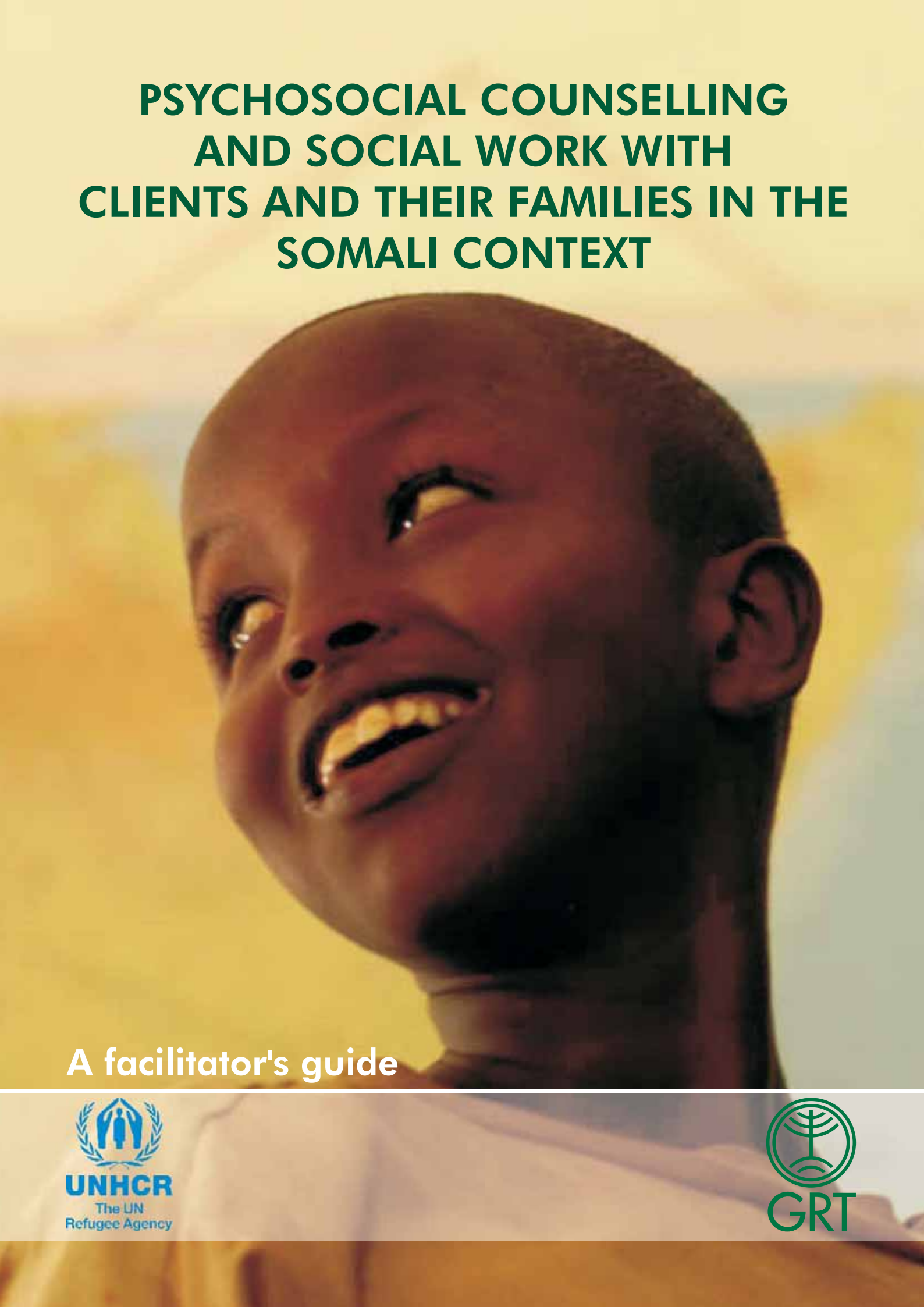
PSYCHOSOCIAL COUNSELLING AND SOCIAL WORK WITH CLIENTS AND THEIR FAMILIES IN THE SOMALI CONTEXT



A facilitator's guide

UNHCR
The UN
Refugee Agency

GRT

PSYCHOSOCIAL COUNSELLING AND SOCIAL WORK WITH CLIENTS AND THEIR FAMILIES IN THE SOMALI CONTEXT

A Facilitator's Guide

Version 1, 2009

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Picture by: Massimiliano Reggi

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FOREWORD

Twenty-years-old Ahmed Ali, one of over 1.5 million internally displaced Somalis, fled from Mogadishu to save his life a few years ago, following heavy fighting that killed his parents and many of his relatives. Talking about his experience, Ahmed says: 'I believe that every young man from Mogadishu suffers from depression due to lack of hope for improvement in the future and deep sadness.'

My work experience in Somalia and the interactions I had with displaced Somalis convinced me that Ahmed is unfortunately right and that protection agencies should pay more attention to the psychological impact that the war in Somalia has had on the population. But the need for life-saving interventions in Somalia has overshadowed the urgency to provide psycho-social support to the victims of the violence, as over half of the population necessitate urgent humanitarian assistance and international and national agencies struggle to provide assistance to meet the basic needs (access to water, shelter, health care, education and food) of millions of desperate people.

I firmly believe that hope for peace in Somalia completely relies on the ability of young Somalis to fight for a better future and that it is part of our protection work to support traumatized Somali women, men and children.

I am therefore pleased that our partnership with GRT has not only resulted into the support to thousands of traumatized people, who are now psychologically ready to continue with their lives, but also in the development of a very solid tool that will allow many other agencies in Somalia to provide adequate support to the growing number of people in need of psychological support.

Guillermo Bettocchi
UNCHR Representative to Somalia

ACKNOWLEDGMENT

This handbook is the product of an extensive review of the mental health & psychosocial interventions carried out in the past decade in Somalia in response to an increasing need of humanitarian assistance to the most marginalized and vulnerable groups of the population. We would therefore like to acknowledge the valuable inputs and support given to this process, with special mention of all who worked in support of the Somali Population.

This exercise wouldn't have been possible without the precious contribution of all the women and men who have cooperated with GRT in the past 13 years, illuminating exchanges of visions and working practices in the Somali context, always interesting and often innovative.

Francesca Rivelli, Antonietta Romano and Hassan Sheick all of GRT Nairobi office deserve a big mention in the this acknowledgement for their precious effort in the realization of this manual. Ulrike Last conceived the idea itself of translating GRT expertise into a teaching tool, making it possible at the very beginning.

A special mention should be given to GRT/UNA staff in Bosaso, particularly Mohammoud Isse Farah, and all the social workers for their everyday support and help to the victims of the long-aged atrocious conflict in Somalia for whom this manual is dedicated.

Thanks to Prof. Paolo Inghilleri -University of Milan- for the accurate reading and comments on the second draft version. We would also like to thank the staff of our local Somaliland partner organization, GAVO especially Mr. Abdirizak Mohamed Warsame for testing this training material.

We must thank the international consultants Asia Abdulkadir and Massimiliano Reggi for their keen curiosity and tireless enthusiasm in exploring the subject and the Somali context. Finally, we would like to thank Mr. Hassan Mohammed for making this manual accessible to the Somali readers.

AIM OF THE HANDBOOK

The present handbook is designed to be used as training support handbook for helping professionals in the Somali context. The focus is on psychosocial needs for the rehabilitation of persons with trauma, mental health related forms of distress and those who have experienced gender based violence and gender related abuses. The guidelines, developed within a UNHCR funded programme in Somalia, are intended to assist staffs, who are concerned with providing protection and assistance to refugees and IDP. The extent of the problem of GBV and psychosocial needs in the context of refugees requires all staff to understand and master basic skills in addressing it.

It assumes a holistic understanding of the individuals as social actors living, influencing and being influenced by a complex and unstable environment.

This is a first version, based on observations and psychosocial work of international and national professionals in the Somali context (mainly based on field experiences and training outcomes in Puntland and Somaliland). Formal counselling services are not well or widely established all over Somalia. In such contexts, informal systems of support can be of great value to the patient and are believed to be especially helpful to survivors with limited social support resources as they decrease feelings of isolation, and encourage survivors to share their experiences and establish their own informal support networks (WHO, 2003).

The training handbook can be used as a main source going through session by session. Trainers may also decide to work with some sessions and not others, or they decide to combine aspects of the session with other training materials as is felt more appropriate to the context. Sessions or Modules can be adapted, modified and changed to suit either the levels of the participants or a particular context. Therefore, it is highly recommended that trainer has certain information about the participants (level of education, gender, and previous training experience) prior to the training. It is understood that any theoretical training (class training) to be effective and of practical use for participants, should be followed by on-the-job training methodologies in real settings.

The handbook is structured in a way that key concepts are illustrated with stories, games and exercises. Most of the materials can be adapted and used in different ways to make learning enjoyable and accessible to participants with varying of education level.

The case studies and stories have been adapted and changed to portray what happens to clients in real life. There are some stories that are based on myths and popular stories from Somali cultures. There are a number of discussion and questions at the end of the case studies and stories.

WHO CAN USE THIS HANDBOOK?

Health professionals, social workers, educators, and professional/non professional helpers will benefit from this handbook. Other, such as stakeholders, policy makers, project managers, and researchers may find the manual of use.

Picture by: Valeria Turrisi

Part 1

Introduction to Psychosocial Counselling

Written by: Massimiliano Reggi

Module 1
Some Key Concepts

Learning Objectives for Module 1

At the end of this Module participants will:

- Be able to understand and define what "Psychosocial" means and what a "Bio-Psycho-Social "model is;
- Be able to analyse the complexity of a given situation identifying the linkages and mutual influence between social and psychological factors;
- Be able to understand and use of the categories of *disease, illness* and *sickness* in the local context addressing conditions of distress of individuals from a holistic perspective;
- Understand and define what is an *Explanatory Model* and approach patients and families' ones.
- Confront and involve them local healers within the given social relations framework

Methodology

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

Materials

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

Unit 1. The Bio-Psycho-Social Model

Definition of Health

Exercise. Engage an initial discussion with participants on the meaning of the word "Health", asking them to provide examples from their daily experience.

Note for the trainer:

The definition of Health in the WHO Preamble of the Constitution is "*not merely the absence of disease or infirmity*", but rather, "*a state of complete physical, mental and social well-being*"[1]. Mental, physical and social health are vital strands of life that are closely interwoven and deeply interdependent. As understanding of this relationship grows, it becomes ever more evident that mental health is crucial to the overall well-being of individuals, societies and countries.

Take few minutes to discuss and collect examples from the participants. Write on the flip-chart and read the definition of *Health* set by WHO, explain it and extend the discussion connecting the answers provided during the exercise with the WHO definition.

Introduction to Bio-Psycho-Social Model

Exercise 1. On a flip-chart write the word "bio-psycho-social" and set the initial discussion questioning the participants on the following:

- What do you think bio-psycho-social stands for?

Note for the trainer:

The bio-psycho-social model moves from the original conceptualization by Engel (1977), highlighting the interdependence between physical, psychological and social well-being in creating a positive health condition of the person.

We may generally consider the three prefix referring to as following:

- *Bio* as the biological or physical aspects of the person and his/her biological needs;
- *Psycho* denoting the psychological elements which refers to feelings, thoughts, attitudes, emotions and are normally understood as "internal" and linked to the mind;
- *Social* 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 comes under the framework of *System Theory*, 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).

The individual has a central and active role and is freed from being the victim of biological *cause-effect* relations.

[1] www.who.int

The way all these factors interact is complex and the individual is considered as a social actor, who is part of the socio-cultural environment which also contributes, with its presence, to create and modify.

It is crucial to understand the dynamic interrelation of the three levels and their mutual influence.

It is worth to remind that mind and body are not separable as distinct entities, and have not to be considered as such.

Exercise 2. Draw on a flip chart three intersecting circles and label them: biological; psychological; social. Read the case study below and encourage the participant to discuss the case according to what has emerged so far during the session and to the following guiding questions.

Case Study

Zahra, 28years old, had suffered in the past of periodical emotional crisis, involving feeling of sadness, being useless, withdrawal. She used to be supported by the family in particular by the older sister, and to be well involved in domestic and social affairs by the neighbours. Zahra and the family have always lived in a small village. Once she was visited by a doctor who made a diagnosis of depression and started to take regularly light dosage of anti-depressant tablets, prescribed by the doctor and received through relatives in the UK. The crisis were controlled and reduced in entity. The last month due to insecurity in the region Zahra and the family had to flee and went to Galkayo where they currently live in an IDP camp; the older sister died during a crossfire shooting.

