk of respiratory depression may be greater with diazepam than with lorazepam. If lorazepam is available this has preference.
- 0.1 mg/kg up to a max of 4 mg. Rate of administration: 0.5 cc/min. Dilute 1:1 prior to administration (can use sterile water, D5W, or normal saline)

Phenytoin
- Loading dose of phenytoin is 15-20 mg/kg body weight. Rate limiting side effects are hypotension and bradycardia. Therefore monitoring of vital signs are necessary!
- The fastest rate administer phenytoin i.v. is 50 mg/minute.
- If no iv line is available give intravenous injections 5–6 mg/kg i.v. three times with 30 min in between.
- It should be given i.v and not i.m because the absorption after i.m. administration is not reliable.
- Infuse in normal saline as phenytoin crystallizes in glucose/ dextrose solutions
- Watch for hypotension and arrythmias
- Do not give phenytoin i.m.
- The maintenance dose of phenytoine after status epilepticus is 5-7 mg/kg/day (300-400 mg per day in adults) divided in doses i.v every 8 hours.

Valproate
Valproate (30 mg/kg over 15 min). Dilute 1:1 with sterile water.

Phenobarbitone
- First choice in neonates with status epileptics
- 3–5 mg/kg two or three times during the first 24 hours i.m.. Max. of 600 mg (i.e., 30 kg patient)
- If in iv line: Rate of administration: 1 mg/kg/min.
- Continue checking pulse, respiration and blood pressure. Watch for respiratory depression especially if diazepam or lorazepam have been given.
- Maintenance dose. After the loading dose is given, continue with the maintenance dose. When a patient is able to swallow, continue maintenance therapy orally: phenobarbitone 2-3 mg/kg/day orally.

Table: Drug treatment of status epilepticus in adults

Drug	Dosage	Advantages/disadvantages /complications

Lorazepam or Diazepam Diazepam gel	0.1mg/kg IV at rate not greater than 2mg/min 10mg IV over 2minutes 0.2mg/kg rectally	Fast acting, effective half-life 15minutes for diazepam and 14 hours for lorazepam. Abrupt respiratory depression or hypotension in 5%, especially when given in combination with other sedatives. Seizure recurrence in 50% of patients; therefore must add maintenance drug (phenytoin or phenobarbital)
Proceed immediately to phenytoin		
Phenytoin	1000-1500mg(20mg/kg) slowly at rate not greater than 50mg/min (cannot be given in dextrose solution)	Peak serum concentration 10-20 minutes following IV infusion. Little or no respiratory depression. Drug levels in the brain are therapeutic at completion of infusion. Effective as maintenance drug. Hypotension and cardiac arrhythmias can occur
If seizures persist, another 10mg/kg phenytoin can be adiministered'if seizures still continue, proceed immediately to Phenobarbital		
Phenobarbital	1000-1500mg(20mg/kg) IV slowly 50mg/min)	Pead brain levels within 30minutes. Effective as maintenance drug. Respiratory depression and hypotension common at higher doses. (intubations and ventilatiory support should be immediately available)
If above is ineffective, proceed immediately to general anesthesia		

MODULE 2.10: Delirium

Learning Objectives
After this module the participants will be able to:
• Identify people with delirium who present to the health services
• Make a treatment plan for people with delirium

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip-chat, markers, pen & papers, reference manuals

Time
1-2 hours

From the needs assessment in the Great Lakes region, it was ascertained that Delirium, not Dementia was a more pressing issue. Therefore training on Delirium was conducted and Dementia was omitted. For the sake of completion here, we have included a brief section on Dementia – this can be expanded upon based on the local context.

Learning objectives
At the end of the session the participants will be able to:
• Describe the symptoms of delirium
• Identify probable cases
• Make a management plan for delirium

Methodology for trainer
Introduction
The facilitator introduces the topic by defining delirium and explaining that delirium is a serious concern, and yet is often not well diagnosed. Participants are asked if they have seen patients with delirium and provides the following examples:
• A patient after an operation who is confused and disoriented
• A patient who suddenly withdraws from alcohol and gets completely 'mad'
• A patient with high fever who suddenly has strange behavior

Delirium: symptoms, causes and management
Trainer gives an interactive presentation covering delirium using the PowerPoint Presentation for module 2.10, slide 1-16.
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Key messages: Delirium
• Delirium is highly prevalent among people with medical disorders.
• Delirium is a syndrome with many different causes.
• It is important to treat the underlying cause of delirium.
• Medication and psychosocial interventions are important in cognitive disorders.
• Dementia is a cognitive disorder with a slow and insidious onset that differs from delirium.
• There is no cure to dementia but symptoms can be managed.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
o *PowerPoint Slides for Module 2.10 (Handout for participants)*
o *Study Material for Trainers for module 2.10.*

Study Material: Module 2.10

Delirium[14]

Clinical features of delirium
The major symptom of delirium is
  1. *impairment of consciousness*, resulting in a reduced level of alertness, a decreased level of attention and diminished awareness of the environment.
This is usually accompanied by
  2. other impairments of cognitive function,
  3. and by emotional symptoms (emotional lability), perceptual disturbances (hallucinations or illusions)
  4. behavioral disturbances (inappropriate, impulsive, irrational, or violent behavior.

Delirium is usually a reversible disorder but it can become irreversible.
Onset of delirium is usually acute, and the symptoms occur within a few hours. The course is fluctuating, with periods in which the patient seems to be normal, and periods, particularly in the night, in which the patients is very confused and agitated. Patients with delirium often have disturbed sleep.

Delirium is common among hospitalized patients (In Europe and USA around 10% of all hospitalized patients are thought to have delirium, and after surgery this figure is even higher). Very young and elderly patients are more susceptible to delirium. Patients with history of delirium of brain damage or a beginning dementia are more likely to have an episode of delirium than the general population. The prognosis of delirium is variable: if the cause is identified and eliminated the prognosis is usually excellent. Symptoms usually recede 3 to 7 days after the causable factor is treated. The underlying cause however can be untreatable and lead to death.

Causes of delirium
Delirium is a syndrome that can have many causes. The similarity between all these causes is that they lead to brain dysfunction. The list of causes is long. Major causes include:
• Medication
  o Opiates
  o Medication with anticholinergic effects, particularly if drugs with anticholinergic effects are combined, for biperiden combined with amitriptylline
  o Diuretics
  o Digoxin
  o Sedative medication
• Medical conditions
  o Septicaemia
  o Metabolic changes
  o Renal failure
  o Cardiac failure
  o Lung failure
  o Hyperglycaemia
  o Hypoglycaemia
  o Thiamine deficiency
• Febrile illnesses
  o Urine tract infection
  o Pulmonary infections

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[14] For this chapter the following resources were used: Kaplan and Sadock (2010), Gelder et al. (2007, Gill et al. (2007).

- o etc
- Intracranial causes
  - o Head injury
  - o Encephalitis
  - o Brain tumor
  - o Epilepsy
- Other
  - o Dehydration
  - o Anaemia

The list of causes is much longer. Most important is to realize that a delirium is always caused by an underlying problem that needs to be identified and treated.

Mental State Examination in delirium
Patients have
- Fluctuating levels of consciousness
- Difficulty sustaining attention. Impaired attention can be assessed with bedside tests that require sustained attention to a task that has not been memorized, such as reciting the days of the week or months of the year backwards,
- Problems in orientation (ask the patient where he is and what day and time it is. Ask him if he knows what your profession is)
- Short-term memory problems
- (sometimes) problems in perception: the patient may have hallucinations, particularly visual hallucinations.
- Psychomotor disturbances, usually agitation, but it can also be the opposite: an extreme apathy.
- Poor insight and impaired judgment.

Differential diagnosis
1. Dementia.
2. Acute psychosis, schizophrenia and mania. These disorders usually do not have the rapidly fluctuating course of delirium, nor do they impair the level of consciousness or significantly impair cognition.

Assessment
Delirium is a medical emergency, and its cause must be identified as rapidly as possible.

Physical examination
In patients with delirium a careful and complete *physical examination* is necessary. This should include testing vital signs such as temperature, pulse, blood pressure, and respiration.

Medical history
It is also necessary to check carefully what kind of medication the patient uses and what kind of physical disorders the patient has.

Lab examination
Lab examination is indicated to identify potential causes for the delirium:
- Electrolytes,
- Blood cell count with differential blood count,
- Liver and renal function tests
- Urine analysis
- ECG etc.

Treatment
Find the cause
The most important point is to identify and treat the underlying cause, correct metabolic

abnormalities and ensure proper hydration and electrolyte balance. Identify and where possible discontinue medication that may have contributed to the delirium.

Non pharmacological interventions
The hospital environment should be optimized:
- Protect the patient: remove potentially dangerous objects, make the bed safe, instruct that a family member should always be present next to the patient;
- If possible place the person in a quiet room, preferably together with a trusted family member;
- Provide orientation to the patient: clock, calendar etc;
- Provide clear explanation to the family members. Assure them that the condition is reversible and that the person is not becoming crazy;
- Instruct family members and the staff need to be instructed to provide 're-orientation cues' to the patient: tell the patient where he/she is, what the time and day is, who they are. They should be advised to maintain a calm and reassuring attitude to the patient. This will help the patient to stay oriented;
- Medical staff should always introduce themselves to the patient: tell who they are and what they are going to do.

Pharmacological interventions
Medication can be used to treat the symptoms of the delirium:
- Antipsychotic medication can be used to control the agitation and hallucinations (Usually start with 1 mg and repeat regularly each 4-6 hours. Usually a dosis of maximum 10 mg per day is sufficient to control the agitation. Haloperidol should preferably be administered orally, but when the patient is not able to take it orally it can be given i.m.
- Benzodiazepines should be avoided because they can increase the confusion.

Delirium causes much anxiety with the family of the patient and the nursing staff. Because delirium usually occurs in patients of general medical wards and not on the psychiatry ward it is important that the medical doctors from the psychiatry department are available to advise their colleagues at other wards. It can be helpful to organize seminars to doctors and nurses of other wards about delirium and its treatment.

MODULE 2.11: Developmental Disorders

Learning Objectives:
After this module the participants will be able to:
- Identify people with developmental disorders
- Make a treatment plan - in line with the WHO mhGAP Intervention Guide - for people with developmental disorders
- Become familiar with developmental disorders and behavioral issues in children

Methodology
Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises. (see the ANNEX for the handout of the PowerPoint).

Materials
Flip-chat, markers, pen & papers, power point presentation, reference manuals

Time
3-4 hours

Methodology for trainer
This module will concentrate on Developmental Disorders only. The behavioural disorders as described in mhGAP are not included in this package.

Introduction
- The trainer introduces the topic by explaining what we mean by developmental disorders. The trainer can use PowerPoint Slides for Module 2.11. (slides 1-5) but can also write the key points on a flipchart and invite the participants to reflect on it.
- Do an exercise with the participants in writing down the milestones of children and the typical ages they occur (see slide 6 and 7)
- Participants are asked whether there are many children with developmental disorders among the refugees they work with. What names do the people use for them?

Assessment and management
- Facilitator gives an interactive using PowerPoint Slides for Module 2.11. (slides 8-17).
- Role play: How to give advise: one of the participants plays a health worker who gives psycho-education to the parents of a child with mental retardation. The parents came for treatment, but the health worker has to explain them what the condition is, that there is no cure, but that still the parents can do many things to improve the wellbeing of heir child
- Discussion: Discuss with the participants how to link to Community Based Rehabilitation services

Key Messages
- Developmental disorders begin in childhood and generally persist into adulthood.
- Interventions focus on psychosocial strategies including psycho-education for families and teachers, community-based rehabilitation strategies, support to care givers and protecting the rights of these vulnerable individuals.
- Avoid institutionalized care for developmental disorders.
- For developmental disorders, refer to specialized services if available.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module

o *PowerPoint Slides for Module 2.11. (Handout for participants)*
o *Study Material for Trainers for module 2.11.*
o Integrated Management of Childhood Illness (IMCI) http://www.who.int/child_adolescent_health/topics/prevention_care/child/imci/en/index.html

Study Material: Module 2.11

What is a developmental disorder?
A disorder with onset in childhood with a steady course related to central nervous system impairment and delay in function that persists into adulthood. These include:
1. Intellectual disability/ mental retardation: impairment of skills across multiple developmental areas
2. Pervasive developmental disorders such as Autism: impaired social behavior communication and language and a narrow spectrum of activities and interest originating in childhood

1. Intellectual Disability/Mental Retardation
Clinical features
Mental retardation is a developmental disability which appears in childhood and is defined by level of intellectual functioning (measured by standard intelligence tests) which is lower than average and results in significant limitation in person's adaptation functioning.
- Intellectual functioning level is defined by standardized tests that measure the ability to reason in terms of mental age (intelligence quotient or IQ).
- Mental retardation is defined as an IQ score below 70.
- Adaptive skills are a term that refers to skills needed for daily life. Such as
  o Communication skills: Ability to produce and understand language
  o Home-living skills
  o Use of community resources
  o Social skills and health, safety, leisure, self-care
  o Self-direction
  o Functional academic skills (reading, writing, and arithmetic)
  o Job-related skills.
Low IQ scores and limitations in adaptive skills are the hallmarks of mental retardation. Children who are mentally retarded reach developmental milestones significantly later than expected but not all. IQ is not required in acute cases to make the diagnosis. Diagnosis is based on clinical observation and history.

Common features in mental retardation are:
- Delayed developmental milestones such as
  o Motor: sitting up, crawling, walking, climbing stairs etc
  o Language: delayed speaking, difficulty pronouncing letters or words
  o Social: smiling, recognition of parents and others etc.
- Continued infantile behavior
- Decreased learning ability e.g. difficulties in school, difficulty in learning new things etc.
- Lack of curiosity
- Difficulty in self care
- Failure to meet intellectual developmental markers according to age
- Behavior problems e.g. temper tantrums, head banging, bedwetting, aggression etc

Common behavior problem with MR:
- Self-injuring behavior: skin picking, head banging, biting
- Stereotypical behavior: rocking; hand flapping, certain noise
- Aggression or destruction of households
- Sexually offending behavior:
- Sleep disturbance
- Hyperactivity, frequent move, inability to sit
- Attention deficit; difficulty concentration

Mental retardation comprises four general categories: mild, moderate, severe and profound. Categories are based on scores obtained through use of age-standardized

tests of cognitive ability.

Developmental Characteristics Related to Level of Mental Retardation

Mild MR	Moderate MR	Severe MR	Profound MR
75% cases of MR	10-25% cases of MR	8-10% cases of MR	1-2% cases of MR
IQ: 50 to 70	IQ: 35 to 49	IQ: 20 to 34	IQ: < 20
Slow in all areas	Noticeable delays, especially in speech	Marked and obvious delays; walks very late	Marked delays in all areas
May have no unusual physical signs	May have some unusual physical signs	Little or no communication skills	Congenital abnormalities often present
Can acquire practical skills	Can learn simple communication	May be taught daily routines and repetitive activities	Need close supervision
Useful reading and math skills up to grades 3 to 6 level	Can learn elementary health and safety habits self-care	May be trained in simple	Often Need attendant care

Etiology
Some causes of mental retardation are:
• Congenital infections such as cytomegalovirus, toxoplasmosis, herpes, syphilis, rubella and HIV etc
• Prolonged maternal fever in the first trimester
• Exposure to anticonvulsants or alcohol
• Complications of prematurity, especially in extremely low-birth-weight infants
• Metabolic disorders: hypothyroidism, phenylketonuria (PKU)
• Genetic abnormalities: fragile X syndrome, neurofibromatosis, tuberous sclerosis etc
• Brain Infections e.g. meningitis, encephalitis, etc
• Head Trauma during labor or latter in life
• Chromosomal abnormalities e.g. Down syndrome (trisomy 21)

Diagnosis
Diagnosis is dependent on a comprehensive personal and family medical history, a complete physical examination and a careful developmental assessment of the child. The diagnosis of mental retardation in young children is frequently missed.

The three most common errors made by clinicians who overlook the possibility of mental retardation are:
• Normal appearance (child does not look retarded)
• Child who is ambulatory is unlikely to be retarded
• If retardation is actually considered, concluding that it is not possible to test young children x Failing to consider the diagnosis.

Management
MR is not a mental disorder but MR person can develop mental disorders e.g. depression, anxiety disorder, psychosis, substance abuse etc. There is not treatment for MR, treatment will focus on associated diseases e.g. epilepsy or coexisting mental disorder. The approach is individualized education and skills training. Psychosocial counseling should be considered for mild to moderate mental retardation. As long as possible medications should not be used to restrict behaviors, except for short-term intervention in patients self harm and are aggressive to others, Medication is needed for other medical problems such as epilepsy. For any mental problems psychosocial intervention should be first choice.

Psycho-education
Educating patient and the family on the nature of symptoms, duration and changes over time, possible risk factors, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention.

Some important tips:
- Early training can help towards independence and self-care.
- There is no cure for mental retardation
- Mental retardation is not the fault of the child
- Mental retardation is not a punishment for the sins.
- Some children may be disruptive or overactive
- A mentally retarded child can learn many things; it just takes them more time and effort than other children.
- Teaching the child requires a lot of patience and encouragement.
- Praise the child when s/he is doing something well than to punish her/him when a mistake is made.
- These children are capable of loving relationships.
- Families may feel great loss or feel overwhelmed by the burden of caring for a retarded child.
- Children and adults to be allowed to function at the highest level of their ability in school, work and family.
- Parents can share practical advice and emotional support.
-

MODULE 2.12: Psychological Trauma

Learning Objectives
At the end of the session the participants will be able to:
- Describe the concepts of 'psychological trauma' and 'posttraumatic stress disorder'
- Have an informed opinion about the utility of these concepts for refugees in +African settings
- Do an assessment of a patient with a traumatic event in the past
- Describe some treatment principles for people with trauma-related complaints

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals

Time
3 hours

Methodology for trainers
Introduction: Interactive Lecture

a) *Introduction (group work + interactive lecture)*
- The trainer introduces the topic of *trauma* by asking the participants to sit in small groups for 10 minutes and write down *what happens when a person is confronted with a sudden danger?* Ask the participants to divide the responses in 4 main categories:
  - physical reaction
  - emotional reactions
  - cognitive reactions
  - behavioral/interpersonal reactions
- The work of the small groups is brought into the plenary by the trainer who ask the groups what they answered for each category. Examples are provided below for the trainer:
  - o **Emotional reactions** - Shock, daze, grief, anxiety, guilt, anger, numbness, helplessness, shame, emptiness, decreased ability to feel pleasure/interest/love
  - o **Cognitive reactions** - Nightmares, poor concentration, unwanted memories of the disaster, self-blame, confusion, disorientation, indecisiveness, worry
  - o **Physical reactions** - Difficulty sleeping, exaggerated startle response, tension, fatigue, irritability, aches and pains, tachycardia, nausea, change in appetite, change in libido
  - o **Interpersonal reactions** - Distrust, conflict, withdrawal, work problems, school problems, irritability, decreased intimacy, feeling rejected or abandoned;
- Then the trainer explains some concepts using slides of PowerPoint 2.12. (slides 1-9)
- *Key Point: Most people are resilient!*
  - o These are <u>normal emotional responses</u> (distress) in times of extreme stress.
  - o It <u>can</u> become a mental disorder if
    - Symptoms persist
    - Duration is too long
    - Social and occupational function is disturbed
  - o But the vast majority of persons do NOT develop a disorder after trauma

b) *What is psychological trauma? (interactive lecture)*
- The trainer gives an interactive presentation using PowerPoint presentation 2.12. (slides 10-25) covering a description psychological trauma and related mental disorders. It is important to relate to the way people present in the health centre.

The symptoms are often not mentioned spontaneously but need to be elicited by the health worker in an active way.
- *Key Point: Many disorders can follow a traumatic event, not just PTSD*, but also Depression, suicidality panic attacks, substance abuse, alcohol abuse.

c) *How to help people who have experienced a psychological trauma?(Interactive lecture*
- Ask the participants if they see patients with mental symptoms due to psychological trauma. Ask the participants whether the refugees or the local population around the camps have words to describe psychological trauma. What do they do when a person has such complains? Do people go the health worker? If not, where do they go?
    - Treatment: Depends on the nature and severity of the symptoms. mhGAP can be used as a guide here. Treatment generally includes:
        o Psycho-education
        o Sleep regulation
        o Taking rest
        o Avoiding maladaptive behaviors, e.g. substance abuse, self medication
        o Medications: should be prescribed with caution and only for severe symptoms causing a significant degree of impairment
        o Psychosocial interventions such as support groups can provide opportunities to the person to share his/her feelings and find courage and comfort.

- NB Realize that among the participants there may be people who have experiences shocking events themselves and may have complaints related to these events. It is important that the trainer does not push participants to open up about their own experiences. Sometimes a participant wishes to share what happened to him or her and how he or she reacted. It is important that such disclosure is contained and the person is not going over the edge in sharing experiences.

- Present some outline for helping people with psychological trauma through Powerpoint 2.12 (slides 26 – 31)

d) *Relaxation exercise (demonstration + group exercise)*
The trainer explain that one technique to control overwhelming emotions and thought is to concentrate on breathing and the body. The relaxation exercises according to Jacobson are built around the principle that alternation of creating muscle tension and muscle relaxation helps the person to become aware of his or her body and helps him/her to relax.

o The trainer first explains the procedure by telling what he will do.
o Then the trainer does the whole procedure together with one volunteer or co-trainer. He/she explains how to contract and relax the different muscle groups.
o Then the trainer invites the whole group to do the exercise.

Key messages
- Traumatic events that threaten the life or the integrity of a person can lead to strong emotional reactions
- Most people will not develop a mental disorder after having been exposed to a traumatic event.
- Best way to assist a person who has recently been exposed to a distressing event is by following the principles of Psychological First Aid
- Some people can develop a post traumatic stress disorder after exposure to a shocking event

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Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
o *PowerPoint Slides for Module 2.12. (Handout for participants)*
o *Study Material for Trainers for module 2.12.*

Study Material for Trainers: Module 2.12

Trauma and trauma related problems

Distressing events and their impacts
Distressing events (such as war, natural disasters, accidents, fires, rape, kidnapping, riots) can impact individuals, families and communities in different ways. Examples of such distressing events are
• Natural disasters (earthquake, flood, severe storm)
• Violence between persons (severe domestic violence, being threatened with a weapon, kidnapping, torture)
• Sexual aggression (rape, sexual abuse)
• War related incidents (bomb blast, suicide attacks, having to fight in combat,
• Others (serious injury, attack of wild animal, traffic accident)

In the immediate aftermath of such events some may need emergency rescue or medical help, but many can benefit from practical assistance and basic human comfort and compassion. Most persons have the ability to cope and recover, even from the most terrible events.

Some distressing events can be a 'psycho trauma'. This is an experience where the soul gets 'badly hurt' when a person experiences or is witnessing a life threatening situation or a situation that includes danger of injury which is so severe that the victim is horrified and feels helpless and powerless during and shortly after the event.

In general there three ways in which a person can react when facing an imminent danger
• Flight
• Fight
• Freeze
Particularly the third type of reaction, when the organism is 'paralyzed' by the event and does not know what to do, can have a negative impact.

The impact of a traumatic experience depends on:
• Length of the experience
• Level of predictability (of is fully unpredictable the impact is more negative)
• Level of control (having no control over the situation makes the impact more negative)

When a person experiences an event that is extremely stressful, he will have by nature a strong fear reaction. This is a normal reactions of in response to those abnormal events. Due to the danger that the person faces physiological reactions changes in the body occur such as:
• Secretion of some hormones like cortisol, adraline and noradrenaline
• Activation of the autonomic stress reactions leading to reactions in the following systems:
  o Cardiovascular system: Palpitation, Shock
  o CNS: Dizziness, Paralysis
  o Urinary system: Urinary retention, frequency, uncontrolled urination
  o Gastrointestinal system: Diarrhea, Constipation
  o Skeletal-muscle: Muscle weakness, relaxation
  o Skin: Pallor

The reactions during the event by the body and psyche are called *alarm response.* Generally this is an understandable and normal reaction. Most of the time this reaction will subside within a few days or weeks.

Symptoms which appear immediately after a traumatic experience can include
- *Physical reactions:* Increased heart frequency, high blood pressure, tension in the muscles, hyperventilation, trembling, digestion problems
- *Emotional reactions*: Being fearful, desperate helpless and upset, aggressive, feeling ashamed (for example because of loss of control), uncontrolled mourning
- *Thinking :* Difficulty to concentrate, not being able to think clearly, chaos or emptiness in the head, wondering ('what would have been if…..???'), accusing oneself, being disorientated.
- *Behavior*: Restless, nervous, aroused, acting without an aim or plan, numbing behavior (drugs etc)
- *Dissociation*: Seeing the happenings from the outside like through a glass wall, believing it is not true.
- *Depersonalization:* Own feelings are not considered to belong to oneself, functioning like an automatism

Usually these reactions will subside. Sometimes however, the fear reaction persists in the person and does not decrease in time. The person can develop symptoms of an acute stress disorder or a post traumatic stress disorder (PTSD). PTSD occurs only after exceptionally stressful events, but not every response to such events is PTSD. The person can also develop various other kinds of anxiety disorders or depression. It is very important to realize that most people will not develop PTSD after a distressing event.

Whether a person fully recovers from such an experience or not depends on the presence of risk factors and protective factors.

Risk factors
- Bad psychological health and prior mental disorders in self or in family members
- Being very young or old
- Chronic sickness, chronic pain, addiction
- Experience of loss (death, divorce), loneliness, no support
- Low socioeconomic status

Protective factors
- Social support, having a good social network
- Effective coping strategies, like dealing with such experiences in an open and direct way
- Having interest in the world
- Good health
- Good knowledge about oneself, abilities, resources

WHO IS VULNERABLE?
Etiological factors influencing the transition from distress to disorder following trauma
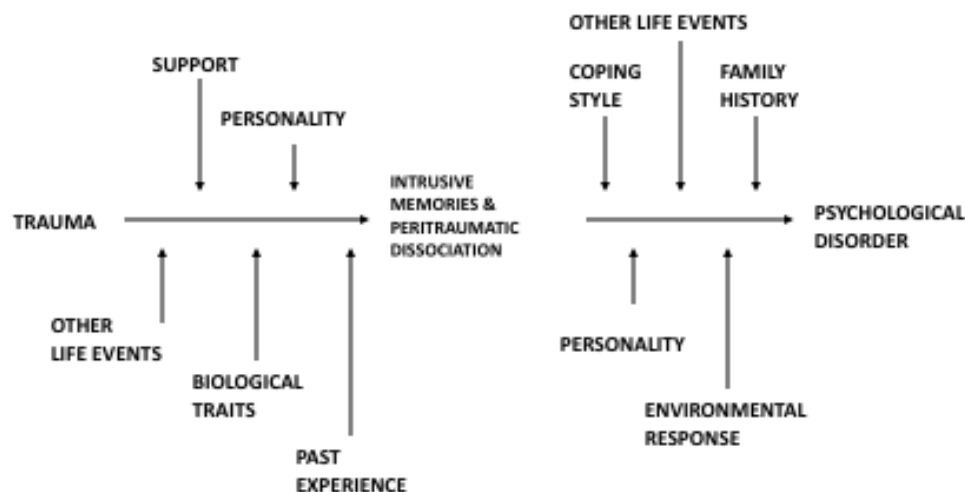
Source: De Jong and Komproe

Psychological First Aid[15]

Distressing events (such as war, natural disasters, accidents, fires, rape, kidnapping, riots) can impact individuals, families and communities in different ways. In the immediate aftermath, some may need emergency rescue or medical help, but many can benefit from practical assistance and basic human comfort and compassion. Most persons have the ability to cope and recover, even from the most terrible events. Certain things may be particularly helpful:

- feeling safe, connected to others, calm and hopeful;
- having access to social, physical and emotional support;
- being able to help themselves, as individuals and communities.

People who do not feel well-supported by others following a critical event may have more emotional problems later. Perhaps you find yourself at the scene of an accident where people have been hurt, or you are called to see a survivor of a bomb blast or a kidnapping or a shooting. As a professional person (doctor, nurse, counselor) – you can help persons in crisis by learning and practicing the most supportive things to do and say.

How to assist?

The following text is
To assist people in the aftermath of a crisis follow the principles of Psychological First Aid

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[15] This part is based in WHO/WVI/WTF (2010).

(PFA). Psychological First Aid is a set of guidelines how to assist a person. impacted by distressing events. PFA is not counseling or debriefing. PFA is not: pressuring people to tell you all their feelings and reactions to an event. PFA is being available to listen to people's stories.

In this manual for doctors in EPHS hospitals we will only discuss the basic principles. More information can be found in the PFA manual that WHO and other organizations have made (see Table below for a summary)

Psychological First Aid Pocket Guide

Providing Psychological First Aid responsibly means:
1. Respect safety, dignity and rights.
2. Adapt what you do to take account of the person's culture.
3. Be aware of other emergency response measures.
4. Look after yourself.

Prepare	• Learn about the crisis event. • Learn about available services and supports. • Learn about safety and security concerns.

Action Principles of PFA:

Principle	Action
LOOK	• Check for safety. • Check for people with obvious urgent basic needs. • Check for people with serious distress reactions.
LISTEN	• Approach people who may need support. • Ask about people's needs and concerns. • Listen to people and help them to feel calm.
LINK	• Help people address basic needs and access services. • Help people cope with problems. • Give information. • Connect people with loved ones and social support.

Ethics:
Ethical do's and don'ts are offered as guidance to avoid causing further harm to the person, to provide the best care possible and to act only in their best interest. Offer help in ways that are most appropriate and comfortable to the people you are supporting. Consider what this ethical guidance means in terms of your cultural context.

Do's	Don'ts
• Be honest and trustworthy. • Respect people's right to make their own decisions. • Be aware of and set aside your own biases and prejudices. • Make it clear to affected people that even if they refuse help now, they can still access help in the future. • Respect privacy and keep the person's story confidential, if this is appropriate. • Behave appropriately by considering the person's culture, age and gender.	• Don't exploit your relationship as a helper. • Don't ask the person for any money or favor for helping them. • Don't make false promises or give false information. • Don't exaggerate your skills. • Don't force help on people and don't be intrusive or pushy. • Don't pressure people to tell you their story. • Don't share the person's story with others. • Don't judge the person for their actions or

	feelings.

People who need more than PFA alone:
Some people will need much more than PFA alone. Know your limits and ask for help from others who can provide medical or other assistance to save life.

> **People who need more advanced support immediately**:
> - People with serious, life-threatening injuries who need emergency medical care.
> - People who are so upset that they cannot care for themselves or their children.
> - People who may hurt themselves.
> - People who may hurt others.

Medical treatment of acute stress reactions
Psychological First Aid can be done by anyone. Apart from PFA a doctor trained in mental health can do more with a person who has an acute stress reaction. Many people affected by trauma will experience emotional reactions. These can include a feeling of being numb or in a daze, fear, sleep difficulties, repeated thoughts of the event, irritability, nightmares and having difficulty concentrating. This is a normal response to a traumatic incident and lasts for a short period (typically two to four weeks).
- Offer a follow up appointment in about a month to identify subjects whose stressful symptoms are not settling. Most stress reactions will resolve with time but some people these experiences continue for months or even years after the trauma. They begin to interfere with the person's daily life and may lead to new problems, such as alcohol misuse or problems in relationships with other people.
- If anxiety is severe, an anxiolytic drug such as alprazolam or diazepam may be prescribed for a day or two.

Post-traumatic stress disorder (PTSD):
Post traumatic stress disorder is a severe disorder that is characterized by the onset of psychiatric symptoms after exposure to a traumatic event. Such a traumatic event involves either witnessing or experiencing threatened death or injury or witnessing or experiencing threat to physical integrity. Further, the response to the traumatic event involves intense fear or horror.

People with post-traumatic stress disorder (PTSD) have three types of complaints and must be accompanied by a significant impairment in functioning of at least one month's duration:
- *Reliving the trauma again and again.* The person relives the trauma through visions of the incident, nightmares and 'flashbacks' (feeling as if the traumatic incident is repeating itself at the present time).
- *Avoiding things.* The person has several of the following symptoms: avoids situations that remind her of the traumatic incident; she is unable to remember things related to the trauma; and feels emotionally distant from people.
- *Increased arousal.* The person has at least two of the following symptoms of increased arousal: Arousal means 'awake'. Hyper arousal is a state of being too alert: Sleep is disturbed, the person feels irritable, has difficulty concentrating and is easily startled or scared.

It is important to realize that the traumatic event can have much wider consequences than only the symptoms of PTSD.

The traumatic events can have many consequences in the person, including
- Somatization, (feeling physical illness and chronic pains).
- Victimization (experience that one is always the victim of the circumstances and one can do nothing to improve the situation)
- Loss of meaning in life (wondering why one is on earth)

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- Loss of identity

Many patients with PTSD feel depressed and lose interest in daily life, feel tired or suffer aches and pains, and have suicidal feelings. People with PTSD experience difficulties in working, relationships with others and, in the case of children, studying.

Therefore in patients who have experienced traumatic events we frequently see other mental and psychosocial problems such as
- Depression
- Suicidal thoughts and attempts
- Problems in relationships, family
- Sexual problems
- Addiction
- Somatic complaints

Treatment for Post traumatic Stress disorder:
Biological Management
Medication is often not very helpful for a person with PTSD. Anxiolytic drugs should be avoided for established PTSD because prolonged use may lead to dependence. Sometimes sleeping tablets and tranquillizers (such a diazepam) are prescribed, but this often helps only temporarily. When there are also depressive symptoms fluoxetine can be helpful in a patient with PTSD

Psycho-education
It is very important that the person and the family are aware of the symptoms. Sometimes the family is angry with the patient because s/he is so irritable. Sometimes the patient thinks that her/his lack of concentration will increase over time. When a person understands that the symptoms are part of a disease that can improve over time s/he will feel reassured.

A person with a PTSD feels unsafe and in constant danger. The symptoms can decrease if the person has a place where s/he can feel relaxed or safe, such as a certain place for praying, a garden with beautiful flowers.

It is often helpful to do activities that distract the mind from the terrible event. Some activities such as knitting, gardening, carpentry, or drawing can be helpful because they:
- Are not too difficult
- Have some element of repetition and distraction
- Can be done for a short time, and be resumed easily at a later time
- Give the person the feeling that s/he is able to master something or to create something that is good and new

Psychosocial support
The general basic psychosocial approach is
- To provide emotional support
- Psycho-education on normal responses to severe stress
- Tell the patient about the importance of confronting situations and memories related to the traumatic events

It can be helpful to talk with a person about what has happened. This is often a very painful thing for the patient, because s/he often tries to forget about the event. A few points to keep in mind when talking to a person with PTSD:
- The person has experienced an event that was threatening and very painful to her/him. This means the health worker should never force the patient to continue. It is the patient who decides if s/he is willing to continue talking about what happened.
- The role of the healthcare provider is to encourage in such a way that it is not threatening to the patient and gives the patient a feeling that s/he is safe now.

Treatment may also need to deal with the person's feelings of guilt about perceived shortcomings in responding during the events, grief, and guilt about the meaning and purpose of life and death.

Psychological treatment based on principles of cognitive behavioral therapy
Psychological treatment based on principles of cognitive behavioral therapy for PTSD is challenging but can be very effective. One needs to be well trained before doing it. This is the task of a professional counselor and should NOT be attempted by others. Usually psychotherapy consists of three phases:

1. Stabilization
- Building a trustful relationship with the client
- Explore resources
- Explore the symptoms, the thoughts and feelings which come along with the memories
- Teach self-calming techniques and relaxation exercises
- Teach client how to develop a safe place in your imagination

2. Confrontation with the experience (= exposure therapy)
Exposure therapy means that the client will be confronted with the traumatic experience. This is a painful and difficult process. A counselor will only do this when the patient agrees and is mentally stable enough to do this treatment.
The approach used is called Narrative Exposure Treatment (NET). It consists of two elements: 1) reconstructing the life story of the patient (narration) and 2) assisting the patient to re-experience the most painful experiences (the traumatic experiences) in the client's life, while the counselor is with the patient and assisting him or her. The recall of images of the traumatic events leads to strong emotions. When first recalled these images are often fragmentary and are not related clearly in time to the other contents of memory;

3. Integration
Integration of the traumatic event in the life history. The last phase of the therapy consist of assisting the client to give the traumatic events a place in the life story of the client. In this phase the counselor will discuss questions related to the meaning of life, values, resources and will encourage the client to explore new aspects of the personal life, family relationships and future activities which are now possible.

MODULE 2.13: Other significant emotional or medically unexplained complaints

Learning Objectives
After this module the participants will be able to:
- Identify people with significant emotional complaints that are not covered in the earlier modules but are a reason for clinical concern
- Identify people medically unexplained complaints who present to the health services.
- Assess 'medically unexplained symptoms'
- Make a treatment plan for individuals with 'other significant emotional or medically unexplained complaints'

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals

Time
3 hours

Methodology for trainer
This module will cover the mhGAP category entitled 'Other Significant Emotional or Medically Unexplained Complaints' which includes anxiety, depressive or somatic complaints that are not listed in the mhGAP guide as a priority area.
For the trainers we have included a separate section on anxiety disorders. This is too much to be taught to general health workers in a basic training such as this one. These additional materials may be used in advanced trainings or when specific issues are raised during clinical supervision.

What do we mean by other significant emotional or medically unexplained complaints

o *Group discussion*
The trainer introduces the topic by explaining that health workers are often confronted with patients who present complaints that fall into one of the following categories:
- o Emotional symptoms such as feeling anxious, worried or sad while the person does not have a 'depression' as presented in the mhGAP.
- o physical symptoms or 'somatic complaints' for which even after appropriate examination, lab tests and other explorations we cannot find a clear cause. Some complaints do not fit clearly in one of the usual diagnostic categories. A health worker may sometimes have reasons to believe the complaints may be linked to social or psychological factors.

The trainer asks the participants:
- *Do you see patients with such emotional or unexplained medical complaints?*
- *How often? What kind of patients? Can you give a typical example?*
- *What is your current management of such patients?*

Examples of these conditions include: anxiety, excessive worry, or somatic complaints (for example stomach pain, dizziness, headaches, pain etc.) while no medical cause can be identified.

o The trainer gives an interactive lecture covering a description of significant emotional

or medically unexplained complaints, using the PowerPoint Slides for Module 2.13 (slides 1-15)

Assessment of these complaints using the mhGAP Intervention Guide

o The trainer gives an interactive lecture covering a description of significant emotional or medically unexplained complaints, using the PowerPoint Slides for Module 2.13 (slides 16 – 22)

o Role play: diagnosis
One of the trainers or trainees play a person with unexplained medical complaints. See the text for the role play a the end of this module.

Management of other significant emotional or medically unexplained complaints

o The trainer gives an interactive lecture covering a description of significant emotional or medically unexplained complaints, using the PowerPoint Slides for Module 2.13 (slides 23 - 27)

o Role play: management
One of the trainers or trainees play a person with unexplained medical complaints. See the text for the role play a the end of this module.

Breathing Exercise: Optional
If time allows the trainer can do a breathing exercise with the participants. See Exercise at the end of this session. .

Key messages
• Unexplained medical complaints are frequently presented in primary care but often misdiagnosed.
• Medically unexplained complaints may not have a clear cause, but they are nevertheless real complaints and the patient suffers from them.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module

Resource materials to use in this module
o *PowerPoint Slides for Module 2.13. (Handout for participants)*
o *Study Material for Trainers for module 2.12.*
o *Text for Role play*
o *Instruction for breathing exercise*
o *Study Material for trainers for (see end of this session)*

Text for role play Module 2.13.

The patient is a 32 year old woman called Jeanine.
She is married, and has three children. Originally she is from the Dem Republic of Congo, and lives in the refugee camp for 12 years now.

She visits the health centre because she often has headache. She quite frequently visits the health centre for complaints such as tiredness, sleeplessness and nausea.

She has had had lab test (blood check) that was normal. No anemia, no signs for infection. Also normal: thyroid hormone.

She will not say this spontaneously, but will reveal it when she is nicely asked: she worries that she may have a serious disorder such as HIV or cancer. She is unhappy with the husband who is not often taking care of her and the children.
She feels quite lonely, because her own mother is not here. She missed her a lot.
She has three cousins who are in another section of the camp. She feels 'too proud' to share her problems with them and she now tries to avoid the cousins, while before she has good relations with them.

When asked about her mood: She does not feel unhappy or sad all the time. Some times, briefly it may happen, but in general she is optimistic. She is active in the church. She still has interest in things, and likes listening to the radio, who is with her neighbours.

She feels tired all the time and she does not understand why.

There is no recent loss.
There has not been a history of trauma, apart from the escape from DRC to the camp, when they had to leave all the belongings and the house was burnt. Nobody got killed, only she got separated from the mother and father.

Material to use for Module 2.13: Instructions for breathing exercise

Breathing and relaxation exercises
Relaxation helps to reduce physical and mental tension. It can also provide relief from insomnia and stress. For people with generalized anxiety, these techniques are often very helpful.

Instructions for breathing exercise
• Choose a quiet room with little noise where you will have no interruptions
• Give your client the following instructions:
  o Close your eyes or look at an object or on the wall. This will help you to concentrate
  o After a moment, start concentrating of the rhythm of your breathing, observe your breath, especially the breathing out. Prolong gently the breathing out and wait till the breathing in comes all by itself
  o Pay attention to how your body feels. Become aware of how your back feels, how you sit in your chair and in which way the bottom of your feet touch the ground
  o Become aware of your breathing and inhale and exhale consciously
  o Now concentrate on taking slow, deep, regular, steady breaths through the nose. Observe the rhythm of breathing in and out. Observe the pauses in between.
  o When you exhale, imagine that you let go all tension in your body. If you feel while breathing somewhere is a barrier which disables you to breathe through your whole body: then stay there! If you feel the pressure in your chest try to concentrate on it! Breath into this point and then let the pressure go in leaving the breath leave your body
  o Imagine, that with every breath leaving your body: the worries, the pain, the thoughts also slowly leave you
  o When you inhale, imagine that you take in new energy with each breath. You can take all this energy, as you own it!
• First explain the exercise, then instruct him in doing it, finally try to exercise together so that the client does not feel observed
• Explain that he can exercise this daily and after a while use it in a variety of situations, when she/he needs to relax!

Study Material for trainers : Module 2.13

Other Significant and Unexplained Complaints

Unexplained somatic complaints
Somatic symptoms which are not clearly associated with physical or medical causes are common in patients in general medical settings. Most of these symptoms are transient, but a minority is persistent and disabling. A large number of people with unexplained somatic complaints have a depression or an anxiety disorder.

What are medically unexplained symptoms?
1. Symptoms and the clinical presentation are incompatible with known physical illness
2. Absence of positive physical signs or lab results

How can medically unexplained symptoms be caused?
• Due to undetected physical pathology
• Due to physiological changes as a result of emotional arousal (due to psychosocial stressors)
• Misinterpretation of normal bodily sensations

Assessment
Adequate medical assessment is essential. At the end of this the doctor should explain in a nice and clear way
1. The purpose and the results of the investigations carried out, and why it has been concluded that there is no medical cause for the symptoms
2. That the symptoms are nevertheless real and that patient and doctor should seek for other causes and ways to improve the symptoms and the suffering of the patient.
It can be helpful to refer the patient to a psychosocial counselor, for an assessment of the psychosocial stressors.

General approach to management of medically unexplained symptoms
The basic management plan consists of the following elements:
1. Emphasize that the symptoms are real and that you as a doctor are familiar with these complaints. Do not provide inappropriate reassurance such as telling the patient that 'nothing is wrong' or that it is 'all imaginatory'. After all, there is something wrong and the patient will not feel understood if you tell that he has nothing, because he/she feels otherwise.
2. Explain the role of psychosocial factors in all medical conditions
3. Offer and discuss a psychosocial explanation of the symptoms (this can be done by the doctor but also by a trained nurse or a psychosocial counselor)
4. Allow adequate time for patient and family to ask questions
5. Make a treatment plan with the consent of the patient, consisting of
   • Treatment of any medical problem contributing to the symptoms
   • Treatment of associated mental disorder (often a depression or an anxiety disorder)
   • Improve the physical condition by advising regular physical activity
   • Make a step plan for the patient to return gradually to normal activities
   • Minimize the use of benzodiazepines or placebo's
   • If appropriate: ask the patient to keep a diary to explore the possible relation between symptoms and associated psychosocial stressors.
Such treatment is ideally done by a multidisciplinary team in which both doctor and nurse or psychosocial counselor have a role.

Conversion disorder
Conversion disorder is one of a group of disorders called 'somatoform disorders' who are all characterized by physical symptoms suggesting a medical condition, yet the

symptoms are not fully explained by the medical condition. The symptoms are severe enough to cause the patient significant distress or functional impairment.

The psychiatric classification of somatoform disorders is complex. We will only describe conversion disorder below because this condition is regularly seen among this refugee population.

This is a disorder characterized by one or more neurological symptoms associated with psychological conflict in the person. Previously this illness was called hysteria or hysterical neurosis. Conversion disorder is a condition where patients present with neurological symptoms such as numbness, paralysis or fits, but no neurological explanation can be found. These problems arise in response to difficulties in the patient's life but the nature of the association between the psychological factors and the neurological symptoms remains unclear. The psychological conflict or stress may not always be apparent initially, but it becomes evident in the course of obtaining a patient's history. The symptoms thought to be triggered by acute psychosocial stress that the individual could not process psychologically. The most common reported symptoms are weakness, paralysis, pseudo seizures, involuntary movements (e.g., tremors), and sensory disturbances. Symptoms are not considered to be under voluntary control, and, should not be explained by any physical disorder or known pathological mechanism.

Some common risk factors for dissociation are:
• Childhood traumatic experiences
• Loss of a loved one
• Sexual assault/rape
• Kidnapping
• Torture
• Accidents
• During war
• Use of substances

Clinical features

We focus on motor symptoms here. Motor symptoms might include weakness or paralysis, inability to talk, a choking sensation in the throat, and urinary incontinence. Does not usually follow known anatomical or physiological routes. It is characterized by inconsistency and instability of the presence and severity of the signs and symptoms. Paralyzed limbs might move 'accidentally' while performing activity or when attention is shifted.

Conversion disorder can present with any motor or sensory symptom including any of the following:
• Weakness/paralysis of a limb or the entire body
• Impaired hearing or vision
• Loss/disturbance of sensation
• Impairment or loss of speech
• Non-epileptic seizures
• Fixed dystonia unlike normal dystonia
• Tremor, myoclonus or other movement disorders
• Gait problems

The intensity of the disability is usually to a level that affects activities of daily living. Symptoms are often aggravated by anxiety and tension states, such as the death of a relative or a war situation. Common presentation in Afghanistan is fainting or peudoseizures which usually mistaken for epileptic seizures.

Diagnosis

The diagnosis is frequently clinical, based on history and physical examination. The onset

is usually acute and sudden, though there may be a gradual form. The signs leading towards a non-organic diagnosis include inconsistent findings, no adjustment between physical and functional findings, and inconsistency between the symptoms and anatomical or physiological systems. There are rarely lead to physical changes or disability, so pressure sores, contractures or muscle atrophy are rare.

The diagnosis of conversion disorder involves three elements

1. Exclusion of neurological disease e.g. epilepsy
2. Exclusion of deliberate cheating
3. Determination of a psychological mechanism.

Doctors must be aware that the diagnosis of conversion disorder does not exclude the presence of underlying disease.

Differential diagnosis of conversion disorder

It is a major task to distinguish conversion disorder from organically based disorder. Here are some tips:

- *Paralysis*. In conversion paralysis is inconsistent; it does not follow motor path ways. No pathological reflexes (like Babinsky's sign) are present. Spastic paralysis and cogwheel rigidity are absent in conversion disorder.
- *Blindness*. Non pupillary response is seen in neurological blindness. In conversion the pupil reacts normally
- *Deafness*. Loud noise will awaked sleeping patient with conversion disorder but not patient with organic deafness.
- *Sensory*. In conversion disorder sensory loss does not follow dermatomes;
- *Pain.* pain most often related to head, face, back and abdomen. Look for organic findings-muscular spasm, osteoarthritis.
- *Pseudoseizures*. In conversion disorder one rarely sees incontinence, loss of motor control and tongue biting. An aura usually is present in organic epilepsy. (Please consult the chapter on epilepsy in this manual) Differences between epileptic seizures and non-epileptic seizures are shown in the table below. In non-epileptic seizures often the person is able to hear the relatives talking or is able to see the environment. In epileptic seizures often (but not always) tongue bite and urine incontinence is seen. In non-epileptic seizures this is rare. True epileptic seizures can happen everywhere, at any time, and in any social setting. They can also happen when the person is alone or when in dangerous circumstances. A person with epilepsy often has the scars of injuries and burns. Non-epileptic seizures mostly always happen in social situations in which tension occurs. They rarely happen when the person is alone. During a seizure one can do the flailing hand test while the patient is lying on her/his back on the floor. The investigator brings the hand about 40–50 cm above the head of the patient and lets it drop. In epilepsy the hand will fall vertically and hit the face. In non-epileptic seizures the patient is able to control the movement of the hand so that it does not hit the face.
- Epileptic seizures often have a short duration (usually less than 15 minutes) after which the person wakes up in a state of confusion. Non-epileptic attacks can have a duration of several hours.

	Epileptic Seizure	**Non-Epileptic Seizure**
Precipitating factor before attack	Rare	Often (emotion)
Circumstances	Can be everywhere, while asleep, or when alone	In social situations
Motor signs	Stereotyped	Variable
Consciousness	Lost	Not lost
Injury or burns	Present	Not present

Tongue bite	Common	Rare
Incontinence	Common	Rare
Time	1–10 minutes	Many minutes (up to hours)
Confusion after seizure	Present	Not present
Flailing of hand test	Positive	Negative

Treatment of conversion disorder

Treatment includes the following:

1. Explanation. This must be clear and coherent. It must emphasize the genuineness of the condition that it is common, potentially reversible and does not mean that the sufferer is a psychotic. Taking an etiologically neutral stance by describing the symptoms as functional may be helpful but further studies are required. Ideally the patient should be followed up neurologically if needed for a while to ensure that the diagnosis has been understood.
2. Physiotherapy where appropriate when motor symptoms are present
3. Treatment of comorbid depression or anxiety if present.
4. Psychosocial intervention

MODULE 2.14: Intervention Guidelines and Community-oriented Strategies

Learning Objectives
At the end of the session the participants will be able to:
- Think about community strategies for care and the importance of creating linkages in a refugee setting
- Be aware of sound prescribing practices
- Describe mhGAP recommended interventions for mental disorders
- Be knowledgeable of advanced psychosocial interventions

Methodology
Lecture, brainstorming, case studies, discussions, group exercises.

Materials
Flip chat, markers, pen & papers, reference manuals

Time
3 hours

Methodology for trainers
Community Strategies for Care:
Brainstorm session:
1. Ask participants to think about Psychosocial Interventions as a Primary Health Worker and what their role could be.
2. Ask about existing structures in the community and how they could treat patients through these mechanisms. What are the gaps?
3. *Hint*: Things to encourage them to think about: referrals, building capacity within the community through existing structures, identifying local methods that are currently effective, identifying points of linkages, involving community in health awareness programs, etc.
4. *Trainer-specific input:* We recommend that the trainer for this module observe the community at hand and present on the various community-based intervention strategies that exist within the local infrastructure.

Pharmacology and Prescribing Practices: General Rules[16]
- <u>Discuss risks and benefits with the patient and families.</u>
Potential risks and benefits to each individual patient must be taken into consideration when thinking about prescribing medications. These issues should be discussed in depth with patients, family members and/or patients' care givers before initiation of medications.
- <u>Involve the patient as much as possible.</u>
Health care workers should make a point to actively involve patients in their treatment plan, specifically regarding the prescribed medication. Psychological implications and concerns should be discussed here.
- <u>Psychopharmacologic medications are most effective in conjunction with non-pharmacologic interventions.</u>
Treating most psychiatric disorders is often achieved by pharmacologic and non-pharmacologic means. Using both methods is associated with better outcomes. Per the WHO, "Consequently, health care providers should not passively consider medications as their only therapeutic strategy, and patients should not be given a message suggesting that modifications of thought, mood and conduct can be achieved by pharmacological means only. Articulated, comprehensive and individualized treatment plans may represent the best therapeutic option."

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[16] WHO Psychopharmacologic Treatment of Psychiatric Disorders in Primary Care

- <u>Medications should not be issued without a thorough clinical assessment and establishing a diagnosis.</u>

A thorough clinical assessment with an accurate diagnosis will result in best outcomes. Psychological stressors should be fully explored as well before establishing the diagnosis.

- <u>Indicate to the patient that most pharmacologic treatment is time-limited.</u>

The time indicated for treatment will vary according to the treatment type and the type of medications. For psychosis and bipolar disorder, maintenance medications are important in preventing symptoms. Whereas, for depression, course of treatment will be less and depend on the medications involved.

- <u>Titrate medication slowly.</u>

Medications should always be titrated slowly, especially for the elderly and those with concomitant health issues (cardiovascular, renal disease etc). Prescribers should start with the recommended starting dose and titrate slowly. The titration rate and dispensation of medications will depend on the clinical response to treatment, and the patient's social, psychological and geographical situation. For example, if the patient is from a rural area and has difficulty accessing medications, they should be given a larger supply than those with better access to a pharmacy.

- <u>Medications should be prescribed for severe mental issues where there is a significant impairment in functioning due to symptoms or concomitant safety issues</u>

(suicidality, acute psychosis, acute agitation, post-partum psychosis/depression, bipolar episodes, etc.). With depression specifically, there must be biological symptoms present (neurovegetative symptoms) such as change in appetite, concentration, energy, sleep patterns, guilt, motor slowing/agitation, and/or suicidal ideation that warrant medications.

Psychiatric Emergencies:
- Urgent Clinical Issues:
  - Suicide / risk of self-harm
  - Homicide / risk of harm to others
  - Inability to care for self

  These are indications for acute clinical care and hospitalization.
- Suicidality and homicidality constitute medical emergencies and are indications for hospitalization
- Violence
- Other severe mental disorders and associated severe symptoms

mhGAP evidence-based and future interventions
- The following table is from mhGAP and represents recommended evidence-based interventions for each of the identified priority areas and examples of interventions are will be included in the package.
- Please note that this is a comprehensive guide and we understand that in refugee settings, resources are constrained and not always available. We encourage however that psychosocial strategies be strongly integrated into treatment systems.

<u>Figure. Evidence-based interventions Examples of interventions to be included in the package</u>

Condition	Evidence-Based Interventions	Examples of Interventions to be included in the package
Depression	Anti-depressant medication	Treatment with older or newer antidepressants by trained
	Psychosocial Interventions	primary health-care

		professionals. Psychosocial interventions such as cognitive behavior therapy or problem solving. Referral and supervisory support by specialists.
Schizophrenia and other psychotic disorders	Treatment with antipsychotic medicines Family or community psychosocial interventions	Treatment with older antipsychotics by trained primary health-care professionals within community setting. Community-based rehabilitation. Referral and supervisory support by specialists.
Suicide	Restriction of access to common methods of suicide Prevention and treatment of depression, and alcohol and drug dependence	Multisectoral measures that relate to public health, such as restriction of availability of most toxic pesticides, and storage of supplies in secure facilities. See examples of interventions for depression, disorders due to use of alcohol, and disorders due to use of illicit drugs.
Epilepsy	Identification and treatment with antiepileptic medicines	Treatment with first-line antiepileptic medicines by trained primary health-care professionals. Referral and supervisory support by specialists.
Dementia	Interventions directed towards care givers	Basic education about dementia and specific training on management of problem behaviors by trained primary health-care professionals.
Disorders due to use of alcohol	Comprehensive policy measures aimed at reduction of harmful use of alcohol Interventions for hazardous drinking and treatment of alcohol use disorders with pharmacological and psychosocial interventions	Policy and legislative interventions including regulation of availability of alcohol, enactment of appropriate drink-driving policies, and reduction of the demand for alcohol through taxation and pricing mechanisms. Screening and brief interventions by trained

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		primary health-care professionals. Early identification and treatment of alcohol use disorders in primary health care. Referral and supervisory support by specialists.
Disorders due to illicit drug use	Pharmacological and psychosocial interventions, including agonist maintenance treatment for opioid dependence	Psychosocially assisted pharmacotherapy of opioid dependence using opioid agonists such as methadone or buprenorphine. Early identification and provision of prevention and treatment interventions for drug use disorders by trained primary health-care professionals. Referral and supervisory support by specialists.
Mental disorders in children	Prevention of developmental disorders Pharmacological and psychosocial interventions	Measures within health sector such as provision of skilled care at birth, effective community-based services for maternal and child health care, prenatal screening for Down's syndrome, and prevention of alcohol abuse by mothers. Multisectoral measures that relate to public health such as to reduce child abuse. Identification and initial care in primary health-care settings. Referral and supervisory support by specialists.

Source: WHO mhGAP Action Program: Scaling up care for mental, neurological and substance use disorders

mhGAP evidence-based and future interventions
- The following table is from mhGAP and represents recommended evidence-based interventions for each of the identified priority areas and examples of interventions are will be included in the package.

Advanced Psychosocial Interventions (mhGAP)
The following are a list of advanced interventions. We do not feel that these are appropriate for this training but would like you to be aware that they exist. For more

information, please consult mhGAP.
- Behavioral Activation
- CBT
- Contingency Management Therapy
- Family Counseling of therapy
- Interpersonal Therapy
- Motivational Enhancement Therapy
- Parent Skills Training
- Problem-solving counseling or therapy
- Relaxation training
- Social skills therapy

Key messages
- A large interaction of factors will determine who develops a disorder from exposure to a traumatic event
- *Most people are resilient* and most will not develop a disorder after a life-threatening traumatic event.
- There are common mental health and psychological reactions to trauma that are healthy and normal.
- A variety of disorders can develop from trauma, not just PTSD.

Evaluation
Ask the participants at the end of the session what they have learned.

Resource materials to use in this module
- *Study Material for trainers*
- WHO Psychopharmacologic Treatment of Psychiatric Disorders in Primary Care

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PART THREE: TRAINING FOR COMMUNITY AND PSYCHOSOCIAL WORKERS

THEME 1 PSYCHOSOCIAL SUPPORT: General Understanding and Principles of Psychosocial Support

Description of the participants
The module is meant for both general community workers and specialized psychosocial workers, but is also relevant for health workers. If possible, health workers should participate in this module. General community workers are participants who have a level of education that reaches O-level: people who have finished secondary school. They are refugees or nationals who are already involved in community services and psychosocial units without specific training in psychosocial support. Specialized psychosocial workers are participants who have an advanced level of education with diplomas in various disciplines such as education, psychology, agriculture or social services. Some have had training in trauma counseling, general counseling or psychosocial training. In some modules, participants are combined, whereas other modules are for specific groups.

General objectives
To introduce participants to essential aspects of psychosocial work.

Specific objectives
At the end of this module, participants are expected to:
- Define the concept of psychosocial and illustrate it by examples.
- Describe the various psychosocial problems of refugees and the similarities and differences for specific groups, in terms of gender, age, ethnicity, etc.
- Explain the concept of empowerment and its importance in psychosocial support.
- Understand the essential personal characteristics required to provide effective psychosocial work and to reflect on one's own characteristics.

Time
1 day

Materials
Flip-chart, markers, cards, and if available, beamer and laptop

This part consists of 3 Modules:

	THEME 1 PYSCHOSOCIAL SUPPORT: General Understanding and Principles of Psychosocial Support	general community workers, specialized psychosocial workers and health workers	1 days
3.1	Introduction to key concepts of psychosocial support		3 hours
3.2	Principles of psychosocial support		4 hours
3.3	Personal characteristics of a community and psychosocial worker		2½ hours

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MODULE PS 3.1: Introduction to key concepts of psychosocial support

Learning objectives
At the end of the Module the participants will be able to:
- Explain key concepts (bio, psycho, social, psychosocial, psychosocial problems, psychosocial support, the interaction between psycho and social) in the field of psychosocial support and illustrate them with examples.
- Identify psychosocial problems related to a variety of age groups among the refugees.

Time
3 hours

Materials
Flip-chart, markers, cards

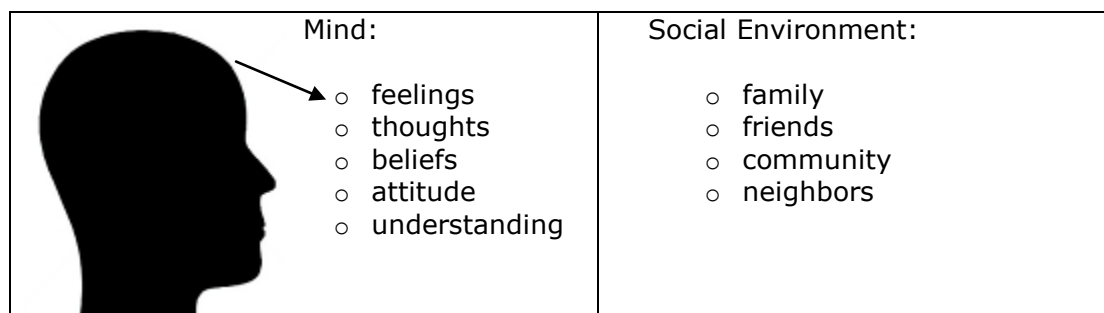**Methodology for the trainer: brainstorming, interactive lecture, discussion**
a) Introduction of the concepts (brainstorming and interactive lecture, ¾ hr)
Brainstorming to explore what the participants already know. The trainer draws the participants' attention by stating that the topic of psychosocial is the nucleus of all other lessons to be discussed either today or in the future, as far as psychosocial work is concerned. Understanding this topic is like inserting a key to open a locked door. Invite the participants to share their knowledge and ideas about the psychosocial. Write the question "what is psychosocial?" on a flip-chart and ask participants to share their ideas. Write the ideas on the flip-chart and thank every participant for their contribution and link it with your explanation as follows.

Interactive lecture: using a flip-chart, explain the following concepts:
- **Bio** is the biological or physical aspects of a person and his/her biological needs.
- **Psycho** means **the mind** (ask participants what the word is for *mind* in their own language). The mind refers to a person's thinking, feeling, emotions, understanding, beliefs and attitude.
- **Social** refers to the way a person relates with his or her social environment including: family, friends, neighbors and community and additionally, the influence of what happens in the community. The *social* component may refer to supernatural powers and as such, can be understood as unchangeable or beyond the control of the person.
- **Psychosocial** combines the words **psycho** and **social.** The word *psychosocial* may be new for participants who are not familiar with a related professional field. In general, the psychosocial is used as an adjective in combination with another word, for example: psychosocial problem, psychosocial intervention, psychosocial support.
  - **Psychosocial problems** refer to conditions and situations where a negative *psychological state* (feeling sad, feeling stressed, feeling irritable) is strongly related to and influenced by the current *social environment.* The individual may not be fully aware of the relationship of his state of mind with his or her environment. The relation is dynamic: a person who is distressed or upset will interact differently with his environment (for example: due to feeling sad the person may neglect his children, make a mess of finance etc). Psychosocial problem are often related interpersonal problems. For example domestic violence or relationship problem).For example: family conflicts may lead to neglect of children, to alcohol abuse, to domestic violence. This may lead to problems with school, with finance, with neighbours and that will increase the problems of the family. In general physical problems (poverty, homelessness) and general health problems (malaria, HIV) are not considered psychosocial problems by themselves, but they can lead to psychosocial problems if the support mechanisms of the person fall short.

- o **Psychosocial support** usually refers to approaches to support survivors of disasters, violence and other adverse situations by helping the person coping with the situation and by fostering resilience of communities and individuals. Psychosocial support aims at enabling people to restore normal life and empower affected people. Examples of psychosocial support include activities that people do themselves, such as talking to each other or giving practical support, as well as activities facilitated by psychosocial workers, such as: psycho-education, encouragement and support of communal functioning, self-initiative and self-help, individual, and family or group counseling. In contrast, handing out medications or food are generally not considered psychosocial support.
- Use a diagram to explain the interaction between psycho and social. Draw a picture of a head and write in or near it the word **mind** and below "mind", list the words **feelings, thoughts, beliefs, attitude** and **understanding.** The other side represents a person in the social environment, so write the words **social environment** to the right and below this write the words **family, friends, community,** and **neighbors** (see the diagram below). Illustrate the dynamics between the psychological and social problems with examples (think of refugee status, losses etc. Make sure that the illustration reflects that a problem starting on one side can influence and affect the other side and in return can make the initial problem more severe).

Mind:	Social Environment:
o feelings o thoughts o beliefs o attitude o understanding	o family o friends o community o neighbors

- Provide the participants with the handout PS 3.1.

b) Psychosocial problems in various groups (group work interactive lecture (1¾ hrs)
- *Group work (30 minutes)*
  Ask participants if they have understood the dynamic relationship between social and psychological experiences. Divide participants into groups. Ask each group to think of refugees in the setting (camp) where they work and create a list of social and psychological problems that the participant has noted. Each group of participants discusses one particular age group:
  o children ages 0 to 12
  o youth ages 13 to 25
  o adults ages 26 to 49
  o old people ages 50 and above[17]
  Instruction for group work:
  o All participants should be actively involved in the discussion
  o Each group selects a moderator and a reporter
  o Discuss the psychosocial problems in the assigned age group
- *Group presentations (45 minutes)*
  Each reporter briefly presents list of social and psychological problems for a maximum of 10 minutes per group. The trainer helps each group to distinguish between problems that are social and those that are psychological and then leads a discussion on how the problems influence each other*.*

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[17] We are speaking in the context of countries with limited life expectancies.

- *Interactive lecture (30 minutes)*
To summarize the essential points the facilitator uses several flip-charts

Children (0-12 years)	Youth (13–25 years)	Adults (26-49 years)	Old people (50 and above)
o lack of support for orphans o rejection o rape o identity problems o limited education o malnutrition o HIV/AIDs o mistreatment…	o educational problems o unwanted pregnancies o family rejection o hunger-related problems o drug abuse o rape o rebellious behavior o early marriage o stealing o psychosomatic complaints o nervous behavior o drug use o alcoholism o HIV AIDs…	o loss o changing roles between men and women o alcohol abuse o drug use o disputes between couples o polygamy o rape o domestic violence o epilepsy o mental illnesses o loss o HIV AIDs….	o food-related problems o clothing-related problems, o feeling of being rejected o lack of respect o chronic physical illness o psychosomatic complaints…

The trainer emphasizes that some psychosocial problems are specific for each age group, while others are more general. It is important to realize that there are a variety of groups in a community and there are differing psychosocial problems within these groups. For example, psychosocial problems are not the same for:
- Men and women
- Various ethnic groups
- Powerful persons and marginalized persons
Ask the participants to give examples of subgroups.

c)   Linking theory to practice in this Module (Plenary discussion, 30 minutes)
The trainer invites the participants to reflect on their daily work with refugees and link what they do with what has been discussed so far in this Module.

Resource materials to use in this module
- The International Federation Reference Centre for Psychosocial Support materials. See website: http://psp.drk.dk

Study Material 1: Module 3.1.

1.   The psychosocial approach [18]

Most mental health programs distinguish mental disorders from other distress or psychosocial problems. In general, medication may be appropriate to treat mental disorders, and therefore a psychiatrist or at least a medical doctor or nurse may be required.

Psychosocial problems such as isolation, stigmatization, sadness, fear, family violence, stress, etc. can lead to severe mental health, social or economic problems, as people are unable to complete their daily tasks or fulfill their roles. However, most psychosocial problems are also the result of bad socio-economic circumstances, caused by natural and/or man-made disasters like war, torture, terrorism, or political and domestic violence. Nobody will deny the importance of addressing the psychosocial problems of people after a natural or man-made disaster or as part of a refugee's experience.

The term *psychosocial intervention* refers to any program (usually a non-physical) that aims to improve the psychosocial well being of people. But since there are so many interventions that might contribute to this overall goal, reference points are needed to evaluate the appropriateness of a diversity of interventions.

Empowering people to care for themselves, restoring the social fabric/ cohesion and building people's capacity starts when people recognize their own resilience (the ability to "bounce back" and to manage the difficulties they face). They do this by drawing on the skills and knowledge they have learned in their communities, as well as on social networks, support and common values. Interventions should be targeted both at the individual and the community level and should promote individual and cultural forms of social healing, coping strategies, conflict resolution, reconciliation, as well as the rehabilitation of health and other social infrastructures. This will be realized using a range of community-based interventions that mutually reinforce each other and thus have a synergistic and potentiating effect.

Family disputes, war and violence as well as socio-economic problems, like poverty, unemployment and loss of social roles are often at the root of more serious disorders. Addressing these root causes and finding culturally acceptable and feasible solutions to these problems are major challenges. This requires a multi-sectoral approach to address the close ties between psychosocial and mental health status, on the one hand, and issues of poverty reduction and other structural social issues, including education, peace-building and conflict mediation on the other hand. Interventions focusing on direct psychosocial well being should go together with programs focusing on structural problems (poverty, social inequalities) that result in psychosocial problems. To work on these issues directly, a multi-agency approach is needed.

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[18] Source: HealthNet TPO, *Training manual; a community based psychosocial program, 2008.*

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Study material 2: Module 3.1.

Introduction
Communities in conflict areas have specific characteristics. The social fabric is often destroyed by man-made, sometimes natural disasters; families are scattered, community members mistrust each other, institutions, political and legal systems designed to protect and support people malfunction or disappear. Frequently, conflict causes an increase in social tension as well as damage to the (health) infrastructure and destruction of economic capital, resulting in an increase in poverty. Cultural notions and practices are under pressure and families lose their function as a safety net and support system.

These specific aspects of post-conflict situations frequently create a shift in power relations at all levels of a society; power relations are most of the time gendered and often related to ethnicity and/or class. Shifts in gender relations provoke a continuation of violence, often narrowing down within families and communities (e.g. domestic violence). Because the communal destruction of cultural identity manifests in physical, psychological and social aspects, these situations can be considered as collective trauma. If we want to properly analyze and use an effective approach to the problem we need to adopt a holistic view. The omnipresence of social problems justifies the introduction psychosocial well-being.

Psycho means the mind. The mind refers to persons' thinking, feeling, emotions, understanding beliefs and attitude. **Social** refers to the way a person relates with his or her environment including family, friends, neighbors and community and the influence of what goes on in the natural environment.

Psychosocial combines the words **psycho** and **social.** It is generally used to describe something that is not physical. The word *psychosocial* may be new for participants who are not familiar with a related professional field. In general, the psychosocial is used as an adjective in combination with another word, for example: psychosocial problem, psychosocial intervention, psychosocial support. Psychosocial refers to the dynamic relationship between the psychosocial and social dimension of a person, and one influences the other. The psychological dimension includes the internal, emotional and thought processes of a person, his or her feelings and reactions. The social dimension includes relationships, family and community networks, social values and cultural practices.

Psychosocial problems refer to conditions and situations where a negative *psychological state* (feeling sad, feeling stressed, feeling irritable) is strongly related to and influenced by the current *social environment.* The individual may not be fully aware of the relationship of his state of mind with his or her environment. The relation is dynamic: a person who is distressed or upset will interact differently with his environment (for example: due to feeling sad the person may neglect his children, make a mess of finance etc). Psychosocial problem are often related interpersonal problems. For example domestic violence or relationship problem).For example: family conflicts may lead to neglect of children, to alcohol abuse, to domestic violence. This may lead to problems with school, with finance, with neighbours and that will increase the problems of the family. In general physical problems (poverty, homelessness) and general health problems (malaria, HIV) are not considered psychosocial problems by themselves, but they can lead to psychosocial problems if the support mechanisms of the person fall short.

Psychosocial support usually refers to approaches to support survivors of disasters, violence and other adverse situations by helping the person coping with the situation and by fostering resilience of communities and individuals. Psychosocial support aims at enabling people to restore normal life and empower affected people. Examples of

psychosocial support include activities that people do themselves, such as talking to each other or giving practical support, as well as activities facilitated by psychosocial workers, such as: psycho-education, encouragement and support of communal functioning, self-initiative and self-help, individual, and family or group counseling. In contrast, handing out medications or food are generally not considered psychosocial support.

The psychosocial framework of 2005-2007 of the IFRC defines psychosocial support as "a process of facilitating resilience within individuals, families and communities." By respecting the independence, dignity and coping mechanisms of individuals and communities, psychosocial support promotes the restoration of social cohesion. If people are empowered to care for themselves and each other, their individual and communal self-confidence and resources will improve. Psychosocial support concerns psycho-education, empowerment, encouragement and support of communal functioning, mutual responsibility and compassion, self-initiative and self-help, individual, family and group counseling. Psychosocial support, in an early stage, can be considered an important prevention tool against developing severe stress or mental health problems. Psychosocial support and mental health care are subject to principles such as: don't harm, don't stigmatize or isolate.

Study material 3: Module 3.1.

What is "psychosocial approach"? Children as an example[19].
The term "psychosocial" has been developed to encompass the complex nature of child development, building upon the close interplay of the *psychological* and *social* aspects of cognitive and emotional growth. Children's psychological development includes the capacity to perceive, analyze, learn, and experience emotion. Social development includes the ability to form attachments to care givers and peers, maintain social relationships, and learn the social codes of behavior of one's own culture. Psychosocial approach, therefore, recognizes that there is an ongoing connection between a child's feelings, thoughts, perceptions, and the development of the child as a social being within his or her social environment. Children's reactions to extreme events will vary according to *individual* characteristics and *environmental* factors.