Guiding questions:

- Which psychological, social, biological factors can you identify in the story?
- Do you think that the psychological factors recognized can be /are modifiable by other factors (social, biological) identified?
- If yes, how?
- Imagine a change in one of the aspects identified, how can this modify or influence other aspects at the different levels?

Note for the trainer:

Lead the trainees to understand the interdependence of the possible psychological, social and biological factors identified. Give examples and link them; explain and demonstrate how the three levels are practically continuously influencing each other.

As one of possible examples of discussion, engage in questions like: "How is the course of an illness influenced by social factors (stigmatization in the community, possibility of participation in social life, social welfare), psychological factors (how do I react to treatment; how do I perceive the illness, how do I perceive other understanding/support of my condition?) and medical factors (effect of medicine, therapeutic continuity) at once? "

Additional Note. In the Somali context "depression" as intended by western medicine may not be considered as a disorder or a disease. The explanatory meaningful of the case study is valid even in the case that some of the trainees may argue that you can not talk about "illness" for such case. See Part 2: Module 1-Unit 4 for details.

Recalling *Psychosocial*

Exercise 3. It could be helpful, at the end of this session, to recall the meaning of the word "psychosocial" and, once more, the importance of the dynamic relationship between the psychological and social factors/ effects involved and their mutual influence. You may use a new case study, like the following, or ask one volunteer to describe a specific moment in his/her life when he/she has experienced forms of distress and discuss together with the participants, starting form the inner feelings of the person to the external factors. You will have to lead the discussion in order to keep the participants on the focus and to avoid

any embarrassing situation for the volunteer and to contextually protect him/her in case of feelings of discomfort.

Case study (additional)

A 15 years old girl is repetitively verbally criticized by a teacher during a class because of his unsatisfactory results at school. At the exit of the school a group of peers verbally abuses the girl blaming her in front of everybody.

Reflect with the participants on the influence that this event may have on the girl: which kind of feelings she may feel? Which kind of behaviour may she undertake? Which may the consequences be at different relational levels?

Note for the trainer:

The word *Psychosocial* may be new for most of the participants, if they are not familiar with the related professional field. For others the word can be easily confused with the most common "psychological" and, in practice, misused.

Moreover if we consider the existing predominance of the biological framework in many scientific environments, the *psychological* component (possibly viewed as directly linked to changes in the "internal" world of the person through the use of medicines) may take the leading position in the personal "explanatory model[2]"of the trainee.

The *social* component, often referred to be dependant on wider socio-political powers or to some extent to supernatural powers, can be understood as unchangeable and in some case beyond the control of the person.

Although it is clear that the Somali counsellor/help professional is not asked to change the social environment as component of his/her role, this may negatively affect the perception of the importance of the social components.

The trainer will address this issue explaining the potential in appropriately understanding and managing the relation with clients[3] in the social context, and how much the social and psychosocial work with clients and their families is important according to rehabilitative perspectives.

See Module 2 -Part 2 of the present manual for a detailed section on psychosocial work.

[2] See Unit 3 in this Module for details

[3] The world *Client* is used in this manual to refer to the person who is seeking help for any form of psychosocial distress and is in a helping relationship with a professional helper. This meaning is linked to Roger's humanistic theory (see Module 3- Part 1 for details).

Unit 2. Disease, Illness and Sickness

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

Medicine as a cultural system

Moving from the initial conceptualization of A. Kleinmann' Narrative Based Medicine at the Harvard University, we will consider *medicine*, any type of medicine, as a *cultural system*[4].

In this view by *cultural system* we mean 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.

Health, Illness and medicine thus become symbolic systems formed by set of meanings, values, behavioural norms and by their mutual interrelations which, in every society, shape the experience of illness.

Note for the trainer.

This conceptualization enables us to display under the correct light what in many countries all over the world is the non-scientific understanding of "medicine" (which normally stays for "western medicine"). Often, in fact, *medicine* is understood as something technical which is neutral and scientific and the only and reliable professional tool to be employed in every situation and context. Understanding medicine as a cultural system helps us to better connect the knowledge which scientific medicine involves and assumes in the local context with its medical, social, psychological and political implications at various level. It also provides us with a framework where the person is at the centre of the arena and where the personal experience is given sense and importance.

Disease, Illness and Sickness

Medical Anthropology discipline develops a specific differentiation of three terms which are, in the common use and understanding, used as synonymous: disease, illness and sickness. These approaches[5] focus on the meaning of the experience of a disorder developed by a person in a specific context adopting a holistic perspective:

- Disease: It can be considered as the bio-medical definition of pathology.

  In other worlds: an organic lesion, the external pathogenic agent /event which determines an alteration objectively verifiable on the base of biomedical knowledge and tools, a pathology identifiable according to the medical categorization (nosography) of the medical system in use.

- Illness: It can be defined as the subjective experience of being unhealthy (the sufferer point of view).

  In other words: the state of sufferance as it is experienced by the person, the subjective feelings of pain, the inner experience of distress on the base of personal perception of, which is always culturally embedded.

- Sickness: It can be defined as a social meaning of distress or a process for socializing disease and illness

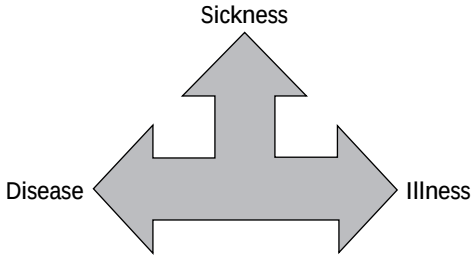
[4] Kleinman, A., 1980, "Patients and healers in the context of culture: an exploration of the borderland between anthropology, medicine and psychiatry", University of California, Berkeley, p. 131

[5] Various scholars have, in the years, developed, reviewed, and modified such approaches from/to different perspectives such as B. Good, A. Kleinmann, A. Young and others.

In other words, citing a A. Young (1982) statement... " Sickness is the process though which worrisome behavioural and biological signs, particularly ones originating in disease, are given socially recognizable meanings (…) Every culture has rules for translating signs into symptoms, for linking symptomatologies to ethnologies and interventions, and for using the evidence provided by interventions to confirm translations and legitimize outcomes. The path a person follows from translation to socially significant outcomes constitutes his sickness"

To give some examples consider, among other possible, the following aspects that qualify the meaning of sickness:

- The sociocultural codes and practices through which distresses are socially created, identified, labelled and addressed;
- The social/power relations involved in creating and modifying the distribution of sickness in a community;
- The social acknowledgement of being unhealthy (including social role of the sick person)
- Illness of individuals is always socially embedded because of the interaction of people, as social agents, in the physical and social environment;
- The community take care (or doesn't) of the sick person.



The concept of "distress" involves a complex variety of interrelated levels of meanings and social actions.

Consider the following summarizing statements:

…a person is not feeling well (ill), the doctor certifies his/her disease and the local community recognize him/her as sick person…

...the illness provides the sufferer with the meanings of his/her distress, the disease enable him/her to get access to medical treatments and the sickness enable a set of reactions from the community (i.e. stay at home, possibility of not working or, on a different note, stigmatisation, isolation)…

At a different level we also have to consider that Illness, Disease and Sickness may not be present at the same time.

Consider the following examples, among other possible:

- disease and sickness without illness (disorders which are medically and socially recognized but asymptomatic; i.e. some cancer, some high values in blood tests...);
- illness without disease and sickness (some form of anxiety, melancholy...).

Note for the Trainer.

The trainer may decide whether to give a lecture on all the topics above or to give a partial lecture alternating examples and engaging discussions with the participants.

The trainer will moreover find the best way to link the present Unit to Unit 1, since some of the concepts may be recall alternatively to help the trainees in the learning process. The following exercises may be employed during present Unit.

Exercise 1. At the end of the session divide the participants in small groups and ask them to list all the possible combinations of presence/absence of disease-illness-sickness in their context. In plenary ask one volunteer from each group to read their findings and discuss the motivations with the entire class.

Exercise 2. Alternatively the trainer may indicate a specific form of distress and engage the class in plenary discussion about the elements which qualify the disease, illness and sickness of the selected distress. You may use the case of clinical *depression* which in the Somali context can be a source of contradictory perspectives from different professionals and/or professionals from different geographical areas (what can be diagnosed as clinical depression by western psychiatry – disease in this sense- it may be understood as form of possessions or only a temporary /normal state of sadness in the context). Despite the presence of *illness* in all of these different scenarios, the family – and to a different extent the social environment- may decide to do not employ any therapeutic measure to deal with such form of distress, or to do not bring the person to a doctor because the interpretation made about the source of distress doesn't include doctors as possible helpful professionals. It is reported that in some clinics patients admitted in the hospital with a symptomatology of major depression or psychotic depression have been kept at home for years before being brought to a clinic.

On the same note you may choose the case of "*Buufis*", which is also contradictory because of its locally evolving meaning and for the different interpretations it involves in different regions of the Somali territories (i.e. some might consider it as a sickness without illness and disease; for others a illness without diseases or sickness, for other not a form of distress at all).

Unit 3. Explanatory models

Exercise 1. In plenary, ask the participants about their understanding of the expression "explanatory model".

Note for the trainer.

Take a few minutes to discuss and facilitate, with verbal hints, the explanation of some of the relevant aspects you will recall during the lecture below.

The Explanatory Models (EMs[6]) 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.

The EMs are cognitive maps connected to deep emotions and feelings, which orientate decisions, practices, actions toward the best solution for the problem.

EMs are, thus, a set of beliefs which "contains any or all of five issues:

- Aetiology (*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… (i.e. work, relations, project)?	How can I cope with this?

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.

Exercise 2. Engage now the class asking them to contextualize what just taught thinking at their working experience. You may ask questions like:"*Do you think you have ever used this framework?*" or "*Have you aver consider these kinds of information useful, from your perspective or from the perspective of client?"* or "*Is there a moment in your work where you get this kind of information?"*

[6] See the conceptualization made by A. Kleinmann (1978, 1980)

Note for the trainer.

Debating with the class on the exercise 2 and helping the discussion with practical examples move then gradually to the next exercise, which will serve as introduction to the next topic.

Note that the possibility of argumentation to such arguments depends on the professional experience of the trainees. For those who have never practically and directly been involved in patient/family-helper relations, it may be more difficult to understand the process and why such information is necessary.

Exercise 3 Divide in small groups and ask the participants to imagine themselves in a helping setting being the professional who have to investigate about a person with mental health problems and his/her family' explanatory models.

Each group will list a set of possible questions according to the "five issues contained in the beliefs" of people as set in the above explanation.

You may recall one of the case studies in the present manual as guiding story-line to facilitate the participants to imagine themselves in a real situation.

Note for the trainer.

Discuss the outputs of each group and write on a flip-chart all the original questions. You can thus deepen the discussion adding concrete examples, trying to link the different outputs and introducing the next section. If not mentioned by trainees you will add other examples of questions like those here below.

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?
- 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 important results do you hope to receive from the treatment?
- Who else can help you?

Exercise 4. Ask the following question and engage a discussion on the issue, in plenary:

" Does the Clinician/Psychiatrist/Traditional Healers employ Explanatory Models?".

Note for the trainer.

You have focused the attention so far in understanding what an Explanatory Model is and how it works, mainly gathering examples from the patient/family perspective. Every actor involved in the helping relationship engage different Explanatory Models. Some participants may assume, incorrectly, that EMs only refers to non-professional figures (such as patient and familial).

The following examples from various professionals working in the area may be of use for the discussion.

- Physician's EM is based on scientific evidence of "disease"… it employs beliefs and criteria developed in its profession, in medicine, genetic, etc.
- Koranic healer's EM is based on Holly Koran evidence… It employs supernatural and religious beliefs, faith…
- Other traditional healer's EM may employ a mix of Koranic knowledge, pre-Islamic believes, evidence of effects of plants-made remedy…

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.

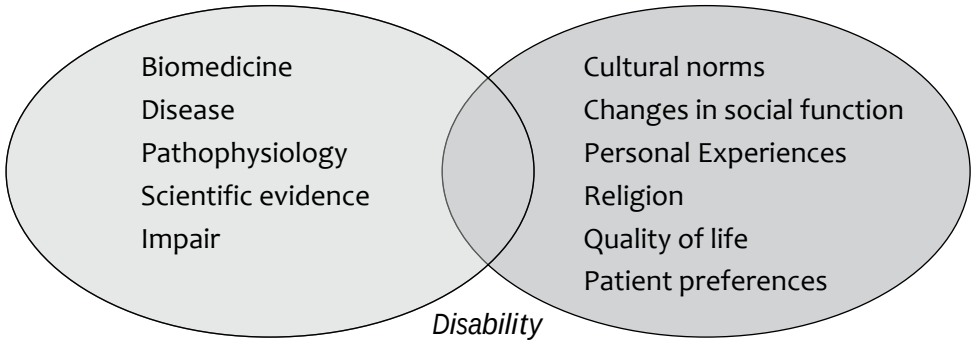


Figure 1. Dominance of Explanatory models (physician and Patient' EMs)[7]

Exercise 5. To continue and conclude the overview on Explanatory Models, you will now bring the discussion with participants to highlight the importance of EMs.