Psychosocial programs support the child's cognitive, emotional, and social development holistically, and strengthen the child's social support systems. Emphasis is placed on strengthening social environments that nurture children's healthy psychosocial development at various levels, with the family, community, and children themselves. At all levels, psychosocial approach must keep in mind the best interests of the child.
The psychological and social aspects of humanitarian assistance to children and their families are necessary components in responding to the overall developmental needs of children in complex emergency situations. The fundamental aim is to improve children's well-being by:
• Restoring the normal flow of development;
• Protecting children from the accumulation of distressful and harmful events;
• Enhancing the capacity of families to care for their children; and
• Enabling children to be active and positive agents in rebuilding their communities.

Child development
Globally, societies have different interpretations of what is meant by "child development." There are variations within geographical regions and cultures, and significant differences exist across lines such as North and South, East and West, urban and rural. Views of children are culturally and historically constructed, and they reflect the values, needs and practices of each society.

Nonetheless, some features of child development do apply across cultural boundaries. In all cultures, child development is a complex and dynamic process that involves growth and change at many levels. And, while it is possible to talk about the various aspects of development (physical, cognitive, emotional, social, and spiritual) as separate facets in the developmental process, in reality these aspects are interdependent and mutually reinforcing. For example, a relationship exists between the development of speech and the ability to walk; emotional stress can reduce disease resistance and damage health. Nutritional deficiencies can impair cognitive, speech and motor development and functioning as well as cause overall developmental delays. Chronic physical illness can create a host of emotional and social problems. Additionally, children's development is inextricably connected to their social and cultural environments, particularly the families and communities that are their life-support systems.

Through social interaction, children acquire gender and ethnic identities, internalize culturally-constructed norms and values, participate in formal education and other social institutions, and learn to become functional members of their societies. Children's development is a significant part of the process of becoming socially integrated and

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[19] This handout is copied with minimal adaptations from Arntson, L. and C. Knudsen, *Psychosocial care & protection of children in emergencies: A field guide* 2004: Save the children federation, p. 4-10.

connected to the wider social world. This is no less true in crisis situations than in normal daily life.

A holistic approach to child development, then, emphasizes the importance of viewing children as members of a dynamic social system, focusing not on the individual child but on the child interacting with the family, clan, community, ethnic group, and society. If war erupts and community destruction and family deaths result, there is a profound impact on children. Similarly, if families experience intense poverty and children are driven into armed banditry and crime, this fuels turmoil in the wider society. In settings where children's lives are already threatened by malnutrition and ill health, the occurrence of war or natural disaster disrupts the world as children know it.

Child development theory is an important component in considering psychosocial approach, as children will react to events and have differing needs depending upon their developmental status and stage. Development is guided by biological, temperamental, and cultural differences that are influenced by their environment. Babies and young children share a basic need to form a fundamental bond with their caretaker and receive adequate nutrition; children aged 6-11 years are developing feelings of empowerment and competence; children aged 13 years and older are seeking ways to form their individual identity distinct from their family.

It is important to note that the two phases of most rapid cognitive, physical and emotional growth and development are *early infancy* and *adolescence*. In early infancy, children must have consistent care, adequate nutrition, and an attachment to a primary caregiver in order to survive. In adolescence, the critical period of transition from childhood to adulthood, children's earlier development is consolidated and life-long attitudes, beliefs, values and behavior patterns are established. With this understanding of child development, two emergency approach priorities emerge: ensuring that infants have a primary caregiver and adequate nutritional support; and ensuring that the special needs, vulnerabilities, and capacities of adolescents are supported.

Children who have a healthy psychosocial status have been found to have certain capacities throughout their development that allow them to function normally even in environments of extreme duress. They include the ability to:
- Form stable and secure attachments to care givers
- Develop meaningful peer attachments, friendships, and social ties
- Maintain a sense of belonging
- Feel a sense of self-worth and value
- Trust others
- Seek opportunities for intellectual, physical, and spiritual development
- Maintain physical and economic security
- Have hope, optimism and a belief in the future

Enabling children to develop these capacities forms the basis of sound psychosocial approach.

Role of the family

The family is the fundamental social unit in almost all societies and plays a critical role in meeting basic human needs. Children depend on their families for their survival and for their well-being. A caretaker's illness, death, or separation deprives the child of the many developmental benefits of parental care. Every step should be taken during a crisis therefore to prevent families from being separated, or to reunite separated family members. Providing support to families allows them to offer stability and improved care to their children. It helps parents to feel confident and secure in their care-giving, which also improves children's psychosocial well-being. As a result, psychosocial interventions may provide support which targets not only children directly, but also their caretakers through parenting peer support, early childhood development activities or livelihoods support such as skills training. Ensuring that care givers have the time to care for themselves and their families in threatening environments is also integral to children's

psychosocial well-being, as care givers under extreme stress will not be able to provide essential support to their children. Establishing regularly scheduled activities for children and youth is therefore important not only for the child's own development and psychosocial recovery, but also to allow care givers time to tend to other important activities such as getting rations, engaging in social activities, or just relaxing.
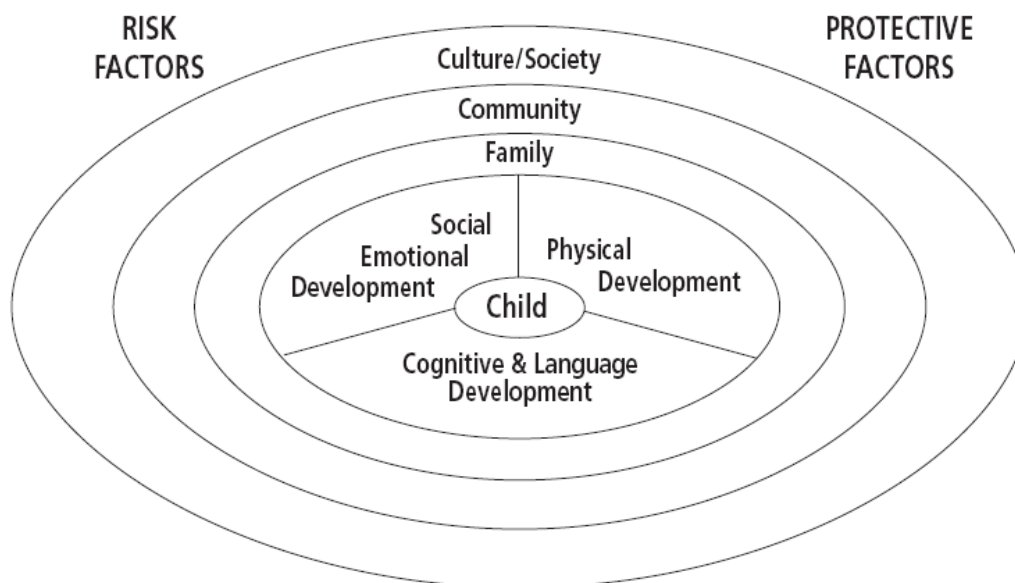
Role of the community
In all societies, families are the first to protect their children and help them grow into strong and healthy adults. But children also interact beyond the family circle through a range of social activities with friends, teachers, religious leaders, and other community members. This broad community interaction helps them build their identities and understand the cultural norms and values which enable them to become functioning members of their societies.

A child's understanding of the world is not only influenced by her direct experience of events, but also by her family, friends, and her community which help to interpret or "mediate" these events. A child's well-being and healthy psychosocial development are, then, dependent upon how she interacts within the broader social context of family, community, and culture. It is the rules, ideas, and explanations that accompany a child's experience which guide her behavior and inform her understanding of the world. When conflict erupts, there are far-reaching consequences at the community level as traditional structures erode, authority figures weaken, cultural norms and coping mechanisms disintegrate, and traditional support relationships disappear. In times of crisis, distrust and isolation become more common, making children even more vulnerable to psychosocial harm.

The social environment or "ecology" in which children develop plays an important role in their behavior, attitude, and sense of self. The diagram below shows the inter-related levels of support. Children interact within the nested social systems of family (including clan and kinship group) and wider society (including community institutions and religious and ethnic networks). A child's well-being and healthy development require strong and responsive social support systems at the family and societal level. Children develop and bring their own ways of understanding and adapting to a situation, but the degree to which they can find or draw on these coping mechanisms depends on internal as well as external resources. During times of crisis, these social support systems may break down temporarily. As children try to cope with extreme violence, loss, fear, and social upheaval, it is important to understand that their usual resources may no longer be at their disposal. To promote psychosocial recovery, it is essential, therefore, to not only support the child directly, but also attempt to restore these social and community mechanisms in order to provide the child with additional external resources and support.

Social Ecology of the Child[5]

RISK FACTORS

PROTECTIVE FACTORS

Culture/Society
Community
Family
Social Emotional Development
Physical Development
Child
Cognitive & Language Development

Resiliency

During conflict, emergencies, and other threatening events, some children are able to continue functioning more easily than others. These different reactions are common and the result of many factors including family and community support, past experience, and individual temperament. To describe those children who are able to cope more easily or even flourish in a rapidly changing environment, we use the term "resilient." Even in the face of extremely stressful circumstances, such as violence, loss of family members, and displacement, resilient children are able to draw on internal resources and external support to help them cope and adapt. Although all children react differently to stress, research has found that resilient children do share certain characteristics or protective factors which seem to protect them in the short term and help them avoid long-term negative psychosocial effects.

These factors are:
• Strong attachment to caring adults and/or peers;
• An ability to seek out positive, encouraging role models;
• Easy interaction with adults and peers;
• A level of independence and an ability to request help when necessary;
• Regular engagement in active play;
• An ability to adapt to change;
• A tendency to think before acting;
• Confidence to act or control aspects of his or her life or circumstances; and
• An active interest in hobbies or activities.
By strengthening these protective factors for all children, resiliency will also be strengthened.

These are characteristics that can be enhanced through a careful understanding of children's capacities and needs. Children's inherent resiliency can be strengthened by age-appropriate interventions which allow children to develop or augment these characteristics even in emergency settings, thereby creating a more protective environment for the child. The protective factors listed above include internal resources, such as confidence and judgment, as well as external resources, such as an ability to

seek out support and role models. This emphasizes that a resilient child is one who can call on a variety of support mechanisms when faced with new challenges.

Adopting the concept of resiliency in programming is extremely powerful for at least two reasons. First, it directs attention to the fact that all children have assets and strengths and leads to program design that builds upon them. Second, the concept of resiliency provides a hopeful perspective from which to work with children and youth. There is a strong tendency, especially in emergencies, to focus exclusively on problems and trauma, and forget that children, families, and communities also have strengths and competencies.

Take home exercise:
Formulate the risk and protective factors for other vulnerable groups in the camps, using the diagram of the social ecology.

MODULE PS 3.2: Principles of psychosocial support

Learning objectives
At the end of the Module participants will be able to
- Explain the essential principles of psychosocial support
- Explain the following concepts:
  - empowerment
  - community based approach
  - holistic approach
  - explanatory models
  - disease, illness and sickness
  - human rights
- Explain the ´do no harm principles´ and have participants provide examples from their own experiences

Time
4 hrs

Materials
Flip-chart, markers

Methodology for the trainer: Interactive lecture, brainstorming
a) Principles of psychosocial support (interactive lecture, 3 hrs)

- Interactive lecture: ask the participants to identify which principles should be taken into account when providing psychosocial support. Write the answers on the flip-chart. List those principles that are related to the concepts described here and modify the others using these concepts or add other relevant concepts.
  - empowerment
  - community based approach
  - holistic approach
  - explanatory models (refer to combined Modules and summarize)
  - Disease, illness and sickness (refer to combined Modules and summarize)
  - human rights
- Interactive lecture: for each concept follow the four steps below:
  - Explain the definition of each concept (see explanation in the Study Material for the trainer)
  - Ask participants for examples related to these key concepts. Be sure to have the participants explain the concepts in terms of their example to ensure adequate comprehension.
  - Encourage participants to suggest local metaphors from their community that encourage this concept: they should brainstorm for the meaning of each metaphor given. This helps to identify appropriate metaphors.
  - Ask one participant to give an example of a person with a specific problem. Ask the rest of the classroom to identify various groups of people who can be of help in such circumstances.
  - Brainstorm on the influence each identified helper can have on the person with the problem.

b) Do no harm (interactive lecture, 1 hour)
Unintentional harm (participatory lecture, ½ hour)
The trainer explains the following in his or her own words:
Staff in community services and health services try to assist people who have mental health or psychosocial problems. For this we have all kinds of intervention techniques as discussed in this training. However, our assistance can also cause unintentional harm. Sometimes the effects of our interventions may be significantly different than what we intended. Sometimes we try to help, but the result is to make problem even more severe

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or to create new problems as a result of our actions. We have to realize that this can happen and be open about the possibility. We must do our best to minimize the chance that our action exacerbates rather than improves the person's problems.

The trainer invites the participants to provide examples, they have witnessed or experienced, of psychosocial or mental health interventions that had a negative impact. List the examples given by the participants on the flip-chart by using key words.

Problem	Intervention	Intended outcome	Unintended outcome

Resource materials to use in this module
1. International Federation of Red Cross reference centre for psychosocial support materials. See website: http://psp.drk.dk
2. Inter-agency standing Committee materials. www.humanitarianinfo.org

Study Material 1: Module 3.2

Do No harm
If participants have difficulty expressing clear examples, the trainer can probe by giving hints or examples such as:

Example 1:
- Problem: A young girl has been raped by her cousin.
- Intervention: The psychosocial worker organizes a group meeting with all family members and neighbors to discuss this problem.
- Intended outcome: Family members are motivated to take action to prevent such problems from happening again.
- Unintended outcome: Some family members are angry at the girl for having shared family matters with outsiders. The brothers of the cousin side with him and threaten the raped girl saying that she is a liar and they will teach her a lesson. A serious family conflict arises and the whole family blames the girl for having caused this discord. Not only do the neighbors consider the girl to be a bad girl, but people in the street now call her a whore.

Example 2:
- Problem: A wife is repeatedly severely beaten by her husband.
- Intervention: The psychosocial worker tells the person that it is bad to divorce and she should endure, pray and hope the man will change.
- Intended outcome: The woman will have hope.
- Unintended outcome: The abuse continues and the woman feels worse because she is sure nobody can help her.
- What would have been a better intervention? (For example, help the woman to list all possible solutions for her problem and discuss the advantages and disadvantages of each with her. Once the woman has chosen a solution, make an action plan with her).

How can we prevent doing harm to our clients? (Interactive lecture, ½ hour)
There are many things we can do to prevent our interventions from causing harmful consequences. The facilitator discusses the following points, provides examples and asks participants to reflect on the material.

- Reflect on human rights aspects and how power relations can change because of your interventions. For example: programs for only women can sometimes have a paradoxical effect in which men feel left out and begin to misbehave even more towards their wives.
- Assess in advance whether an intervention can make clients become dependent and helpless. For example: sometimes our interventions give the client the impression that he or she is really worthless and always needs to be helped and guided.
- Participate in coordination groups to learn from other stakeholders and to minimize duplication and prevent gaps in services.
- Design interventions on the basis of sufficient information. If you do not have sufficient information, first collect all the information you require before you start an intervention. Example: If the problem is that a girl is not going to school, it may not be an appropriate intervention to start educating her parents that it is important to send their child to school. You first need to know *why* the child is not attending school. Maybe her parents think it is not important for a girl to be educated, maybe they fear that something bad will happen to their child in school, or maybe they need their child to do household chores, etc.
- Evaluate the results of interventions using participatory approaches. This can be done in an informal way. Example: you can ask the clients what they think can be done to improve the intervention. It can be done in a formal way, for example, by holding focus group discussions organized by external evaluators.

- Be sensitive to local culture and habits. Example: in some cultures it is considered inappropriate to talk openly about family related problems.
- Pay attention to gender differences and the way your interventions impact males and females.
- Organize regular training and supervision in state-of-the-art interventions.

Study material 2: Module 3.2

'Do No Harm' principle based on IASC.
Various ways to reduce harm to people who are being helped as stated in the IASC guidelines:
1. Participate in coordination groups to learn from others and to minimize duplication and gaps in response.
2. Design interventions on the basis of sufficient information.
3. Commit to evaluation, openness to scrutiny and external reviews.
4. Develop cultural sensitivity and competence in the areas in which you they intervene/work.
5. Stay updated on the evidence base regarding effective practices, human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches.

Study material 3: Module 3.2

Community-based approach[20]

Community

"Community" can be described as a group of people that recognizes itself or is recognized by outsiders as sharing common cultural, religious or other social features, backgrounds and interests, and that forms a collective identity with shared goals. However, what is externally perceived as a community might in fact be an entity with many sub-groups or communities. It might be divided into clans or castes or by social class, language or religion. A community might be inclusive and protective of its members; but it might also be socially controlling, making it difficult for sub-groups, particularly minorities and marginalized groups, to express their opinions and claim their rights.

Refugees and displaced persons living in temporary "communities" often have different nationalities, religions, languages, ethnicity, and backgrounds, and do not perceive themselves as belonging to any community. Whether they live in camps, in transit and reception centers, or in urban dwellings, lack of economic options, restrictions on freedom of movement and/or imposed decisions on accommodation often dictate who their next door neighbors will be. In some urban situations, internally displaced persons might prefer to keep their identities hidden, thus making it difficult to contact members of informal groups and mobilize people around common problems. In other instances, displaced persons living in urban areas might have assimilated well into existing sub-groups and may not need support. Working with displaced persons requires learning about members of the host community, who are also stakeholders, and addressing their concerns whenever feasible.

A community-based approach

A community-based approach is a way of working in partnership with persons of concern during all stages of UNHCR's program cycle. It recognizes the resilience, capacities, skills and resources of persons of concern, builds on these to deliver protection and solutions, and supports the community's own goals. The approach is not limited to a particular function or sector of work; it should guide all UNHCR staff and partners in their work with persons of concern. It demands that we understand and consider the political context, the receiving population, gender roles, community dynamics, and protection risks, concerns and priorities. It also requires that we recognize our role as trainers, our limitations in capacity and resources, the temporary nature of our presence, and the long-term impact of our interventions.

A community-based approach can help communities work to prevent social problems and to deal directly with those that do arise, instead of having external actors step in and assume these responsibilities. It supports persons of concern in re-establishing familiar cultural patterns and support structures. Indeed, the goals of the community-based approach are to reinforce the dignity and self-esteem of people of concern and to empower all the actors to work together to support the different members of the community in exercising and enjoying their human rights.

There are some of the difficulties in adopting a community-based approach. Ideally, the community freely defines its priorities. But the responsibility of the UNHCR and the implementing partners is to respect individual human rights and the goals of their agencies, and this might not coincide with community practices or priorities. UNHCR and partner staff must therefore work with the community to find ways to respond to the

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[20] This handout is copied with adaptations from: UNHCR, *A community-based approach in UNHCR operations*. 2008

priorities of the community and uphold their mandate to protect all of its members and respect individuals' rights.

In the daily work, this can mean introducing new practices, such as vaccinating children, educating girls, creating mechanisms for the fair distribution of food and assistance items, encouraging women to participate in decision-making processes, and preventing sexual and gender-based violence.

Meaningful participation

"Participation" refers to the full and equal involvement of all members of the community in decision-making processes and activities that affect their lives, in both public and private spheres. The level of participation will depend upon how rewarding people find the experience and whether they gain something from the process. Participation also requires that instead of "informing and deciding for people", we listen to them. Our role is to facilitate discussions and analysis with persons of concern so that they can identify their own priorities and preferred outcomes.

Participation:
- Is a right, and essential for informed decision-making;
- Promotes protection and reduces feelings of powerlessness;
- Enables UNHCR to draw on the insights, knowledge, capacities,
- Skills and resources of persons of concern; empowers women, men, girls and boys of different backgrounds
- To rebuild self-esteem and self-confidence; and helps people of concern cope with the trauma of forced displacement.

Without broad participation, only a few will decide for all, and those few might control information and resources. This can lead to abuse of power, including among refugees. Meaningful participation by all will often require special efforts to ensure that those traditionally marginalized, such as women, children, older persons, persons with disabilities and minority groups, are given support and specific opportunities to contribute. It might also be necessary to work with traditional leaders to encourage their active support. This is essential for avoiding token participation and failure, which reinforces marginalization and discrimination. In some settings, particularly in IDP contexts, some persons of concern might be unable or unwilling to freely express themselves in the presence of authorities.

A number of international legal standards emphasize the importance of the right to participate, particularly for women and children. This right is closely linked to the right to information: People must have opportunities to ask questions about their rights and, if necessary, to challenge the content and help determine what and how information is disseminated.

Age, gender and diversity analysis

An integral part of a rights- and community-based approach is analyzing the different realities people face because of their age, their gender, and their diversity, which relates to ethnicity, religion, disability, and sexual orientation, among other factors. Too often, a failure to consider the particular circumstances of each group has led to actions that have unintentionally resulted in further exclusion and discrimination.

Empowerment

Power can be defined as the capacity to make informed choices and have the freedom to take action. Empowerment is not something that is "done" to people; it is the process by which individuals in the community analyze their situation, enhance their knowledge and resources, strengthen their capacity to claim their rights, and take action to achieve their goals. At the same time, their capacities and skills are recognized by others.

Empowerment is gaining control of the decisions that impact one's life, as an individual or a group. This is mainly achieved by creating structures that allow people to regain control over some aspects of their life, a feeling of belonging and being useful[21]. Empowerment requires change at the individual and structural levels.
On a personal level, empowerment includes the ways a person increases his or her capabilities that lead to self-esteem, self-confidence, initiative and control.

On a community level, empowerment allows the community to analyze their situation, to define their concerns and to solve them, so as to fully enjoy their rights. A universal principle of helping is that giving assistance can cause dependence. Helping does not mean taking over from the person who needs help, but it means supporting the person so that he or she is able to function independently in the future. This means that we need to help the person to help him or herself. Effective helpers bear in mind that their role is temporary. The attitude is, therefore, aimed at building the confidence of the person needing help. If helpers take over from the person needing help, then the latter feel increasingly inadequate and thus more dysfunctional when they are on their own. Strategies to encourage empowerment should be in place from the beginning of the helping process. Psychosocial care focuses on the empowerment of communities by mobilizing utilized resources and strengthening and supporting pre-existing resources, such as community healers and existing support groups.

In all societies, there are some people who are more powerful than others because of age, gender roles, ethnicity, political affiliation, economic situation, or other reasons. During displacement, power relations shift. Sometimes those who had previously been excluded suddenly have an opportunity to be involved in decision-making processes. These various changes must be analyzed and understood.

Power relations between men and women are often based on gender roles, some of which might limit individuals' capacities to enjoy their rights. For example, some men are taught that, to behave "as a man," one has to be authoritarian and even use violence as a means of control. This can be a restrictive and negative experience, particularly if the men feel that they have to suppress their emotions, use force to command respect, and maintain a distant relationship with their children. Exploring the origins of that image of masculinity can provide an opportunity for discussing gender roles and power relations. These same dynamics may well influence how traditional leaders interact in the community, the expectations and frustrations of youth, and how traditional justice systems rule on such matters as domestic violence, divorce and women's behavior. Women will help sustain such systems if they believe that this is what "makes a man." Therefore, any changes in gender roles will require that women and men discuss how they would like to relate to each other and how this can benefit the family and the community.

Another important power relationship is that between humanitarian actors, including government partners, and the community members who rely on them to ensure appropriate use of resources.

Community empowerment can also result in the empowerment of humanitarian workers. Instead of working in an atmosphere of seeming mutual dependence, with the sometimes overwhelming feeling of impotence in the face of enormous challenges, humanitarian workers can be more realistic about their limited roles. Recognizing the capacities of members of the community will foster a more constructive relationship, based on mutual respect, with persons of concern. In turn, UNHCR staff and partners will become more effective in delivering protection and supporting solutions.

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[21] IFRC Reference Centre for Psychosocial Support and P. Hansen, *Psychosocial interventions - A handbook.*

A Holistic approach comes from a Greek word *holè*, meaning totality. In psychosocial helping, the holistic approach consists of treating an individual in his or her entirety. This approach shows that each individual is connected to various components around him or her that influence his or her character negatively or positively. In the same way, an individual does not live as an island. To better understand an individual in his or her thoughts, feelings, character, and social relationship, a community worker must take all influences into account to better assist him or her.

Schematically, it can be represented as follows:
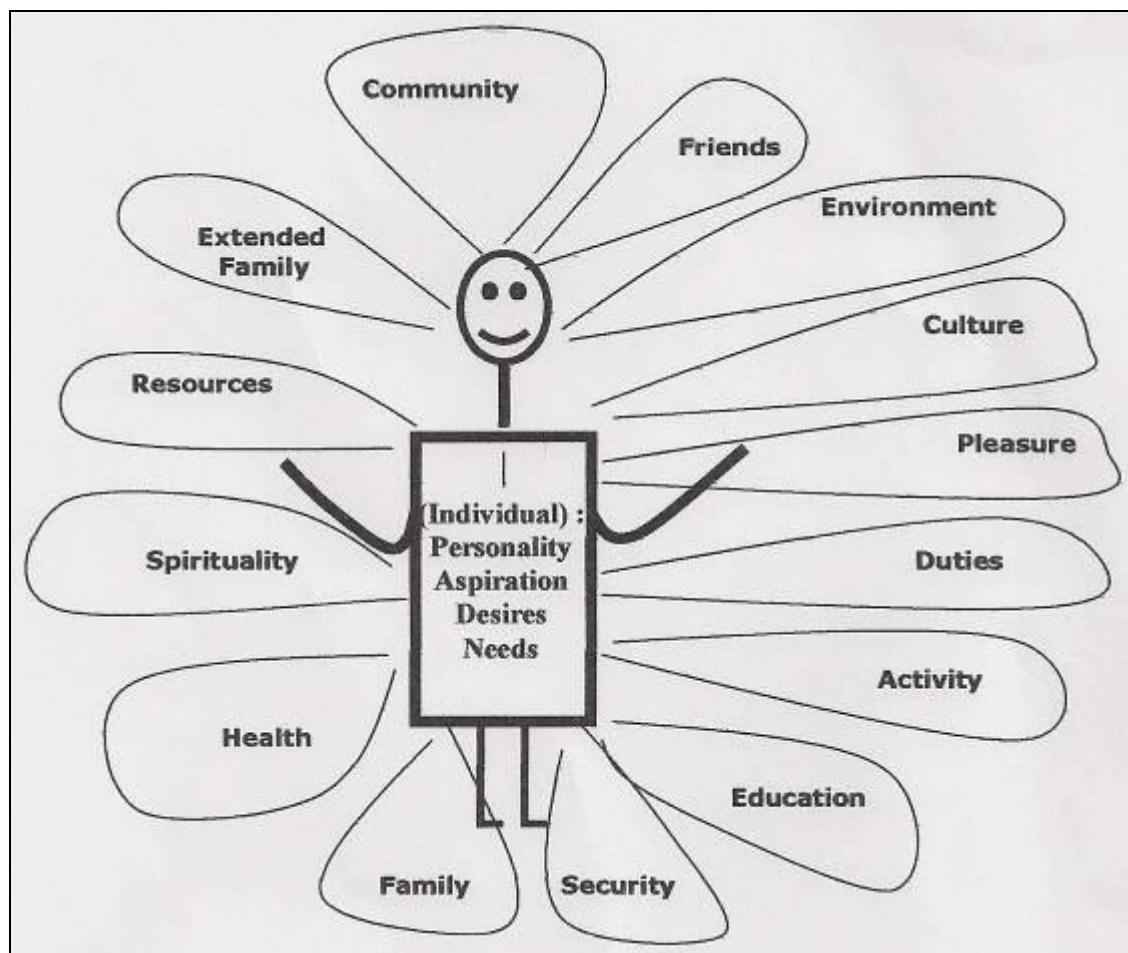
Guiding principles: A rights-based approach

A rights-based approach is a *conceptual framework* that integrates the norms, standards and principles of the international human rights system into the policies, programs and processes of development and humanitarian actors. It therefore focuses on both procedures and outcomes.

A rights-based approach is founded on the principles of *participation* and *empowering individuals and communities* to promote change and enable them to exercise their rights and comply with their duties. It identifies rights-holders (women, girls, boys and men of concern) and duty-bearers (principally the State and its agents), and seeks to strengthen the capacities of rights-holders to make their claims and of duty-bearers to satisfy those claims. This requires an attitudinal shift in how to work with and for persons of concern: They are no longer viewed as beneficiaries of aid, but as rights-holders with legal entitlements.

One of the most important roles of organization [s] is to support rights-holders to claim their rights. This requires major shifts in the way many agencies are working. Rather than delivering services and doing advocacy work on behalf of poor and disadvantaged people, a rights-based approach requires organizations to support people to demand what they are entitled to. … A rights-based approach demands that agencies work together to support broad processes of change in society. Supporting participatory processes that bring together government and civil society is one of the most effective ways to change relationships between rights-holders and duty-bearers[22].

Recommended principles for targeting psychosocial projects
In an evaluation of a group of psychosocial projects funded by the Norwegian Ministry of Foreign Affairs, the evaluative team recommended a number of principles for future project design.[23] These include:

- Focus on human rights: Policies that guide psychosocial projects should be anchored in the UN Universal Declaration on Human Rights and the Convention on the Rights of the Child.
- Focus on integrated approach: Projects should promote human rights, reconciliation, and psychosocial wellbeing by being integrated into a comprehensive approach to address the range of people's needs in complex emergencies.
- Focus on resources of beneficiaries: Interventions should be carried out with the participation of members of the affected community, recognizing the personal and professional resources that exist. However, caution should be exercised to ensure that some groups are not singled out for more or less assistance—which may stigmatize the benefited group, cause jealous reactions, or create new conflicts. Avoid "pathologizing" individuals by focusing on their trauma and problems, and instead work with them as "clients" or survivors of human rights violations.
- Focus on needs of the whole community: Interventions should be preventive while also providing support to those who have been exposed to severe human rights violations.
- Focus on several levels of psychosocial intervention: A wide range of interventions potentially affect the psychological and social well-being of people, from community development to mutual support building, to counseling. These may be implemented at the same time, and their collective purpose should include the facilitation of peace-building processes, the reduction of tensions between groups, and the diminishing social marginalization of human rights survivors.

Why use a rights- and community-based approach?
It builds or strengthened the capacity and autonomy of individuals and communities

- Community members take responsibility for analyzing protection risks and jointly developing protection strategies, assistance responses and solutions.
- It recognizes and supports the ways in which persons of concern protect themselves through their own social networks and community resources while ensuring individual rights.

It promotes respect for rights and the accountabilities of leadership strictures, agencies and states.

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[22] *Joachim Theis,* "Challenges for a Rights-based Approach," in *Children's Rights Information Newsletter*, No. 18, March 2005, p. 28.

[23] Agger, I., E. Jareg, A. Herzberg, J. Mimica, and C. Rebien. (1999). Evaluation of Norwegian Support to Psycho-Social Projects in Bosnia-Herzegovina and the Caucasus. Oslo: The Royal Ministry of Foreign Affairs. Arntson, L. and C. Knudsen, *Psychosocial care & protection of children in emergencies: A field guide* 2004: Save the Children Federation, p. 23.

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- Community members see that their systems are recognized, reinforced and respected.
- Persons of concern learn about their rights and can support gradual change through which practices that violate human rights are identified and openly discussed, particularly in relation to women and children.
- It clarifies roles and responsibilities in relation to rights-holders and duty-bearers, including humanitarian agencies and governments.

It underpins age, gender and diversity mainstreaming
- It improves understanding of the relations between women and men, different generations and the diverse groups within the community.
- It requires participation of all groups in decision-making processes and representative structures that respect the rights of individuals.
- It provides for age, gender and diversity analyses of the situation, of protection and program responses, and for targeted action to address discrimination.

It improves the quality and effectiveness of UNHCR operations
- UNHCR staff and partners are more likely to be alerted to protection problems in a timely fashion if a relationship of trust is nurtured.
- It ensures that activities are of direct relevance to the communities and will meet their various protection needs. Failing to understand a community and its ways of working can lead to inappropriate interventions that will fail.
- It reduces opportunities for exploitation and abuse.
- It generates an attitudinal change whereby refugees and other displaced persons, rather than external actors, are at the centre of decisions, responses and solutions, and their skills and contributions are recognized.
- It improves UNHCR's accountability to people of concern through participatory monitoring and evaluation.

It provides a basis for sustainable responses and durable solutions
- It improves understanding of the local context and allows the UNHCR operation to be more closely linked with other development initiatives and with government structures.
- It focuses on solutions from the beginning, in partnership with the community, and thus can reduce the potential for protracted displacement situations.
- By involving all members of the community, it leads to greater effectiveness and long-term sustainability of programming.

MODULE PS 3.3: Personal characteristics of a community and psychosocial worker

Learning objective
At the end of this Module, participants are expected:
- To identify characteristics of a person called to help people who are in difficult situations
- To identify own the weaknesses and strengths
- To recognize the motivation to be a caregiver
- To identify significant others' opinions about being a caregiver

Time
2½ hours

Materials
Flip-chart, markers and cards

Methodology for the trainer: (individual, group work, brainstorming and interactive lecture)
a) Group work (45 minutes):
Premier explanation: being a caregiver, one has to have skills. An effective caregiver needs not only skills but also good appreciation of himself. This self-knowledge needs for understanding the motivation to be a caregiver in order to have an effective process of giving the psychosocial help. Helping others is difficult work and requires a strong commitment. It is important to have knowledge of self. This self-knowledge is also needed for understanding the strength and weakness of self. It is very important for care givers to have their own lives under control. If someone hasn't cope with their own problem he/she will difficult to be empathy of other people's problems. It can be difficult to sense another person's feelings if your own problems fill your mind.
- Write down the following question for the participants on the flip-chart: "What are the characteristics of a person called to help others?".
- Instruction for group work: ask the participants to formulate and write down the characteristics in small groups. Organize groups by asking participants to count 1,2,3…., or use an alternative criteria to form groups. Allow room for questions for clarification. Each group assigns a moderator and a reporter. Indicate the venues where they can gather for the work in groups. Distribute cards and markers to each group (20 minutes).
- Group presentation (25 minutes): Each group presents what they have identified and explains why these characteristics are important. The rest of the class is allowed to ask questions for clarification or make comments.

B) Self-analysis. Premier explanation:
understanding self is related with the decision of being a caregiver. There are many motives to choose to be a caregiver. If we look further we will figure out that there are no pure altruism. No one helps solely in order to do good for someone else. Often people choose to help others because it makes them feel worthwhile. Sometimes people have suffered themselves and want to be kind to others to repay kindness that was shown to them. Other caregiver might have the reason to help in order to help him/herself. One has to understand his/her own motive in choosing to be a caregiver in order to prepare of the responsibility and commitment within the task. Helping others is difficult work and requires a strong commitment. It is important to have knowledge of self. Procedure in Self-Analyses: participant is given a questionnaire and answering it individually (see handout PS 3.3.). The question is a helping tool for participant in analyzing of his/her decision to choose to be a caregiver. Participants answer the question personally (40 minutes). After finishing the questioner, participants discuss it by group as follows:
- First: Each participant finds one partner to discuss about the answer of the questioner (10 minutes).

- <u>Second:</u> After the first step is finished, the participants go back to the big group and discuss about the difficulties of communicating personal detail with someone new. How hard to trust somebody that we just new. Trust leads the roles of discloser in communicate.(15 minutes)
- <u>Third:</u> Each of the participants finds the partner that he has known for a period of time. Then each of the partners shares their information about the strength he/she knows about his/her partner. This sharing is possible, as they have known each other for a period of time. They can share the strength of his/her partner that might not recognize by him. After finished the this step, then all participant join to the forum and share about the discussion. (10 minutes)

C) Participatory conclusion (30 minutes):
Summarize and encircle or write down the most important characteristics for the participants. See handout of module 3.3. Trainers together with participants take a conclusion about this Module. The conclusion is needed as a remainder of the content of the Module. In this Module, it is important to understand that there is many reason in choosing to be a caregiver. There are also many factors that influence the decision of being caregiver. From this Module, participants are able to recognize his/her strength-weakness-motivator-biases-inhibitor and other factor that contributes in the decision to be caregiver. This self-knowledge can strengthen the decision. "He who has a Why to live for, can bear with almost any How". The trainer makes a common list of all the idea.

Resource materials to use in this module
- International Federation of Red Cross: Reference centre for psychosocial support materials.
- Baron, Nancy. *Basic Psychosocial Awareness And Intervention Strategies*. 2000
- *Manual of Mental Health Refugees*, Published by the World Health Organization in collaboration with the office of the United Nation High Commissioner for Refugees.
- Community Mental Health in Cambodia, Published by the Transcultural Psychosocial Organization (TPO) Cambodia, 1997

Study material 1: Module 3.3

Self-Analyses:
There are many motives to choose to be a caregiver. If we look further we will figure out that there are no pure altruism. No one helps solely in order to do good for someone else. Often people choose to help others because it makes them feel worthwhile. Sometimes people have suffered themselves and want to be kind to others to repay kindness that was shown to them. Other caregiver might have the reason to help in order to help him/herself. This questionnaire is a helping tool for participant in analyzing of his/her decision to choose to be a caregiver.

Participants answer the question personally.
- Why do I choose to be a caregiver for others?
- What do I get for myself by helping others?
- What strengths do I have that allow me to be a good helper for others?
- What weaknesses do I have that might block me to be a good helper for others?
- What does my family feel about me helping others?
- The external factors that might be an obstacle for me in helping others and other barrier that can interrupt the process.

For example: *A woman wishes to become a caregiver. She has tried to join activities of mothers in the community but the mothers wouldn't accept her. She was rejected by the mothers and did not understand why. After trying to understand why, she learned that the mothers rejected her because of her husband who is an activist and one of the targeted people that the army has been looking for. The mothers are afraid of the potential impact. Her husband in this case is an obstacle for her to become a caregiver.*

- Discuss here the above situation and what assumptions and implications led to this woman not being able to become a caregiver.

For example: *Henri, one of the caregiver meets Alin, a 9 year old boy in the refugee camp. Alin is having depression because of his parents and his brothers haven't been found. Henri is unwilling to help this child because of his dislike based on his previous experience with Alin's ethnic group in his neighborhood.*

Study material 2: Module 3.3

The following characteristics, among others, are necessary to offer quality assistance

Empathetic	Calm manner
Non-judgmental attitude	Positive attitude to life
Dependability	Openness
Honesty	Respect for others
Genuine caring	Self confidence
Clear thinking	Good sense of humor
Common sense	Flexibility
Self-awareness	Warmth
Healthy	Reliable
Attentive	Simple
Tolerant	Good communicator
Supportive	Good listener
Resourceful	Others

Base on the personality care givers above it reflects that:
- Caregivers must fully respect the person they are trying to help, regardless of values and beliefs. Caregivers must recognize the differences between them and the person they are helping, and they must respect these differences.
- Caregivers should try to empathize with the person they wish to help. This means trying as best as they can to imagine themselves in the person's position and trying to understand how that person sees the world. How does this person feel about his/her life? How does this person view the world? What is best for this person to do?
- Caregiver shall not assume that they know the way another person feels because that is how they would feel. Each person has a unique life history and a particular set of values, needs, desires and beliefs. Caregivers give full respect of other's value, needs, beliefs, and desires. Let these differences not becoming the prejudice of other.
- Caregiver should not try to judge or control other people's life instead on giving the trust for the person to rule their own life. Caregiver is only takes part of giving companionship and support for them.
- This understanding can be base of guidance for caregiver in doing the process of helping.[24]

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[24] Baron, Nancy. *Basic Psychosocial Awareness And Intervention Strategies*. 2000

THEME 2: PYSCHOSOCIAL SUPPORT: Foster mutual support and self-help

Description of the participants
This part is meant for specialized psychosocial workers and general community workers. However, some modules of this module are intended for participants who are general workers only whereas other sections are intended for specialized psychosocial workers only.

General objective
At the end of the Module the participants are expected:
- To explain psychosocial interventions used in a psychosocial response such as: psycho-education, awareness-raising, support groups, referral, and advocacy.
- To identify interventions to be used that are based on a situation story.
- To use practically focused counseling skills.
- To use practical psychosocial interventions.
- To use basic communication skills.

Time
5 days

Methodology
Discussion, brainstorming, case study, role play, interactive lecture

Materials
Flip-chart, markers

This part consists of 7 Modules:

	THEME 2: PYSCHOSOCIAL SUPPORT: Foster mutual support and self-help		5 days
3.4	Basic communication skills	general community workers and specialized psychosocial workers.	4½ - 8 hours
3.5	Introduction to problem -solving counseling	specialized psychosocial workers	3 hours
3.6	Family problem -solving counseling	specialized psychosocial workers	3¼ hours
3.7	Group problem -solving counseling	specialized psychosocial workers	3 hours
3.8	Referral and advocacy	general community workers and specialized psychosocial workers	1½ hours
3.9	Awareness-raising / sensitization and Psychosocial education	general community workers and specialized psychosocial workers	3½ hours
3.10	Support groups	general community workers and specialized psychosocial workers	3 hours

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MODULE PS 3.4: Basic communication skills

Learning objectives
At the end of the Module the participants are expected to:
o   Understand the importance of active listening skills
o   Use active listening skills in their work
o   Use basic communication skills in role play activities
o   Help the participants clearly observe and understand what is required for good communication when helping people

Time
4-8 hours

Materials
Flip-chart, cards, markers

Methodology for the trainer: Role play, micro lecture, discussion, observation, demonstration, interactive learning

a)   Introduction
Introduce the topic for today "Communication skills" and briefly explain the following:
"Communication skills are broadly divided into two parts. Namely, basic communication skills and advance communication skills. Basic communication skills are the foundation for any helping relationship whether it is counseling, or psychotherapy, or social work or general medical practice. Whereas, advance communication skills, as the name suggests, are advance in terms of their use and relatively difficult to learn. Advance communication skills are generally used in problem solving counseling along with basic communication skills. Further, basic communication skills are put under active listening skills because active listening is possible only by the use of basic communication skills that means when we say active listening we mean basic communication skills."

Listening exercise (30 minutes)
Split the group in pairs. The couples talk to each other about something that is important to them (for example a relationship, a problem, their job etc) for about three minutes. After the first person has spoken for three minutes, the couples change roles. Return to the large group and discuss the exercise:
•   How did you feel when the other person listened to you carefully?
•   How did you know that s/he was hearing you?
•   In what way did she or he show that she or he was listening to you?
•   How did you feel when the other person did not listen to you?
•   How could you tell that s/he was not listening to you?

During the discussion, on the whiteboard or in a flip-chart, list the skills used by the participants under verbal and non-verbal responses (skills). After the discussion is over summarize the skills they have used and briefly explain that active listening is possible only through the use of verbal and non-verbal ways (skills) of communication.
•   Briefly explain (micro-lecture) the importance of nonverbal communication
•   Present the list of nonverbal communication skills and explain all the skills (see Handout for Module PS 2.2.).

b)   Role play by trainers (demonstration role play, observation, discussion and interactive learning, 2½ hrs)
•   (The trainers) Prepare a role play for bad listening and one for good listening in advance; but the case must include the daily activities or experiences of the participants. Share the case with participants. Invites a co-trainer and performs a role play using the prepared situation. First show an example of bad listening, little

empathy, and inadequate questioning. Show a lack of concern and add confusion during the role play.

- Ask the participants to note the weaknesses in the communication they have observed. Writes down the observations and ask the participants to comment or give examples of similar situations from their own practice.
- (The trainers) Repeat their role play; however, this time, they demonstrate good communication skills.
- Ask the participants to make comments and compare the second role play with the first role play, and to consider the key concepts discussed at the start of the module.
- Ask the participants to decide the best ways to use communication strategies in the future and the reasons they have chosen these approaches.

c)   *Basic communication skills: Practicing community skills (role play, observation, discussion, 1½ hrs)*
- The participants form trios for further practice to master skills. Ask each group to perform a role play on basic communication skills. One participant plays the caregiver, one the client and one is an observer. The time is divided as follows: 10 minutes role play and 5 minutes feedback from the observer, then change roles and continue till all participants have played the role of the caregiver.
- After the role play exercise, bring the participants together to comment on their general findings and ask questions.

Key message
It is important to discuss with the participants that the skills are not the helping process itself, but rather they are essential tools for developing relationships and interacting with clients. They are not ends in themselves, but a means or instrument to be used to achieve outcomes.

Resource materials for this module
The interventions described here is based on the work of Gerard Egan, The skilled helper: a problem management approach to helping. Egan's approach is useful in helping people solve problems and develop opportunities. The goals of using the model are to help people 'to manage their problems in living more effectively and develop unused opportunities more fully', and to 'help people become better at helping themselves in their everyday lives.' (Egan G., 'The Skilled Helper', 1998, p7-8). There is an emphasis on empowerment, which makes this approach useful for refugee settings. Also the person s own agenda is central, and the model seeks to move the person towards action leading to outcomes which they choose and value.

As Study Material you will find a five page introduction to this model that will help you as trainer to get familiar with this model of basic problem solving counseling.

- Patrick JM Nelson (non dated) An Easy Introduction to Egan's Skilled Helper Solution Focused Counseling Approach http://www.mystrongfamily.org/downloads/PDFs/SFP-EasyIntroToEgan.pdf

For those who want to read more we advise to buy to full book:
- Gerard Egan (2009) The Skilled Helper, International Edition. Wadsworth

Study material: Module 3.4

Introduction of the Basic Communication skills
These skills are not the helping process itself, but they are essential tools for developing relationships and interacting with clients. They are not ends in themselves but means or instruments to be used to achieve outcomes. The following basic communication skills are important:

1.Attending
Refers to ways that helpers can be with their clients both physically and psychologically. Effective attending does two things: it tells clients that you are with the client and it puts you in a position to listen carefully to their concerns.

The skills of attending can be summarized in the acronym SOLER. The letters stand for:
- ***S:** Sit squarely*
Face the client squarely, which means adopting a posture that indicates involvement. Sitting in "L" or 90 degree position is often considered to be appropriate (culture sensitivity). Sit in equal position. If you are sitting on a chair let the client sit on the chair and if you are sitting in the floor let the client sit in the floor. This makes the client feel equal and respected.
- **O:** *Open posture*.
Always ask yourself: To what degree does my present posture communicates openness and availability? Be culture sensitivity. In some cultures crossed arms and crossed legs can be signs of lessened involvement with or availability with others. An open posture can be the sign that you are open to the client and to what she or he has to say. It is very important to be aware of your posture and ask yourself, whether or not your present posture is communicating openness and availability to the client. But if your legs are crossed, this doesn't necessarily mean that you are not involved with the client.
- **L:** Leaning
A slight inclination towards a person is often seen as saying, "I'm with you, and I'm interested in you and in what you have to say". Leaning back can be a way of saying, "I'm not entirely with you" or "I'm bored". So you can lean slightly towards you client while listening and show your interest in what the client is saying. Leaning too far forward, however, or doing so too soon, may frighten a client. The way you do it should of course also be cultural sensitive.
- **E:** Eye contact
While talking to the clients, look at them. Make frequent and soft eye contact, but be particularly aware of different cultural practices with this behavior. Maintain eye contact in a natural fashion. Don't make the client feel that you are staring and make sure that the client is not feeling uncomfortable due to your eye contact. At the beginning of the Module, it is good to have less eye contact to make it comfortable for the client and more eye contact as the Module progresses and rapport is built.
- **R:** *Relax*
During the helping process try to be relaxed. If you are not relaxed then you may be fidgeting nervously or engaging in distracting facial expressions. The client may wonder what's making you nervous. Seeing you relaxed might help the client to be relaxed. Also, if you are relaxed you can think, focus and understand the client better. Try to be relaxed or natural.

There are 4 important things when you attend to a person:
- Not fidgeting nervously or engaging in distracting facial expression.
- Becoming comfortable when using your body as a vehicle of contact and expression. The helper needs to look relaxed and natural. As a trainer the community worker leads the conversation calmly and with total confidence. The client hears the words and interprets the helper's movement, tone of the voice, facial expression and others.

- Awareness of your body as a source of communication does not mean that you <u>are preoccupied</u> by your body as a source of communication, but you <u>learn to use your body as a means of communication.</u>
- Social-emotional presence: showing a clear cut willingness to work with the client through both your verbally and your non verbal behavior

2. Active listening

In active listening, it is important that the speaker feel that listener is empathetic and accepting. A good listener tries to understand how the other is experiencing the contact and to shape his or her responses so that speaker understands why the listener is responding in a certain manner. Furthermore, the listener must be prepared to meet the wishes of the speaker. It is important to listen carefully, all through the helping process, to what the client is saying both verbally and nonverbally. Complete listening involves 3 elements:

- Observing and reading the client's nonverbal behavior.
- Listening to and understanding the client's verbal message.
- Listening to the context, the whole person in the context of the social setting of his or her life.

3. Empathy

Empathy is the capacity to recognize and, to some extent, share feelings (such as sadness and happiness) that are being experienced by the clients. Empathy as a communication skill enables helpers to communicate their understanding to the clients. Empathy is directly therapeutic. It contributes to the success of the overall helping process. It involves:

- Listening to clients
- Understanding their concerns
- Communicating with them so they have increased self-awareness and ability to act

Through empathy:

- You build a working alliance with the clients.
- Help clients explore themselves and their concerns. When clients are understood, they tend to move on, to explore issues more widely and deeply.

4. Probing

The purpose of questioning is to help clients to focus and be specific about their feelings or the problems they experience. For example, asking open questions will help clients to express what they feel and will help them to understand their behavior. Probing is invasive; it declares your perception of what is important to address. Probing is neither wrong nor inadvisable if used sensitively. Without asking questions, formulating statements or requesting clarification or missing parts, the consultations have the potential of becoming vague or directionless.

MODULE PS 3.5: Introduction to problem-solving counseling

Learning objectives
At the end of the Module the participants are expected to:
- Identify two key elements of counseling.
- Use practical and basic counseling skills, using role play.

Time
3 hours

Materials
Flip-chart, markers, cards

Methodology for the trainer: reading, participatory lecture
a) Discussing principles of counseling (1 hour)
Give the handouts on counseling to the participants for Module 2.2. Ask the participants to read the definition, the purpose and the principles of counseling. Discuss with participants the most important key statements for each point. Allow the participants to ask questions and make clarifications.

b) Role play by the participants (2 hours)
- Prepare an event and ask two participants to come forward. One of them takes the role of a community worker and the second person is the client. Ask the rest of the class to carefully observe the role play about individual counseling. After 10 minutes, ask the actors to stop the role play. Thank the actors for their effort.
- Ask the participants to comment on the role play. Start by listing positive elements followed by elements that need improvement.
- Ask participants to define what they mean by counseling. Write down all the answers and stress those that include elements such as dialogue, conversation, question asking, feedback, and others.
- Ask participants what they want to achieve when they organize counseling Modules. Write down all the answers and make corrections as needed.
- Ask participants the best ways to conduct a good counseling Module. Write down the answers and encourage the participants to react to the given statements.
- Have the participants form trios for further practice to master counseling skills. All three participants in a trio have to play the role of the helper, the client and the observer. After every role play, the observer discusses the strong elements and the aspects that need improvement. The helper and the client briefly express how it felt to be in their role. Next the participants change roles (10 minutes role play and 5 minutes evaluation per setting).

Study Material for trainer for Module 3.5.
This section is based on the chapter 'A problem management approach to helping' from:
- Gerard Egan (2009) *The Skilled Helper*, International Edition. Wadsworth. (For those who want to read more we advise buying the book.)

Resource materials to use in this module
- Sapkota, R.P., Danvers, K., Tol, W.A., & Jordans, M.J.D. (eds.) (2007). *Psychosocial counseling for people affected by armed conflict in Nepal: A trainer's manual*. Kathmandu; Sahara Paramarsha Kendra/USAID

Study material 1: Module 3.5 [25]

1. Definition of Counseling

Counseling is a technique of exchange and communication between an intervening party and his client where the intervening party helps his client to find some solutions to his/her problem. The intervening party encourages his client to speak of his/her problem, he gives emotional support, he asks clear questions to really know the core problem and finally helps his client to come out of his/her problem by the execution of a plan of action established in common agreement between the two parties.

What counseling is not:
- To give the orders, or commands, or to put a pressure on the client.
- To terrorize and give some attentions.
- To index or demoralize.
- To judge and criticize.
- To lack interest to answer.
- To educate when is not appropriated.

Difference between giving advice and counseling
Theoretically, to give an advice, it is to give a straight answer to someone else after he has exposed his problem. Your interlocutor doesn't take an active part in searching for solutions. Whereas counseling means that the person who exposes the problem is totally involved in the resolution of the difficulties in which she is confronted.

2. Purpose of counseling

Counseling Modules help the interlocutor:
- To understand what happened to him.
- To surmount the feelings of guilt.
- To express his anger.
- To become aware that he is not responsible of the threatening situation.
- To benefit from the networks and the services of support.
- To analyze, with the help of the community worker, the needs and the possible solutions to the problems.

3. Principles of counseling

- *Building* a *trusting helping relationship*: The helper cannot help a person when there is no trust between the helper and the one who is helped. Before doing counseling, it is a prerequisite to start establishing the relations of mutual trust first. People feel free and ready to share when they feel the person they are talking to are trustworthy. For example: Start by greeting the person, give him a seat and introduce yourself and the work you do. Tell the client to briefly introduce himself, guarantee the confidentiality as part of the ethics of the work, if they are people around the venue, set a separate place for discussion that guarantee the confidentiality.
- *Confidentiality*: It is necessary to respect the private life of the person to be assisted. It is necessary to reassure him that all information discussed will be kept between the helper and the assisted person. Information can only be shared with permission of the assisted person
- *Self determination*: The person can take her real decisions. The helper's role is to give the options and the opportunities, or to help the person to explore the best alternatives in relation to his/her capacities.

- *Positive approach*: Every time, it is necessary to recognize the positive initiatives and to reward them.
- *Exploration of the feelings*: To discuss on the feelings to attend better. To help people to speak of their feelings has a therapeutic effect. Unexpressed feelings can become destructive and can lead to somatic complaints in the long run. Expressing one's emotions often brings relief.
- *Show empathy*: To try to enter the client's world. The principle gives a room to offer the emotional support.
- *Unconditional acceptance*: The assistant must accept the person without conditions.
- *To be open*: The community worker must appear open and available towards the interlocutor.
- *To have techniques of conversation*: The helper must have some communication skills, be able to make summaries, to reflect, and must have good attitudes.
- *Perspective of the person*: Respect the situations, the person's expressions and to take them into consideration.

4. Important points in the process of counseling: a summary
a. Empowerment.
Psychosocial empower those in need and promote self sufficiency.
Ways to do it:
- Show respect to the assisted individual/groups (when an individual is respected by a community worker, s/he feels good values him/herself).
- Show compassion.
- Appreciate the initiatives already undertaken.
- Never judge or blame your client.
- Encourage the individual to construct his/her self esteem.
- Encourages people to develop their own facilities to help themselves.
NB The process of empowerment/autonomy is continuous. The community worker must help the interlocutor to always explore on his resources and utilize them although the helping module.

b. Building a trusting helping relationship
Ways to build confidence:
- Show that you are interested and are concerned by the problems of your client.
- Show him respect.
- Show an attitude of confidentiality.
- Maintain regular contact with your client.
NB: The process to construct mutual trust is continual.

c. Empathy
Empathy is the capacity to recognize and, to some extent, share feelings (such as sadness or happiness) experienced by clients. It involves:
- Listening to clients
- Understanding their concerns
- Communicating with clients to increase their self-awareness and ability to act

Empathy, as a communication skill, enables helpers to communicate their understanding to clients. Empathy is in itself is therapeutic. It contributes to the success of the overall helping process. Through empathy you:
- Build a working alliance with clients
- Help clients explore themselves and their concerns. When clients are understood, they tend to move on, to explore issues more widely and deeply

d. Attentive listening
Ways to listen attentively:
- Maintain eye contact without fixing the client (cultural sensitivity).
- Do not interrupt the person when he speaks.

- Sit down face-to-face (cultural).
- Avoid creating distractions.
- Encourage your clients by gestures, a glance.

What do you listen to?
- The words that are used.
- The tone of the voice.
- The movements of the client body.
- The silence.
- Lack of words (or expression).

e. Active listening
In active listening, it is important that the speaker feels that the listener is empathetic and accepting. A good listener tries to understand how the speaker is experiencing the contact. A good listener shapes their response so the speaker understands why the listener responds the way they do. Furthermore, the listener must be prepared to meet the wishes of the other person. It is important to listen carefully, throughout the helping process, to what the client is saying both verbally and nonverbally. Active listening means hearing verbal message, perceiving non-verbal communication and responding appropriately to both. Active listening is more than just paying attention to what is said. Active listening means being able to focus and concentrate, to summarize and reflect, to ask relevant questions and be silent, to give respect and structure. Active listening means not only the use of one's sense of hearing but all the senses. In other words, it means being responsive and communicating that you are following what the person speaking means.

Complete listening involves 3 elements:
- Observing and reading the client's nonverbal behavior
- Listening to and understanding the client's verbal message
- Listening to the context; the whole person in the context of the social setting of his or her life

Active listening - why?
- Facilitates and stimulates communication and expression.
- Makes the client feel understood.
- Respects the client's problems and feelings and takes the individual seriously at all times.
- Enables the client feel our warmth, acceptance and gives attention to the client.
- Helps the client express his or her pent-up feelings/emotions.

Active listening- how?
- Seek first to understand, then to be understood.
- Concentrate on what is being said and how it is being said.
- Be aware of your own biases or values; they may distort what you hear.
- Listen and look for the feelings and basic assumptions underlying remarks.
- Do not rehearse your answers while the other person is talking.
- Do not interrupt, especially to correct mistakes or make points and pause to think before answering.
- Clarify the message and describe the situation without judging it.
- Avoid expressions of approval or disapproval, but affirm that you understand.
- Do not insist on having the last word.
- Use non-verbal and verbal communication skills.

f. Probe for all necessary information
In order to truly understand people's difficulties and to begin to help them, helpers must get a lot of information. To get this information community worker must ask questions and probe for details from the clients.

Information seeking skills:
- Questioning: questions that require a yes or no answer provide little information. An open statement that probes for information is more beneficial like:<please tell me about what frightens you>.
- Probing: Ask questions calmly and slowly. Don't push and avoid sounding like an interrogator.
- Leading: The community worker leads the conversation to get all of the information but still follows the client talk at his pace.

g. Affirming

It is very important that you are affirming every time when client says something. This makes the client feel that you are interested and you are listening what she or he is saying. Affirming can be done by nodding your head and by humming (saying ah... hah) or simply you can say *YE* or *HAZUR.* Be natural because too much of or mechanical affirming might irritate the client; it must be cultural appropriate.

h. Silence

Keeping silence is one of the very important skills used in the contact with the client. Often care givers are afraid to keep silence during the Modules, not knowing that it is a necessary skill. Keeping silence gives you and client time to think, organize the information, understand it and respond better. You can even keep silence for a while when you are stuck and have nothing to say or the client is being reluctant. If you keep silence for longer time (e.g. 4-5 minutes) often client initiates the conversation. So it is good to keep silence at times.

i. Observation

The caregiver should be constantly aware of the client and of self. Clients tell us about their world by nonverbal means. Observation skills are a critical tool in determining how the client interprets the world. You should be able to identify these discrepancies, to name them appropriately, and, sometimes to feed them back to the client (observe and reflect).

What to observe?
- Non-verbal behavior (client's eye contact patterns, body language, and vocal qualities, facial expressions - brow furrowing, lip tightening or loosening, blushing etc)
- Discrepancies and these discrepancies may be between nonverbal behaviors, between two statements, between what clients say and what they do, or between statements and nonverbal behavior.

j. Encourage expression of feelings

If feelings are not expressed, the client remains with his/her problems and this can lead to emotional disturbances.
Indeed, all people who often need help find it hard to express their feelings especially when the client has not yet build trust. Finally, the community worker should encourage people to express their feelings to free themselves emotionally.

k. Provide emotional comfort and support

Some ways to provide comfort and support:
- Use a kind, calm and gentle voice.
- Use your body to show your interest. Sit closely and lean towards the person This is cultural sensitive. In some cultures, sitting face to face when you of opposite sex or of different ages may be interpreted as an offence. Distance between two individuals engaged in a discussion is significance in some cultures.
- Use your facial expression to show your concern.
- Respond to how the person feels, not how you feel.
- Be sincere, don't overdo your concern.

5. Assess the problems

Often the client has multiple problems and finds it hard to express his/her problems because he/she feels embarrassed or lacks trust in the community worker.
Ways to proceed:

- What kind of assistance does he want to receive?
- How do thoughts, feelings, desires and the client's behaviors contribute or accentuate the problem?
- How did the situation in the life of the individual or the other difficulties prevent for a long time that the solution of the problem is found?
- What is the impact of the family and the community on the individual?
- What has already been tempted to help the customer?

6. Develop a plan of action

The community worker and the client develop a plan of action or the plan of treatment together.
In their progression of the plan they have to:

- Inventory the strengths and the client's weaknesses.
- Prioritize the problems.
- Determine the goals.
- Establish a plan including strategies to accomplish the goals and a timetable for accomplishment.

7. Step by step implementation of the plan of action

Once you have prioritized the problems, start the solving process beginning with the problem which is more hurting.

10. Follow-up the success of the plan of action

After achieving goals, people continue to periodically need support and reassurance. The community worker will make periodic visits until the client feels confident with his independent ability at problem solving.

11. End the helping process

A helping relationship can end if:

- All the goals accomplished.
- Some of the goals accomplished.
- Effort made but no improvement.
- The client is able to work independently or the client is referred.

Study material 2: Module 3.5

Verbal communication skills[26]
Verbal communication means the exchange of messages through words or phrases. It has to do with the contents of what we are talking about, the words that are spoken.

List of basic verbal communication skills
I. Questioning
II. Paraphrasing
III. Repeating key words
IV. Summarizing
V. Reflection of feeling

I. Questioning
   Questioning skills – why?
   - A major component of active listening
   - Helps start the conversation
   - Helps explore, to clarify or further define some issues
   - Provides a systematic way for understanding different
   - aspects of clients life
   - Helps guide the conversation
   - Helps produce new information

   Questioning skills – How?
   Closed questions
   These questions are useful at the beginning of the conversation, to gather information. These questions call for a specific response however be careful because these questions limit the client in his\her response. These types of questions are used to gain factual information and can be answered in a few words or sentences and often begin with is, are, do and usually elicit "yes" or "no" response. For example: *Do you like it here? Do you often do that? Is that good for you?*

   Open questions
   These questions stimulate the client to structure his\her thoughts and explore the situation and enables the client to give any answers in his\her own words meaning that these questions allow client to speak freely and openly and also gives the room to express thoughts and feelings. These questions cannot be answered in few words and generally begin with what, how, or could. For example: *Could you tell me more about how you felt? How did you feel at that time? What were you thinking at that time? What would you like to talk about today?*

II. Paraphrasing
Paraphrasing – why?
- Confirms that counselor has listened to and understood the client
- Gives the client an opportunity to correct any inaccuracies
- Helps the client organize disjointed thoughts
- Helps the client to continue a certain topic
- Helps the client explore his or her problems in a less forceful and directive way that direct questioning techniques

Paraphrasing – how?

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[26] Copied with adaptations from: **SAPKOTA, R.P., DANVERS, K., TOL, W.A. & JORDANS, M.J.D. (EDS.)**

(2007). *Psychosocial counselling for people affected by armed conflict in Nepal: A trainer's manual.*

Kathmandu; Sahara Paramarsha Kendra/USAID, pag, 50-59

Paraphrasing is to repeat in short a client's statement in your own words. It can be in the form of statement or a question. A caregiver restates client's words and ideas in own words (not the same as repeating or parroting what the client says). It focuses on immediate statements without adding to or altering the meaning of the client's statement. For example: *"You say that you have had difficulties in the relationship with your husband for quite some time now and that it is therefore difficult for you to concentrate"* am I right? *"If I understand what you are saying is, you want to quit your leave your husband but you are not sure of the consequences of such an action".*

III. Repeating key words
Repeating key words – why?
• To encourage the client to continue talking
• To give emphasis to a particular topic
• To gather more information on key issues

Repeating key words – how?
The caregiver repeats the words or part of the sentence that the client has just said. These are words or parts of a sentence that were emotionally charged or important in content. The caregiver repeats these words if she or he wants to explore more or to encourage the client to talk more on that topic. For example: Client: *"I feel so fed-up and hopeless these days; I feel nobody is helping me and no one cares about me.* Caregiver: *"you said nobody is helping you?"* or *"you feel hopeless?"* or *"no one cares?"* or *"hopeless, Could you explain that a bit?"*

IV. Summarizing
Summarizing –why?
• To provide focus and direction to the client and/or the problem.
• To check if you, as a listener have understood the story and the message of the client.
• To give the client the feeling that you really are listening to him/her.
• To encourage the client to continue talking.
• Often when scattered elements are brought together the client sees the "bigger picture" more clearly.

Summarizing – when?
• At the beginning of a new Module (starting from second Module)
• In the course of Module that is going nowhere
• When the client (or caregiver) gets stuck
• When there is too much information and caregiver needs an overview
• Summarize the story of the client after each part and subject of conversation (only when there is sufficient new information).

Summarizing – how?
Summarizing is similar to paraphrasing except that a longer time and more information is involved. Summarizing includes enumerating the key thesis, recapitulation of the conversation thus far, and reformulating a longer statement into shorter, more direct form. For example: "so you are saying that…" or "so far, we have talked about…" or "In today's Module we have talked about two main topics and those topics are…"

V. Reflection of feelings
Reflection of feelings - why?
• This is one of the most powerful skills to show that you understand the client's situation.
• Often the implicit feelings/emotions are the cause of presented problems and reflection of feeling make those feelings/emotions explicit
• To help the client check and understand his or her feelings/emotions

Reflection of feelings – how?
The caregiver listens and observes carefully to the explicit (expressed) and implicit (unexpressed) feelings of the client and reflects his or her understanding back to the client. In reflection of feeling counselor adds to the paraphrase those feeling words that are in tune with the client's emotional experience.

Formula: You feel …… [feeling/emotion expressed by the client]…. because (or when)…. [the experiences and behaviors that give rise to the feelings (cause of the feelings)]…….For example: "I have a feeling that you are sad because you couldn't pass S.L.C.", "You are angry because you couldn't make it through your exam" "Correct me if I am wrong, you are worried because you see your future uncertain".

MODULE PS 3.6: Family problem- solving counseling

Participants in this Module
This Module is meant for specialized psychosocial workers.

Learning objectives
At the end of the Module the participants are expected to:
- Understand how a family functions and how to classify families according to their level of functioning in a local context
- Understand the basic principles and strategies of family counseling and be able to discuss the knowledge and skills necessary for family counseling
- Explain the reasons that bring a family to counseling
- Demonstrate family problem-solving counseling skills through role play.

Time
3¼ hours

Materials
Flip-chart, cards, markers

Methodology for the trainer: demonstration, role play, observation, interactive lecture, discussion.
a) *Interactive lecture about family functioning (1hr)*
- Ask the participants to describe a refugee family and how it functions. List the responses from the participants.
- Ask the participants to read handout 1 PS 3.6. Divide the participants into small groups and ask them to discuss what causes a family to be dysfunctional.
- Conduct a plenary discussion of what the small groups consider as most important causes of family dysfunction.
b) *Role play demonstration (30 minutes)*
- Prepare a script for a family event and ask six participants to come forward. The trainer takes the role of a community worker and the rest of the group is the family. Everybody gets instructions (written on a card) regarding his or her position in the family and his or her part of the problem. Ask the rest of the class to carefully observe the role play. After 10 minutes, stop the role play and thank everyone for their effort.
- Ask the observers to make comments about what they observed and ask all participants to define what they mean by family problem-solving counseling. Underline the importance of considering the family hierarchy.
c) *Brainstorm family counseling* (30 minutes)
- Ask participants to describe the circumstances in which they can organize a family problem-solving counseling. List all the answers and the trainer comments on them.
- Have the participants form small groups and ask them to brainstorm on effective ways to conduct family problem-solving counseling and appropriate counseling steps for a dysfunctional family.
- Lead a plenary discussion of what the small groups consider as the most effective ways to conduct family counseling.
d) *Role play family counseling by participants(1hour)*
- Have participants form groups for further practical exercises to master their skills. Ask each group to prepare a family problem-solving counseling Module.
- Ask each group to practice their family problem-solving counseling skills and have the rest of the class observe carefully. Ask the class to make comments about what they observed.
e) *Evaluation (15 minutes)*
- Key message: A family is a resource base for every problem and its solution. The family is the best unit for the protection and care of children.

Study material: Module 3.6[27]

Reference 5.1.1

Family

1) Characteristics:

- The family is composed of people united by ties of marriage, blood, or adoption.
- The members of the family typically live together under one roof and constitute a single household or if they live apart, they consider the household their home.
- The family is composed of people who interact and communicate with one another in their social roles such as husband and wife, mother and father, son and daughter, brother and sister.
- The family maintains a common culture derived mainly from the general culture, but each family has some distinctive features.

2) Functions of family:

Functions vary over time and from one society to another. Though seemingly universal, functions involve:

1) Providing care, nurturing, rearing, challenging, and protecting the young.
2) Socialising: the family is the main social institution responsible for the early development of the personality of the individual. It is the first *group* that will influence the child's attitude, norms, values, and practices. This is the individual's first interpretation of the physical and social world and the establishment of the likes and dislikes.
3) Reproducing and regulating sexual behaviour: reproduction is a prerequisite for the survival of society.
4) Providing affection, love, and emotional support: the warmth and affection that children get from their parents can hardly be obtained from outside.
5) Providing the means by which an individual can grow to his/her full potential.

Basic philosophy in family welfare and development

1) Every member of the family has the right to be provided with opportunities to develop his/her personality.
2) Every member of the family has the right to be loved and respected. The family should encourage the total development of a holistic personality of all the family members.
3) Family life remains the single, strongest social force in human development.
4) The family is the focus — of realising human survival and the transmission of culture and values.
5) The family is the system — it consists of members and any change in one member affects every other member.
6) The family is an important element of social cohesion and an essential factor in the general social and spiritual/religious life of its members.

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[27] Jordans, M.J.D., *Training handbook on psychosocial counselling for children in especially difficult circumstances: A trainer's guide. Third edition*. 2003, Kathmandu: UNICEF, pag, 185-188

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Fact sheet 5.1.1

Classification of family functioning levels[2]

The following classification provides a broad overview of how families function.

1. The OPTIMAL FAMILY (most desirable or satisfactory)

- Relationship patterns and communication indicate high levels of affection.
- Differences of individual members respected; personal limits are clear.
- Intimate interpersonal relations; children are viewed as individuals in their own right.
- Members do not compete; instead, they rely on negotiation to approach conflicts.
- Members express a wide range of feelings and a high level of understanding for one another.
- Family is harmonised and positive.

2. COMPETENT BUT DISTRESSED FAMILIES

- Mothers often have partnership with one child.
- Personal limits are distinct however there is not the same degree of closeness as in optimal families.
- Individuals have a tendency to "scape-goat" situations (action or process of casting blame for shortcomings) and to be critical.
- Individuals express restricted range of feelings.
- Parental conflict is present but subdued or suppressed, although the impact on the family is obvious.

3. DYSFUNCTIONAL FAMILIES

There are three categories in this classification:
a) The dominant - submissive families
b) The chronically conflicted families
c) The severely dysfunctional families

3.1 Dominant - Submissive

- The dominant – submissive: one parent dominates and controls every aspect of family life. The dominance is either accepted or circumvented through acting-out behaviour.
- The members do not negotiate. The dominant parent makes all the decisions, and pays little or no attention to the opinions and feelings of the others.

- Members are quick to attribute blame on one another, rather than to accept responsibility.
- The prevailing mood is hostility and sadness.
- There is not much understanding between one another.
- Either parent may seem dysfunctional but experience shows that it is more likely to be the submissive parent.

3.2 Conflicted Families
- They are always fighting.
- Each parent seeks to dominate the other; neither will share power, and neither is willing to accept a submissive role. Struggles are maintained through any devise or manipulation.
- The children are drawn into the conflict, sometime in stable coalitions with one parent, but often in transient coalitions — first, with one parent, then with the other.
- They cannot negotiate because each problem will precipitate into another round of conflict — the parents never work things out together and the children do not learn to solve problems.
- These families tend to deny any difficulties.

3.3 Severely Disturbed Families
- These families neither support maturation and growth for the parents, nor encourage autonomy in the children.
- Two patterns of dysfunction:
    1. One parent who holds a peculiar view of the world dominates the family. Typically, the dominant parent has a _psychiatric disorder_.
    2. _Chaotic family:_ There is not enough influence from any one member of the family to provide leadership. This family shows vague and indistinct boundaries between members. Consequently, it is often difficult for a counsellor to understand family communications. The members often appear strange and bizarre to others and they do not relate to their surroundings.

Fact sheet 5.1.2

Helping develop effective communication in families

The counsellor should help the family develop effective ways to share information and feelings with each other. The counsellor can help the members to identify things that they do that interfere with effective communication.

Things that interfere with communication:
1. Interrupting - not allowing a person to finish what he is saying.
2. Confronting - attacking the person for what he is saying.
3. Dominating - doing all the talking.
4. Judging - saying, " That is good" or, "That is bad."
5. Advising - saying, " If I were you…"
6. Interpreting - putting words into someone's mouth.
7. Probing - being nosy (unnecessarily curious and intrusive).
8. Putting down - minimising the value of what others are saying.

The counsellor can help the family identify their patterns of communication in the sessions by helping members recognise what they are doing.

Through these methods, the counsellor can strengthen positive elements in the interaction between the family members, and thus strengthen effective communication.