Below a list of important aspects of Ems, as you were asked to answer the following:

" What do we need Explanatory Models for ? "

- They are a useful way of looking at the process by which illness is patterned, interpreted and treated;
- They look at illness causes, meaning of symptoms, nature of the pathology, course of sickness and treatments as understood by both the healer and the patient;
- EMs can only be fully understood by considering the specific context (social, cultural, economic, political) in which they are employed;
- When the patient creates a personalized "working label" for his/her problem, he/she gains power and control.

"*Unfortunately, patients do not overtly express their true concerns in up to 75% of acute care visits… When these concerns are explored, there is an improved satisfaction, adherence, and disease outcomes"*[8].

- The physician (or social-health worker) should create a positive setting and engage the patient and familial in order to let them freely express their point of views, expectations, fears, constraints, and beliefs.

[7] Adapted from Kleinman
[8] Lang et. al. 2000

Module 2
Exploring Mental Health

Learning Objectives for Module 2

At the end of this Module participants will:

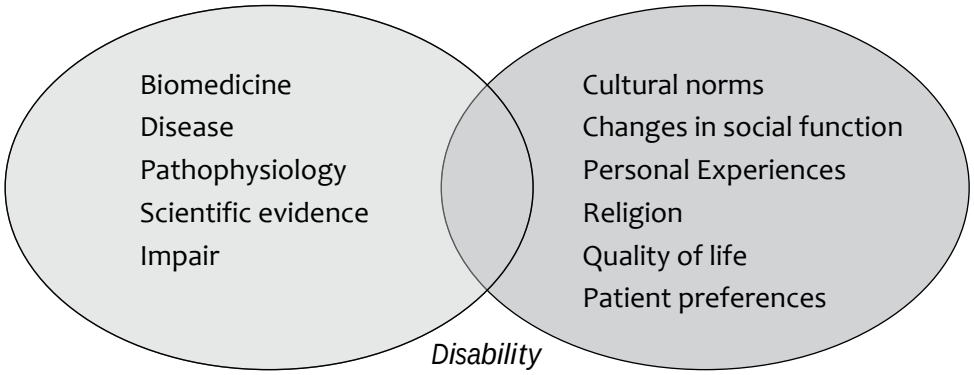
- Understand what a good Mental Health is and its relevance for people' well-being ;
- Have a basic understanding of common mental health disorders and their characteristic features;
- Be able to identify symptoms and how they became relevant in the overall understanding of mental illnesses;
- Have an introductory knowledge of the main causes and common forms of treatments of mental disorders.

Methodology

Lecture, brainstorming, discussions, group exercises.

Materials

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



Unit 1. Introduction to Mental Health

Exercise 1. Ask the participants about their understanding of *Mental Health* and its influence to the overall well-being of the individual.

Note for the trainer:

In this section the objective is to get an initial understanding to what is mental health, what is a mental disorder and how the mental states are interrelated to biological and social ones. Do not enter into a detailed discussion of the different characteristics of mental diseases, which will be discussed later. Bring the attention of participant to general understanding.

Mental Illness / Health are directly understood to be related to the mind, but *mind* and *body* are not separate entities and must not be considered as such. Mind and Body are deeply interrelated and not independent entities. If one is affected in any way, the other is affected too.

A person with *good Mental Health condition*s should normally be able to think clearly, properly address/ solve problems faced in life, enjoy good relations with others, feel spiritually at ease.

On the contrary, *mental illness* is "any illness experienced by a person which affects their emotions, thoughts or behavior, which is out of keeping with their cultural belief and personality, and is producing a negative effect on their lives or the lives of their families".

Recall now the definition of Health in the WHO Constitution introduced in the first Unit.

Mental, physical and social health are vital strands of life that are closely interwoven and deeply interdependent. As understanding of this relationship grows, it becomes ever more evident that mental health is crucial to the overall well-being of individuals, societies and countries.

When it's more appropriate for the discussion go back to the drawing on the flip-chart of three intersecting circle used in the previous unit; alternatively draw as follow:

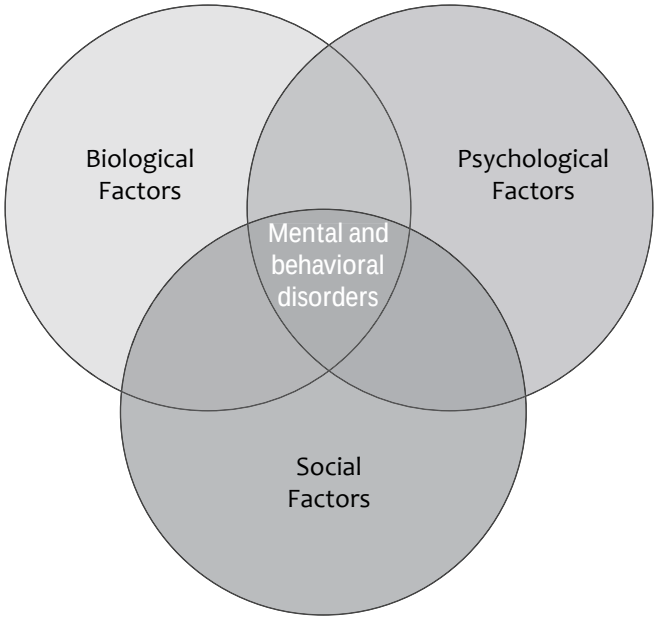


Figure 1. Interaction of biological, psychological and social factors in the development of mental disorders (WHO, 2001).

WHO insists on the fact that artificial separation of biological from psychological and social factors has been a formidable obstacle to a true understanding of mental and behavioural disorders. In reality, these disorders are similar to many physical illnesses in that they are the result of a complex interaction of all these factors.

For years, scientists have argued over the relative importance of *genetics versus environment* in the development of mental and behavioural disorders.

Modern scientific evidence indicates that mental and behavioural disorders are the result of *genetics plus environment* or, in other words, the interaction of biology with psychological and social factors.

It is now scientifically accepted the shifting of paradigm from the bio-medical to the bio-psycho-social model. Today we know that most illnesses, mental and physical, are influenced by a combination of biological, psychological, and social factors.

At psychiatric level the biological factors include the organic ones, the functions of peripheral and central nervous system, the genetic; *the psychological level* involves the "inner" world of the person (thoughts, emotions, feelings, attitudes); *the social level* refers to the behaviour of the person in relation to the family, peers, community as well as the cultural beliefs (including religion), or the formal-informal institutions of the community which influence the daily life of the person (i.e. clan, sub-clan, local government, etc.).

Relevance and Concerns about Mental Illnesses

Exercise 2. Discuss with participants on the relevance of Mental Disorders in their context and about the perceptions they have on the burden and concerns related to mental illness.

Some hints for the discussion[9]:

- Mental Illnesses affects us all: it is estimated that around 20-25% of all adults will experience a mental health problem in their lifetime;
- Mental Illnesses are a major public health burden: mental disorders represent in fact 4 of the 10 leading causes of disability worldwide[10]; 450 million worldwide;
- Mental Illness are very disabling;
- Mental Health services are very inadequate;
- Societies are rapidly changing;
- Mental Illness leads to stigma;
- Mental illnesses can be treated with simple, relatively inexpensive methods;

Symptoms

The trainer will introduce, involving the trainees in the discussion, the concept of *sign* and *symptom* and their importance in the psychiatric field.

Symptoms are signs with clinical relevance, according to the diagnostic system in use.

A *psychiatric symptom* can be properly understood and better addressed (depending on the needs through counselling, medical treatment, psychosocial support, etc.) if the professional considers the three main aspects involved and cited earlier (biological, psychological and social-cultural).

[9] Some of the data mentioned here are from WHO Mental Health Report (2001) and subsequent available WHO statistics
[10] Leading causes of disabilities-adjusted life years (DALYs), WHO (2001)

Mental Illnesses produce symptoms which are identifiable by the sufferer, the familial and professional workers. They can be divided into 5 main categories:

- Physical : somatic symptoms. i.e. aches;
- Feeling : emotional symptoms. i.e. feeling sad ;
- Thinking : cognitive symptoms. i.e. flight of ideas;
- Behaving : behavioural symptoms. i.e. aggressiveness;
- Imagining : perceptual symptoms. They arise from one (or more at the same time) of the sensory organs (i.e. hallucinations).

Exercise 3. Together with the participants select one of the 5 main categories above (i.e. Imagining) and, on a flip-chart, list as many related symptoms as you can. In the case of *imagining* separate the symptoms according to the sensory organ involved.

After this collective exercise divide the participants in 4 groups (if possible, otherwise be flexible!) and assign each of them the remaining 4 categories (physical, feeling, thinking, behaving) asking to list relevant symptoms for the category, as just done in plenary. Give them 10-15 minutes to complete the exercise on a flip-chart and in turn ask one group representative to illustrate it to the audiences. Discuss the outcomes with the participants.

Unit 2. Common Mental Health Disorders

Note for the trainer:

In this session you will explore the main aspects of some common Mental Health disorders present in the Somali context (*Acute Psychosis & Chronic Psychosis, Depression, Mania and Bipolar Disorder, Anxiety, Substance abuse and dependence, Mental Retardation*). This session has not to be considered exhaustive of the topic; it will serve as an initial guide and starting reference for deeper knowledge.

Mental and behavioural disorders are a set of disorders, internationally defined by the WHO' *International statistical classification of diseases and related health problems (ICD-10)* and the *APA(American Psychiatric Association)' Diagnostic and Statistical Manual of mental disorders, 4th edition reviewed (DSM IV-R).*

The *WHO – 2001 World Health Report on Mental Health* can be used by the trainer as teaching material if necessity arises during the training.

The WHO' *Mental Health of Refugees*[11] address the topic of this session in the context of displacement and

Exercise 1. Ask the participants to explain their understanding of Mental Illness and to provide examples from their personal experience of people suffering from a form of Mental Illness. Engage a general discussion on general aspects and perceptions about mental disorders, using the following hints for the discussion:

- While symptoms vary substantially, mental disorders are generally characterized by some combination of abnormal thoughts, emotions, behaviour and relationships with others;
- One incidence of abnormal behaviour or a short period of abnormal mood does not, itself, signify the presence of a mental or behavioural disorder;
- *Not all human distress is mental disorder*. Individuals may be distressed because of personal or social circumstances;
- Diverse ways of thinking and behaving across cultures may influence the way mental disorders manifest but are not, of themselves, indicative of a disorder;
- Nor can social, religious, or political beliefs be taken as evidence of mental disorder;
- Any classification of Mental Disorder *classifies syndromes and conditions, but not individuals*. A person should never be equated with a disorder – physical or mental.

Note for the Trainer:

At the end of each of the following sections describing some different types of common mental disorders and their features, engage the class in discussion on the relevance of such disorder in their context. You may use questions like "is there any name to call this kind of disorder or some aspects of it? Is there a common symptomatology in any form of distress which has a local name?

Always remember to link and facilitate the understanding of these common disorders, as defined by the international scientific community, with the local context and be open to criticism from the audiences. Every form of distress must be understood in the context, symptoms have to be understood locally and not as universal signs.

Some form of disorders (which may get a specific label following a psychiatric investigation) may have a completely different form of understanding in the local context, with different attribution of source of problems, causes, course, etc. Some local forms of distress may not be recognized as such by the international community and not finding a place in categorizations.

11 WHO, Geneva, 1996

When the helper uses its professional tools to understand the peculiar situation of a person with mental health problems in the familial and socio-cultural context where it evolves, it will be an asset for the setting of an appropriate problem solving rehabilitation path.

1. Chronic Psychosis

In brief...

Chronic Psychosis, such as *Schizophrenia*, is a severe form of Mental Disorder; the burden on families and patients is usually high.

Schizophrenic patient represents the stereotypic example of "mad person", *Waali* in the Somali context.

Chronic means that the illness lasts from several months to years and requires long-term treatment.

Psychotic patients experience specific features not noticeable in non-psychotic patients such as: talk/think irrelevantly, have no insight of illness, experience hallucinations and have strange believes not based on reality.

Symptomatic features of Chronic Psychosis

Physical:
- Extraordinary and strange complaints (i.e. animal inside the body);

Feeling:
- Lack of emotions;
- Loss of interest and motivation in daily activities;
- Depression;
- Feeling scared of being harmed.

Thinking:
- Difficulty thinking clearly;
- Strange thoughts - *delusions* (i.e. believing other are trying to harm him/ mind controlled by external forces)

Behaving:
- Withdrawal from usual activities;
- Restlessness;
- Aggressive behaviour; lack of self care
- Bizarre behaviour (i.e. hoarding rubbish)
- answering questions with irrelevant answers

Imagining:
- hearing voices that talk about him (*hallucinations*)
- seeing things that other cannot (*hallucinations*)

2. Acute (brief) Psychosis

Symptoms are similar to those of schizophrenia and mania (see later).

The key is that symptoms begin suddenly and last less than a month. *Common features* are:

- Hearing of voices or seeing things that others cannot
- Strange beliefs or fears
- Confusion and talking nonsense
- Apprehension
- Several Behavioural changes that can not be explained (i.e. restlessness and aggression)
- Fearful emotional state or rapidly changing emotions (from tears to laughter)

3. Depression

In brief...

Depression is a common emotional problem, which, clinically, is referred to as *Mood (affective) Disorder.*

It involves emotions that almost everyone suffers from at least at some time in their life, such as sadness, feeling miserable, etc.

To some extent it can be considered "normal"; clinical problems arise when these feelings start to interfere with normal life, lasting for long time, such as more than a month, in association with disabling symptoms, such as tiredness and difficulty concentrating, affecting daily life rendering easy thing impossible to be done.

Symptomatic features of Depression

Physical :
- Tiredness and a feeling of fatigue and weakness;
- Vague aches and pains all over the body.

Feeling:
- Feeling sad and miserable;
- A loss of interest in life, social interactions, work, etc.;
- Guilty feelings.

Thinking :
- Hopelessness about the future:
- Difficulty making decisions:
- Thoughts that it would be better if he/she were not alive:
- Suicidal ideas and plans:
- Difficulty in concentrating.

Behaving:
- Disturbed sleep (usually reduced sleep, but occasionally too much sleep);
- Poor appetite (sometimes increased appetite);
- Reduced sex drive.

4. Mania and Bipolar Disorder

In brief...

Bipolar Disorder (also called manic-depressive disorder) is one of the most severe forms of mental illness and is characterized by recurrent episodes of mania-*high mood-* and (more often) depression-*low mood-*.

In contrast to Schizophrenia, this condition is typically episodic: there are some periods in which sufferers are completely well even if they are not taking treatment.

The Depressed phase is similar to depression, although often more serious.

Symptomatic features of Mania

Feeling:
- Feeling on the top of the world;
- Feeling happy without reasons;
- Irritability;

Thinking:
- Believing that he has special powers or is a special person;
- Believing that others are trying to harm him;
- Denying that there is any illness at all.

Behaving:
- Rapid speech;
- Being socially irresponsible (i.e. sexually inappropriate);
- Being unable to relax or seat still;
- Sleeping less;
- Trying to do many things but not managing to complete anything;
- Refusing treatment.

Imagining:
- Hearing voices that others cannot (often these voices tell him/her that s/he is an important person who can do great things)

5. Anxiety (emotional disturbance associated with fear and worry)

In brief...

Sensation of feeling fearful and nervous, constantly worry.

Normal in certain situations, become an illness if it last long - more than two weeks- and interfere with daily life.

It often affects people overwhelmed by many problems (i.e. refugees), such as loss of property, unemployment, lack of shelter or proper food.

Some forms of anxiety may occur after a person has been involved in traumatic event (i.e. Post Traumatic Stress Disorder).

Symptomatic features of Anxiety

Physical :
- Rapid and irregular heart-beat (palpitation);
- Feeling of suffocation;
- Dizziness;
- Trembling, shaking all over;
- Headaches;
- Pin and needles (sensation of ants crawling) on limbs or face.

Feeling:
- Feeling as if something terrible is going to happen to him/her;
- Feeling scared.

Thinking :
- Worrying too much about his/her problems or health;
- Thoughts that s/he is going to die, lose control or go mad (often associated with severe physical symptoms and extreme fear);
- Repeatedly thinking the same distressing thought again and again despite efforts to stop thinking them.

Behaving:
- Avoiding situations that he/she is scared of (i.e. marketplaces);
- Poor sleep;
- Restlessness, getting easily tired.

6. Substance Abuse

In brief...

People who abuse substances risk developing many problems which are affecting health, family, personal, and economic affairs.

Refugees have a potentially large number of new users, who could quickly become heavy users.

Vulnerable people, such as refugees, IDPs, asylum seekers, returnees may begin to use alcohol or other drugs as a way 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 behaviour in the normal way, or when family-social ties are damaged and impoverished for any reasons, young people in particular may start taking alcohol or drugs.

Substances of abuse/drugs are generally called *psychoactive substances.*

Psychoactive substance is any substance, which produces a change in the way they feel, think or behave and affects the Central Nervous System in different ways are such as:

Stimulating (i.e. Cocaine, amphetamines, Qaat):

- Speed up brain activity;
- make the person feel they have extra strength;
- in small doses: feel alert & awake;
- in high doses: tense, panicky, restless;
- difficulty controlling thoughts, may hallucinate, suspicious, confused;
- withdrawal reaction mild: hunger and fatigue.

Depressing (i.e. Alcohol, inhalant, barbiturates, marijuana, tranquilliser; Opium & heroin:

- Slowing down brain activities;
- in small doses: feel relaxed;
- in high doses: drowsy and unconscious;
- withdrawal reaction severe: fever, restlessness, confusion, nausea, convulsions.

Hallucinating (i.e. LSD, mescaline):

- distorting perception ;
- hallucinations;
- create excitement, confusion, suspicious;
- No withdrawal state

Symptomatic features of Qaat

Physical:

- Some degree of brain stimulation;
- Hypothermia (lowering of body temperature);
- Sweating and dehydration (loss of body water);
- Increased blood pressure;
- Migraine headache.

Thinking:
- Increased brain activity;
- Flight of ideas;
- Grandiose thinking;

Feeling:
- Feeling high;
- Depression (post);

Behaving:
- Increased (some decreased) loquacity & rapid speech;
- Tiredness and sleepless;
- Increased libido /Decreased sexual functioning;
- Irritability and Increased Suspiciousness;
- Loss of interest in anything but Qaat;

Imaging:
- Some degree of delusional features (mixing imagined plans with reality) & reported cases of mild hallucinations

7. Mental Retardation

In brief...

Mental Retardation is not a Mental Illness in the strict sense of the term.

Mental Retardation is rather a state than an illness, a condition which is present from very early childhood and remains during the course of one's life.

It means that the brain development of the child is slower or delayed compared to other children (see also IQ).

Being used in discriminatory way it should be advisable to use the term *"Learning Disability".*

Common Features

According to DSM-IV R criteria are identified in IQ level (<70) and deficits or impairment in *Adaptive functioning.*

Adaptive functioning refers to how effectively an individual copes with ordinary life demands (i.e. Communication, Self-care, Home living, Social/interpersonal skills, Use of community resources, Functional academic skills, Self-direction, Work, Leisure, Health, Safety):

- Delays in achieving milestones (sitting up, walking, speaking);
- Difficulties in school, coping with studies and repeated failures;
- Difficulties in relating to others;
- In adolescence inappropriate sexual behaviour;
- In adulthood problem in everyday activities (cooking, managing money, and staying on a job...);

Causes

Many organic causes have been discovered but majority of cases cannot be explained, especially for mild mental retardation,

The two-group approach:

Organic mental retardation includes chromosome abnormalities, genetic and constitutional factors, neurobiological influences; adverse biological conditions (e.g., malnutrition, exposure to toxins, prenatal and perinatal stressors[12]), infections, traumas, and accidental poisonings during infancy and childhood.

Cultural-familial mental retardation includes family history of mental retardation, economic deprivation, inadequate child care, poor nutrition, and parental psychopathology, deprivation of physical and emotional care and social stimulation.

Prevention, Education, Treatment

- Child's overall adjustment is a function of parental participation, family resources, social supports, level of intellectual deficit, temperament;
- Treatment involves a multi-component, integrated strategy that considers children's needs within the context of their individual development, family and institutional setting, and community;
- Prenatal education and screening may prevent some cases of MR,
- Psychosocial treatments:
  - intensive, child-focused, early intervention efforts (particularly for disadvantaged children);
  - optimal timing for intervention is in the preschool years;
  - behavioural techniques include shaping, modelling, graduated guidance, and social skills training;
  - family oriented interventions help families cope with the demands of raising a child with MR

12 A s*tressor* is any fact, event, situation in life which can trigger a reaction at individual' emotional, physical, cognitive level that may elicit a mild to sever form of stress. Stressors can be either positive or negative (preparation for weddings, death of familiar, loss of job, etc.), although negative stressors are normally more directly related to incipient development of distressed conditions. Usually before the onset of a psychiatric disorder an increased in number of stressors is observable.

Unit 3. Main causes and Treatments of Mental Illnesses

The last Unit of the present Module is a synthetic overview of the main causes and treatments of Mental Disorders. Since the present handbook does not aim to address such aspects in depth, the information on this Unit will be thus deliberately synthetic. While in the next sections of the handbook you will find a detailed explanations of some techniques and approaches to treatments of mental disorders (although not focused on the Somali context), you can consult the text books cited earlier, the handbook references, and relative bibliography.

Main Causes of Mental Disorders

Stressful Life Events /Serious External stressors:

Including death of loved ones, economic problems, physical or sexual abuses, taking drugs, chronic stress, serious head injuries, unemployment, violence and trauma, marital conflicts, displacement, loss experiences (properties, status), insecurity (physical, hygienic, food), difficult families background (violence, emotional neglect during childhood), inner psychological conflicts.

Chemical or biological imbalance:

A person with brain chemical imbalance (neurotransmitters) will have bizarre behaviour because messages are not being sent properly or interpreted correctly. Some examples:

- Low level of Serotonin, norepinephrine and dopamine in Depression;
- High level of norepinephrine and epinephrine during a manic episode
- Dopamine and Serotonin imbalance in Schizophrenia

Some medical problems (kidney, liver failure) and some medicines can sometimes cause a severe mental problem.

Genes or heredity:

Although there is presence of hereditary aspects in some of the mental disorders, like for diabetes and heart diseases, these are influenced by environmental factors. Nevertheless, it does not mean that they are incurable or untreatable.

Treatments of Mental Illnesses

- (psychotropic) Medication:

- *Antipsychotic* are used to treat severe mental disorders; they are used for symptoms like hallucinations, delusions, confusion, altered perceptions, disorganized speech, and aggressiveness. Examples , among others, are : Chloropromazine, Haloperidol, Thioridazine, Olanzapine, Risperidone;
- *Antidepressants* are utilized to relieve symptoms of anxiety and depression such as sadness, feelings of failure, loss of interest in life, sleep disturbances, excessive guilt, loss of energy/fatigue, thoughts of death and suicidal thoughts. Examples, among others, are :Amitriptyline, Despiramine, Fluoxetine;
- *Mood Stabilizers* are utilized to control manic-depressive illness, and treat symptoms of Mania such as rapid talking, decreased need for sleep, racing thoughts, distractibility, irritability, behavioural excesses, grandiosity. They are also used to treat seizures. Examples, among others, are: Carbamazepine, Sodium Valproate, Lithium Carbonate;
- *Anxiolytics* are used to reduce anxiety and sleep problems. Examples, others, are: Diazepam, Lorazepam.

Psychotropic Medications have side effects that must be monitored.

- Psychosocial Interventions:

- Patient /Family education;
- Counselling (individual, group, crisis...);
- Psychotherapy (family, individual, various schools...);
- Skills Training (vocational, social...);
- Crisis intervention (clinic, telephone, home...);
- Self-help groups;
- Hospitalization (short, medium, long-term);
- Community Awareness;
- Relaxation exercise;
- others...

- Traditional and Spiritual Treatments:

- Koranic;
- Dawo-Somali and herbal;
- Saar-Mingis;
- others...

Note. Among international aid agencies, health professionals and policy makers the use of the words *psychosocial well-being* and *mental health* is source of debate and confusion. For some the two words are interchangeable, others clearly distinguish among the two (usually referring to mental health while dealing with more severe form of psychosocial distress up to psychiatric pathologies) while others consider the term psychosocial well-being wider than mental health, preferring to use the first also because for its explicit pointing at the social and cultural influence on well-being.

Module 3
Introduction to Counselling

Learning Objectives for Module 3

At the end of this Module participants will:

- Be able to understand and define what is *counselling* is and what is not ;
- Understand the potentialities of professional counselling ;
- Understand the difference between professional counselling and non professional counselling ;
- Have a general understanding of different types of counselling.