1. Identify and observe the child's (or other members') initiatives for interaction. There are always *initiatives* for interaction, — either positive or negative, though it depends on the reaction whether the interaction will escalate in a conflict or not.
2. By responding positively to these initiatives, (e.g. *rather than acting upon the behaviour one can react upon the reason behind the behaviour*) the family members can subsequently develop positive interaction patterns.

The example above is based on theory from Western countries, but is has been used in teaching people in Asia and Africa and found useful. As with many theories these should not be seen as 'universal'. There may be important variations in different settings, and the text above is to be seen as a source for inspiration.

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Study material 2: Module 3.6

Family problem-solving counseling: A Family problem- solving counseling is a psychosocial intervention method used when there is dysfunction in a family structure. The counseling involves the family members, sometimes only focusing on a specific family member. Situations can include: domestic violence, mistreatment of a child, substance abuse, family disputes, and others.

Some considerations in family problem-solving counseling
- Interventions are shared among members of the family.
- The techniques of attentive listening must be seriously respected.
- The community worker must keep a balance while listening to all the members involved in family **problem-solving** counseling.
- The community worker must respect the family's hierarchy, that means who speaks first or who takes the lead in the family. Respect of the order is of significant importance in family counseling. To minimize it may cause the failure of the Module. The community worker must take care to not bring additional problems to the family.
- The community worker must act quietly while attending to individuals in a family problem-solving counseling Module.
- Where, for instance, the father is the head of the family, it is necessary that the community worker collaborates with him to organize the rest of the family.
- In some circumstances, the women are regarded as the chief of the family, for example: when a woman is a widow or perhaps a wife is regarded as the leader.
- To have more information, the community worker must encourage everyone to speak.
- The relationship between the family and the community worker is a partnership
- Base the helping goals on the family's goals and wishes for change.
- Interventions must be action oriented, based of strengths and needs of a family
- Assist the parents to learn different ways of parenting (see also handout 2 for Module 3.1.)
- Assist the family to fulfill practical needs as well as emotional needs.
- Concentrate on recurrent patterns of relationship and interaction
- Help restructure dysfunctional patterns of intervention
- Help the family to gain access to other resources in the camp.

Strategies for family problem-solving **counseling**[28]
A. Developing strengths
- Teach the family new positive ways to address recurring problems through discussion and implementation of alternative solutions
- Teach or assist the family how to access and use internal and external resources.
- Address concrete difficulties; help the family to define small, achievable tasks that will change the way they manage the situation. This will change the way they manage the situation. This will give them a sense of accomplishment and motivate them to address other issues.
- Help the family to learn to use effective interpersonal skills amongst themselves, i.e. new ways to interact with another.
B. Role modeling
- During Modules with parents and children, demonstrate new behavior and ways to cope.
- Demonstrate a different way of negotiating differences during family meeting,
C. Community organizations

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[28] Jordans, M.J.D., *Training handbook on psychosocial counselling for children in especially difficult circumstances: A trainer's guide. Third edition*. 2003, Kathmandu: UNICEF, p. 183-184.

- Coordinated services
- Networking among resources
- Support groups.

MODULE PS 3.7: Group problem-solving counseling

Participants in the Module
This Module is meant for specialized community service providers only.

Learning objectives
At the end of the Module the participants are expected to:
• Understand the basic principles of group problem-solving counseling
• Conduct a group problem-solving counseling on a basic level

Time
3 hours

Materials
Flip-chart, markers

Methodology for the trainer: Demonstration, observation
a) Demonstration by the trainer (1 hour)
• Prepare an event and ask 8 participants to come forward. The trainer takes the role of a psychosocial worker and the rest of the participants constitute a group of people with a similar problem (clients). Ask the rest of the class to carefully observe the demonstration.
• After 15 minutes, the trainer stops the play. Thank all the people who participated in the exercise and ask the rest of the class to comment on what they observed.
• Ask participants to explain, from the observations they made, what they understand as group counseling.
• Stress the importance and the role of each person in the group.

b) Demonstration by participants (2 hrs)
• Have the participants form groups for a role play presentation.
• Instruction for the group work: Assume that psychosocial worker already has a group of people (the participants become the clients) with similar problems. Let the psychosocial worker suppose that he or she wants to solve an identified problem using a group.
• Ask each group to prepare their presentation (25 minutes). Ask them to choose one person to facilitate. Show them the location where they can prepare.
• Ask each group to present their role play and ask the rest of the class to follow carefully.
• Have the all participants comment after each group's role play presentation.

Resource materials to use in this module.
HealthNet TPO Burundi: Training module psychosocial assistant, pp.56.

Study material 1: Module 3.7

Working with groups can be very useful for vulnerable group of people, such as widows, victims of abuse and trauma survivors, as well as for a group of people with similar problems. And especially for youth, for who peer groups are very important, it is an effective psychosocial intervention. It can facilitate daily aspects of life in the camp as well as commonly shared difficulties and problems. The group functions simultaneously as a mechanism for support and feedback. It strengthens possibilities for change, as collective goals are often more committing than individual ones. Furthermore working with groups is a strong tool to enhance and practice social skills because it involves learning to understand and respect other people's viewpoint as well as learning to balance one's interpersonal interactions. It reinforces the resolution of the problems in a group and gives the members an opportunity to share their feelings and experiences, thus, encouraging mutual learning.

Two main components of working with groups are modeling and group cohesion. The former refers to a process of learning behaviors and attitudes through observing other people's behavior and attitudes and its consequences. Group cohesion refers to the group formation process; a group, through disagreements, feelings, leadership etc, slowly shapes itself in an organization with norms and values to which one belongs. This feeling of belonging (or group cohesion) in itself can be of great support. It is important to always sit in a circle and create and atmosphere of openness, equality and warmth. In other words, group counseling is a process by which a community worker, together with the group, tries to solve a problem or change a situation. Group problem-solving counseling is about clarifying concerns, feelings, problems, values, ideas and suggestions through discussions with others who are in similar circumstances.

Group problem-solving counseling has the advantages of people working together, learning from one another, belonging to a group, and enhancing the empowerment of the group members. In group problem-solving counseling, the community worker takes the role of a trainer or a mediator—not a leader.

Purpose of group problem-solving **counseling:**
- Group counseling enables people to develop harmonious relationships among the members so that each member receives support and positive and constructive feedback.
- It enables participants to share information and issues affecting their lives.
- It enhances problem-solving skills and solves problems that exist in a group.
- It helps members to share and discuss feelings (worries, fears, and so on) and creates a sense of belonging.
- Members of the group gain greater social skills and learn how important it is to communicate with peers.

Principles of group problem-solving **counseling**
Group problem-solving counseling intends to enhance:
Hope: *A*fter a while, group participants might see the potential results of the Modules, which could, in turn, give the participants hope for an improved situation.
Universality: It is very comforting for members to realize that they are not alone with their thoughts, feelings and ideas.
Group cohesion: The feeling of belonging to a group.
Social skills: Through the experience of the Modules, the participants learn adequate social skills, which are essential for changing a situation.

Example of groups: widows, parents, mental patients, teenage-mothers, victims of torture, etc.

Study material 2: Module-3.7[29]

Process of Working with Groups - An Overview -
Beginning
- Introduction of group members
- Setting the atmosphere
- Defining the common rules for the group process
- Explaining the purpose of the group intervention

Exploration
- Exploring the common problems or issues
- Exploring the group member's expectations

Goals
- Setting the goals for the group process
- Structuring the themes and topics

Working together (through exploration of a theme)
- Sharing, discussing, confronting
- Exploring alternatives
- Solution oriented action

Termination
- Generalizing the learning outside the group

Study material 3: Module 3.7.[30]

Basic principles of working with groups
1. Group Dynamics
A group is more than the sum of its individual members; with time it becomes a unity that has its own rules norms and values. It becomes a system in which each member fulfils a role (e.g. some may have leadership roles others silent supporters) and in which a structure of interactions is observable on the bases of such roles or interpersonal relations (e.g. conflicts between people, subgroups). Each member brings to the group his/her personal thoughts, habits and feelings that all together create an interesting dynamics.

2. Communication skills
Group mediation is based on a set of communication skills that also form the basis for individual counseling. These skills are essential to create the right atmosphere and to make everyone feel heard, understood and supported. The main skills are; (1) asking open and closed questions; (2) reflecting feelings that one or more members are expressing (empathy); (3) reflecting content by paraphrasing what one or more members are saying; (4) summarizing large parts of interaction to give structure and understanding; (5) repeating key words or parts of a sentence to encourage continued expression; (6) non-verbal communication (see also below).

3. Interaction patterns[31]

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[29] Adapted from Nations International Labour Organization 2001, *Specialized Training Manual on Psychosocial Counseling for Trafficked Youth. Handling the Trauma of Sexual Exploitation, p. 37*
[30] Adapted from Nations International Labour Organization 2001, *Specialized Training Manual on Psychosocial Counseling for Trafficked Youth. Handling the Trauma of Sexual Exploitation, p. 38-39.*
[31] It is important to be aware of possible cultural differences in interaction patterns, the mediator should respect that.

It is essential for the mediator to notice the flow of information in a group. This gives the mediator an understanding of existing subgroups or coalitions and power relations. Specifically this means observing who talks when and to who and who interrupts who and when? Who criticizes, who encourages etc? To do that it is essential to also observe non-verbal communication during the interaction; who is given full or no attention, who is given eye contact during silence in disagreements, do people raise their voice, are people sitting in a way that expresses disinterest or disagreement etc. It is also important for the mediator to be aware of his/her own non-verbal communication. Similarly, it is also essential for the mediator to be aware of his/her place in the interaction patterns. For example is the mediator directing the conversation in a way that all interactions go directly to him/her and from him/her directly to individual members? Or are the members talking to each other with periodic interjections of the mediator, mainly directed to the group as a whole[32].

4. Interpersonal influence
One of the main reasons for working with groups is that the individual group members can learn from each other. This can be direct coping skills or knowledge but it can also be other people's perspective and attitude. Learning also takes place because one receives feedback after reflecting ideas or thought, which gives information on how someone is perceived by others. Self-disclosure, sharing personal experiences, emotions and ideas with the group, is commonly an important instrument for interpersonal influence.

5. Support
Especially for groups who have a similar problem in common the mere fact of being together with others who have gone through the same may give emotional support (e.g. 'I am not the only one who feels so sad'). It may result in a feeling of being understood, something that people who have not gone through similar experiences are maybe not able to provide.

6. Active mediation
The mediator guides the flow of communication, giving equal opportunity to speak to all members, and has an overall view of the group process and dynamics. S/he uses communication skills, avoids providing solutions, makes sure that different viewpoints are being heard and clarifies where necessary. Here the term active mediation is used because it entails that the mediator gives direction if needed however s/he lets the process go as it goes as much as possible without interrupting.

7. Expression
As in individual counseling, working with groups is mostly directed to the expression of feelings and thoughts. Whether it concerns a solvable problem, preparing for potential problems in the future or reactions to unpleasant experiences the expression of the disturbing thoughts and feelings are the basic component within the group setting. On the basis of such expressions discussions, exchanges and interactions are continued, hopefully resulting in the desired outcomes.

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[32] The latter example is desirable in the context of the group work taught in this session.

Study material 4: Module 3.7[33]

Theme centered group work[34]

It is very suitable for discussing and sharing issues with a group of people who have gone through very similar and disturbing experiences. Basically theme centered group work means that one or several relevant topics are selected and the group meets to explore issues around that identified theme. This group work aims to help individuals understand how their stories are different and similar to others in the group. Theme centered group work is based on changing attention between the individual ('I'), his/her interaction with the group ('we') around a certain theme. In this respect we can talk of *dynamic balancing*[35], referring to the strategy of leading the process from the individual (stories about personal experiences) to the group (how group members relate to each other) to the theme. The theme provides a structure to the meetings that is often satisfying for the primarily youth (who generally need more structure then adults) and the mediator (who has the theme to fall back on). Keeping the above in mind, it is also important to be aware of the changes that occur throughout the process. It is not beneficial to strictly follow the theme if the group or its individual members have apparent need for change in topic.

Example: Themes for sexual abused youth can be; family issues, anger, isolation, stigma, future, respect, trust, aggression, self-esteem, safety, humiliation, sexuality.

Study material 5: Module 3.7[36]

Focusing during working with groups[37]
Introduction
Focusing refers to the mediator's skills to direct his/her attention to certain aspects of the process or interactions, in order to give those more emphasize. Because there is many people involved, in groups much is going on at the same time. It is the mediator who needs to decide what to give attention and what not.

How to focus?
Pacing
Pacing refers to the skill of staying with what has been said. The mediator focuses the attention on the present subject or statement by acknowledging understanding and by exploring the issue. Basic communication skills are the instrument to pace.

Leading
Leading is a more active way of focusing the attention and often follows pacing. This means that the mediator slightly changes the direction of the conversation by asking another question about the issue or by diverting the attention to another member's reaction to what has been said. The mediator may for example ask for the present feelings of the individual or the group.

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[33] Copied from Nations International Labour Organization 2001, *Specialized Training Manual on Psychosocial Counseling for Trafficked Youth. Handling the Trauma of Sexual Exploitation, p. 40.*

[34] Based on *Ivey, Pederson & Ivey, 2001,* in turn based on work of *R. Cohn.*

[35] This term is taken from *R. Cohn in Ivey, Pederson & Ivey, 2001*.

[36] Copied with minimal adaptations from Nations International Labour Organization 2001, *Specialized Training Manual on Psychosocial Counseling for Trafficked Youth. Handling the Trauma of Sexual Exploitation, p. 41-44.*

[37] In adapted form based on *Ivey, Pederson & Ivey, 2001.*

Linking
Linking means that the mediator is able to focus the attention on similarities and connections between people and topics. This may mean that the mediator links a certain story to the overall theme, to common issues or to what someone has said about that issue at an earlier stage. It also refers to the process of making connections between other aspects of focusing (see below).

Who to focus on?
The mediator needs to pay attention to what is happening to individual members in the group, to the overall group and to the reactions and interactions of 2 or a few people (subgroups) within the larger group. Sometimes the mediator needs to focus on the individual38; for example when one person is in clear emotional distress or when the mediator asks one person's opinion on an issue. Sometimes subgroups form an essential part of the overall group process. For example when some members are disagreeing and others agreeing or when two members have a conflict or when few people with similar experiences or opinions are connected with each other. The feelings and issues of the subgroups may be very relevant for the group process or the individuals involved.

What to focus on?
Content
On what information does the mediator focus his/her attention? The most obvious focus is the content of what has been said by the group members. Content in this respect refers to the words, the message, the meaning, the feelings, the opinion and the attitude people are conveying. Focusing the content is related to the theme, problems or concerns that are central to the group work. This, as with pacing, is manly achieved by using basic communication skills.

Context
Sometimes aspects of the 'external world' that individual group members bring with them can be enriching to the process and important to see the issues in the most relevant perspective. Such aspects can be one's cultural, spiritual, religious, moral, economic or social background. These are issues that are directly or indirectly related to the theme of the group as well as the individual within the group, other examples are one's family, health, community etc. The mediator then focuses on how such context issues influence the individual, subgroups or the entire group in dealing with a common topic (e.g. how do you deal with this crisis from your spiritual tradition). The mediator needs to be aware that group members always bring their personal context with them, in which any changes need to take place.

Time and situation
Especially for refugees the stories they tell may be related to *past* experiences (there-and-then). Expression of these experiences can be very valuable for the group and the individual, however to achieve actual changes in current feelings and situations it also important to link the member's stories to the *present* (here-and-now). Focus on the present is important to receive feedback about immediate behavior and situations.

Attention
Most of the information above on focusing also goes for individual counseling. Then, instead of group and sub-group the counselor may focus on individual, family or community.

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[38] Sometimes focusing on individuals within the group is the primary method of group counseling. In this session however the emphasize is on the group work.

Example on group work on the theme *future*

Transcript	Process Comments
Maria: I am very frustrated that I have to live here in this center instead of my village, as if I am a prisoner, as if I have done something wrong. I like the center and all the people, but still.	Self-disclosure, focus on the present
Mediator: You feel angry because you think it is not fair that you can't go back home.	Reflection of feeling Focus on individual through pacing
Maria: Yes exactly. When I was still living with my parents and going to school everything was so much easier. I never had to worry about the future.	Self-disclosure Focus on theme and the past
Mediator: How do you feel now about the future?	Focus on individual through leading (open question), focus on the present
Maria: I don't know what will happen, nobody wants me anymore. So where to go, what to do?	
Mediator: The thought about the future seems to upset you. Florence and Grace, I see you are nodding your head, do you recognize these feelings?	Reflect feeling, focus on the theme Focus on subgroups through leading
Grace: Yes I do recognize it, I also feel that way Maria. Thinking about the future sometimes makes me cry. For me it helps to then sit alone and recite mantra, which calms me down.	Self-disclosure Coping strategy
Mediator: Grace I hear you say that thinking about the future makes you also sad, however you find some comfort in your religion. (Grace nods her head). Do others in the group also find comfort in their religion or spirituality?	Reflection of feeling and content Focus on group through leading Focus on context

MODULE PS 3.8: Referral and advocacy (and case management)

Learning objectives
At the end of the Module the participants are expected to:
- Explain when to refer clients to specialized services
- Make inventories of all helping services and groups existing in the camp
- Explain the concept of advocacy
- Explain when advocacy is needed
- Explain the concept of case management

Time
1½ hrs

Materials
Flip-chart, marker

Methodology for the trainer: *discussion, participatory lecture*,
- *Brainstorming (15 minutes)*.Write the words "Referral" and "Advocacy" on the flip-chart. Ask the participants what they understand by the terms:
    - Referral
    - Advocacy
    - Case management

  Write down their ideas.
- *Discussion in classroom (30 minutes).* Encourage participants to share their experiences on referral and advocacy as follows: Think about cases that you referred to another helping institution and those you advocated for.
    - Why did you refer the case?
    - Why did you advocate for the person?
    - Where did you refer the case?
    - Where did you perform the advocacy?
- *Interactive lecture (30 minutes)*. Guide the participants to identify the existing helping structures in the community (formal and informal). Make sure the following are considered: health institutions, traditional healers, community workers, security guard, opinion leader, religious leaders
- *Discussion:* Modes of referral.

  Ask participants to identify the ways a person can be referred for further assistance? Add to the list:
    - Referral forms
    - Physically accompanying the person

Resource materials to use in this module
HealthNet TPO Burundi: Training module psychosocial assistant, page 56

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Study material 1: Module 3.8.[39]

Community workers have limits when delivering psychosocial services. Sometimes the specific assistance people need may not be available from the helper. In such cases, the helper may send the person to another institution with the capacity to offer assistance to the helper. This is called referral. In this case, helpers need to know what helping services are available in their area and all services that are being offered.

On the other hand, the person needing assistance may be too vulnerable to speak or seek help for him or herself. Helpers in this case need to speak on the client's behalf or may go themselves to seek the needed assistance for the client(s). This is called Advocacy. For effective referral and advocacy, the community workers need to be informed about the possibilities and specialized services.

Often a situation/family is so complex that the persons in need require help to manage all their problems to ensure they receive the right care and support.

Case management
The definitions of referral and advocacy are essential elements of case management, and referral and advocacy follow a multi-leveled preventive approach focusing on both mental health and psychosocial well-being. Two concepts that underlie this are (1) ecological resilience, and (2) existing community resources. One of the strategies to strengthen ecological resilience is to assess and work with existing resources, which is the focus of this module.

First, 'ecological resilience' is defined as those assets and processes existent on all social-ecological levels that have shown to have a relationship with good developmental outcomes after exposure to situations of armed conflict. We see ecological resilience as a reservoir of factors at different social-ecological levels that can enhance psychosocial wellbeing. people under strain can seek out and utilize resources from this reservoir to enhance their chances of retaining or obtaining psychosocial wellbeing.

Second, these are core reasons for strengthening resilience through existing resources; (1) Cross-sectional non-vertical care systems are preferred for reasons of applicability and feasibility; (2) Linkage with both formal and informal existing resources are preferred for reasons of availability, sustainability and relevance of service provision; (3) Active community involvement is preferred to reach children out of school and to tap into responsibility of the community to support, reducing dependability on external service/resources.

Moreover, working with contextual community activities, traditional healing and religious practices, availing norms and coping, will increase cultural relevance of a combined (i.e. traditional and novel interventions) care system. The critical question that underlies this module is;

> *"To what extent are existing resources and resilience sufficient to restore the balance between present risk and protective factors or to what extent can external mental health care or psychosocial services support and integrate this balance?"*

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[39] This handout is copied with adaptations from: Jordans, M.J.D., Tol, W.A., Komproe, I.H., Lasuba, A.C., Ntamutumba, P., Susanty, D., Vallipuram, A. & de Jong, J.T.V.M. (2008). *Module 6: Existing resources and case-management.* In: *Children in areas affected by political violence: a resource package for a comprehensive psychosocial care approach.* Amsterdam: HealthNet TPO/ PLAN, Netherlands.

2. Implementation steps[40]

Assessment of existing healing practices and community services
It is through careful participatory assessment that resources available at different social-ecological levels can be identified and the interaction between them observed. Moreover, it has been our observation that damage to the social fabric and resources available at different social-ecological levels is variable, depending amongst others on pre-conflict family and community characteristics and the type of conflict situation. Furthermore, any psychosocial interventions should be embedded in, and linked to, initiatives and services focused on peace-building, poverty reduction, education and health care.

Negotiation and involvement of social agents
Based on the results from the needs assessment discussions should be held with community social agents, especially those involved in the care of children, to develop a framework for utilization of resources. Such negotiation entails discussing which types of available services and interventions might be appropriate for the problems identified in the needs assessment. Additionally, the active involvement of these social agents needs to be discussed. Involvement has a dual function, (i) it ensures sustainability and responsibility of community members, and (ii) it is also a strategy to improve psychosocial wellbeing. An example of the former is to ask community members to contribute to sustain interventions or to support individual families in need of material support. An example of the latter is to include children in pro-social activities as volunteers doing community services or to include adolescents in peace-building activities.

Collaboration and referral to existing care and healing services
Collaboration with existing services (informal and formal), such as schools, health care and traditional healing, should be actively sought. Additionally, psychosocial care services should link with non-mental health care, such as religious practices, nutrition project, micro-finance schemes, youth and child clubs, etc. The aim of such linkages is to provide the most needed services to indicated children and their families and, in turn, such services will improve the psychosocial well-being. Practically, this means referral from the program's services to external services.

Case management
Case-management is the process in which the above steps come together and are integrated with other clinical and non-clinical services. A care giver as a case-manager coordinates services to individuals, families, and communities, based upon assessment and planning. Case management is a client-centered, goal-oriented process for assessing the need of an individual for particular services and assisting him/her to obtain those services, often across institutional boundaries. It is usually done with individuals or families but one can used with communities if they are actively involved in the helping process for their own members.

Tasks:
- Develop, support, maintain clients' treatment process
- Target and improve conditions which obstruct client progress or the maintenance of their progress
- Develop & maintain partnerships (individual/agencies/community)

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[40] The family of children is one of the main available resources when dealing with problems or when increasing existing community resilience. This will not be discussed within this module, but rather in the module on parental support.

- Asset-based community and resource assessment
- Comprehensive, collaborative, systemic planning & coordination

Activities:
- Guide and support child through different steps of a treatment process
- Link the child and/or family to existing services in the community that are requited for the treatment process
- Follow-up on the external services provided, both with the third party as well as with the child/family itself

Case management is intended to help patients take advantage of community services that have the potential to enhance their treatment experience. Psychosocial problems, especially in low-income and conflict settings, are mostly not singular and often go alongside a set of larger problems, related to (mental) health-, economic-, educational-problems. Often the non-mental health problems are overriding in severity and importance from the perception of the clients and are often causes for increased distress and accumulated burden. Linkage with services other-then psychosocial counseling, can therefore become in essential in supporting those children with identified problems as well as increasing the effectiveness of the counseling service. Moreover, case management has the tendency to increase treatment maintenance.
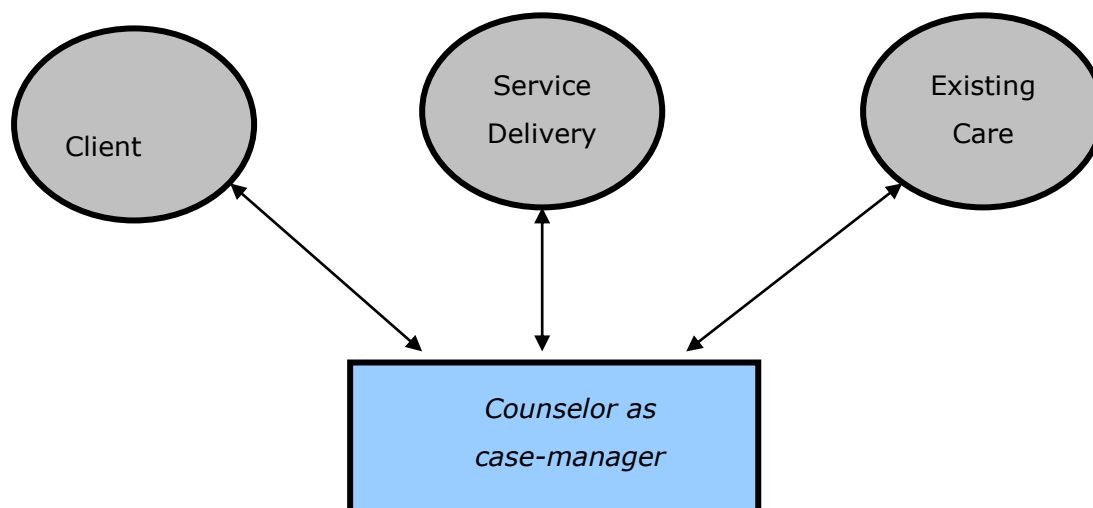

Figure 1: Case management

Integration of steps: Case management plan

In the following cases it is crucial to have a case-management plan at hand and have that case-management plan form the basis of the 'treatment' or follow-up:

1. *Intellectual disability*

The essential feature of intellectual disability is significantly sub-average general intellectual functioning. It is accompanied by significant limitations in adaptive functioning such as; self care, communication, social/ interpersonal skills, use of community resources, functional academic skills. When intellectual disability is detected case management involves the following activities: the care giver should *raise the level of understanding of the adults close to* the intellectual disabled person *to prevent maltreatment and stigmatization*. Secondly, when it concern mild intellectual disability case management should focus on *integration* of the child within the peer group and within the school setting and in case of an adult is the social environment. When it concerns severe intellectual disability, referral to more *specialized services* need to be arranged, if available, where learning daily functioning and life skills are encouraged.

2. People with epilepsy

When people have recurrent fits a *medical check-up* should be arranged to assess the nature of the fits. Case management therefore entails a medical consultation. If epilepsy is diagnosed effective *medication* is available. Once medication is started case management further entails ensuring *treatment compliance*, making sure that the person is receiving the medication as per indication.

3. Families with chronic child abuse, neglect and parental mental illness

Home visitation programs are indicated when child abuse and/or neglect is suspected or reported. Many direct therapeutic interventions are not beneficial or not contra-indicated when abuse is present. Home visitation program, combined with *discussion about the child's well-being*, is mainly a case-management task and might form the start of a longer family interventions strategy.

4. Crisis care

Especially in crises situations the counselor core task is to reduce risk and to ensure basic safety and needs. Case management has the potential to help patients access the community support they need to stabilize their lives so they are able to focus on treatment. In case of suicidal tendencies this includes reducing direct risks of suicide.

3. Suggested points of attention and lessons learned

Planning and harmonization of services; At time of project development and planning of intervention, assessment and integration of existing resources should be taken into account, as outlined above. Commonly, these aspects are either overseen or integrated once the program and its services have started.

Case management integrated; especially when working with counselors as service providers, case management should be integrated in the training course, services and skills. Case-management becomes the hinge pin in linking new interventions with those already available. Job descriptions and training courses should clearly focus on the role and tasks as a case-managers.

MODULE PS 3.9: Awareness-raising /sensitization and psychosocial education

Learning objectives
At the end of the Module the participants are expected to:
- Explain what they understand by awareness-raising and psychosocial education.
- Explain the importance of organizing modules on awareness-raising and psychosocial education on psychosocial problems, mental health problems and epilepsy.
- Demonstrate how a practical awareness-raising Module is conducted.

Time
3½ hours

Materials
Flip-chart, markers

Methodology for the trainer: *Interactive lecture, brainstorming, discussion and demonstration.*
a) *Brainstorming (30 minutes).* Ask participants what they understand by the terms awareness-raising and psychosocial education. Write the answers on the flip-chart. Explain the difference between awareness-raising and psycho-education (Refer to the Study Material for the trainer).

b) *Awareness-raising*
- Ask participants why people in the community need information on psychosocial problems, mental health or epilepsy.
- Explain that in the community there are always people who do not have information on the above-mentioned problems. On the other hand, they may know about the existence of the problems but are not informed about the impact on an individual, family or community.
- *Demonstration (30 minutes).* The trainer demonstrates how one proceeds in a community awareness module (refer to the Study Material for the trainer).
- *Interactive Lecture (30 minutes)*. Conclude by saying that by awareness-raising you help the community members to realize the sorts of problems that are around them. You stress the importance of addressing a problem to prevent other negative consequences or an exacerbation of the situation. You draw the attention of the participants to the multiple consequences that are possible if no one addresses the problems. Make sure the participants explain why they call a situation "a problem". Most important is to show that people in need also have something to offer before they seek outside help.

c) *Psychosocial education.* Ask participants to identify groups that they educate. Make sure all the groups in the community are identified for future education Modules (children, youth, adults, and old persons). Ask participants to identify several psychosocial problems encountered by the above-mentioned group and why psycho-education is needed. Write down the answers.

d) *Demonstration by the trainer*. The trainer performs the first demonstration on psycho-education. Refer to the Study Material for the trainer

e) *Demonstration by participants (2 hours)*
- Organize groups by asking participants to count 1,2,3…., or use another criteria to form groups. Ask half of the groups to perform a community awareness session, and the other half to perform a psychosocial education session. Allow room for questions for clarification. Each group assigns a moderator and a presenter. Indicate the venues where the groups can gather for their work. Distribute cards and markers to

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each group. During the presentations carefully follow the presentation and correct messages that are not clear.

- *Make sure the facilitation is done in the language of participants.*

Resource materials for this Module
1. HealthNet TPO Burundi: Training module psychosocial assistant.

Study material 1: Module 3.9

Awareness-raising/sensitization of the community
The population of the camp often needs to be informed about mental health problems, psychosocial problems, such as domestic violence or epilepsy since problems affect one's wellbeing. The aims of awareness-raising are therefore:
- To reinforce the understanding and highlight the impact of psychosocial problems, mental health problems or epilepsy on the life of the community, families and individual
- To promote support among the refugees and social adjustment
- To reinforce the capacities of the families and those of other intervening parties to offer minimal psychosocial support within the camp

Methodology of a Module on awareness-raising
1. Introduction of the trainer (name and work) and announcement of the topic, which is awareness of psychosocial problems
2. Presentation of the objectives (what do you want to achieve after the facilitation).
3. Development of the topic step-by-step.
   - Ask participants to invent situations that make them feel bad, upset, unhappy, hopeless, frustrated: situations that bring negative repetitive thoughts, etc. Ask that participants what they call "a problem".
   - Find out what the reasons are that the participants define a situation to be a problem.
   - Discuss whether all participants agree with the given answers.
   - Ask the participants to identify helping mechanisms that are being used by community members to solve problems.
   - Draw the attention of the participants to how problems affect one's feelings, thoughts, and attitudes, and how they affect the social relationships of the individual.
   - To close the Module, invite the participants to attend the next Modules on psycho-education where there will be deeper discussion to improve understanding of the dynamic between psychosocial problems and the subsequent effects on the individual. Mention that further discussion will focus on the role of the community in the helping process and include a group discussion about all places where people get support.

Psycho-education is a community-based intervention that promotes the awareness of adverse psychological reactions to prolonged stress and traumatic experiences. It helps people understand their inner painful conditions and attendant implications for their well being and coping capacities.

Steps in psycho-education
- *Introduction of the trainer and the topic for the day.*
  o Why the topic was chosen for the day.
  o Presentation of the objectives.
- *Development of the topic*
  o Causes of the problem and summary of key messages.
  o Consequences on the well being of the individual, community.
  o Remedies/prevention and short summary.
- *Conclusion*
  o Make a general summary.
  o Evaluate knowledge.
  o Allow room for participants to ask questions.
  o Make a plan of action with the participants.
- Thank the group for their effort and attendance.

Study material 2: Module 3.9

Awareness Raising and Community Psycho-Education[41]

1. Rationale for awareness raising

As mentioned in, psychosocial interventions for people in areas of armed conflict should be based on a participatory needs assessment in order to match the offered services with perceived community needs. Yet, even with high prevalence of mental health and psychosocial problems and with community-perceived need for support for this type of problems, sufficient attention needs to be given to sensitize community members to the services offered. Different levels of sensitization are proposed to assure acceptance of the proposed interventions, increase the level of participation of community stakeholders, confirm the relevance of services offered based on needs and perceptions, increase the active role of community members as well as that of existing resources in supporting the plight of adults and children, and, increase access to services.

Review of the literature (Tyano & Fleischman, 2007) on public awareness of child and adolescent mental health has raised a string of observation related to awareness raising: (1) Prevalence of mental disorder among children ranges between 10 and 20% globally, over 40% of the countries have no mental health policy and 90% of the countries have no mental health policy for children; (2) Such mental health needs of children are seriously underserved; (3) The main barriers to relevant care are, (i) lack of awareness by parents and children of mental health disorder and services and, (ii) lack of understanding by primary health care workers and teachers of mental health problems; (iv) public knowledge have a significant effect on help seeking as the stigma and discrimination related to mental health is the single most important obstacle to overcome.

The overriding rationale behind community sensitization is that of primary prevention. Primary prevention includes activities aimed at the community at large to prevent healthy, albeit at-risk, populations to develop psychosocial problems. De Jong (2002) specifies the following (among others) interventions at this level; (i) *public education* to provide information for those that have gone through extremely stressful events, and (ii) *community empowerment* to revitalize helping skills within a community that are insufficiently utilized to target this type of problems.

Overall, the combined sensitization activities aim to achieve the following:

1.1 *Project acceptance.* Political, cultural and ethical acceptability of proposed services have to be addressed before actual service provision.

1.2 *De-stigmatization of mental health problems, epilepsy, sexual or domestic violence etc.* Extensive explanation of mental health and psychosocial care and problems, and its origins plays a crucial part in reducing stigma attached to these concepts. Misconceptions about mental health problems prevent for example the community support of rape victims.

1.3 *Increasing understanding (normalization) and identification of psychosocial issues of refugees.* Provide information about the reactions that are common and normal among people reared in conflict settings, as well as information about the severe reactions and problems that needs extra attention.

1.4 *Raise awareness on community-, and/or target group specific psychosocial issues.* Psycho-education on issues related to the psycho-social wellbeing of the

[41] Adopted with minimal changes from: Jordans, M.J.D., Tol, W.A., Komproe, I.H., Lasuba, A.C., Ntamutumba, P., Susanty, D., Vallipuram, A. & de Jong, J.T.V.M. (2008). *Module 3: Awareness raising and community psychoeducation.* In: *Children in areas affected by political violence: a resource package for a comprehensive psychosocial care approach.* Amsterdam: HealthNet TPO/ PLAN Netherlands.

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community at large, which in turn have an impact on the well-being of different age and gender groups. For example alcoholism, child rearing, conflict mediation, sexual violence.

1.5 *Mobilization of existing resources and roles.* Providing information to community stakeholders on how to help people that have problems, as well as vulnerable families in general, as well as strengthening coping and healing strategies.

2. Implementation steps

The above is done by targeting different sub-groups within the community and through different types of sensitization activities, ranging from short meeting with officials to longer-term psycho-education Modules. Three levels of sensitization are proposed, from initial short term sensitization to later more intensive sensitization. Children as an example;

1. Community-level sensitization for acceptance and de-stigmatizations of psychosocial problems and care.
2. School-level sensitization for understanding, screening/identification and support of key stakeholders for the children with problems (i.e. teachers and parents).
3. Target group level sensitization for knowledge and mobilization around specific topics related to the psychosocial well-being of community, families and children.
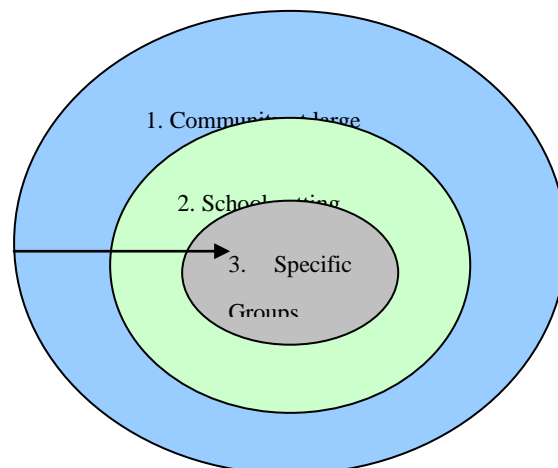

Figure 1: Three levels of community sensitization

Within each of these levels of sensitization different types of activities can be organized, depending on the need and care spectrum. Typically, the following steps are followed:

Step 1: Permission for care provision within school setting from authorities (formal local government), as well as acceptance from key community people/groups (community elders, traditional healers, religious leaders).