Methodology

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

Materials

Flip chat, pen & paper, markers, clothes and other materials for role playing, power point presentation, and reference materials.

Unit 1. Definitions of Counselling

Exercise 1. Write the word *Counselling* on the flip chart and ask the participants to think about its meaning. After few minutes ask them to describe it to the class and list on the flip-chart the characteristics emerged.

Note for the Trainers:

Counselling exits in different forms and settings; it can be often confused by "talking" to people in need, especially if we come to the most common form of mutual help (via close relatives or friends).

Purpose of this training handbook is to explain a specific form of counselling: *professional counselling in health settings*, with focus on *mental health*; being the psychosocial well-being of the person the main goal. The trainer who decides to develop further some of the aspects treated in this handbook will find several manuals on the subject, although generic and not focused on the Somali context. In the next sections some practical exercises (i.e. role plays) are designed as examples to guide the trainees to an in-depth comprehension of what thought theoretically by the trainer. This is a crucial aspect of the training as a whole and, if time and resources allow, the trainer will add more practical exercises, selecting the specific skills and components that will require more attention, according to the needs of the class.

The best way to understand what counselling is and how a counsellor works, after a theoretical brief, is to practice and observing other professional practising in a real scenario.

Exercise 2. After having explained the note above, provide the trainees with some definitions of Professional Counselling, such as:

The World Health Organization (WHO) defines counselling as a process of dialogue and mutual interaction aimed at:

- Facilitating
- Problem solving
- Motivating
- Decision-making

The United Nations Population Fund (UNFPA) defines counselling as a particular way of helping that involves:

- A skilled helper and one or more "clients" (people seeking help, the term "client" suggests an equal relationship).
- An accepting, trusting and safe relationship
- A process whereby clients learn how to understand better themselves and their present situations
- A process whereby clients are helped to construct goals for the future
- A process whereby clients are helped to acquire the skills and courage to pursue these goals.

Counselling is face-to–face communication through a dynamic process of interaction between two or more people during which the counsellor helps the client to take decisions. It involves *active listening*[13] to people talking about their problems; giving them comfort in an atmosphere of empathy and helping them to work out what to do about their problems, working at the empowerment of the client.

13 See further for details

Counselling is a helping relationship aimed at enabling a client to explore a personal problem, giving the client increased awareness of choices than what they already have in dealing with the problem, and assisting her/him to make an informed decision what to do about the problem.

Counselling is an information-exchange process, with the additional component of sharing feelings and emotions that the client finds difficult or disturbing, which act as constraints to functioning and so that the client is not able to resolve alone within usual social relationship.

Exercise 3. Discuss with the participants the list of characteristics (exercise 1) previously identified and written on the flip-chart, and engage them taking into consideration the following inputs:

- having heard different definitions of what is a professional counselling, do you think the characteristics you previously identified (*note*: point at the list, one by one) can be seen as part of a counselling process?
- if not, what do you think this characteristic has more to do with?

Note for the trainer:

Highlight and engage the discussion focusing on the eventual discrepancies raised, and open windows to what will be taught next.

Unit 2. Types of counselling

Note for Trainer:

Exercise 1. In continuity with last exercises in the previous Unit, recall the differences between professional and non-professional counselling. See Modules 3 of part 3 on Gender Based Violence for details.

Before reading the following paragraph ask the participants to describe which kind of counselling they employ during their daily working routine or, more generally, ask them to describe which of their working activities are strictly related to what has been understood to be a counselling process.

Read then the following examples of some different types of existing professional counselling.

Note for trainers. The list is not exhaustive and the intention is to show the variety of techniques developed in the field. According to the situation and needs of the trainees, the trainer may in advance prepare a detailed list on one or more of the types of counselling, and discuss them with the trainees.

Alternatively, after the reading of the list below, the trainer may read short case studies and ask the trainees to identify the best kind of counselling for the case.

The following types of counselling can be used together or alone, depending on the treatment plan.

Crisis intervention counselling

'Crisis' is here intended in cases of emergency (such as rape, spouse abuse), when an individual is faced with a life-threatening situation. The person may be *paralysed* by the overwhelming situation, may feel of having lost control on the situation/life and often s/he may have lost significant persons or have the feeling of having lost possibility to seek help.

The counsellor will help the client to get through the crisis and refer to further counselling or other care, if needed; crisis counselling usually concentrate on helping a person around the time of crisis and can only take place when there is the possibility for interpersonal interaction.

Preventive Counselling

This form of counselling is devoted towards stopping something before it develops (1) so when 'a risk' of developing the behaviour is identified, or trying to stop further development (2).

(1) It focuses on identifying and exploring risk behaviours; it aims to motivate the individual towards risk reduction;

(2) It focuses towards stopping or minimizing a problem.

Problem-Solving Counselling

It is structured, involving active empathetic listening, to help individuals to identify problems, analyse them and find alternative solutions. The aim is to help clients to accept circumstances and to reduce adverse impact of the problem in her/his psychosocial well being.

Decision – Making Counselling

It usually works well after a problem-solving process has taken place, when the client is facing the risk around making difficult decisions.

The counsellor will work with the client without playing an advisory role or making the decision for the client.

Individual counselling

Very common form of one-on-one counselling (client-counsellor). Some problems are very personal and difficult to confront with others present.

Family therapy

Family therapy can help family members resolve issues among each other. It also can help them adopt ways to help another family member to get well. Family members can learn how actions and ways of communicating can worsen problems. With help, new and improved ways of communicating can be explored and practiced. In western settings family therapy is often used when an adolescent has a problem with alcohol and substance abuse.

Group therapy (and self-help group)

In group therapy, people join in a group and discuss their problems together. The session is guided by a counsellor. Members in the group often share the same problem, but not always. The group session provides a place where people can confide with others who understand their struggles. They also can learn how they see themselves and how they are seen by others. Members gain strength by knowing that they are not alone with their problems.

It can be set as a Self-help group.

Exercise 2. If applicable to the professional background of trainees, ask now if one or more of the techniques just explained has never been used by them or observed, as explained or only in some aspects, in a help setting. Discuss with the participants.

Note for the trainer:

Gradually trainees are getting to the core of being a counsellor and understand what a professional counselling in helping settings is. If doubts arise among participants, especially in the realm of professional *vs* non professional counselling, reassure them and move to the next Units. Consider also a possible connection to Part 3 when other details concerning the use of professional *vs* non professional counselling will be properly addressed.

Unit 3. What IS counselling *vs* what IS NOT

Note for the trainer:

Before moving to the next module, where you will explore the profession of counsellor, let's focus on a last crucial aspect which often creates misunderstandings among trainees: what counselling is NOT.

This is linked to what discussed earlier and will be discusses again in Part 3, about the differences between non professional and professional counselling.

As we have discussed, one of the main characteristics of the non-professional counselling (sometimes called 'traditional' or 'familiar') is *giving advices*, usually by a person who knows the other (the 'client' if they were in a professional setting) well.

This is exactly what the professional counsellor avoids to do.

The professional counsellor doesn't give advices and rarely uses his/her personal knowledge of other in the helping relation. He/she relies on his/her professional skills and on the competent exploration of the situation and its challenges, obstacles, resources, strengths and opportunities.

In general the counsellor may not know at all the clients.

Exercise 1. Ask the participants to divide in small groups (2-4 persons each) and think and discuss among them about the following hints and answering the last question:

- Giving advises is something familiar to everybody, in informal settings. Have you ever given advices during your professional activities?
- Why *giving advices* is not useful during counselling?
- What is the difference between *giving advices* and *providing information*, which are the characteristics of both?

Give 10-15 minutes to discuss in group than ask to one of each group to share with the class their findings. Divide the flip-chart into two columns and list characteristics emerging for *Advice* (left column) and *Information* (right column).

Then read the following and double-check with the answers listed in the flip-chart, addressing possible incongruence.

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GIVING ADVICES is telling someone what you think they should do and how you think they should do it; it is giving your personal opinion, implying that you propose your own personal view of the situation and suggest the best way to solve it.

Giving advice is not useful in professional health counselling because:

- You can't know if you are giving the right advice.
- You might give the wrong advice and it can have a bad outcome for the client. This can lead to a client's problems getting worse and to you getting a reputation as a bad counsellor.
- Counselling is about the client' opinion and judgements, not the counsellors.
- Counselling is about empowering clients to make their own decisions about their own lives. Telling someone what to do does not help a person to understand her/his choices. It is up to the client to decide the best way to solve her/his problems.

- The equity is essential in the counselling relationship. If the counsellor gives advises, the role of expert is reinforced and equity is denied.
- Often the person doesn't desire to receive advises, but prefer to be listened and understood.
- A client might feel you are not respecting her/him if you tell her/him what to do.
- Giving advice is based on own values and beliefs, it suits more with who is giving it than who is receiving it.
- Advises take in consideration only the more superficial aspects of a problem, ignoring or going around the deepest issues and not helping to change the behaviour of the patient.

*****

GIVING INFORMATION is telling someone facts so they can make an informed decision about what to do.

Giving information is useful in health professional counselling session because:

- It empowers a client to have control over her/his choices.
- It shows you respect the client's opinion and judgements.
- The client has responsibility for making the right decisions about her/his life, not the counsellor.
- The client is the one who will have to live with the consequences of her/his decision, not the counsellor.

Exercise 2. To conclude the session address the issue of '*being required by clients for advices'*, as outlined in the passage below, discussing the dilemma with trainees, then summarize the outcomes of the lecture so far, using the list drawn at the end of the session.

Note for the trainer:

In a context where people is not familiar with the figure of *counsellor* and *counselling* as a profession, it may be not clear yet the difference between this and other kind of non-professional forms of mutual help usually employed with no mediations.

If some of the participants have already field experience as professional helper/counsellor in health settings, they may argue that *some people do ask for advices and expect for receiving them*, *especially when they start a counselling process*.

This usually happens because clients see the counsellor as an expert and they need some time before to get to know that the role of counsellor is to accompany them, and to drive them in the difficult task of self-exploration, rather than give advices and indications on the way to be followed.

Now close the session showing the following summary (that you'll have written on the flip chart or prepared on a power point presentation in advance) and verify the degree of understanding by the students.

Counseling in a health setting IS:

- Communication between a person with a problem and another person who is helping to solve the problem
- Listening
- Making the other person feel understood and respected
- Helping to empower a person to cope with crisis
- Giving information and building skills

- Helping a person to make her/his own decision
- Providing support
- Helping a person to face their problems, examine their options and decide a course of action
- Helping client to build self-confidence

Counseling in a health setting IS NOT:

- Giving advice
- Teaching
- Interrupting
- Pretending to be interested
- Judging
- Interrogating
- Moralizing
- Blaming
- Not being gender sensitive
- Making choice for a person
- Talking about yourself

Module 4
Skills in Counselling

Learning Objectives for Module 4

At the end of this Module participants will:

- Understand what a professional counsellor does and which are favourable attitudes of a good counsellor;
- Understand and acquire basic counselling skills;
- Have a clear understanding of main methodological skills and attitudes to be developed during a counselling process;
- Be able to set a counselling plan and to conducts a complete counselling session with clients in need;

Methodology

Lecture, discussions, group exercises, case studies, role plays

Materials

Flip chat, markers, pen & paper; clothes and other materials for role playing; reference manuals.

Unit 1. To be a Counsellor

Paraphrasing a famous statement by anthropologist C. Geertz, to better understand what a discipline is, we can observe what those who practice it do. To understand what *counselling* is we will thus start observing what a *counsellor* does.

In many countries to become an official *counsellor*, the person must undertake a 2 to 3 years course in one of the many recognized schools (including theoretical, practical training and stages), which lead to the achievement of a national Diploma.

In this section we will explain and work on the main characteristics a good counsellor must acquire, and practice during counselling, and on the main steps necessary to develop a counselling process.

Note for the Trainer:

Read the following, addressing some aspects identifying a good counsellor:

The Counsellor is an expert in communication and relationship, able to facilitate/promote the client self-awareness.

S/he's able to support the emotive complexity of the client in transitions/need helping the client to find his/her road to change for the achievement of psychosocial well-being.

The Counsellor is a professional figure able to help individuals and groups to develop their potentiality, communicative and relational resources:

- it facilitates the assessment, identification, definition of clients' problems and their positive solutions;
- helps the client in finding and utilize internal and external resources available;
- welcome, support, listen people facing stressful life situations and challenges;
- promotes awareness and ability to act in the clients;
- provide encouragement and guidance;
- help people cope more effectively with the problems of living;
- helps clients to identify their problems and helps them find their own solutions;
- "facilitate instead of providing advices".

According to the humanist framework (Carl Rogers -1951- proposed a "client-centred" model of counselling), rather than impose her or his own goals on the client, the counsellor's task is to enable the client to make judgements and decisions about what he/she wants and needs.

The basic tool of the client-centred therapist is unconditional positive regard that is a complete and unqualified acceptance and respect for the client's feelings and actions.

Again, following Rogers' intuitions, if a person is in need the best way to help is not telling him/her what to do, but rather to help her/him to understand the situation and manage the problem.

This approach moves the emphasis of the helper from technical-procedural abilities and skills to the "human qualities" of the operator, that means shifting the attention from "know-how" to "know how to be" in the relationship; the skills acquired by the helper should take on dowries such as: sensibility, genuine acceptance, non-judgemental attitude, flexibility, patient, coherence.

All these aspects have to be refined through practice and time.

Exercise 1. Discuss with the participants about the role of a counsellor, as it has been understood through your presentation. Address doubts and, if necessary, put some of them in *standby* for the next Unit.

Unit 2. Basic Counselling skills

Exercise 1. Now that participants should have a basic understanding of what counselling *is* and what a counsellor *does*, engage a class discussion asking which are, in their opinions, the main skills a good counsellor should have/acquire/practice. List them on a flip chart.

Note for the trainer:

The following are the main skills and attitudes a good counsellor should have, according to Roger's *core conditions*:

- Empathy (empathetic comprehension). Is the ability to "standing in the other person's shoes", looking at the world through their eyes and asking, "what is likely to be in this person's situation". Observing the other's point of view, without filtering it through our personal lens, will furthermore let us to avoid a judgmental attitude toward the person and will enable us to deeply understand him/her.

  Key fact is that Empathy is different from sympathy.

  If you feel sympathy, you will tend to take sides and this will distort or affect your ability to hear the whole story about her/his problem. You will no longer very objective in understanding the reality of the client's problem situation. A good counselor tries to understand and share the client's feeling, not to be overwhelmed by them.

  Empathy involves accepting her/his point of view and being interested in exploring its implication on her/his behavior.

  It is not enough to experience empathy, it is also important to be able to transmit empathy.

- Congruency. Quality and attitude of genuineness, of spontaneous expression in constructive way, of the helper personality. This involves sincerity and honesty by the helpers who need to be themselves, implying that they have to know themselves first.

  Congruency avoids the risky attitude of having the helper to be seen as the expert, looking from top to the bottom the client.

  Congruency is also crucial to obtain trust of the clients, which is one of the core steps of the help relationship (see also following Unit).

- Unconditional Positive Regard involves avoidance of any attitude of judgment towards the client, absence of pre-conditions for accepting the client as a person with his/her own subjectivity and as a person tending to change.

  It means also to show a sincere interest to the client, absolutely far from any kind of rewards or other similar kinds of expectations; it implies the comprehension of the other in the full respect of differences.

  This means that even if the helper' view radically differ from the client' view, the client deserve respect and positive regard, they have to feel to be fully accepted as a person by the counsellor.

  To this *core* list we can add some more attitudes as identified, in particular, by R. Carkhuff:

- Confrontation; it is an attitude of constructive "confrontation" on some specific aspects of the client' behaviour, which appear to be contradictory and incoherent and towards which the client is not aware (for instance because of activated defence mechanisms). The goal here is to overcome those barriers which obstruct the development of the individual, helping the last to be aware of them and to have an objective reading of the situation.

- Immediacy is the ability to express openly, friendly, directly and with clarity the impressions and information regarding the way the relationship is developing. This has the main goal in providing an example (a "model") of how it is possible to openly communicate to the other (in a relationship) what you think about him/her in regard to yourself.

Note for the trainer:

Even if the participants had demonstrated clear comprehension of the present and precedent units and they positively engaged the last question, it is unlikely, unless they have precedent knowledge about counselling, that they had used the terms listed before. This may create a bit of frustration in some students, because they may think to have not clearly understood what have been taught so far.

Exercise 1bis. If this happens try to reassure them and match the positive answers given by the participants with the explanation and list you have just made, in order to bring their *words* into the general framework just outlined.

Note for the trainer:

The following list may also be incorporated in the previous section. Decide when to describe them according to class feedbacks and level of understanding. If participants are experienced in the field you may incorporate the following list to earlier lists; in case they are new to the field it could be wise to split the list using *Exercise 1bis* as a moment of collective reflection and summary. Then proceed discussing the following:

- Listening means complete attention to what is said, at the way is said and at what is not said; listening must be *participated*, active (see next Unit).
- Respect for the individual; keep at the same time two different points of view of the client: respect and acceptance of the peculiarity of the client, its limits, its *time*; the second being trustful of the potential developing of the client in the relationship for its own well-being; treating the client with dignity and accepting them without judgement.
- Self-awareness and reflexivity; this involves the commitment of the counsellor to a continuous work on him/herself, being able to understand his/her "position" in the relationship, observing him/herself from outside, being able to manage his/her own problematic issues of the moment, being a guide and support in another' life. Self awareness means that the counsellor observes and knows his/herself making sure that you do not impose your own values, beliefs and attitudes on to your client; the counsellor should be, thus, able to identify his/her own values, beliefs, and attitudes. Knowing *where/how you* as a counsellor *are* in the relationship at any time.
- Motivation; counsellor consciousness on the personal motivation driving him/her to be a professional helper; it is necessary to maintain the meaning of one's role in the helping relationship, avoiding unjustified sense of superiority. It also helps the client to leave the relationship when the counselling relationship has helped him/her to acquire autonomy.
- Knowledge; information given by the counsellor must be accurate and consistent; this involves three levels: theoretical knowledge, know-how (technically, managing of relationship dynamics, emotions…); know how-to-be in the relation (self-awareness).
- Confidentiality. All the information emerging in a helping relationship is confidential; from the beginning this has to be made clear and explicated to the client.

Exercise 2. As stated in the previous note, according to the background and level of understanding of the participants, you may repeat Exercise 1bis with the list just explained and/or summarize the characteristics outlined above providing additional examples.

Note for the trainer:

You will now move to some crucial methodological aspects of the counselling processes. As we have seen in the previous Units, there are many different types of counselling thus many specific tools and skills to be developed by the counsellor. The following are some basic skills that are useful in any kind of counselling process:

Active listening.

It is the key of the helping relationship. It refers to the ability of being open toward the source of communication, attentive and focused on its messages.

To be a good helper you have to be a good listener and a good observer. The (active) listening process means you are empathetic and non-directive towards the client.

Being a good listener means being able to listen with ears and with eyes: "neutralizing" inner values, social constraints and stereotypes, being attentive to the non-verbal communication of the client and the communicative modality through which the client is expressing him-herself (tone of voice, facial expression, proxemics, looking, gestures…)

This technique is necessary to establish, during the first meeting with the client, a positive feeling of trust, acceptation and comprehension of the other. The counsellor must *participate* in the communication, verbally and non-verbally.

Some active listening techniques are:

- Questioning. Rogers suggest using *semantic questions* such as "*What this mean for you?"*

  Although we don't have to ask too many questions, it is crucial which kind of questions we ask to the client.

  Some questions may be a barrier to communication, for instance the counsellor may have the tendency of asking questions that seek information s/he needs in order to complete the theories s/he has developed about the person and his/her problems.

  Instead questioning must be focused on the client' need, not on the helper' needs.

  Another important distinction is between open and closed questions.

  - Closed questions are those questions that may drive the speaker to provide short, specific answers that, normally, tend to close the communication channels. To give an example a closed question can be: "Did you feel well after that experience?". These questions usually bring the respondent to a yes or not answer, and don't motivate the respondent to go more deeply into his/her feelings.
  - At the opposite side we have Open questions. They tend to open up the communication and give the possibility to the respondent to say what s/he wants to say about the topic under discussion. On the same note of previous example an open question may be: "How did you feel after that experience?"

- Keep the door open: It often happens that a person has something in mind and desires to communicate it. For many reasons s/he may not be able to start to talk about it, there can be barriers (i.e. emotional) in talking about that. Leaving the door open is an attitude through which the counsellor invites the person to talk; the helper may have noticed, perhaps through the non-verbal communication of the client, the s/he would like to say something more or that s/he has the desire to talk about something else.

An attentive counsellor let the client understand both verbally and non-verbally that s/he is available and ready for that, with questions such as: "You seem a bit down at the moment, would you like to talk about that?"

- Minimal encourages. Words like "Really?", "Go on", "Yes" or even sounds like "ah-hah/haye" are indicators telling the other person that you are listening and you are with them. Note that they don't imply that you agree to what the other person is saying.

Responding.

Responding can be also seen as part of the active *listening* processes and of *non-directive communication* attitude. It doesn't mean just responding and talking to the client as if you were in a normal conversation; rather it is based on specific techniques and attitudes which help to create a positive counselling setting.

Responding in counselling is the skill through which we communicate to the client accurate understanding of what s/he said. This is done *reflecting* client's messages at different levels:

- Reflecting content; ability of going through all the details provided by the client during the conversation- in particular fact, ideas, not feeling at this stage-, arriving at the central message the client is trying to convey; the helper will express this to the client usually in a tentative tone 'Is that right?'; to do this effectively the helper must be able to see things from the client perspective;
- Reflecting feelings; it involves the attempt done by the helper to understand the client' feelings; it is also expressed through tentative tone since the helper doesn't have to tell which are the feelings the client is experiencing or should feel, rather it invites for confirmation by the client in order to understand if your understanding is accurate. A response can be "you must fell exhausted?". (The client could, or could not, confirm the assumption);
- Summarizing; it is a brief statement, usually –but not exclusively- at the end of the session, that tries to represent feelings and thoughts that have been expressed by the client, trying to identify the main issue(s) emerged. It provides opportunities to confirm understanding, to conclude discussion about a particular issue or to make transition between different stages of the helping process.
- Reformulation; it means re-saying what the client has just said, giving the possibility to the client to listen of what is the tone of his/her communication using his/her same words. The importance of this technique resides in the possibility for the client to have a progressive understanding of the contents and meaning of its communication; on the other side helps the counsellor to reduce to a minimum the risk of personal interpretations.

Attending and observing

Attending and observing are parts of the communication process to be set with the client. Develop the skills of attending and observing well means for the helper to create a positive, safe, environment (thus not referring only to the physical one) for communication.

The act of *attending* involves receiving information more effectively from the client and, at the same time, a way of telling her/him that we are sincerely trying to listen to and understand what they are saying. Both the receptive and expressive components of attending involve body language.

In *observing*, we pay special attention to body language, realizing that a large part of human communication is non-verbal and that non-verbal communication plays a big role in any kind of communication, and it is of extreme importance in helping settings.

To attend effectively to a client, the counsellor must present itself in a manner that communicates full interest and attentiveness on what the client is saying or trying to say. Attending is crucial to create a climate of *attention* and *respect* to prepare the counsellor to hear properly what the client is saying and communicate the counsellor's interest to the client.

To attend well the counsellor should consider three different levels:

- Attend psychologically; means suspending your preconceived ideas about the speaker or the subject on which the client is talking. It means suspending our personal values and trying not to judge the client.

  With practice we can learn to take a neutral position and focus our attention on the "here and now" moment of the client's attempts to express themselves.

- Attend contextually; means ensuring that the communication setting is comfortable, free of distraction or interruptions (or as free as possible) and one in which the client feels safe and secure.

  It is important to have a proper space where to receive the client, where nobody else should be allowed to enter and any other activities should be interrupted both to protect the confidential nature of the interview and to facilitate the counselling process.

  Sometimes this is not possible (IDP camps, houses, other informal crowded settings). Thus, the counsellor should find an adequate way for the context in which s/he can reduce at minimum the interferences from what is external to the counselling relations.

  For many clients, this means also to ensure a place that does not replicate some negative aspects of the client's ordinary life (and to some extend we can say to do not replicate negative aspects of social life). This means of course to not replicate any violent or insecure aspects of life; the client must feel safe and protected, with precise definition of what the relation and the environment can provide him/her.

  In a community where *violence and insecurity* are one of the underneath causes creating the ground for experiencing mental disorders and psychosocial distress in general, the helping relationship must be set in a way that creates a clear separation from these aspects. This means to not replicate such aspects both at environmental level and at -most important- relational level. The helping relationship must be free of any possible sign of violence and insecurity. All the techniques in the present Module serves in this direction.

- Attend behaviourally; means focusing your attention on the client also with your body: facing the client square on with your shoulders parallel to those of the speaker, avoiding crossing arms or leaning back in the chair (both signs of disinterest), and establishing eye contact (if culturally appropriated).