Step 2: Discussion with principals and teachers of children targeted for the planned services about reasons, aims and process of interventions, as well as the role of the school staff.

Step 3: Pre-screening briefing to raise awareness about the interventions to parents and teachers, ask for their involvement in the screening process and to actualize expectations regarding the service provision. See also module on screening.

Step 4: Psycho-education for parents and teachers parallel to the provision of services, focusing on creating understanding on some basic concepts such as; (i) 'psychosocial'; (ii) stress and trauma; (iii) coping and resilience; (iv)

impact of violence, as well as (v) the role of the parents and teachers to support children.

Box 3: Psycho-education for understanding and normalizing impact of conflict

Enhance understanding and acceptance of the impact of violence on children, families and communities

- The impact of adversities *("many people that have gone through such terrible situations have similar problems afterwards")*; discussion of commonly observed psychosocial problems, symptoms and signs of distress etc.
- Information on age-related risk taking behaviors, especially for adolescents and emphasize that such reactions are normal
- Identification of children who are affected by conflict and are in need of help
- Explanations of typical post traumatic stress reactions in age appropriate language *("if you have seen something terrible happen, you may see picture of it in your mind" "it can be hard to concentrate after you have gone through something frightening")*
- The role of traumatic reminders *("it is common to be reminded of what happened to you if you are in the same place")*
- Stress, coping, social support and the role of teachers, parents and the community in supporting

Box 4: Psycho-education on promoting existing resources

Facilitating existing support systems and helpful adjustment responses (promoting existing resources)

- Encourage existing coping strategies (e.g. forms of worshipping/rituals, community gatherings)
- Encourage existing care systems (e.g. traditional healers, self-help groups, priests/monks)
- Encourage existing social support systems (e.g. family, neighbors, religious or community leaders)
- Encourage peer activities (e.g. recreation, sports, dancing, child clubs)
- Re-establishment of normal schooling and daily routines
- Enhance parents and teachers capacity to deal with distress and complaint among children

Step 5: Assessment of common community issues related to mental health and psychosocial well-being.

Step 6: Multiple-Module psycho-education of specific community groups (i.e. only mothers, only traditional healers, only teachers) to raise awareness on specific issues such as parental support, recognition of mental health problems, epilepsy, substance abuse, teen pregnancies etc.

Box 5: Specific topics

Psycho-education of topics on a Module-to-Module basis to raise understanding, to identify people who need support and to discuss existing community coping strategies to help reduce the psychosocial problems.

- Child development and growth
  - o Normal and abnormal developmental reactions and behaviors
- Parenting
  - o How to handle difficult behaviors

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<blockquote>

- o How to use punishment and rewards
- Life skills
  - o Teaching people skills to address daily challenges
  - o Assertiveness, individual coping, friendship formation, problem solving, creative thinking, stress-management
- Helping skills
  - o Helping each other (to deal with psychosocial problems)
  - o Communication, empathy and compassion
- Substance abuse
  - o Abuse or use of alcohol?
  - o Impact of alcohol on individual and family
  - o Strategies to minimize consumption
- Gender-based violence
  - o Teaching about shifts in gender roles due to the refugee status and the risks for gender-based violence
  - o Impact of violence on mental health
  - o Strategies to tackle violence

</blockquote>

All steps: In all psycho-education Modules the trainers follow a basic structure. First, introducing the reasons for the 'meeting' and introduces the theme. Second, the participants are encouraged to discuss around the given theme and the questions posed by the trainer (e.g. perceptions and consequences of the given problem; prevention and remedies for the given problem). Third, discussion is concluded and summarized by the trainers at the end of the Module, emphasizing core messages related to the specific theme.

3. Recommendations

3.1 *Risk of non-awareness raising*; Due to the stigma of mental health and novelty of interventions psychosocial care programs run risks of misperceptions; (i) people are called 'crazy' when participating in psychosocial and mental health programs; (ii) the activities are misinterpreted as new religions; (iii) misunderstanding about the content of intervention (people not understanding why conflict related and traumatic experiences are discussed in the Modules; the intervention is a panacea that can cure all people's problems instantly; clarifying that no compensation will be provided as a result any of the activities; clarifying why screening is conducted and the fact that all people will be able to receive some activity.). Not adequately addressing these may make service provision both unethical and challenging.

3.2 *Multi-layered sensitization*; for the above mentioned reasons experience has learned that one-off sensitization Modules are insufficient; follow-up with *more detailed psycho-education for all people* on issues of psychosocial impact of conflict and dealing with problem behaviors is found to be helpful. Sensitization and community psycho-education should not just target vulnerable refugee groups, but also the different care providers, the local UNHCR other local organizations and officials involved, communities at-large and religious leaders and traditional healers in specific. Hence, different target groups and a multitude of issues lead to the necessity of a multi-layered approach.

3.3 *Linkage with existing local knowledge*; Though the term might not suggest so, psycho-education involves matching the need for sensitization with the available knowledge, perceptions and services within a community. Much care must be given to not be an external agency that imposes ideas (and interventions) that do not correspond to local understanding. The art of the sensitization to adapt the topics and structure based on the needs and perceptions existing within the community.

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3.4 *Adapting language and terminology;* Based on the point above, to match the pre-existing knowledge and understanding of these and similar concepts that prevail within the community (including existing terms, norms and values related to the topics being discussed). Manuals and fact sheets are tools for the trainer but are often not suitable for direct use within the community setting.

3.5 *Linkage with existing community activity*; community members are generally already occupied with their own activities, making it difficult to get people to come to organized community gatherings. Integrating psycho-education with routine community activity may solve that problem and also reduce budgeting such as transportation or meals that are often asked by community.

MODULE PS 3.10: Support groups

Learning objectives
At the end of the Module the participants are expected to:
- Explain what they understand by support groups
- Explain the importance of creating support groups in the promotion of the well being of the people
- Identify activities that can be organized in such groups
- Know the ground rules and guidelines for creating and running a support group

Time
3 hours

Materials
Flip-chart, markers

Methodology for the trainer: Brainstorming, discussion, group work, interactive lecture, participatory presentation,
- *Brainstorming (10 minutes).*
  Ask participants to explain what they understand by "support groups". Note the answers on the flip-chart. Explain the meaning and purpose of support groups. Refer to the Study Material for trainer
- *Group Work (30 minutes).*
  Create groups of participants by counting 1,2,3,…or use an alternative method. Explain that each group will choose a moderator and a recorder. Indicate the venue where the group can work. Write down the statement "Make a list of people who can participate in support groups and identify activities that can be organized within these groups" on the flip-chart.
- *Participatory presentation (30 minutes per group).*
  Make sure that activities are group-oriented.
- Interactive lecture: Explain that a community worker can use the opportunity to organize psychosocial activities such as: psycho education, recreational activities, advocacy, and others.
- Ask participants to re-form in the same small groups to discuss and write down the most important rules and steps for creating a support group and the process of running of a support group.
- Interactive presentation (use handout 2 for this Module)
- Conduct the process of a support group, as explained in the discussion, on a subject selected by the participants.
- The trainer discusses the process with the participants.

Resource materials for this Module
Wikipedia.org/wiki: support groups

Study material 1: Module 3.10

Group interventions[42]

While during a psycho education Module the participants get basic information, group interventions connect participants as active listeners and talkers. During group discussions people can discuss all kind of topics, not necessarily psychosocial topics. Group interventions have the advantage above individual 'counseling' Modules while more people can be reached at the same time, giving people the opportunity to share experiences and learn from each other. Depending of the kind of group work, the trainer has a more or less important role. In a self-help group, it are the participants who 'own' the group

There are different kind of group interventions, all depending of the purpose the group comes together.
a. group discussions (for men and women); a group of people that have a common interest or a common problem/task that come together to discuss/solve a problem or perform a task regarding a particular life problem or life situation
b. support groups or self help groups; people come together to tell their story or discuss a problem with the specific aim to receive support or learn from other participants. While in a support group the trainer has a more or less important role (guards the 'process), the group ultimately can become an independent self help group. In Afghanistan, it are mostly women who are willing to participate in these kind of groups
c. Specific group interventions for and with children in order to strengthen the coping mechanisms of children in need of psychosocial care; sports, games, drama, storytelling.

Support groups

Most people who experience extreme stress such as violence, torture, rape or serious accident react automatically. Usually they react very well and do what is necessary to escape or to survive. When the danger is over, they may feel shock and find it hard to believe that they have escape. They may tremble and feel fear, anger or grief for hours or days. They feel very comforting to have someone to reassure them and them that they are safe and it is all over.

Often victim of violence don't want to be reminded of what has happened or do not want other people talk about the past. At other times, it is as though all the terrible things are happening again. One who experience extreme stress at a times remembering everything that has happened, he/she see all the details and feel very unhappy afraid, angry or humiliated.

People can change after such an experience, for example a woman who may be irritated all the time, although before, she was a likeable person. She may avoid contact with other people. People who undergo extreme stress need other people care in giving him/her feel of secure so they are able to communicate or interact with others. The support from significant others will help them digesting the painful memories gradually.

Support groups are groups of individuals, identified within the camp, for the purpose of creating a network and promoting re-connection to the general population. The aim of the group is to have a place to share concerns and build confidence in order to face the daily challenges of life. Support group members provide each other with various types of help for a particular shared, usually burdensome situation. Help may take the form of

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[42] This information is with adaptations form Baron, Nancy. *Basic Psychosocial Awareness And Intervention Strategies*. 2000

providing and evaluating relevant information, relating experiences, listening to and accepting others' experiences, providing understanding and establishing social networks.

<u>Definition</u>

Support group means a group of people who has similar problems and has goal to deal with the problems by exchanging experiences. Process of giving support in a group is through persistence meetings by discussing one another painful experiences and problems and how it affected their lives. The objectives are to reinforce self-esteem and consideration and to promote resilience, connectedness and coping mechanisms.

What is a support group?

A support group is a group of people that have a common interest or a common problem and that come together to discuss a particular life problem or life situation. People come together to tell their story. On the other hand, the groups should not be so specific that you can no find enough members. Be careful in using words; do not name your group: 'Women with familial problems'. People will not feel at ease to participate if the whole village knows what they are struggling with.

Possible groups might be: 'women suffering from sad feelings', 'women suffering from stress', 'widows', 'woman without children'. The clinic might be used when working with people suffering from more specific problems: mental retardation, epileptic patients etc. A support group meets regularly over a certain time, once a week for ten weeks e.g.

Why is a support group important?
- To express feelings, what they notice inside themselves, in their relations with others, family, friends.
- To talk about that what causes them stress
- To receive support in seeking solutions to personal problems
- To help another to overcome obstacles to daily functioning by giving and receiving emotional support
- To relieve other members of the community

The aim is to reduce symptoms, fear, anxiety, isolation, and sad feelings and to learn cultural appropriate coping mechanisms and new strategies for behavior by sharing experiences, knowledge and skills. Through listening and sharing experiences with others who have similar difficulties and life situations, people can empty their hearts, reduce grief and learn about different ways of dealing with their problems, obtain a greater understanding of their life, feel useful and valued and obtain a sense of hope.

The following activities can be organized to promote the well being of the people in the group: psycho-education, awareness-raising, recreational activities (singing, storytelling, traditional dances), advocacy, stress management, and others. The main role of the trainer during discussion is to coordinate information exchange on the daily living conditions or stressors among the group. Participants in the group are given an equal opportunity, respect and freedom to express their concerns.

Example of support groups:
- People affected or infected by HIV
- A group of handicapped people
- A group of elderly people
- The families of mentally ill patients
- Unaccompanied children
- Widows
- Others

The reason to build support group
- To give one another the opportunity to talk about their past and their problems.
- To gain experience on how to deal with problems in a group

- To learn from one another's experiences about effective ways of coping. How one member coped may help another to cope in a similar way.
- To help their group members to talk about their feelings and ventilate their emotions
- To learn to respect confidentiality. The sharing of problems or others are remains within the group.
- To obtain support from others.

Process in support group
- Invite persons with similar problems to form mutual support group to exchange experiences.
- The members of the group can be male or female due to different ways of solving their problems.
- Involve people who have already cope with the problems to help others with similar problems.
- The group generally consists of 6 – 10 persons.
- In the first or second Module the group members can discuss how the group will be organized and how its meetings can best be fitted into local routines in deciding the best time, duration, place, date and frequency of meetings. It is also important to discuss and be clear about the reasons for coming together.
- For the first discussion, some preliminary issues are preferable.
- The caregiver can offer to facilitate and provide initial guidance in running the group, but the group is for the member and its success depend on every member taking an active part in the meetings.
- The group member can help one another share the emotions related with painful experience.
- After several meetings the group members may want to continue until they feel that they have had enough opportunity to tell their stories. Every member get the opportunity to talk about their past.
- Telling stories several times helps one take up the threads of life again.

Ground rules of a support group
There are several ground rules. These rules enable the meetings to run smoothly and help to create an environment in which the participants can talk openly about their problems, express personal opinions and feelings and demonstrate mutual understanding and support.
- Group members should keep confidential the stories that are told by the group members during the meeting, like in our religion: disclosing secrets can be seen as sin
  - Do not interrupt when somebody is speaking. If you want to clarify an important point, ask permission to the member talking
  - All group members should listen to the group member talking and not talk to each other or cause disturbance; tea is for before or after the Module
  - Group members should not mock or criticize others even if their views or ways of thinking may be different from their own. This will discourage the others from expressing their true feelings and may cause them to feel excluded.
  - Once the members are willing to participate, they should be there on time and not leave before the Module is over. When any group member is unable to attend a group meeting for personal reasons that member should inform other group members; make clear that is the intention that they attend all the Modules

Support group: a guideline
A support group can be done in many ways: make sure that
- You have between 4 and 10 participants
- The groups last between 1 and 2 hours
- You involve one or more female influential figures
- You informed a community leader of your purpose and your visits
- You make clear that you are not there to give money, material support or medicine

- That you have a calm place to work; inform the community leader and the members that you want as little disturbance as possible; organize a baby-sit
- There is an introduction including goal-setting
- The ground rules are explained
- The participants form a group, so everybody should be at ease and have the opportunity to talk. Ask if everyone feels comfortable at their places and if the place is okay
- You let the group do the talking; as a trainer you guide and interfere when necessary but stay polite
- You ask questions and not give opinions. If somebody never talks, try to ask a question; 'what do you think, do you have the same problem?
- You also ask for about more positive events and that there is some positive goal setting; ask what they like to do
- You have some basic knowledge about the problems you want to talk about (psycho-educative material)
- You discuss coping styles
- You have an interested attitude (eye contact, voice, language, body language) and that you give support and reassurance
- If possible, you choose a co-leader to assist you
- You do not impose your solution, try to make them find their own solutions
- You ask open questions: How? Who? What? Where? When?

Study material 2: Module 3.10

Peer Support Groups[43]
What is a Peer Support Group?
 "Peer support builds on resources that friends spontaneously offer one another, and it happens anywhere, in any organization, and in any age-group." *(Cowie and Wallance 2000).*

Naturally, people of the same age sit together to form a peer support group. A peer group is a small group of people, where individuals with similar ages, close relations, and similar views join together in equal participation (Kishler and other, 1993).

In peer groups, a group of people/ children with similar characteristics (age group, education, problems) sit together [for discussions]. Knowing that others have the same emotional difficulties and problems in the group, people feel that they are not alone and others also have similar difficulties. Through the process of peer support groups, people feel supported because they are joined by other people in similar situations among whom they can share their feelings.

Benefits from Peer Support Groups (children as an example):
• Children can share their memories, feelings, and experiences.
• Children learn how to cope with their problems through different activities.
• Children develop personal and social skills, such as communication skills, improving self-esteem, and learning to ask for help and support.
• Children and young people have the opportunity to experience different roles and responsibilities, and to learn leadership skills and team working (Cowie and others 2002).
• Children can improve school behavior, attendance and academic performance.
• Children learn to give and take supportive, positive, and developmental feedback.
• Children learn to respect others.
• Children are encouraged to maintain healthy friendships.

Who is present during Peer Support Groups and what are their responsibilities?
1. The presenter (rotating role): Every member of the group should be the presenter at some point. The role of the presenter is to present her problems so the group can listen and share their thoughts.

2. The trainer (permanent role): The trainer is a role that is maintained throughout the Module. One person needs to take the trainer role each Module. The *trainer* can be anyone, but s/he is not the leader of group. The trainer has a range of different responsibilities, but s/he does not do everything by her/himself. S/he has to check within the members who have taken responsibilities for room reservations, management of required materials, and supplying information for absent group members, etc. Most importantly, the trainer has to assure a safe emotional environment for every member to present their problems. S/he helps to clarify the problem when other members are having difficulty expressing themselves. S/he also facilitates the sharing of successful strategies and how to create action plans. The trainer has to respect the views of everybody and needs to foster a safe emotional environment.

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[43] These types of peer support have been adapted/ modified from the approaches identified by Helen Cowie, in

A Peer Support Forum (Cowie and Wallance, 2000) and Kohrt, B., Lamichhane, N., & Jha, R. (2007) *Course book for community psychosocial workers providing psychosocial support for children associated with armed forces and armed groups.* Published by Transcultural Psychosocial Organization Nepal and UNICEF Nepal: Kathmandu, Nepal, p.78-82.

3. Members: Everyone else in the group is a member. The members participate by sharing their views, expressing interest in the presenter's story, etc.

Peer Support Group Module steps:

* First step: Establishing the atmosphere: In this step, each member can talk about her difficulties (for example, girls' health problems, arguments in the family, fighting with neighbors/ friends, etc). In this step, general problems are discussed. The presenter is chosen who will discuss her problem in the next step.

* Second step: Choosing the problem and problem presentation: The presenter who has been chosen in a previous Module will present a problem this time. Or, it might be one of a number of issues brought to this Module. In this step a decision needs to be reached about which issue to discuss.

* Third step: Problem clarification: In this step, the trainer encourages the presenter to present her problem. For this, she has to paraphrase and ask helpful open questions as is necessary. This helps the presenter to clarify her problem.

* Fourth step: Suggestions and feedback: In this step, members share similar kinds of problem they have had, and they describe they resolved their problems. They may suggest to the presenter how her problem can be solved. The discussion is not restricted to only successful experiences or only unsuccessful experiences. Members can share whatever they choose in relation to the presenter's problem as long as it is in a supportive and respectful manner.

* Fifth step: Developing an action plan: In this step, the group discusses recommendations and suggestions from the previous step. A detailed action plan should be made addressing where, how, why, and when to use problem solutions. For example: "What am I going to do the next time my problem happens?" "Why am I going to do it?" "Who could help and support me with this?" "How will I know when I have been successful with my strategy?"

* Sixth step: Evaluation: The purpose of step six is to review how children implemented their action plans from a previous Module. In this step, the participants discuss how their previous action plan was used in the real world. They should discuss if it met their goals for helping their psychosocial wellbeing. In this step, the group should also review this Module overall and provide feedback to one another. In addition, the group should decide who will be the next presenter, what will be the issue and problem in the next Module.

Types of peer group support :

Circle of friends: In a circle of friends, children volunteer to be part of a group. The circle of friends help each other when they have problems such as experiencing a family illness, death, being disabled, etc. The friends support and encourage each other. This approach has also been used to help children who have behavioral problems.

Mentoring: Mentoring is a "process in which an older person volunteers to engage in a relationship with an adolescent or younger person to provide some assistance in his/ her development," (Granatir, 2005). The mentor should be at least two years senior to the mentee (Gensemer, 2000). It involves the supportive relation between two peers for a period of time. The older one (mentor) provides support to younger one (mentee), when the latter one has difficulties. This makes their friendship strong.

Peer Mediation: In peer mediation, children encourage problem solving between friends. For example, it teaches children to stop bullying others and stop blaming others. Peer mediation can reduce quarrels, exclusions, violence, etc. In this approach children are

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empowered with the skills of conflict resolution. They learn how to resolve threats, altercations, and fighting in non-violent ways.

Peer advocacy: When children cannot represent their views and interests, then there is a need of peer advocacy. Peer advocacy may happen in school, youth groups, community groups, etc. This approach is particularly useful for advocating for the needs of underprivileged or vulnerable children, for example girl CAAFAG or Dalit CAAFAG.

Peer tutoring: Peer tutoring is a process where one can learn to help others. This approach is particularly useful in helping pupils improve their reading skills. When a student is a bit more advanced than the other, she can help her friend in her studies. Peers can assist in learning, reading, thinking, writing, speaking, etc. (*Peer tutoring is especially useful to help CAAFAG readjust to schools when they have had their studies interrupted because of their association with an armed group. Peers can help CAAFAG returning to school who are weak in certain subject areas.*)

THEME 3 PYSCHOSOCIAL SUPPORT: Psychosocial support to people with mental, neurological and substance use disorders

Description of the participants
This module is meant for both general and specialized community workers, working with refugees and for dedicated mental health workers in the refugee camps.

Learning Objectives
This module is meant to assist community workers to work more effectively with people who suffer from mental, neurological and substance (MNS) use disorders. This module should be coordinated with the modules for health workers, who are simultaneously trained in the medical approach to these disorders.

After this module the participants will be able to:
- Identify people with *probable* mental, neurological and substance use disorders, both in the community and among the clients in their case load.
- Describe some of the basic characteristics of MNS disorders
- Make a psychosocial management plan for individual with MNS disorders that is in line with the health care based interventions as done by the medical staff
- Develop community based interventions to foster community awareness and community support for MNS disorders among refugees.

The module consists of four Modules

	THEME 3 PSYCHOSOCIAL SUPPORT: Psychosocial support to people with mental health, neurological and substance use disorders	**general community workers and specialized psychosocial workers**	**1 day**
3.11	Psychosocial support for people with epilepsy and seizure disorders		**2-2½ hours**
3.12	Psychosocial support for people with severe mental disorders		**2 hours**
3.13	Psychosocial support for people with common mental disorders and medically unexplained symptoms		**2 hours**
3.14	Psychosocial support for people with alcohol and substance use disorders		**2 hours**

MODULE PS 3.11: Psychosocial support for people with epilepsy

Learning objectives
At the end of the Module the participants will be able to:
• List some essential features of epilepsy
• To identify people with probable epilepsy
• To identify psychosocial problems related to epilepsy
• To offer psychosocial support to people with epilepsy and their families
• Convey key message about epilepsy to the community

Methodology
Group discussion, interactive lecture, brainstorming, Didactic materials: IEC on epilepsy

Materials
IEC material, flip-chart, markers

Time
2 hours

Methodology for trainer
One of the trainers in this Module is expected to be a mental health professional. We refer to the sections on epilepsy in the MH module of this training package for more info on epilepsy

What is epilepsy?
Group discussion and interactive lecture: This part of the training can best be given by a health worker who is trained in epilepsy care
• Ask the participants to give local words used for people with epilepsy. Write down on the flip-chart. Ask the participants if they were familiar with those names and give 3-5 minutes to react on that.
• Ask the different symptoms of someone who has epilepsy
• Provide a short lecture on epilepsy using the following points on a flip-chart:
  o Epilepsy is not a mental illness. It is disease caused by electrical changes in the brain. The disease is characterized by repeated epileptic seizures.
  o Epileptic seizures are sudden episodes in which a person loses control over his body.
  o There are many different types of epileptic seizures.
  o The most important ones are:

Generalized seizures ('grand mal')
These are seizures (also called grand mal epileptic fits) in which the person loses consciousness for a few minutes. His body becomes stiff and shakes in jerky manner. Often the person has typical symptoms like biting of the tongue, passing urine and injury because of the sudden fall or the movements. Observers may describe him crying or screaming just before falling, the eyeballs rolling upwards, frothing at the mouth. During the seizure, the person is unconscious and will not respond to talking. The seizure usually ends with him being drowsy or falling asleep.

Absence ('petit-mal')
Occurs more often in children. Short periods (10 seconds or less) of sudden lost consciousness with fluttering eyelids. The person may stop talking mid-sentence and start again afterwards. It can cause serious problems with learning if occurs frequently.

Partial seizures.
These may occur in an awake person or in a person who is confused or has lost touch with her surroundings. The seizures are very varied in their nature. Some can be limited to one area of the body, for example jerky movements of one arm or leg. Other seizures

may involve complex behaviors such as smacking the lips and buttoning and unbuttoning a shirt. Many people experience a warning or 'aura' that the seizure is about to start. Examples of auras are an unusual feeling in the stomach area and hearing, seeing or smelling things that are unusual. Some people may have a partial seizure that then becomes generalized.

Non-epileptic seizures.
There are also seizures that may look somewhat like epilepsy but are different. The symptoms are not like what has been described for epilepsy and often the person does not lose consciousness, and may talk during the seizure.

When you encounter a person who may have epilepsy it is important to refer to the health centre for diagnosis.

Psychosocial problems of people with epilepsy
Group work (15 minutes)
Form working groups. In each group, ask participants to identify psychosocial problems due to epilepsy and makes sure to cover individual, family and community level. Distribute flip-charts, markers, and ask each group to choose a secretary who will present the work.

Plenary presentation (15 minutes).
Ask each group to present the work done in the group. The rest of the participants follow carefully the presentations. At the end of the presentation, ask participants to ask questions or to comment. Make sure that at least the following elements are covered and if needed repeat and write on a flip-chart.

1. Problems on the individual level
• Epilepsy carries a stigma, having a fit is embarrassing.
• People with epilepsy may feel anxious and depressed and loose hope for the future
• People with epilepsy often face exclusion and discrimination, which can lead to social isolation

2. Family level
• Frustration, feeling guilty or culpable
• Poverty
• Rejection of the family by other members of the community

3. Community level
• Others may fear the person with epilepsy and the family
• Lack of interest to the epileptic person
• Rejection
• Exclusion of the family or the epileptic person

Psychosocial management of people with epilepsy (45 minutes)
The general psychosocial management of epilepsy includes
• Understanding and accepting the person with epilepsy in the community, family, schools and /or work place.
• Encourage the person to use the drugs as prescribed by the health worker
• Encourage the client and the family to join the epilepsy support group for social support.

People who may have epilepsy must be seen by a doctor or nurse. If the person has epilepsy the doctor will prescribe medication.

However, only prescribing medication is usually not enough to ensure that the person live fully in the society again. Epilepsy is often *stigmatized*, and there are many false ideas about it in the community. Epilepsy is not contagious, and touching someone with epilepsy cannot transmit the disease to the other person. Children with epilepsy are often rejected from school, and it is important to ensure that they return to school once stabilized. Educating the family and community about epilepsy will often make the person more accepted in the community, and help to ensure that they continue to take treatment once the fits have reduced or stopped.
The trainers

The trainers describes invites the participants in groups to share ideas how to assist persons with epilepsy and their families, writing on a flip-chart the interventions on individual level, family level and community level

Psychosocial support for individuals with epilepsy
- Identify possible cases of epilepsy and refer to health centre
- Discuss with the person what his fears and worries around epilepsy are
- Provide education to the person, for example by explaining that
   o Epilepsy can be controlled with drugs
   o Epilepsy is not infectious
   o Epilepsy is not caused by witchcraft
   o Persons with epilepsy are not mad
- Encourage the person to participate in society and assist in removing obstacles
- Discuss the don'ts for people with epilepsy:
- Do not drive a motorbike or bicycle unless the person did not have any fits for six months.
- Do not go out swimming, play or bathe in any pool of water
- Do not climb heights such as trees, mountains or buildings
- Do not sit near the fire alone because the flickering of the fire can provoke a seizure as well as the danger of getting burnt if the person gets a seizure
- Avoid stressful situations if possible as such situations could lead to a seizure.

Psychosocial support for families of a person with epilepsy
1. Discuss with the family how they see the problem, and provide them with information about epilepsy where needed
2. Explain the family how to assist a person with epilepsy

Psychosocial support for communities
- Raise awareness in the community about epilepsy by organizing awareness and educational programs.
- Combat wrong and harmful ideas about epilepsy.
- Explain how epilepsy can be prevented. Sometimes participants may believe it cannot be prevented. Whatever they say, list and explain the following points:
   o Treat all infections promptly to prevent brain damage
   o Avoid situations that may cause head injury hence brain damage
   o Pregnant women should be encouraged to attend antenatal clinics to get assistance from a trained health personne**l**

Management of person who has an epileptic seizure (optional 30 minutes)
Role play: Have a participant willing to role play a person having a seizure. Ask participants what the family or community usually does to help a person in a seizure. Encourage some participants to come forward to help the person having the seizure. After the role-play explain the following, praise the participants for what they did well and correct what was wrong.

Key Points: **When a person is having a seizure**

- Keep calm. There is no reason to be afraid for yourself and the patient is not going to die
- Protect the client from hurting him/herself by removing harmful objects (sharp objects such as knifes, stones etc) and position the patients elsewhere if needed (away from harmful situations such as fires, water, on the road etc.)
- Protect the client from banging his head on a hard or rough surface by slipping something soft under the head. If nothing can be found use your hands without obstructing the jerks caused by the fits.
- Loosen any tight clothing like tie, belts top button of shirts and blouses
- Turn him on the side so as to avoid choking with saliva or blood.
- Stay with person until recovery
- After recovery re-orientate the person, reassure him and if needed help him to find the way home.
- In case of injury, wash the wounds with soap and water and cover with a clean cloth

Caution!
- Do **not** try to put anything in the mouth during a fit
- Do **not** give anything to eat or drink during a fit
- Do **not** try to stop the jerking

Key messages

- Epilepsy can be fully treated. 70% of people with epilepsy have no more seizures and can stop taking medications after 2 years of treatment
- Epilepsy is not caused by witchcraft. It is not a contagious disease
- All persons suffering from epilepsy should be referred to health centers
- Drugs to control epileptic fits are available in the health centers
- Medical treatment for epilepsy has to be continued for years unless doctor or nurse advise the person to stop.
- Psychosocial workers have an important role in providing information about epilepsy to the community and to reduce the psychosocial problems around epilepsy.

Resource material to use in this module

- WHO (2010) Intervention guide for priority mental, neurological and substance use disorders in non-specialized health settings. Geneva: Department of Mental Health and Substance Abuse, World Health Organization.
- Ministère de la Santé Publique & HealthNet TPO (2007) Santé mentale dans les soins de santé primaires: module de formations des prestataires de soins, Notions de Base. Bujumbura, MSP (in French)
- Vikram Patel (2003) Where there is no psychiatrist. London, Gaskell
- CBM (undated). Community Mental Health Training. Materials for use in Western Africa

MODULE PS 3.12: Psychosocial support for people with severe mental disorders

Learning objectives
At the end of the Module the participants will be able to:
- List some essential features of severe mental disorders including severe depression, psychosis and bipolar disorder and also with regard to suicide and violence/violent tendencies
- To identify people with probable severe mental disorders
- To identify psychosocial problems related to severe mental disorders
- To offer psychosocial support to people with severe mental disorders and their families
- Convey key message about severe mental disorders to the community

Methodology
Group discussion, interactive lecture, case study, brainstorming ,

Time
Time 2 hours

Materials
flip-chart, markers

Methodology for trainer
3.12.1. Introduction to severe mental disorders (interactive lecture) (1 hour)
- Explain that it is important for a psychosocial worker to have basic knowledge on mental health issues. It is important for:
  o identification and referral of probable cases,
  o awareness raising in the community
  o psychosocial support to the patient and the family
- Ask the participant the local names given to people with mental illnesses and discuss the feature of them and the associates ideas (for example the community may believe that people with mental disorders are dangerous and aggressive, or that is the mistake of the people themselves that they have become like this
- A psychiatric nurse or doctor presents a brief overview of the severe mental disorders that are frequently observed in the community/camp. The psychiatrist nurse will focus on severe depression, psychosis and bipolar disorder depending on the level of the participants. Suicide and violence/aggression can also be mentioned here.

3.12.2. Psychosocial problems related to severe mental disorders (1 hour)
- Group work (15 minutes): Ask participants to form groups and identify psychosocial problems on 3 levels: Individual, family and community, due to severe mental illness.
- Group presentation (25 minutes): Each group presents the work. Ask the rest of the group to follow and to make comments. Ask the participants the interventions that can be used to address the problems on the different levels
- Interactive lecture and discussion (20 minutes): Trainer presents an interactive lecture writing the following elements on a flip-chart and combining them with what the participants have said.

Psychosocial problems due to mental illness
- *Individual level:* Family exclusion, stigma, poverty, lack of education, victim of violence (physical , psychological and sexual), isolation, low self esteem, untreated physical illness, rejection, limited opportunities , shame, culpability
- *Family level:* social stigma, family conflicts, discrimination, poverty, feeling of insecurity, culpability, shame, anxiety,

- *Community level*: Discrimination of people with mental disorder, lack of interest to support people with mental disorders and their families, physical harm, insecurity

Psychosocial Support to individuals with severe mental disorder
- Psycho-education for the affected individual about causes, consequences of their illness. Encouragement to try not to isolate themselves, to live positively, and to find existing support groups and services within the camp.
- Referrals to specialized services where available by the community worker
- Inclusion of the person in support groups of people with severe mental disorders
- Where symptoms are acute and the individual is unstable, such as having suicidal thoughts, not functioning within a job or within the family, or suffering from paranoia and running away, this is a reason to consult a specialist and refer to the hospital

Psychosocial support to the family
- Information to the family members on the existence of Severe Mental Disorders aimed at helping the family to offer good care to the members(being gentle to them, involving them in all the family activities, referring them to the helping services
- Give messages to the family about hope of improvement of symptoms and recovery of social functioning and loving with dignity
- Inform families to different helping services within the camp

Psychosocial messages to the community
- In simple words, educate the community on mental health illnesses, causes, clinical signs. For a better information share, it is recommended to invite a psychiatric nurse to give to the presentation.
- Educate the communities on the positive behaviors toward a mentally ill person.
- Inform the community on the existence of treatment and services.

Resource materials to use in this Module
- WHO (2010) Intervention guide for priority mental, neurological and substance use disorders in non-specialized health settings. Geneva: Department of Mental Health and Substance Abuse, World Health Organization.

MODULE PS 3.13: Common mental disorders and medically unexplained complaints

Learning objectives
At the end of the Module the participants will be able to:
- List some essential features of common mental disorders (including anxiety disorders, mild to moderate depression)
- Define 'unexplained physical symptoms'
- Identify people with probable common mental disorders, unexplained medical complaints and somatic symptoms
- To offer psychosocial support to people with common mental disorders or unexplained physical complaints
- Convey key messages about common mental disorders and unexplained medical complaints to the community

Methodology
Group discussion, interactive lecture, case study, brainstorming ,

Materials: IEC material, flip-chart, markers

Time
2 hours

Methodology for trainer
Introduction to common mental disorders and unexplained medical symptoms

Group Exercise:
- The trainer introduces the topic of sadness by asking the participants why people feel sad or lose interest? It will become clear that from time to time every person feels sad or unhappy; this is a normal part of life. In particular when a person experiences an important loss (for example the death of a loved one) or is in difficult circumstances with little prospects for the future.
- Ask the participants when a condition of sadness and loss of interest can become an illness?
- What kind of words do refugees use to indicate people who are very sad and isolate themselves? (example: *akabonge / ibonge* in Kirundi/ Kinyarwanda)
- Ask participants if they encountered people with such complaints in their daily work. Bring the participants to share experiences on the support they normally provide to such cases

The trainer provides an interactive lecture in which the following information is covered.
- From time to time every person feels sad or unhappy, particularly when a person experiences an important loss (e.g., the death of a loved one). This is a normal part of life. Sometimes a person can develop an illness that is characterized by sadness, loss of pleasure and many other symptoms which affect the body including changes in sleep, appetite, energy, motor function, guilty ruminations, anxiety and thinking about ending one's life. This is called <u>depression</u>. A depression is a mental illness that involves the body, mood, and thoughts. It affects the way the person eats and sleeps, the way one feels about oneself, and the way one thinks about oneself and things. A depression is not the same as feeling unhappy or sad. It is a real disease, which can make the person suffer, just as any other disease. It is not a sign of personal weakness. And it is not just a sad mood. Often people have difficulty getting out of bed, going to work or doing duties around the home.
- People with depression often seek treatment in health care centers for their physical symptoms such as tiredness, sleeplessness etc. But often the medical treatment is not sufficient and the patients ends up using unnecessary medication.

- *Medically unexplained complaints* refer to physical complaints for which the doctor cannot find a clear physical cause. Often they are caused by or related to emotional or psychosocial problems, and are due to anxiety. Anxiety can be both experienced in the mind (anxious thoughts, too many thoughts which can cause insomnia, worry etc) or it can be experienced in the body as a physical complaint.