Observation is the skill of using your eyes to collect the widest possible range of information.

You as counsellor must be sensitive to which are the facial expressions, bodily movements and physical appearance of your client. These inform us indirectly about which are the main feelings that he/she is experiencing at the moment of the interview.

The counsellor must be aware that some aspects of the context where the relationship is occurring may influence the way people interact (i.e. lack of light, noisy room, uncomfortable seats, etc.).

Many non-verbal clues tell a lot to a good observer at the time of the interview and also taking in consideration the long-term relation (the changes occurred in similar aspects in different meetings).

To give some example: signs such as frequent swallowing, rubbing palms against clothes, adjusting clothing may reveal sign of anxiety; signs of liking may be carried through closeness, touching, smiling, increased eye contact; boredom can be seen via drumming on a table, tapping feet, jiggling foot, standing around; self-control is often occurring when the persons locking ankles, clenching hands, gripping the wrist while defensiveness may be understood with eyes downcast an turned away, folder or clasped arms, etc.

Exercise 3. Ask to volunteers to come close to you, you will instruct them to act as the client and the counsellor. Talk to them together to explain the general dynamic of the role play session and then independently to give specific instructions according to their roles. You will have prepared and printed a case study (see below and in other sections of the manual for examples) that you will give to the participant acting as the client. Give the volunteers clothes and materials, if necessary, according to the needs of the case study. At the end of the role play (10-15 min.) discuss with the class on the way the counselling session was conducted, focusing on the skills and characteristics of the counsellor taught before the session.

Note for the trainer:

At this stage several *role plays* may be staged and discussed with the trainees. Once the trainer has given the case studies and the parties to be played s/he can decide to let the volunteers acting for 10-15 minutes, or more, or to stop them periodically to bring the attention of participants to specific acts played by the client and/or counsellor. The trainer may decide to use one case study and two volunteers only or to select different stories and different volunteers. This decision is not predictable and depends on the different and always evolving situation.

For instance the trainer may ask the volunteers to interpret the case study given and at the end focus the discussion on the various elements explained before (attending, responding, etc.) or, alternatively, to ask the volunteers to interpret for few minutes specific attitudes and discuss the topics one by one.

If among the participants there is someone who has already experience in counselling the trainer may decide to involve him/her asking to act as counsellor.

The trainer, while commenting the role play with the class and discussing what was done appropriately or wrongly by the actors, may show a different way of "being in the relationship" recalling part of the scenes and playing him/herself to better address specific issues.

As case studies you may use a case from your own experience or, whenever applicable, ask the participants in advance to provide you with some written cases they have dealt with in their working life. Alternatively you may use one of the cases here below or elsewhere in the handbook.

Case study 1

Salad is 14 years old and lives in an orphanage in one of the towns in Somalia. Eight years ago before he came to live in the orphanage he was living happily with his parents, three brothers and sisters until one night his village was attacked by some gunmen and two of his brothers were killed. Salad and the remaining members of his family had to go to live in another village that was safer. Some months after the incident his parents decided that he and his sister must go to live with his uncle in the town. For a while Salad lived happily in his new home. But things started changing for him. His uncle made him work all day fetching water, washing the family clothing and buying things from the market. He did not have enough to eat. One night salad decides to run away from home. He tried to look for the way to his own parents, but could not find the way. He ended up in the orphanage. Presently the orphanage authorities are saying Salad will be sent back to his parents at the end of the year.

Case study 2

A woman is widowed and seeks help from an NGO. She has become depressed because she is unable to adequately provide for her children. After an assessment she decides that her first goal is to provide adequate food and shelter for her family. To maximize her earning power she decides to learn a skill by joining a skills development program for six months. During this time her income will be minimal. After one month she is discouraged because she continued to be poor and wants to quite the training centres

Note for trainer/2:

While some gestures, signs have an evident "meaning" always remember to be aware of the context, the client and the relationship developing at that specific moment among those specific actors, because

some signs that may convey a clear meaning in some context might mean something different in other situations. The meaning changes a lot across cultures, as well as what is culturally appropriate and what is not in different context, but also changes within a context which could be defined as more homogeneous in terms of socio-cultural aspects.

To give an example if it's true that closeness may mean that the client is feeling comfortable creating a positive background for the relation-building if a client is in a maniacal/hypo-maniacal state, this can also be a provocative attempt towards the counsellor (if of opposite sex, for instance) or a way to tell the counsellor "you're not getting to the point, let me tell you which is the true", to convince the counsellor that the idea s/he's getting about the situation is false (regardless of the fact they are false or true).

The counsellor must be aware of these aspects and do not interpret rigidly the non-verbal signs shown by the client, rather always to contextualize them.

Exercise 4. Divide participants in small groups and ask them to identify as many as they can non-verbal signs that may occur during a conversation and match them with the relative meanings. Discuss them with the class in plenary.

Unit 3. Steps in Counselling

Note for the trainer:

You are now moving to the last session of the module on counselling, focusing on the main steps involved in the counselling processes. Time allowing, participants should practice on each of the following steps.

Exercise 1. After the explanation below let participants get some practical experience on each of the steps outlined. As done in the previous Unit, the trainer may initially read a case study and invite two participants for a role play: one is the counsellor one is the client. You may either decide to let two students play the two roles for the whole counselling process or let two participants play the role for 1-2 steps and then change the couples with other participants. You can decide to focus on each step singularly or to engage in a complete role-play session (better if with already experienced staff). At the end of each step discuss in plenary about what it has been as correct or negative in the role played.

Exercise 2. If you have time you can even decide, after having done one role play with the class, to divide in groups of three-four; where the participants can exercise and practise alternatively personifying the different roles: 1 client; 1 counsellor; 1-2 observes).

If you opt for the last solution make sure you had a complete session of role play and discussion in front of the class in advance, led by the trainer.

Trust Building

In some manuals you will find this as the first or second step in counselling. Although this is of course a core statement and without trust building nobody can even think to start a profitable counselling relationship, trust building is something that you always have to work on.

The helper must be aware that trust can easily be lost if something goes wrong during the relationship; this means that through self-awareness and all the techniques previously discussed, the helper must work on trust building throughout the process.

Trust building is a continuous effort from the beginning to the end of a counselling relationship: You have to gain it at the beginning of the relationship, maintain it during the process and end without losing it.

The following steps are based on a problem-solving model of counselling.

To recap, in order to achieve the outcomes the counsellor should:

- help the client to tell his/her story and in doing so gaining greater understanding of their current circumstances;
- help the client to set realistic goals for the future and finding realistic ways to implement these goals;
- help the client to put his/her plans into action.

Steps in problem-solving counselling:

1. Relationship building

The first step in every relationship is to establish the relationship with the client by attending, observing and actively listening to him or her.

It is important that the client feels comfortable and safe in sharing the story since the first meeting, which can also be seen as interlocutory (according to the "difficulty" of the case) to introduce each other, sets the rules and gives all the information concerning the counselling settings and procedures, limits, and plans next meeting (s).

2. Identifying the problems (exploration)

The counsellor's task is to help the client to identify what the actual problems are. In this stage the counsellor uses reflective listening and the other techniques discussed to assist the client in identifying and explore her/his problems.

In this phase it is also useful to identify and explore the point of strengths the person has in general and mainly in relation to the identified problems (this meaning all the possible resources available or to be activated by the client in setting the goals and face the situation).

3. Goal Setting/develop a plan of action

Main task at this stage is to help the client to identify a feasible goal for the future, where the problem is either solved or s/he is better able to manage and cope with it. It involves imagining different scenarios and helping the client to identify and select the better one, to the achievement of which the plan of action will be devoted.

4. Finding solutions and taking decision – the implementation of the plan of action and monitoring

It often happens in counselling that you deal with persons with little sense of future and with feelings of unchangeable situation. The counsellor will help the clients to see beyond their current situation. Brainstorming is used to list possible strategies that could practice to achieve the identified goals. The strategies must be detailed and drawn in plan of actions; the progresses are monitored with the help of the counsellor that "accompanies" the client during the sessions up to the achievements of all goals set.

5. Termination/ending the helping relationship

The client is informed since the beginning that the helping situation has an end. The end is reached when the plan of action is carried out and the achievements are evaluated and effectiveness of the intervention is obtained. This process is done together by the counsellor and the client gradually.

It is important to *close well* the relation because, even if the counselling relation has been properly developed through the empowerment of the client who doesn't have any dependence feeling and attitude toward the counsellor, closing a help relation always involves the feeling of *losing* something. For some client can be difficult to end the relation and they will tend to try ways to continue and keep it alive; this has to be monitored by the counsellor and in case set a gradual plan for positively "discharge" the client from the relation.

Picture by: Massimiliano Reggi

Part 2

Psycho-Social Work in Mental Health

Written by: Massimiliano Reggi

Module 1
Understanding Mental Health in Somalia

Learning Objectives for Module 1

At the end of this Module participants will:

- Be able to assess and address the complexity of a given environment and its influence on Mental Health conditions of individuals;
- Analyse and reflect on local factors influencing Mental Health at community level;
- Be able to have a critique approach toward general ready-to-use frameworks for understanding sufferance at local level promoting in-depth reflections and actions.

Methodology

Brainstorming, discussion.

Materials

Flip chat, markers, power point presentation, reference materials

Introduction

In the present Module we will briefly introduce some reflections concerning Mental Health in the Somali context. They will serve as base for discussion on specific topics and to engage the trainees in deep investigations on the relationship between Mental Health and socio-cultural environment.

The Module is also intended to exercise the ability of questioning, connecting global and local aspects of theories and concepts concerning Mental Health.

The Module is built as to facilitate steps in understanding and "localize" the generic assumptions that are normally found in manuals and based mainly on "western" scientific evidence.

What we propose for the following Units is thus a series of questions, slides and brief information that the trainer may use to facilitate discussions and reflections with the participants.

Unit 1. Mental Health in impoverished environment

According to WHO 2001 Mental Health Report, "estimates suggest that about 450 million people alive today suffer from mental or neurological disorders or from psychosocial problems. Unfortunately, in most parts of the world, mental health and mental disorders are not regarded with anything like the same importance as physical health. Instead, they have been largely ignored or neglected. Partly as a result, the world is suffering from an increasing burden of mental disorders, and a widening "treatment gap". Today, out of 450 million people suffering from a mental or behavioral disorder, yet only a small minority of them receives even the most basic treatment (…)

Already, mental disorders represent 4 of the 10 leading causes of disability worldwide. This growing burden amounts to a huge cost in terms of human misery, disability and economic loss."

According to WHO report "The Effectiveness of Mental Health Services in Primary Care: The View from the Developing World", the average percentage of mental disorders in less developed countries is between 8% and 15% of the total population.

Exercise 1. Following the introduction above, ask the participants if they think there is any linkage between poverty and mental disorders and, if affirmative, ask which are the consequences at a global (states, societies) and at local (families, communities, groups) level .

Focusing on the Somali context, ask the participant for concrete examples.

During the discussion show the following figure:

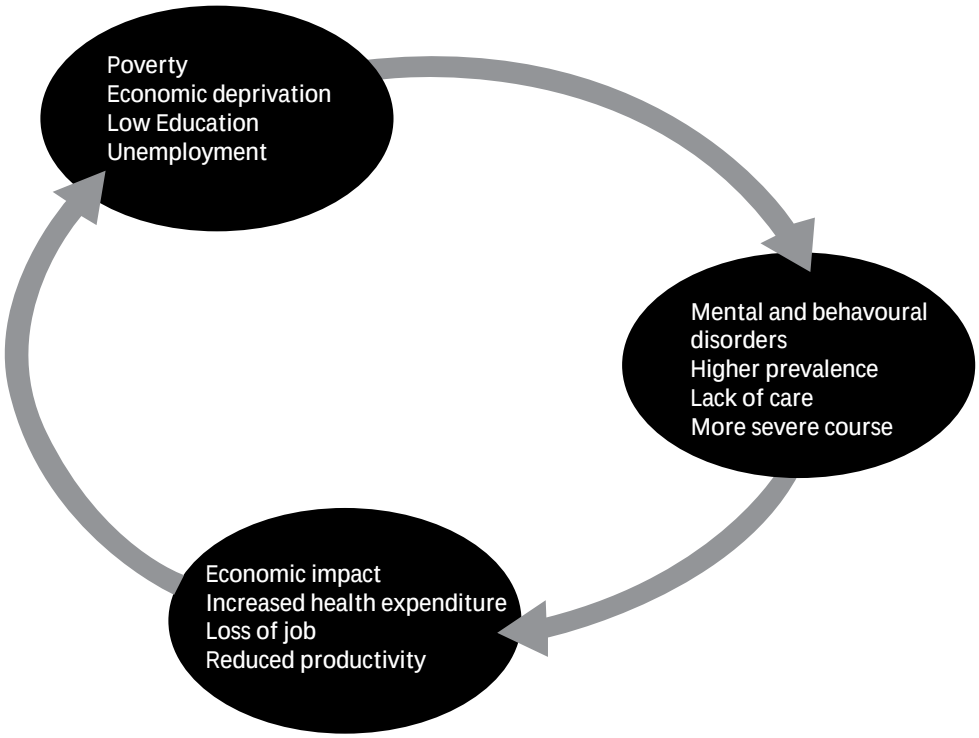


Figure 2. Vicious cycle of Poverty and Mental Health (WHO, 2001)

You may also recall some data on the relevance of mental health issues around the globe (Module 2 – Unit 1) and contextualize for the Somali environment.