For example, having a headache might be a functional way of describing the constant inner thoughts that a woman is having after rape. She might be finding hard to express verbally what she experienced but a headache is easier for her to understand and is a way to ask for help

The following physical complaints may be presented by the person:
- headache with no apparent reason
- Continuous abdominal pain
- General body pain or located on some parts of the body
- Heavy heart or heart beating fast
- Body rash
- Feeling dizzy
- Body tiredness

These symptoms are real. People with these symptoms go to the doctor or nurse, but medical tests are negative. Often such clients visit several health centers and hospitals for medical check-ups seeking help for their complaint. In this case, it is wrong to say that the symptoms are imaginary or 'made up'. When this occurs, it is important for health workers to know that this is likely due to emotional stress and is felt as physical pain rather than emotions.

Psychosocial assistance to people with common mental disorders and unexplained medical complaints (1 hr)

How do we assist an individual with unexplained medical complaints
A medical doctor or nurse may feel irritated about patients with unexplained medical complaints. It is important to
- Ensure that the person is has been in health centre for medical check up
- Ensure that the person is informed by medical staff about results of check up and treatment. If the results do not point at a clear medical disorder explain in simple terms that physical symptoms may be a result of reactions or emotional problems. Reassure the person that the felt symptoms are not the beginning of a terrible illness
- Explain, in simple terms, that there are times when bodily function can lead to pain and other symptoms. Stress and difficulties can makes this worse.
- Explore with the patient what kind of social, interpersonal or other contextual factors might contribute to the complaints. Situations or experiences that are considered as shameful (such as rape or domestic violence) might express themselves physical or mental expressions. It is good to ask for those kind of experiences.
- Community workers can assist the management of people with unexplained medical symptoms by involvement in psychosocial interventions related to their specific social stressors.
- Reactivate social networks and address current psychosocial stressors
    o Find a way, together with the client and the relatives to stop harmful/stress practices, if needed.
    o Try to identify the person's prior social activities that, if re-initiated, would have the potential for providing direct or indirect psychosocial support (e.g., family gatherings, outings with friends, visiting neighbors, social activities at work sites, sports, community activities). Actively encourage the person to resume these social activities and advise family members about this. Community based psychosocial workers or community health workers can play an important role here.

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- Behavioral activation (is doing the activities that the person used to do but may now have become difficult or unpleasurable.
- Relaxation training (breathing exercises, muscle relaxation)
- Psychosocial counseling. This is often helpful for people with common mental disorders. Where professional psychosocial counselors are available people can be referred. If these resources are not available other helpers can offer the opportunity to talk, preferably in a private space. Ask for the person's explanation of the symptoms. Ask for current psychosocial stressors and to the extent possible, address pertinent social issues and problem-solve for psychosocial stressors or relationship difficulties with help of community services/resources. It is helpful for a depressed person to have signs that people are supportive. This means that it is necessary to involve the family.
- Family counseling
- Support groups.
- Referral to a health centre is needed if the person has severe complaints and cannot function properly. In this case a medical staff can evaluate the clients and decide if medical treatment such as medication can be helpful.

Evaluation
Ask the participants at the end of the Module what they have learned.

Resource materials to use in this module
- WHO/UNHCR (1996). Mental Health of Refugees, Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf (Unit 4, page 39- 62)
- Vikram Patel (2003). Where there is no psychiatrist. London, Gaskell.
- WHO (2010) Intervention guide for priority mental, neurological and substance use disorders in non-specialized health settings. Geneva: Department of Mental Health and Substance Abuse, World Health Organization.

Study material: Module 3.13

Depression[44]

Many refugees suffer from depression. Mental illness due to depression can be very serious and may lead to suicide. In most cases however the depression is mild. The symptoms of depression may be disabling and prevent the refugee from studying, working and enjoying any activity.

The most common causes of depression are loss of a family member or friend, and the sickness or death of a child. Other common causes are the loss of valuable property and extreme poverty. Another cause of depression may be a shameful or embarrassing event within the community such as an unwanted pregnancy, the break-up of a marriage or being fired from a job. Hurtful and terrifying experiences such as rape, or being attacked and robbed by criminals can also cause depression.

In some depressed people, you will not be able to find a cause. Some depressions seem to happen for no identifiable reason. Almost all refugees at times feel sad and hopeless about their situation. But even with these feelings, most do not suffer from the mental illness called depression.

Depressed people feel very sad and hopeless for months. Nothing gives them pleasure. They believe that nothing and nobody can help them in their suffering. They do not seek help because they believe their situation cannot be improved.

Symptoms
The most common symptoms of depression are:
- overwhelming sadness and deep sorrow;
- hopelessness;
- thinking about harming oneself;
- crying easily;
- worrying constantly;
- anxiety, tension;
- lack of joy in life;
- lack of energy, easily becoming tired;
- physical complaints such as headaches that do not go away;
- poor sleep;

People with multiple physical complaints
Physical complaints are the commonest reasons for seeking help from a health. Many symptoms, such as fever or cough, can be explained as medical problems. However, there are some complaints for which it is often difficult to find any medical explanation. Examples of such complaints are:
- headaches;
- aches and pains all over the body;
- chest pain;
- heart beating fast (palpitations);
- dizziness;
- low back pain;
- abdominal pain;
- difficulty in breathing.

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[44] Adapted from: WHO/UNHCR (1996). Mental Health of Refugees, Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf and Vikram Patel (2003). Where there is no psychiatrist. London, Gaskell.

These complaints may be related to mental problems and often times are linked to anxiety. People with mental health problems come with physical complaints for many reasons:

- Worry and tension can make a person tense his muscles for long periods. This makes the muscles tender and painful. A good example of this is the 'tension' headache as a result of tensing up neck muscles when worried.
- When people are tense, they tend to breathe faster. This can lead to symptoms such as dizziness, palpitations, tingling or numbness of the fingers and toes, and a choking or breathless sensation.
- The body symptoms can be a way of expressing mental pain
- Painful illnesses can make a person feel unhappy and worried. Here, the pain is caused by a physical illness, but it affects the person's mental health. Feeling depressed can make the pain less bearable.

When to suspect that physical complaints are related to mental illness[45]
You should think of a mental illness particularly in a person who:

- has more than three complaints;
- has complaints that do not fit into any pattern which you associate with a physical disease;
- has had the complaints for more than three months;
- has consulted health workers many times for the same complaints;
- has been examined and has had tests that were normal.

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[45] Vikram Patel (2003), Where there is no Psychiatrist. London, Gaskell, page 87.

MODULE PS 3.14: Alcohol

Learning objectives
At the end of the Module the participants will be able to:
- Describe the problems related to alcohol for community, family and individual
- Describe psychosocial support interventions to reduce problematic alcohol use in the community
- Understand the stages of change model and applied this to clients with substance abuse problems;
- Have insight in specific techniques for use with clients who abuse substances;

Methodology
Group discussion, interactive lecture, brainstorming

Materials
flip-chart, markers

Time
2 hours

Methodology for trainer
Introduction to Alcohol Use Disorders
- Group discussion: Invite participants in groups to reflect on the effects of alcohol use in the refugee camps. Each group uses a flip-chart and divides it into two columns entitled positive aspects and negative aspects. Discuss the effect on the individual, families and community.
- Plenary group discussion

Assisting individual, family and communities to deal with problematic drinking
- Invite participants in groups to discuss how they can assist individuals, families and communities in dealing with problematic alcohol use. (20 minutes)
- Plenary group discussion

Small group exercise (30 minutes)
Divide the participants into small groups. Give each group a blank version of the Stages of Change model (see handout at end of section) and ask them to discuss in their groups and fill in the stages and arrows between the stages. Describe the stages in their own words.
- Reassemble the whole group and ask one person from each small group to come up and draw onto a large blank diagram (or transparency) one stage of change. If necessary, show a large diagram of the correct model to clear up any confusion.
- It can be helpful to leave up a completed diagram throughout the rest of the lecture to refer to the stages of change as you lecture

Behavior diaries lecture and pairs discussion (30 minutes)
- Ask a participant to bring in a case of substance abuse. Explain how to use behavior diaries (Using Handout at end of section).
- Give each pair a blank behavior diary sheet (see Handout at end of section) and ask that the person fill in some examples.
- After 10 minutes, reform the group and ask for some examples of antecedents and consequences.

Problem-solving lecture and action plans, interactive lecture (1 hour)
- Discuss with participants problem-solving and goal setting techniques and discuss how to apply these with clients who abuse substances.
- Action plans and relapse prevention plans lecture: Explain what to include in action plans and relapse prevention plans for clients who abuse substances.

- In pairs, participants should imagine and write down what would be on person in the example's action plan. Note, this is not a role-play exercise. After 15 minutes, ask the group to stick up on the wall their action plans and then go around the room and look at each other's plans

Resource materials to use in this module
- WHO/UNHCR (1996). Mental Health of Refugees, Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf (Unit 4, page 39- 62)
- Vikram Patel (2003). Where there is no psychiatrist. London, Gaskell.
- WHO (2010) Intervention guide for priority mental, neurological and substance use disorders in non-specialized health settings. Geneva: Department of Mental Health and Substance Abuse, World Health Organization.

Study material 1: Module 3.14

Alcohol and substance abuse[46]
Alcohol and other drug problems are common in many societies. In refugee settings it may be even more common. There are several reasons for an increase in the risk of serious alcohol and other drug problems among refugees. People who use alcohol or other drugs risk developing many problems. These include health, family and personal problems. As people use these substances more, they are more at risk. Some of the people may have had these problems before they became refugees. Some refugees may begin to use alcohol or other drugs as away to avoid facing their problems. Others may have a lot of time with nothing useful to do. When families and society stop controlling people's behavior in the normal way, young people in particular may start taking alcohol or drugs.

Refugees risk a lot by taking alcohol or other drugs regularly. These substances can seriously damage health, and when people are living in poor conditions the damage to health is even greater. When refugees spend the small amount of money they have on drugs, they make life even more difficult for others. Social problems caused by drug use can affect not only the family but also the refugee community as a whole. If refugees use alcohol and other drugs regularly, they will make little effort to improve their living conditions. This affects all the refugees. Even if a few people begin to drink a lot or take other drugs, it affects the confidence and discipline of the whole community.

What does drinking too much do to a person and the family?
Drinking too much alcohol can seriously damages health. These are some of the symptoms that can result from problem drinking:
• blackouts – when a person has no memory of what happened after a drinking bout;
• withdrawal reactions, such as becoming tense and shaky and, in severe cases, becoming confused and having fits
• accidents, especially while driving;
• bleeding in the stomach;
• jaundice and liver disease;
• sexual impotence ;
• depression and suicide
• sleep problems
• confused behavior
• unsafe sexual behavior
• Damage to an unborn baby (in cases where mothers drink too much).

In addition to the above physical effects of drinking, there are the *social* effects of problem drinking:
• increased poverty due to reduced ability to work and spending money on alcohol;
• violence in the home and community
• loss of job;
• neglecting the family, leading to family break-up;
• legal problems.

What can a community worker do?
• Help the refugees to organize themselves to prevent a demand for alcohol and drugs within their community. It is also important to prevent outsiders from supplying the refugees with drugs.

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[46]   adapted from: WHO/UNHCR (1996). Mental Health of Refugees, Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf and Vikram Patel (2003). Where there is no psychiatrist. London, Gaskell.

- You may need to tell the leaders of the refugee community about the risk of people starting to use alcohol or other drugs. Warn them that outsiders may try to create a demand for alcohol and other drugs.
- Community leaders should understand that refugees are an easy target for drug dealers. This is especially true 1f the refugees are not well organized as a community and have little or no hope of returning to a normal social life again.
- Encourage the community leaders to watch out for problems. Ask if they think that the use of alcohol and other drugs has already begun or is increasing. Do they think these problems could soon appear? If so, they could ask individual refugees or groups for help in preventing the problems before they begin. They could try to get the whole refugee community to act to prevent drug and alcohol use. They may be able to find out whether outsiders are trying to create a market. They could find out who these outsiders are and where they come from. Then they could decide on the best way to stop them.
- To prevent alcohol and drug problems, everything should be done to improve and keep up the general welfare and morale of the refugees. All refugees should feel useful and should want to do their best for one another and for the whole community. 1f they have useful things to do and have some hope for the future, they will be less likely to take drugs. Warn the whole community that refugees who take drugs have more problems than people living in normal communities who take drugs.

Remember
- Stress the possible effects of alcohol use on the whole community.
- Help the community to understand the risks of alcohol and other drugs.
- Encourage the community always to keep watch for the beginnings of drug use.
- Arrange from time to time for the refugee community to commit itself publicly to stopping the use of alcohol and other drugs. The refugees must also commit themselves to stopping the illicit production and trade of alcohol and other drugs.
- Involve the whole community in group activities to help each other while they wait for a more permanent solution to their problem.
- Arrange for the refugees to discuss how they should organize themselves to prevent alcohol and other drugs from being used in their community.
- Always try to raise and maintain the refugees hope.
- By preventing the problems linked with the use of alcohol and other drugs you can prevent further harm to the refugees. Help them to understand this. They con then organize themselves to protect one another and the whole community from these problems.
- Do not take a moral view on drinking. Even if you feel that drinking is bad, your aim is to help the person.

Helping individuals
Some individual refugees will need special attention and help.
- Ask who uses alcohol or other drugs now and has problems because of this.
- Look out for behavior that suggests alcohol or other drugs are being used. Also look for other signs and results of alcohol and drug use such as physical illness, injuries, drunkenness or strange behavior.
- Find out which of the refugees are known to have been regular or heavy users of alcohol or other drugs before they became refugees. Such people are at special risk.
- Refer people to the health centre for a medical check up!

Previous heavy users or problem users
The refugees will usually know whether anyone in their community is using drugs in a harmful way. If there are no serious problems now, ask community leaders or others with influence if they know of people who were having problems from the use of alcohol and other drugs, or who used drugs every day, before they became refugees. These persons are at special risk if alcohol or other drugs become available. Even if these persons are not using drugs now, the refugee leaders should try to involve them in

community activities or meetings. This will help make them feel valued members of the group. It is important to give them a chance to do even small things for the welfare of all the refugees. Even as a refugee, the former drug taker should be helped to feel more valued than when he or she took drugs.

Current users
- The community usually knows who is taking alcohol or drugs. People may be seen doing this or may show signs of using alcohol or other drugs. Different drugs create similar problems, but remember that each drug has its own particular effect on users.
- Some users may be taking alcohol every day because they cannot cope without. These people are "dependent". Usually they have many problems. They damage their own health, they neglect their families, and they become a burden to their families and to the refugee community.
- People who are dependent on alcohol need to take the drug regularly. If they do not drink they suffer distress and withdrawal symptoms - a mixture of physical and mental symptoms. They feel better almost as soon as they take their drug again.
- Someone who stops taking alcohol sleeps badly, becomes angry and restless easily, feels sick and may shake. In bad cases, the person may not be fully conscious. He or she may feel terrified, may see imaginary things and may even have fits like the fits that people with epilepsy sometimes have. Suddenly taking away alcohol from a person who is dependent on it can be dangerous. It can even cause death.
- Even people who are not dependent on alcohol but still take too much may have alcohol-related problems. These include health problems, poor nutrition, family problems, accidents, fights and other social problems. In a refugee camp, the use of drugs can lead to problems more quickly than in normal life.

Helping people who admit they have a drug problem
Sometimes people with an alcohol or drugs problem can be motivated to help themselves or accept the help of others. They can decide not only to stop taking alcohol or drugs but also to live a more meaningful life. When heavy alcohol users admit they have a problem they start to have a good chance of giving up the drug. Work patiently with such people to help them control their problems, stop using and change all the behavior that goes with alcohol use. This may be easier in a refugee camp than in normal life because, living with the other refugees, the drug user is less isolated.

- Find out who among the refugees is willing and capable to help drug users. Organize a group of community workers and arrange for them to meet together. Explain to them the risks of heavy use of drugs. Discuss with them ways in which they can help users of drugs to control their problem.
- Explain that the most useful skill is the ability to talk to drug users in a friendly way. Suggest that each community worker talks to one drug user as part of the community effort to control the problem. Tell them not to give orders. They should try to find out what the drug users feel about their problem and how likely it is that they can control it. Each community worker should talk and listen to the drug user they are helping every day for a week. Then have another meeting with the community workers. At this meeting, they can tell one another about their experiences. They should describe their difficulties and discuss ways of overcoming them.
- Ask the community workers to discuss why some alcohol and drug users fail to control their problem. Explain that there may be many reasons for this. Drug users may not wish to change because they are not interested in any other aspect of life. They may be used to this way of life. They may not have any other interests. They may not feel part of society or of their families. They may have had unpleasant symptoms when they stopped using alcohol or the drug for a time in the past.

- Ask the community workers what they can do to overcome these barriers. Suggest that the community workers continue to see the individuals they are helping regularly during the following weeks.

People can and do stop taking too much alcohol, especially when others show an interest in helping them. The community workers, just by meeting drug users regularly, may help them to change. Change may also happen because the community shows an interest in the drug users. People who live in a refugee community can feel a particularly strong interest in others and sense of community care. Fear of withdrawal symptoms can be a reason for not stopping drug use. Most users can stop taking their drug if they are determined to do so, without using any other drug. Sometimes stopping a drug suddenly can cause serious symptoms, and it is necessary to prescribe some medicine. Withdrawal is a threat to life only for the few people who are severely dependent on alcohol or drugs.

Drunken behavior
One problem is drunken or intoxicated behavior. A drunken person may be violent and aggressive. Some people are always aggressive after drinking alcohol, but they can usually control aggressive behavior if they know that other people will not accept it. When a drunken person behaves violently in public it is best to take the person away or persuade the other people to go away. Never challenge someone who is drunk and aggressive or try to stop the behavior. He or she may try to attack you. It is usually much better to agree with the drunken person and to try to get the person away from the situation that is causing the violent reaction.

Overdose
An overdose may cause a person to become unconscious. Watch an unconscious person carefully to avoid other harm. Pay special attention to the person's breathing. Patients who are unconscious after taking alcohol often have low levels of glucose in their blood. This can damage the brain, and the damage can remain even after the alcohol has been cleared from the body. An unconscious person should not be given anything by mouth;

Withdrawal
The symptoms that people experience when they stop taking alcohol or other drugs' can be relieved in various ways. Sometimes medicines may be necessary. Diazepam and similar medicines can help to prevent the dangerous withdrawal effects that occur with severe alcohol dependence. They should be given only for a short time and the dose should be reduced gradually. People who stop taking alcohol may have times when they are not fully conscious. These people may have fits, or be confused. They may also see things that are not there. In such cases medicines such as diazepam may be given for a short time, and the doses gradually reduced. People going through withdrawal from alcohol or other drugs should not be left alone. Someone they know well should stay with them. This should be someone who is able to communicate clearly with them and stimulate them to remain conscious. The surroundings should also be stimulating, with good light, for example. If the condition of the person going through alcohol withdrawal becomes much worse, a small amount of alcohol may be given, especially if there are no medicines available.

The community workers should also speak to the families of the alcohol users they are helping. A person who cuts down or stops using drugs should be praised and congratulated on the achievement. Family, friends and community workers should show their satisfaction and give encouragement. Community workers can tell users other things they can do to gain respect. Bring together the community workers and those who have stopped taking drugs to discuss how much others in the community appreciate the change. Community workers and former users can plan together things the former drug users can do that the community would value. They can discuss together how to avoid falling back into alcohol use.

Self help
Former users can plan ways to stop the supply of alcohol to the refugees. In this way they will be helping the whole community and strengthening their loyalty to one another. They will have a sense of a united effort to protect themselves from being used by outsiders. The community workers should keep in regular contact with the former users to help them to maintain the changes they have made in their lives. In this way they can also reach current drug users. Community workers should encourage former drug users to speak to current users and help them stop using drugs. Explain to the community workers that regular contact over a long period is needed to make sure that former drug users do not start taking drugs again.

One way of helping people who have stopped taking alcohol or other drugs is to find them a useful task or encourage them to find a useful task.

Alcoholic drinks are used in many cultures around the world. Some types are international, such as beer and whisky. Other alcoholic drinks are unique to the local culture and people brew alcohol at home. Illegally brewed alcohol can contain dangerous chemicals. Most people who drink do so once in a while, in the company of friends. Some people drink more regularly but never drink more than a moderate amount every day. There are some people who drink too much. This is when you need to become concerned.

How much drinking is 'too much'?
When drinking starts causing health or social difficulties for the person, then the person is drinking too much. Some people may drink too much yet manage to live normally. You must be concerned about such people as well, since sooner or later, the drinking problem will affect their health. When the body becomes used to the effects of alcohol, this is called *tolerance.* Tolerance is itself a sign that the person is drinking too much. By the time a drinker's health is affected, the problems are very serious. There is also another type of drinking pattern which is very dangerous. This is drinking very heavily for a few days at a time. For example, some people drink only at weekends, but then consume a large amount of alcohol. This is called '*binge' drinking.*

Why do some people drink too much?
Many people start drinking by trying out alcohol when they are teenagers. Easy availability of alcohol and peer pressure are important reasons why they start drinking. While many teenagers only experiment with alcohol, some start drinking more regularly. Most people drink sensibly and do not damage their health or family life. Drinking can also start later in life, for example in middle age, particularly at a time of stress. Drinking problems may arise when alcohol is used to help a person cope with difficulties. Some people, especially those who drink regularly, develop a physical and psychological need to have a drink. This is called dependence or addiction. If someone with an alcohol addiction does not get a drink, he will start feeling physically sick; this is called a withdrawal syndrome. The withdrawal sickness is temporarily relieved by drinking more alcohol, but this only serves to keep the dependence going.

When should you suspect that a person has a drinking problem?
Many people with a drinking problem do not seek help until their health is very bad. Even when they do, the drinking problem is often undetected and untreated. It is important to be aware that many health problems are related to drinking. You should briefly ask about drinking behavior when anyone comes to see you, but give special attention to this with people who come with any of the following:
- unexplained accidents or injuries;
- burning in the stomach area or vomiting blood;
- relationship problems in the family or with friends;
- repeated sicknesses and absence from work;

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- mental health problems such as depression and anxiety;
- sleep difficulties;
- sexual difficulties, such as impotence.

What to do for the person with a drinking problem
Most often, health workers treat only the physical illnesses associated with problem drinking. Unless you treat the drinking problem itself, the person will never fully recover. There are three stages to overcoming a drink problem:

- admitting there is a problem;
- stopping or reducing drinking;
- remaining sober.

To admit that there is a drink problem is an essential first step. Often the drinker comes to the clinic only because of family pressure. He may deny he has a problem. It is important not to get angry with him. Instead, talk about other issues (such as work and health) and try to get him to make the links between his drinking and its effects on his life. A person who is forced into treatment without accepting that he has a problem is less likely to give up his habit. One way of improving motivation is to help him face his problem by asking him to list all the reasons for changing his behavior, such as "feeling healthier", "having more money to spend on other things" and "improving relations with my wife". Once the person has admitted that there is a problem, the question to decide is whether she should stop drinking completely (abstinence) or simply reduce her drinking to the 'healthy' limit.

Study material 2: Module 3.14

Stage of Change Counselor's Role[47]
Precontemplation
- Clarify the client is free to choose to change or not Encourage self-exploration Provide information and raise doubt about the risks of the behavior. Contemplation Clarify the client is free to choose to change or not Encourage evaluation of the pros and cons of change Strengthen the client's self-belief that he/she can change.
- Preparation Help the client to make a plan for change Help the client identify social support and coping skills.
- Help with problem solving to overcome obstacles.
- Provide encouragement and support.

Action
- Focus on problem solving and building coping skills
- Provide encouragement and support, and boost self-belief
- Help client overcome feelings of loss and remind client of the long-term benefits

Maintenance
- Make a plan for follow up support Reinforce client's sense of achievement
- Make a relapse prevention plan
- Relapse Discuss the trigger for relapse
- Reassess the client's motivation to change
- Revise the relapse prevention plan and develop stronger coping strategies

Stage 1: Identification
Harmless use or abuse? This can be a difficult question to answer, and depends on many factors including:
- What is the amount of substance use?
- Is the substance use damaging the client's health?
- Is the substance use causing relationship problems for the client?
- Is the substance use preventing the client from working or studying?
- Is the substance use causing financial problems for the client?
- Is the substance use causing legal problems for the client?
- Is the substance use culturally acceptable?
- Is the client worried about his or her substance use?

Willing or unwilling clients?
- Often clients with substance abuse problems who come to counseling do not come of their own free will.
- Commonly clients are identified through the medical system after seeking help for serious physical problems due to drug use.
- Family members may hope the client will give up his or her substance abuse if told to do so by the counselor.
- Doctors, family members and others may identify clients with substance abuse problems who are in either of the precontemplation or the contemplation stages.
- If clients themselves choose to come to counseling, without being forced or persuaded, we assume they are in the contemplation stage of change. If a client has been identified by someone else as having a problem, or if we suspect they have been pressured to attend the Module, it is possible that they are in the precontemplation stage, not believing they have a problem.

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[47] Copied with little adaptations from: SAPKOTA, R.P., DANVERS, K., TOL, W.A. & JORDANS, M.J.D. (EDS.)

(2007). *Psychosocial counseling for people affected by armed conflict in Nepal: A trainer's manual.*

Kathmandu; Sahara Paramarsha Kendra/USAID

Stage 2: Beginning
The beginning stage may be especially difficult with clients with substance abuse problems for several reasons:
- The counselor has to manage his or her own prejudices about substance abusers, and be sure to adopt a non-judgmental and non-blaming attitude.
- The client may feel ashamed or guilty about the substance abuse and so he or she may try to hide the extent of the problem from the counselor.
- The client may be used to being blamed, disapproved of and bullied about his or her substance abuse, and so may be defensive and expect the same attitude from the counselor.
- The client may be in the precontemplation stage of change, and so might be hostile or resistant to talking to the counselor.

Remember:
- It is not possible to use counseling to help people change if they are in the precontemplation stage.
- People cannot be changed through force: they will only change if they want to.
- Counselors can try to move the client to the contemplation stage by:
  o clarifying that the client is free to choose to change or not,
  o encouraging self-exploration,
  o providing information and raising doubt about the risks of the behavior.
- Moving clients from the precontemplation to the Contemplation Stage of Change Rollnick and Miller suggest four basic counseling skills to interview clients in the precontemplation stage with the aim of increasing motivation to change:
  1. Open Questions: The counselor should be curious but non-judgemental about the client's substance use, and use open questions to find out more about the client.
  2. Affirmations: The counselor should provide positive statements about the client in a genuine way. 3. Reflective Listening: The client should use reflective listening skills in a way that gently raises the client's doubt about their substance abuse. The counselor should try to pay more attention to "change talk" and less attention to "no-change talk".
  3. Summarizing: The counselor can stop the client at certain points to summarize what has been said already. Summarizing provides the client with an opportunity to hear his or her own words from the counselor, and this can often provide new insight to the client. Again, when summarizing, the counselor should try to pay more attention to "change talk" and less attention to "no-change talk".

"Good" and "Not so good" things about substance use
- The client is asked to write down good and not so good things about substance abuse.
- The list is used to help clients think about change and increase motivation to change
- Writing down the list is important, because:
- it summarizes the information for the client,
- it helps the client see that the not so good things outweigh the good things,
- the list can be kept and used again later in counseling, for example, to reinforce motivation to change after relapse
- We use the words "not so good" rather than "bad things about substance abuse" because:
  o it avoids alienating the client by using blaming language,
  o it recognizes that at the moment, the client is just exploring his or her thoughts about substance use.
- The counselor can ask the client to fill in the sheet alone, and then review it with the client in the next Module, or the sheet can be completed through discussion.

- When discussing the sheet, counselors may need to prompt clients to come up with "not so good things", through asking questions.
- Some things might be "good" and "not so good".
- In later Modules if the client mentions new "not so good things", they can be added to the sheet.

Keeping a behavior diary of Substance Use
- The point of this is NOT to keep track of how much the client is using (and you should reassure the client that this is not the case!).
- The diary is used to help the client see links between his or her substance use and their feelings and life circumstances.
- The diary can be used to help the client spot triggers for the behavior and also see the consequences of the behavior.
- Clients can keep a diary in any way they choose, but sometimes it is useful for the counselor to give them a structure for the diary:
- The chart has various prompt questions to help the client know what to write
- It focuses attention on the antecedents (things that happen before and cause the behavior) and the consequences (things that happen afterwards because of the behavior).
- This technique is also called an "ABC chart", for Antecedent-Behavior-Consequence.
- The counselor should design individual charts for each client, with prompt questions that they believe might be relevant for that particular client.

Using diaries (continued)
- Diaries should always be reviewed with the client
- Counselors can ask more questions about specific incidents of behavior to find out more about it.
- Remember, the diary is used to help the client and counselor understand more about what motivates the client's behavior.
- It is especially useful in the assessment, formulation and implementation planning stages.
- The following are examples of factors that might be highlighted by using a diary:
- The function of the behavior, that is, how it helps the client (useful when making a formulation of the client's difficulties)
- Negative consequences of behavior (useful for clients in the contemplation stage, and in the relapse stage to strengthen motivation to try again)
- Situations where the client uses drugs to cope with stress (useful in the preparation and action stages, and to show where new coping strategies need to be developed)
- People and places that have become associated with drug use (useful in the preparation and action stages when the client might need to develop plans to avoid those people and places)
- When the client has made progress and is using less (useful in the action and maintenance stages, to congratulate effort and reinforce motivation)

Formulation
- Once rapport has been built, and the counselor has gained enough information about the client, the counselor can begin to draw up a formulation.
- Five formulation factors can be used to summarize the important information about the client.
- The formulation highlights the function of substance abuse for the client – that is, how it helps the client. The formulation also shows us the psychosocial problems that underlie substance use.
- It should highlight any other coping resources the client has, and show where new coping strategies need to be developed.
- The formulation clearly shows the client and counselor where changes need to be made, if the client is to give up is or her substance use.
- It can be used as the starting point for planning what to do next.

- The counselor and client can share and discuss the formulation, as this will help the client understand his or her substance use better, and perhaps strengthen their commitment to change.

Implementation Planning
- The next stage of change is the preparation stage: during this stage, the client and counselor should make a plan of how to change, and identify what they will need to do before the client stops using substances.
- Sometimes it is helpful to set a date a few weeks in advance for when the client will start to cut down or completely stop using substances.
- Remember to seek medical supervision before giving any advice about cutting down or stopping drugs safely.

Problem solving
- The counselor and client come up with a list of potential blocks that might stop the client giving up substances.
- Each block is discussed individually, and possible solutions to the block are brainstormed.
- Once possible solutions have been listed, the counselor asks the client to discuss the pros and cons of each solution.
- Sometimes during this discussion, the counselor might identify skills gaps, and so plan to teach specific coping skills during the implementation stage.

Goal setting and the importance of timing
- Once solutions have been chosen, the counselor and client can translate these into SMART goals:
  - **S**pecific
  - **M**easurable
  - **A**chievable
  - **R**ealistic
  - **T**ime limited
- The timing of goals is extremely important in substance abuse: for many clients, the substance use has become a "psychological crutch" to cope with other problems in the client's life.
- It is extremely important not to remove the crutch without ensuring there are alternative supports in place for the client, or the client is likely to fail.
- So often, the counselor and client may have to work together to create new supports and coping strategies for the client BEFORE starting to reduce or stop the drug.

Stage 3: Implementation
The implementation stage can involve teaching coping strategies, carrying out interventions for associated psychological problems, reviewing and changing goals and building self-confidence. All of these activities are standard counseling activities which can be carried out before the client stops using substances, and whilst the client is still in the preparation stage of change.

Action Plans
The client must be psychologically strong enough before trying to stop using substances. A specific plan should be made with the client about beginning the action stage of change. The plan should include:
- The client's choice about whether to cut down gradually, or whether to stop using substances all in one go. Make sure to have good medical advice, as treatment or admission to hospital might be needed to manage withdrawal symptoms for those stopping substance use completely.
- Friends and family members who can support the client should be identified.
- Clients should identify daily triggers for substance use and work out how to avoid these.

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- Clients should have a plan of what to do when they have a strong craving or wish to take the drug: for example, they might call a friend or supporter, they might go out of the house to distract themselves, they might use relaxation techniques.
- A date should be set for the beginning of the action stage of change.

Relapse Prevention Plans

Once the client has entered the action phase and made a change in their substance abuse, the counselor's role is to continue to support and encourage the client to keep going with their behavior change. After a few weeks the client will enter the maintenance stage of change: in this stage of change, the client's initial excitement and determination about stopping substance use may have lessened. At this point the counselor should help the client to focus on strategies for maintaining change:

- Encouragement and praise from the counselor and friends helps the client sustain motivation to change.
- Reward systems can be used to encourage the client to continue changing.
- Counselors can look back at the good and not so good lists made during assessment, to remind the client of why they decided to give up.
- Imagining and talking about "My life in ten years time if I stay off the drugs" and "My life in ten years time if I go back onto the drugs" can help clients focus on the long-term benefits of change, and increase motivation.
- A relapse prevention plan is useful: this is where
- the client is asked to list stressful life events that might prompt them to take substances (for example, family arguments, new challenges such as a job) and brainstorm how to cope with these.
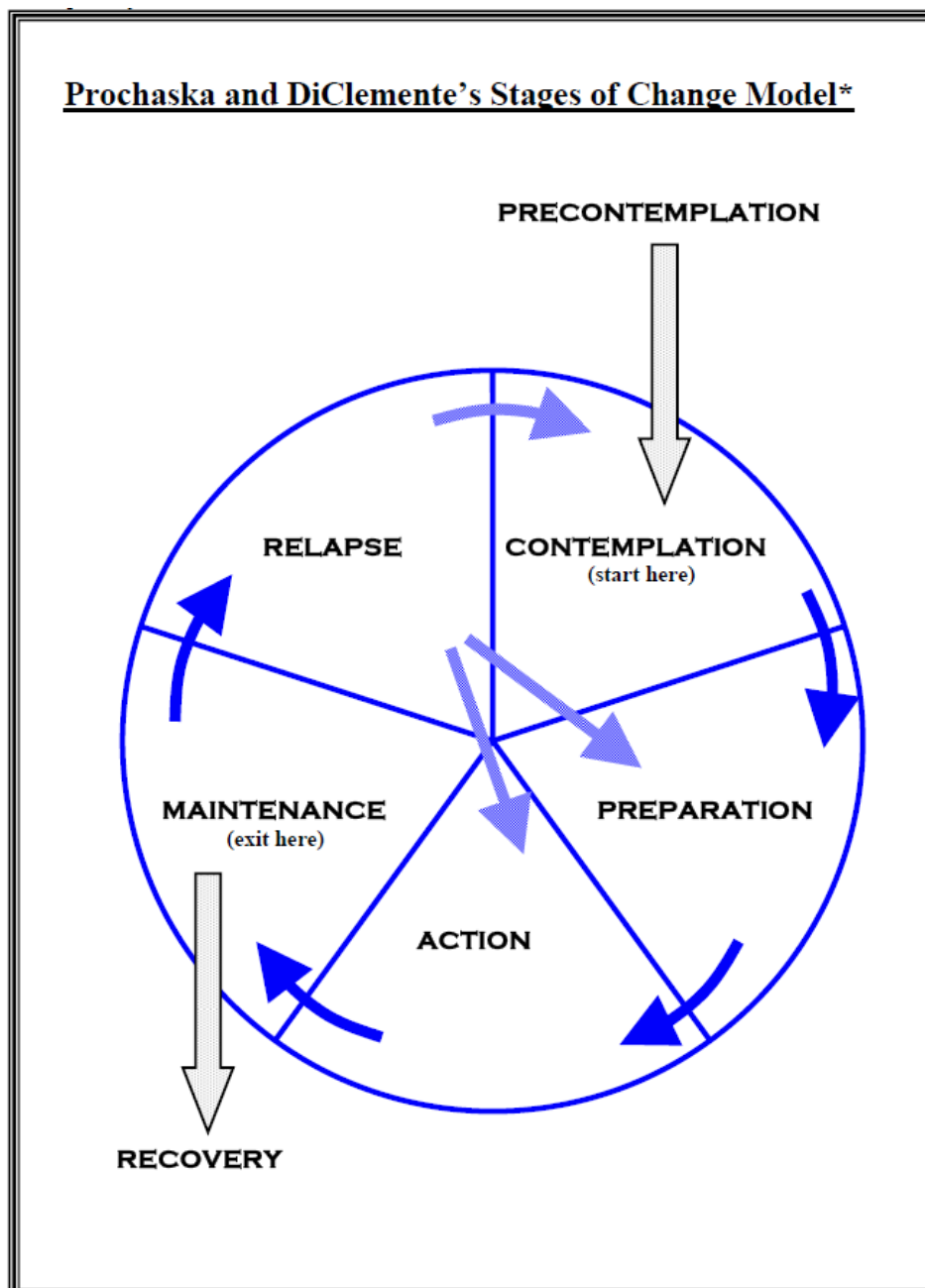

Evaluating progress and dealing with relapse

- Throughout the implementation, counselors should evaluate their client's progress.
- They should keep track of the client's motivation levels, their use of substances and their more general life changes and coping strategies.
- The intervention can be adapted and improved as the implementation stage continues.
- Occasionally people who have stopped using substances will go through a difficult period in their lives, or experience some sort of crisis and return to substance use.
- Sometimes clients will begin using again, and will fall back to the precontemplation stage, thinking there is no problem with their substance use.
- More often, clients will have very mixed feelings about the relapse.
- They may feel ashamed, or that they have failed or let down family members or friends, but also they may have enjoyed using.
- Often clients want to stop using the substance again. When a relapse occurs the following points might be useful:
  o It is important for the counselor to reassure the client that relapses are a common part of the cycle of change.
  o Relapsing does not mean failure: it is just a temporary setback, and can be dealt with.
  o The counselor should assess the client's current motivation and stage of change, and explain to the client that after a relapse, they can go back to the contemplation, preparation or action stages of change.
  o The counselor should help the client identify why the relapse occurred, and think about what the client could have done differently.
  o Sometimes coping strategies might need to be strengthened, or a new plan of action or relapse prevention plan might need to be developed.
  o The counselor should support the client to deal with any thoughts of failure or self-blame.

Stage 6: Ending

When working with clients with substance abuse problems, the following points should be remembered:

- Ending counseling too soon can sometimes contribute to the client relapsing into substance use.
- Endings should be planned well in advance, so the client has time to prepare him or herself.
- Ending counseling should be written in to the relapse prevention plan, so the client can think about how they will cope when they no longer have the counselor to rely on.
- The client and counselor should begin to plan the ending when the client is several weeks into the maintenance stage of change, and not before.
- The counselor should allow the client to request a follow-up appointment in future, should they feel they are tempted to go back to substance use, or should they relapse: the counselor should give clear instructions to the client about how they can be contacted in future if needed.

Prochaska and DiClemente's Stages of Change Model*

PRECONTEMPLATION

RELAPSE

CONTEMPLATION
(start here)

MAINTENANCE
(exit here)

PREPARATION

ACTION

RECOVERY

* This diagram shows a recovery stage, not included in Prochaska and DiClemente's original model.

Prochaska and DiClemente's Stages of Change Model

Precontemplation: The client does not think they have a problem that needs changing.

Contemplation: The client has begun to think they might have a problem, but they are in "two minds" about whether or not they want to change.

Preparation: The client has decided that they do have a problem and they would like to change. This stage involves planning how to make the change.

Action: The client begins to change their behaviour.

Maintenance: Once the client has begun to change their behaviour, they need to sustain this change and develop new patterns of behaviour.

Relapse: Sometimes the client has a relapse, and goes back to the old way of behaving. The client then has to start again at an earlier stage, to try again to change their behaviour.

In addition to Prochaska and DiClemente's six stages, there is a final stage:

Recovery[1]: If the client can sustain their behaviour change in the maintenance stage for weeks, months or years, then they can be said to have recovered permanently from their problem.

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[1] There is debate over the recovery stage, as some clinicians working in the field of addiction believe addicts can never be considered fully recovered, and remain in the maintenance stage for life.

GOOD THINGS ABOUT USING	NOT SO GOOD THINGS ABOUT USING

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What happened just before I decided to take the drug? What was I doing? How was I feeling?	What did I take and when? (Date and time)	Where was I?	Who was I with?	What happened after I took the drug? How was I feeling immediately? How was I feeling later?

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Formulation Example:
Vulnerable factors:

Predisposing factors:

Trigger factors:

Maintaining factors:

Protective factors

Blocks to giving up substance abuse	Possible solutions
I will not sleep as well and the nightmares might come back	
I might get flashbacks during the day	
I have nothing else to do all day, so I might get bored and start using again	
If I get lonely or sad I might be tempted to use	

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THEME 4: PYSCHOSOCIAL SUPPORT: Specific topics

Participants in the module
This module is meant for specialized psychosocial workers.

General objective
This module is meant to offer the specialized psychosocial workers a specific technique (narrative theatre) and to support and help community and psychosocial workers who supervise community workers and psychosocial workers in the camps.

Specific objectives
At the end of this module participants are expected to:
o   Identify and prevent problems of community workers
o   Understand and explain supervision
o   Use narrative theatre techniques

This theme consists of 3 Modules

	THEME 4 PYSCHOSOCIAL SUPPORT: Specific topics		½ day
3.15	Care for Caregivers	general community workers and specialized psychosocial workers	2½ hours
3.16	Psychosocial clinical supervision	specialized psychosocial workers	1½ hours
3.17	Narrative theatre	general community workers and specialized psychosocial workers	2¼ hours

MODULE PS 3.15: Care for care givers

Learning objectives
At the end of this Module, each participant is expected to:
- Be aware of positive and negative stress
- Identify community worker problems
- Recognize negative stress (distress) in oneself
- Identify strategies for prevention and treatment
- Explain a variety of ways to offer psychosocial support
- Use stress management techniques to manage their stress

Time
2½ hours

Materials
Flip-chart, meta-cards, markers

Methodology for the trainer: *Brainstorming, discussion, interactive lecture*
- *Discussion (30 minutes).* Together with the participants, discuss their feelings and attitudes when they assist refugees in the camps. Write down the answers.
    - o Explain that community interventions have challenges like other activities. You may have hardships, sometimes conflicts, with the clients or supervisors and to some extent with your personal problems.
- *Group work (15 minutes)*. Divide the participants into groups. Write the statement "Identify psychosocial problems that psychosocial workers face when delivering services to people" on the flip-chart . Make sure the statement is clear to the participants.
- *Plenary presentation (30 minutes).* Ask each group to present their work. Allow the participants to make comments.

Individual work: Psychological balance (45 minutes)[48]
- Ask all the participants to read *section handout 1 for participants (Module 4.1.) and multi-faceted balancing of needs* of the reader. Draw a picture of Strength + Support Distress on the board as:

- Give all the participants a large piece of paper and ask them to draw the above picture on the paper. Then ask them to list their strengths & supports under Strength + Support and their distresses under Distress (at least five things under each category).
- After everyone finishes the list, ask them to give a number between 1 and 5 to all the things they have listed under Strength + Support and Distress (e.g. I am physically strong 4, I have two pending tasks – 3).
- Then ask them to sum within both the categories (e.g. Strength + Support = 18 and Distress = 13) and to look at the total and see if Strength + Support is bigger than Distress. If not then ask "where do you have to add strength or support?" and "how could you do that?"

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[48] Copied with adaptations from Sapkota, R.P., et al., eds. *Psychosocial counselling for people affected by armed conflict in Nepal: A trainer's manual*. 2007, Sahara Paramarsha Kendra/USAID: Kathmandu, pag. 231-232

- If someone in the group is unable to add anything to the Strength + Support category then the group can help him or her to explore and find strengths or supports so that either the sum of the two categories is balanced or Strength + Support becomes bigger than Distress.
- Summarize the exercise: Everybody has strengths and supports. When situations get difficult it is good to realize what your own strengths and supports are. These you can then weigh against the stress, or the difficulties you are facing. If your strengths and supports are not able to deal with the stress you are in, then it is necessary to increase your strengths or get more support. Tell the participants that they can do this exercise whenever they experience difficulties to make a plan for their personal support strategies.
- Briefly explain the importance of self-care to manage stress and find a balance in your life. Caregivers in the field of mental health and psychosocial work are often very poor at self-careand as time goes by with an increase in workload and responsibility, they get worse rather than better. Work needs to be viewed as part of life, and not the whole of it. It is important to reach a balance between work and leisure, action and reflection, giving and taking. A person's self-care needs to reflect the diverse and complex nature of each human being.

Individual exercise: Self-Care (30 minutes)
Give all the participants Handout 2 for participant (Module 4.1.), *Assessing self-care* and ask them to rate all the items as instructed. After all the participants finish rating, ask them to sum the scores under each category. After the summing-up is done, explain the following:
- The higher the score the more you are aware of self-care and care for yourself. If you have scored 30 or less in Physical self-care, 16 or less in Psychological self-care, 16 or less in Emotional self-care and 28 or less in Spiritual self-care then it indicates that you might need to increase the frequency of those activities listed under each of those categories so as to take proper care of yourself. But remember this is not a standard psychological test and it just gives you an indication of whether you are doing proper self-care or you need to do some things more often.
- Lecture on self-care strategies: a) General self-care strategies b) Specific self-care strategies If possible: All the relaxation exercises, breathing exercises and thinking exercises mentioned under "Specific self-care strategies" should be practiced in the class so that all the participants learn how to use each of those exercises for themselves and with their clients whenever necessary

Resource materials to use in this module
 1. HealthNet TPO Burundi: Training module psychosocial assistant. Page 37-38.

Study material 1: Module 3.15[49]

What is stress?
Stress is a state of psychological and physical arousal, which is initiated as a result of threat, challenge or change in one's environment. It is defined as a condition or feeling experienced when a person perceives that "demands exceed the personal and social resources the individual is able to mobilize." A certain amount of stress is essential for normal health. Stresses can be positive or negative. The positive stress is called **eustress,** and the negative stress is termed **distress.**

Types of stress
1. Day-to –Day stress
2. Cumulative stress
3. Critical incident stress (traumatic stress)
4. Secondary traumatic stress (in counselors and other care givers)

Problems community workers or specialized psychosocial workers can face
- Monotony: Workers sometimes feel they are doing the same activities all the time.
- Psychological or physical aggression by the clients, supervisors or the management
- Conflicts with refugees because you do not provide what they want
- Lack of sufficient knowledge when delivering services
- Feeling of inadequacy
- Being in conflict with a supervisor
- Being accused by a refugee
- Personal problems
- Family problems
- Being overloaded by the or amount of the work

Support provided to community workers
A psychosocial helper sometimes needs:
- Regular support from another psychosocial helper (or a supervisor) in whom he or she has confidence, so that problems are solved in a timely fashion.
- Mediation or problem-solving in cases of conflict with supervisors.
- A stress management Module for the service providers.
- Clinical supervision Modules to upgrade knowledge.
- Encouragement to set aside regular time to meet and share work content and other concerns even if the community worker has no immediate problems.
- Leave time, when a psychosocial helper is overwhelmed by problems
- Provision of motivation.

General self-care strategies
1. Finding a Balance
2. Healthy habits/nurturing oneself
3. Connecting with others/and self

Specific self-care strategies
1. Body Exercises
   - Dancing
   - Singing

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[49] This handout is copied with adaptations from Sapkota, R.P., et al., eds. *Psychosocial counselling for people affected by armed conflict in Nepal: A trainer's manual*. 2007, Sahara Paramarsha Kendra/USAID: Kathmandu, p. 226-230.

- Sporting
- Yoga Module
2. Relaxation Exercises
3. Breathing exercises
   - Normal Breathing
   - Deep breathing
4. Mind: Thinking Exercises
   - Chakra meditations
   - Guided imagery

Practical tips for self-care
1. Self-Esteem Affirmations
Say to yourself
- I am filled with energy, vitality, and self-confidence.
- I am pleased with how I handle my emotional needs.
- I know exactly how to manage my daily schedule to promote my emotional and physical well-being.
- I listen to my body's needs and regulate my activity level to take care of those needs.
- I love and honor my body.
- I fill my mind with positive and self-nourishing thoughts.
- I am a wonderful and worthy person.
- I deserve health, vitality, and peace of mind.
- I have total confidence in my ability to heal myself.
- I feel radiant with abundant energy and vitality.
- The world around me is full of radiant beauty and abundance.
- I am attracted only to those people and situations that support and nurture me.
- I appreciate the positive people and situations that are currently in my life.
- I love and honor myself.
- I enjoy my positive thoughts and feelings.

2. Beat stress with a healthy life style
Taking good care of yourself is very effective to feel less stressed. It will also help you handle life's inevitable challenges with more efficiency and energy.
- Get enough sleep so that you feel rested.
- Get plenty of vigorous exercise, at least three times a week for 20-30 minutes.
- Eat at least three healthy meals a day, with a balance of proteins, vegetables, fruits and grains. Keep nutritious snacks at the office and drink plenty of water.
- Plan your day with detailed goals and a reasonable time schedule for work, family and leisure.
- Get out of the house and meet other people.
- Talk with family/ friends.
- Say "no" if you are not able to take on an assignment at work and discuss your work load with your supervisor before it becomes a problem.
- Do not start smoking more or drinking more.
- Practice relaxation techniques, such as listening to soothing music, practicing yoga or meditation, deep breathing.
- Maintain a positive outlook and a sense of humor.
- Do things you like doing (e.g. writing poetry, singing, sitting in the tea-shop).
- Do the things in your culture that you do when you have difficulties (puja, rituals, praying, etc.).
- See the traditional healer/ priest etc if you feel like seeing one.

3. Time management
- Organize your work place
- List your priorities for the week
- Create a 'to do list'

- Stick to the task at hand
- Take some time out

Study material 2: Module 3.15[50]

Assessing Self-care
The following tool can be used to assess self-care. This tool gives you a general indication for how much you are aware about self-care and how much you care for yourself. Rate the following areas in frequency:
5 = frequently, 4 = often, 3 = sometimes, 2 = rarely, 1 = never

PHYSICAL SELF-CARE
_____ Eat regularly (i.e. breakfast, lunch and dinner)
_____ Eat healthily
_____ Exercise
_____ Get regular medical care for prevention
_____ Get medical care when needed
_____ Take time off when sick
_____ Get massages
_____ Dance, swim, walk, run, play sports, sing, or do other physical activity
 that is fun
_____ Take time to be with yourself,
_____ Take time to be with your partner
_____ Get enough sleep
_____ Wear clothes you like
_____ Take a holiday
_____ Take day trips or mini-holidays
_____ Make time away from demands of work and family
_____ **Total**

PSYCHOLOGICAL SELF-CARE
_____ Make time for self-reflection
_____ Write in a diary
_____ Read a book that is unrelated to work
_____ Decrease stress in your life
_____ Notice your inner experience i.e. listen to your thoughts, feelings
_____ Let others know different aspects of you
_____ Engage your intelligence in a new area i.e. go to an art exhibition sports
 event, theatre or concert
_____ Say No to extra responsibilities being placed upon you
_____**Total**

EMOTIONAL SELF-CARE
_____ Spend time with others whose company you enjoy
_____ Stay in contact with important people in your life
_____ Give yourself affirmations, praise and rewards
_____ Love yourself
_____ Allow yourself to cry
_____ Find things that make you laugh
_____ Express your outrage in social action, letters, donations
_____ Play with children
_____ **Total**

SPIRITUAL SELF-CARE

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[50] This handout is copied with adaptations from Sapkota, R.P., et al., eds. *Psychosocial counselling for people affected by armed conflict in Nepal: A trainer's manual*. 2007, Sahara Paramarsha Kendra/USAID: Kathmandu, pag. 231-232

_____ Spend time with nature
_____ Find a spiritual connection or community
_____ Be open to inspiration
_____ Cherish you optimism and hope
_____ Be open to not knowing
_____ Identify what is meaningful to you and notice its place in your life
_____ Pray
_____ Sing,
_____ Spend time with children
_____ Contribute to causes, which you believe in
_____ Read inspirational books
_____ Listen to inspirational music
_____ **Total**

MODULE PS 3.16: Psychosocial clinical supervision

Participants in the Module
This module is meant for specialized psychosocial workers.

Learning objectives
At the end of this Module, each participant is expected to:
- Explain what he or she understands by supervision
- Explain the characteristics of good supervision

Time
1½ hrs

Materials
Flip-charts, cards, markers

Methodology for the trainer': *Discussion, brainstorming, interactive lecture*
- *Brainstorm* (15 minutes) by asking participants to explain what they call supervision. Write down the answers they give and ask the other participants to reflect on the answers.
- *Group work (25 minutes).* Divide the participants in groups. Write on the flip-chart the question for group work: "What are the characteristics of a good supervision?". Ask the participants if the question is clear. Indicate the venue where the group can work. Ask each group to choose a recorder and a moderator. Distribute flip-charts.
- *Plenary presentations (30 minutes).* All participants listen carefully and reflect on each presentation.
- *Sharing (20 minutes).* Ask participants to share their experiences with the supervision Modules they have had in the course of their daily work.
- *Interactive lecture:* Ask the participants to differentiate between bad supervision and good supervision.

Resource materials to use in this Module
1. Family Health International papers on supervision, 2004
2. Richard, B. J. (2002). Person centered counseling supervision: Personal & Professional.

Study material 1: Module 3.16

I) Understanding the concept of CLINICAL SUPERVISION

    A) <u>Definition of CLINICAL Supervision</u>

Clinical Supervision is a collaborative relation between the person being supervised and the supervisor; the supervisee reports on their activities and has discussion/exchanges with the supervisor and the latter (the supervisor) provides feedback and guidance for improvement, if necessary.

    B) <u>Goals of supervision</u>
- Promotion of professional development (improvement of performance, development of self-confidence to offer quality services)
  o Ensuring good treatment of the client
  o Ensure and guarantee the availability of quality services
- To increase awareness and the on-going self-awareness of the therapist. Supervision is all about the therapist and what they need to become what they want to be! The more support we can get as therapists, the more support we can give to clients.

    C) <u>Forms of supervision</u>

1. Individual supervision is a one-on-one relationship: a supervisor and a supervisee. A commitment to meeting regularly is needed to build the relationship to find the core issues that the helper is struggling with.

2. Peer group supervision is a group of peers meeting to share their experiences. This again is not to "fix" the problem, but to share the underlying feelings that arise in practice. Active listening is practiced. Often groups will invite a supervisor to provide guidance, clarity and support.

Essentially, supervision consists of comparing the actual performance with the expected results, taking into account the beneficiaries' satisfaction.

The aim of supervision is not to formulate negative or positive criticism; rather it is to help the community worker to improve his or her competencies to offer quality services.

Supervision is work focusing on changes, for people who work professionally to have the opportunity to share their experiences and thoughts with a supervisor with the aim that the supervisee will be better equipped and competent in his or her profession. Occupational knowledge is increased, broadened and deepened so the client will receive good care.

    D) <u>Characteristics of good supervision</u>

Good supervision gives the community worker the opportunity to:
- Share what he or she thinks and feels without fear
- Share his or her strengths and weaknesses, or problems encountered
- Promote team work
- Learn from the supervisor
- Acquire knowledge and insights
- Exercise new skills/procedures
- Offer emotional support; very important
- Manage problems that affect them as a caregiver
- Give remarks about their competence and performance
- Address ethical issues
- Give guidance
- Etc

    E) <u>Major steps in supervision</u>

- **Plan**: Elaborate a program of supervision that can be: weekly, monthly,……depending on the need)
- **Organize:** translate the program into a series of activities / a variety of interventions for the community worker you want to work with.
- **Execute / conduct the supervision**: putting supervision into practice

F) Characteristics of a good supervisor
- Has good knowledge/experience and is aware of his or her limits.
- Is empathic and has respect for differences in opinion.
- Emphasizes good points and criticizes weak points in a constructive and supportive manner.
- Promotes reflection and higher order thinking by the supervisee .
- Has a strong understanding of the background of the worker he or she is supervising to be effective in transmitting knowledge.

G) Various aspects of supervision
- **Practical aspect**: Includes: case load, work environment, reporting mechanism, and equipment. The following are the topics that can be discussed at this level:
  o Exchange on the work development, weaknesses, strengths, and deviations of each community worker; setting forth common understanding, vision, language / terminology, as well as strategies for improvement.
  o Discussion on difficult / complex cases and building strategies in the group for how to help in these cases. Sometimes simple cases can be identified. Then the community worker is invited tell how he or she is managing the case. Your input will be to guide the group discussion if issues are not clear.
  o Activity: Suggest a case (difficult/simple case), present the problem history and allow the counselor to present how or she managed the case. Together analyze the strategies used and the assessment conducted. Give constructive comments to the counselor.
  o Present new knowledge on topics selected by a supervisor or the group. This could be knowledge-oriented (e.g. how to manage an emergency, suicide cases) or skills-oriented (e. g how to talk to a child, how to investigate a problem or how to make a plan of action).
- **Managerial / Administrative issues:** Information-sharing about the organization, changes within, promotions, new measures, logistics.
- **Technical aspect of the work**: Exploration of the skills and knowledge of problem assessment—how to do interventions and evaluations of an intervention.
- **Personal aspects of the work**: Focus is on the supervisee. Explore feelings and attitudes towards the work (e.g., sadness, fatigue, inadequacy, or powerlessness). It is very important that in all aspects of supervision each individual has room to express what he or she feels.

II) Group supervision
Definition
Group supervision is a strategy for community workers from a particular location to meet with a supervisor to have an exchange on the progress of their work.

Benefits
Promote self-evaluation
- Discuss difficult cases together and build guiding strategies together
- Build team work
- The supervisor can address the team all together, at one time

Techniques to be used
- Problem-solving a specific case in a group
- Advice (from the supervisor or participants)
- Role play/ micro-skills exercises

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- Use of video and group analysis
- Etc.

Questions used in these exercises should not be in the form of interrogation or punishment. One should avoid questions that require only recall but rather uses critical thinking skills. Supervisors are expected to reframe and summarize answers from the group.

Study material 1: Module 4.2

Module 10: Supervision

1. Rationale

Clinical supervision is an essential component to quality control of provided psychosocial care as well as an essential component to care for the care providers. Clinical supervision should happen at least once every month and preferable once per week and should target all staff involved in providing treatment and interventions.

Supervision is a process of professional support and learning which enables the service providers to develop knowledge and competence. Supervision in is generally conducted; (1) To provide emotional support to the service providers themselves; (2) To help find the solutions of the presented (encountered) case-related problems and concerns; (3) To enhance the professional and personal capacities (continued learning); (4) To monitor and evaluate the work; (5) To enhance and ensure the quality of work. Van der Veer and colleagues (2004) provide a good overview of provision of clinical supervision in areas of armed conflict:

Clinical supervision as a form of emotional support. The supervision session ideally becomes a place for empowerment and increasing self-confidence and preparedness for the service provider. Moreover, the supervision supports the supervisee through encouragement and through empathic understanding. Personal strengths of supervisee also need to be highlighted in order to enhance their confidence. Finally, it provides a forum for the supervisee to raise their own worries, fears, and inter- or intra-personal problems that may inhibit the effectiveness of counselling process or contribute to "burnout".

Clinical supervision as a form of continued education focuses on helping the supervisee to analyse, understand and deal with the problems of their clients. Furthermore it may include review of clinical skills and processes. Finally, supervision may be aimed increasing the self-awareness of the service provider (reflecting on his/her own feelings and thoughts and ideas).

Clinical supervision is a form of monitoring and evaluation of the (para-) professional performance. Supervision provides a way of quality control and ensuring that the work of the service provider is in line with (ethical) standards. Additionally, especially in non-Western settings, implementation of

community based services raises many organisational and operational issues, which can be addressed through supervision meetings.

Clinical supervisors should have extensive clinical experience themselves and should preferably have received training how to provide clinical supervision. One of the central issues that supervisors need to be aware of is the parallels between actual service provision and what happens within the supervision session. In short this entails that the supervision session mirrors an intervention session in that; (1) it discusses the problems and emotions of the service provider; (2) it encourages the service provider to find his/her own solution and to empower him to become more aware of his own resources; (3) it serves as a space for expression of feelings/doubts and for reflection; (4) and that the relationship with the supervisor is important.

2. Implementation

Supervision can be provided in a group as well as individually, with advantages to both methodologies. In a group a wider variety of supervision is possible and peer feedback can be utilized.

Levels of discussion during clinical supervision to be kept in mind by the supervisor (van der Veer, de Jong & Larsen, 2004[1]).

Level 1 – Chaotic and undirected; the supervisee has difficulty in presenting a case in a coherent way and needs support from the supervisor to put thoughts in order to better understand the case.

Level 2 – Coherent story; the supervisee can present a coherent case story but has difficulty in making an assessment of the problem and case conceptualization and needs the supervisor to connect practical experience to learned theoretical concepts.

Level 3 – Analysis; the supervisee is systematically using theoretical constructs to discuss the client's problems and needs the supervisor to analyse this in more depth.

Level 4 – Self awareness; the supervisee is able to understand and analyze the client's problems and needs support from the supervisor to increase his/her emotional awareness in relation to the client.

Level 5 – Synthesis; the supervisee combine theoretical concepts with practical experience, structurally analyse a client's situation and identify his/her own feelings and thoughts in the process and needs the supervisor to identify and deal with personal limitations.

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[1] With slight adaptations

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2.1 Supervision for psychosocial counsellors

These recommendations may be useful for those facilitating a clinical supervision meeting for counsellors.

1. Make agenda at start of (group) supervision meeting, jointly by counsellors and supervisor

2. Explore the counsellor's concerns, using empathy, with a focus on current feelings related to the most recent session

3. As supervisor, do not answer all questions. Get the counsellor/group to answer questions. Give your opinion last

4. Recommendations are linked to concerns of the counsellor

5. Allow the counsellor's story about the session to develop

6. Allow the counsellor to reflect his/her own feelings, thoughts and behaviour in relation to the session or case

7. Help the counsellor further understand the client, preferably specific to the material presented during the session

8. Avoid use of technical words and theoretical discussions

9. When discussing about counsellor-client and counsellor-supervisor relationships, focus on the counsellor's concerns

10. Give genuine compliments

11. In group supervision, encourage all people to talk or give opinion

12. When the counsellor is confused about how to interact with a client, do role-play. The counsellor role plays his/her client and the colleagues rotate being the counsellor. After the role play, list what was learned.

13. If client tells of horrific experience, check whether the counsellor is emotionally affected. If so, give or organize emotional support.

14. If counsellor presents a very complicated case, write all issues (problems and symptoms) on board and discuss what can be done for each issue (see example case discussion format below)

15. A useful question is: "if you could rewind the session what would you do differently?"

2.2 Supervision for (school based) group intervention facilitators

These recommendations may be useful for those facilitating a clinical supervision meeting for counsellors:

1. Make sure that you have sufficient time available to conduct supervision

2. Rapport building and confidentiality (for example, start with informal talking (how are you? how is the family? Etc. and assure that all the personal issues discussed and information shared in the session will remain confidential and you are responsible to keep it confidential).

3. Update on clinical activities and conducted services.

4. Explore the concerns and problems of facilitators, list it out (list the problems according to the category i.e. Technical problems, Managerial problems, Personal problems) and discuss one by one (refer to supervision report sheet).

5. Do not humiliate or insult for the mistakes and also do not focus on the mistakes rather focus on what they have done well and suggest how they can do better. Appreciate the facilitators for what they are doing and give genuine compliments.

6. Feedback and brainstorm solutions/answers from the facilitators and then give your opinion only if necessary. Encourage supervision participants to come up their own solutions as much as possible

7. If something comes up that you do not know about, then do not try to answer by guessing. In clear words tell the facilitators that you are not able to answer it right now and you will let them know after discussing with it with your supervisors

8. Make sure that all the concerns and problems are discussed (ask the facilitators, is there any thing else they want to share or discuss besides what has been discussed)

9. If they have any confusions regarding the group intervention sessions then be ready to make them clear through demonstration. Or make use of role-plays if needed

10. Check whether facilitators are getting adequate support (logistic) and encouragement from the respective managers

11. Check, how the linkage/co-ordination/referral of facilitators with the counsellors is.

12. Check whether the facilitators are emotionally affected by the stories presented by the children or whether they themselves are having psychosocial problems. If so, then make arrangements to meet the counsellor.

13. Check whether all clinical tasks of the facilitators are being done and/or planned (for example pre-screening briefing, screening, referral, awareness raising).

14. Check whether monitoring and evaluation is taking place and review forms

15. At the end, make sure that you have all the required information and thank the facilitators for their time and effort.

3. Recommendations from four-country CTP project

3.1 Clinical supervision sessions need to be <u>conducted regularly and structurally.</u> Ideally, these sessions take place once per week or once per two weeks and include all service providing staff (again ideally in small groups of 8-10 people at a time).

3.2 Supervision meetings should focus on structuring the sessions according to the following parts: (1) <u>Practical part</u> focusing on supporting the staff in all practical matters of implementing the service (transport issues, school entrance issues; follow-up of step-by-step approach). (2) <u>Clinical part</u> focusing on (a) treatment planning; (b) discussion of difficult cases; (c) ongoing learning, as well as any other clinical matters.

3.3 <u>Mixed supervision meetings or exchange meeting between group intervention facilitators (i.e. CBI) and counsellors.</u> This may facilitate coordination between the groups of clinicians and it may improve internal referral. One modality to do this is to assign a small group of CBI facilitators to an experienced counsellor for the clinical part of the supervision meetings.

3.4 <u>Use of video</u> as a way of evaluation of skills and/or discussion of general implementation issues. Video is a powerful and useful tool for supervision as it gives the supervisor the opportunity to focus on micro-skills through stopping the image at any given time to discuss what happens at a certain time. Issues of group facilitation skills and identification of problem behaviours within the group can be addressed easily with video evaluations.

3.5 Supervision meetings should be adapted to <u>better incorporate a care for caregivers</u> component (especially for CBI facilitators). From the experience it appears that many of the service providers indicate high levels of distress in conducting the clinical services. This needs to be structurally addressed by the project coordination team; i.e. discussing personal distress and how to reduce that; recognition of burn out sign and a support system in case of such.

3.6 <u>Commonly discussed supervision topics</u> include: stress and stress management techniques; discussion about intervention strategies (e.g. CBI activities); handling difficult cases; role of the service provider; referral; emotional distress of service providers and care for caregivers; case-load; strength and weaknesses of the service provider; intakes and discharges.

3.7 <u>Field visits by the supervisors</u> are important to create better understanding of the clinical realities in a community based psychosocial care program and to better evaluate the provided services.

3.8 The <u>supervisee-supervisor relation</u> does not need to be a hierarchical one, lesser hierarchy may allow the clinical supervisor to be opener on their problems. Moreover, the supervisor-supervisee relation has proven to be instrumental in maintaining counsellor motivation under difficult field circumstances. As the supervision is also an ongoing learning process for the supervisor, s/he needs to be open towards feedback or criticism from the counsellor and, whenever possible, have colleague for sharing and discussion.

Internal Links

<u>See tools:</u>
Supervision forms for counselors and CBI group facilitators

External Links

http://www.interventionjournal.com/downloads/22pdf/118_128%20Veer.pdf
Van der Veer, G., de Jong, K. & Lansen, J. (2004). Clinical supervision for counsellors in areas of armed conflict. *Intervention, 2 (2), 118 – 128*

MODULE PS 3.17: Narrative theatre

Participants in this Module
This module is meant for both general community workers and specialized psychosocial workers.

Learning objectives
At the end of the Module the participants are expected to:
- Explain the importance of using narrative theatre
- Use narrative theatre techniques to educate people

Time
2 hours

Materials
Flip-chart, makers

Methodology for the trainer: *Demonstration, brainstorming.*
- *Interactive lecture (30 minutes)*. The trainer explains the concept of narrative theatre in psychosocial helping and how it is applied in psychosocial support Refer to the Study Material for trainer.
- *Demonstration (30 minutes).* Demonstrate the multiple steps used in narrative theatre. Allow the participants to make comments and ask questions.
- *Group work (25 minutes).* Divide the class in two groups. Ask each group to think of a scenario of a social problem. Ask the group to prepare the scene.
- *Presentation.* (45 minutes) Each group present what they have prepared. The trainer carefully follows the presentation and makes corrections if necessary.

Resource material to use in this Module
- Sliep,Y. Healing the community by strengthening social capital: a narrative theatre approach, 2009.
- *Sliep, Y. Narrative Theatre for Social Action: A skill for psychosocial* workers http://www.interventionjournal.com/downloads/23pdf/193_209_sliep.pdf

Study material: Module 3.17

After a prolonged period of war and conflict, the whole context of people's lives is negatively affected. People suffer hardship when they try to restart a new life. In addition, the social fabric of the community, that is, the relationships between people, their value system, and how supportive they are to one another is also affected. Other consequences are: being subjected to extreme poverty, meaningless resources, and people losing trust in others. People find that they are unable to rely on their own coping mechanisms and usual ways of solving their problems. The feelings of helplessness and hopelessness invade their daily living. Individuals and families lose the space they normally have to relate to each other.

Narrative theatre creates the possibility for people to both tell stories and to act out these stories. Narrative theatre is used to strengthen the social fabric of a community by moving from problems to strengths. Through a narrative theatre, people meet and explore their problems together. A space to be together and to share concerns is being created. Through the exchange of stories, social bonding (the network established within a community as result of people connecting positively to one another) is created. The word narrative refers to the importance of stories in our lives.[1]
The goal of narrative theatre is to find collective answers for ways to manage individual problems by drawing on the strengths of a community. Another goal of narrative theatre is to help people to solve problems creatively and to work towards a realistic preferred outcome[2] (Yvonne Sliep, 8).

Methodology of a narrative theatre Module
   a) Preparation
   • The choice of the community in which to work and the venue. This is the first step the trainer must take.
   • Determine the groups you want to work with: members of a church, women's group, neighbors, elderly people, youth, etc.
   • Establish who are the local leaders and share ideas and working plans with them.
   • Choose a date and time.
   • Social mapping (asking questions about the people's working hours, social activities, community meetings, availability, and market days)

   b) Finding actors
The actors normally come from the audience but the trainer can also use volunteers. In this way, the trainer holds a briefing on the problem-based story and gives the volunteers the opportunity to practice the drama. It is very important that the characters behave according to how the problem affects the person.

   c) Steps in narrative theatre
• Have someone tell the story that exemplifies the problem and act out the story without stopping. Determine from the gathered group if what was acted out is actually something that exists.
• The trainer initiates a discussion on the drama (what was seen, consequences).
• Mapping the problem (what other problems are derived from the identified problem).
• Act out the story again without pause, so that other story lines can be developed.
• By acting out and repeating scenes with different endings, a deeper understanding of the issues is created, in addition to a way for the group to find the right solutions for themselves (use of role reversal).
• Name the problem and a character to stand for the problem
• Discuss the drama. The trainer encourages further discussion and additional possible solutions.
• Conclusion
   o Identify the lessons learned by the participants and make recommendations
   o Summary by the trainer

PART FOUR: INTERDISCIPLINARY COLLABORATION & CLOSING REMARKS

Closing Session

This training is intended to address the broad perspective of wellbeing, covering the spectrum of emotional responses to displacement, violence, poverty, marginalization and all other challenges associated with living in a refugee camp. As such, different mental health issues with corresponding interventions across disciplines are combined in one manual. This closing part focuses on inter-disciplinary cooperation. An essential aspect of a sound and functional system is one in which various sectors are working together.

This section is designed for all participants: health workers, psychosocial workers and community workers.

Learning Objectives

At the end of this Module participants will:
• Have a chance to collaborate and share their experiences within the training
• Brainstorm on interventions across disciplines
• Come up with an action plan in their communities

Methodology

Introduction exercises, lecture, brainstorming, case studies, discussions, group exercises.

Time

2 to 4 hours

Methodology for the trainer

Interactive Group Session (30 min)

Participants are asked to reflect on the training and main lessons learned and to provide comments and feedback.

Group work (45 min)

Participants are divided into groups with at least one health care worker and one community or psychosocial worker in each group. Each group appoints a chair and reporter. They are asked the following questions:
1. What actions are needed to improve MHPSS services in the camp?
2. Who can take action?
3. How can we better work together from the different backgrounds and disciplines?
4. What additional training or support is needed to achieve this?
Presentation and discussion of group work (flip-charts) (45 min)

Post-test

At the end the post-test should be given at all participants before the closing remarks (15 min)

Interactive group discussion: the Way Forward

Facilitator invites the groups to select practical and realistic action points that can be done in the next period of 6 months and come up with a Plan of Action for the mental health and psychosocial needs in the camps.

Ensure that this session is well documented in the report and specify
• *Who* is responsible (names!)
• *When* should it be realized? (due dates)

- *Which supports* are needed?
  - o Endorsement by local UN structures or NGO management
  - o Collaboration with local universities
  - o Technical assistance
  - o Additional education or training, etc.

Info for the facilitator:
In selection action points we need to ensure the following elements:
- *Specific* – It is important to ensure that the expected action relates to the conditions the activity seeks to change.
- *Measurable* – Quantifiable indicators are preferred. (For example: every week a MHPSS case meeting will be held in each camp)
- *Attainable* – The action should be realistic. For example positioning a full time psychiatrist in each camp will not be possible.
- *Relevant* – The action should be relevant to improve MHPS wellbeing of the participants
- *Time bound* – Specify when the action should be realized

Closing ceremony by UN representative and where possible senior management of involved NGOs and local community leaders
- Group photo
- Distribution of certificates (if available)
- Ensure that all participants have contact details of each other and resources
- Thank-you and Good-byes

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