Unit 2. Mental Health in Somalia - Element for "collective distress"

As we have seen in Module 2 – Unit 1 mental disorders are a combination of biological, psychological and social factors.

A social worker will probably be engaged in drawing therapeutically path involving the mentally ill person and significant persons surrounding him/her. The helper will have more confidence working at individual-social level of the illness, mainly focusing on the individual in its closest social context and network.

Every person with a mental disorder has its own peculiar story, and everybody deserves to be understood within this story (which includes many factors such as biological factors, familial story, personal fragility, economic situation of the country, values, religious values, local resources, etc.).

In the present Unit the social aspects underlying possible causes for developing mental disorders, identifiable as "collective" in the actual Somali context, will be discussed.

Exercise 1. Ask the participants the following:

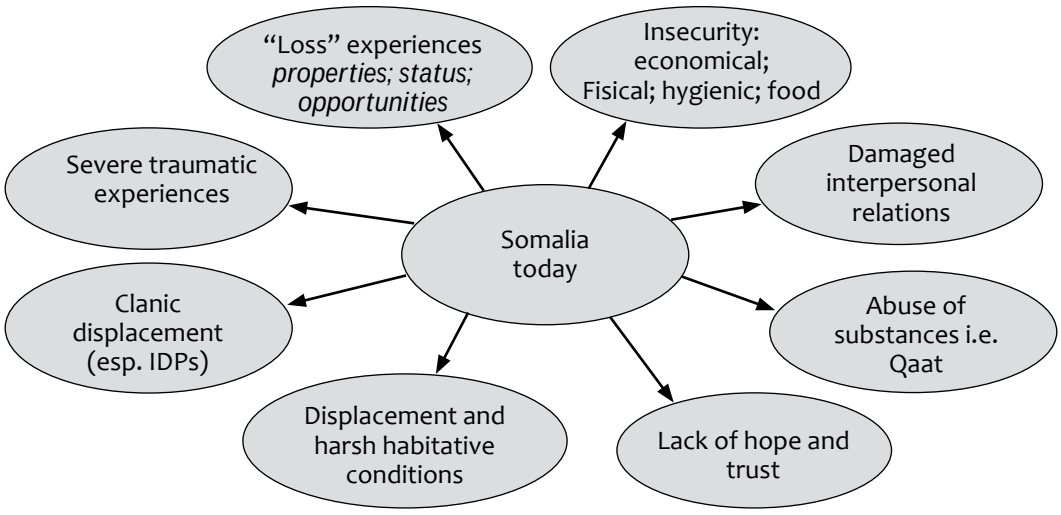
- What do you think are the social aspects potentially playing a role in the development of mental illness in your context? Are there, among those aspects, some which people without mental health problems experience in their life?

What is required to the trainees here is to identify aspects which they think are commonly experienced by any individual living in the Somali context at present. This is also to focus on the socio-political and environmental determinants of health which are evolving and changing in the Somali context after 1991, shadowed by constant uncertainty and insecurity at different levels.

Note that although potential factors for mental disorders are present in a community or in a single person, this doesn't automatically lead the person to develop a mental illness (as you may easily understand observing a family where the social-economical-educational background are similar for all the brothers but maybe only one develops a mental disorder).

The following slide shows a possible summary of some common adverse social features experienced by Somali population at present. The contents of the slide are based on observation carried out in Bosaso, Puntland in the period 05/2003 – 04/2005[14].

Elements for "collective distress"



Slide 1: "Mental health in Somalia: elements for collective distress".

14 "Mental Health Interventions in Somalia. Approaches, challenges and prospects"; Presentation by Massimiliano Reggi -GRT at the International conference "Strengthening the Mental Health System in Low and Middle Income Countries" organized by Cittadinanza onlus and WHO; 15-18 April 2008

Unit 3. Mental Health in Somalia – Common features

In connection to Unit 2 you will move now to some elements which characterize the present "mental health environment" in the Somali context, meaning some of the problems that people with mental health disorder has to face at social level and factors related to the lack of services in the field.

Exercise. Ask the participants the following:

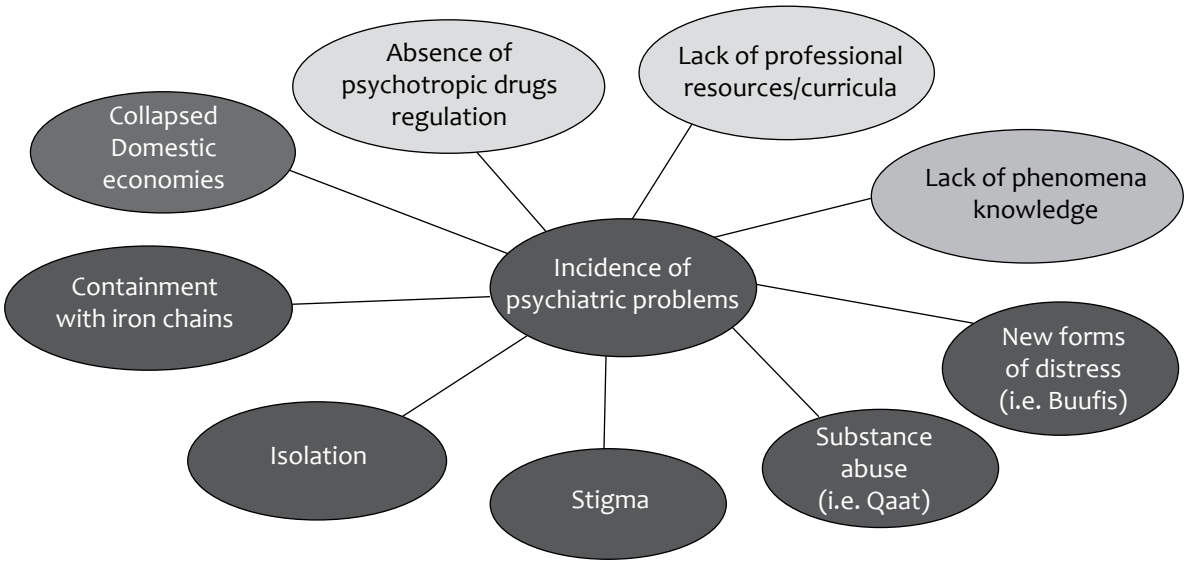
- What do you think are the *common* features that contribute to the development of mental disorders in your community?

While in the previous Unit the focus was more general referring to aspects present among the population as consequences of an historical collective fracture and potentially influencing the development of mental disorders, here the focus is concentrated on the people with mental health problems and the social environment. Again, as in the Unit before, the focus is on general-social components rather than on specific individual idiosyncratic aspects.

The following slide shows a possible understanding of some common features observed among the Somali population at present. The contents of the slide are based on observation carried out in Bosaso, Puntland in the period 05/2003 – 04/2005[15].

Mental Health in Somalia

Common features



Slide 2: "Mental Health in Somalia: common features".

15 "Mental Health Interventions in Somalia. Approaches, challenges and prospects"; Presentation by Massimiliano Reggi -GRT at the International conference "Strengthening the Mental Health System in Low and Middle Income Countries" organized by Cittadinanza onlus and WHO; 15-18 April 2008

Unit 4. Naming and labelling "Mental Illnesses" in the Somali context

In this Unit we will stress the importance of using local framework and explanatory models for understanding the mental health field. A reflection, rather than a "comparison", will be attempted between different ways of categorizing mental illnesses and forms of distress.

Although the "official" categorization of Mental Disorders expressed via western scientific knowledge and articulated in the WHO ICD-10 Manual (*International Statistical Classification of Diseases and Related Health Problems-10th Revision*) may remain on the back-side in this discussion, the participants will be asked to focus on the local categorization done via non-scientific means in present Somali context. Again it is not asked to carry out an exercise of comparison, rather to focus on what locally is produced, labelled, understood as to be a mental health related issue. In every cultures there are names, ways of referring to, characteristic signs and symptoms, understanding of what is a disorder and what is not as well as to the form of dealing with the kind of issues.

It is understood that this exercise has no any claim of *scientific* classification, rather it focuses on the significance of giving importance to and understanding the local explanatory models of "common people" as a way to ensure/improve socio-cultural sustainability of small scale therapeutic interventions, and improve their quality.

Exercise 1. Ask the participants to list all the local names of the different forms of mental diseases/related to forms of distress (they don't have to be necessarily locally intended as a "disease") they know. List them on the flip chart and ask the participants to describe them, detailing the five main issues underlying the local explanatory models as identified in Module 1-Unit 3 (aetiology, onset of symptoms, pathophysiology, course of sickness, treatment).

Note for the trainer:

At the beginning of the exercise insist with the participants in thinking on local terms trying to avoid a sort of mechanic "translation" from medical terminology (schizophrenia, bipolar disorders, etc.). They should instead brainstorm thinking on their personal experience and Somali oral tradition.

For instance, in Somalia an exact translation, with clinical consistency, for the term "depression" doesn't exist (as described in scientific terms; see ICD-10). Somali words such as *Niyadjab* or *Murugaysan,* just to give an example, refer to some of the symptoms and aspects which, together with many others and in specific conditions, may be defined within the broader scientific term of "depression".

Some of the local names that may be listed by participants include:

- *Waali;*
- *Qac;*
- *Buufis;*
- *Khakhayir;*
- *Niyadjab;*
- *Qalbijab;*
- *Murugaysan.*
- *Qulub;*
- *Han Jab…*

Some of the above listed names are not at all mental disorders; to different extents, they are related to one or more aspects implicated in what is locally understood to be a form of mental distress. They may serve to address an in-depth discussion.

Module 2
Psychosocial work in the community

Learning Objectives for Module 2

At the end of this Module participants will:

- Understand what a Psychosocial Rehabilitation Plan is;
- Know how to assess the client's situation and draw, implement and terminate a Psychosocial Rehabilitation Plan;
- Have a clear understanding of some of the most critique aspects to be accounted for during a helping relationship;
- Be able to "be in the relationship" with clients and familial and gather sensitive information in difficult settings;
- Understand the importance and the dynamics of home visiting and community work;
- Be able to assess abilities, constrains, resources of distressed individuals and to define short and long term objectives for rehabilitation.

Methodology

Lesson, brainstorming, case study, role plays, discussion.

Materials

Flip chat, markers, pen& paper, clothes and other materials for role playing; reference manuals.

Unit 1. Introduction

In the last Module we will focus on some aspects of social and psychosocial rehabilitation work with persons with mental health problems and their families.

The following Units refer to common situation you may find in the Somali context and are based on psychologists' and social workers' experience in the field. It is written with a problem-solving approach, which will guide the trainees and give concrete examples for their daily psychosocial activities.

It is understood that any patient, any family in any circumstance have specific needs and face peculiar stressful situations, in other words they have inimitable *stories*, which are unique to them and context based.

The helper will work demonstrating respect and addressing client's *uniqueness.*

It is important for the helper to understand that a wide range of uncertainty can be faced even in more "usual" situation they deal with and that *creativity* is an important *plus* that a good helper should invest and use to help clients to solve their problems.

Furthermore, besides the already mentioned uniqueness of any client's *story*, if the person is affected by a kind of mental disorder you should have at least a basic understanding of the kind of disorder (i.e. patterns of behaviour, possible medication in use and effects, level of burden for the family, adherence with social reality, etc.). There will be probably specialist taking care from the psychiatric point of view of the client (psychiatrist, doctor, etc.), so you don't have to worry about these components and be overwhelmed by them, rather keeping a cooperative attitude toward other professionals involved and as far as possible share with them the therapeutic rehabilitation path drawing for the person. An adequate level of understanding in this direction is important because people with different psychiatric problems will react differently to specific solicitations from a helper. Although the helper doesn't have to *categorize* all the reactions of a person with mental health disorders only and strictly related to the kind of illness, a "direct and prolonged sight" towards a client with severe depression, or in a maniacal state, or psychosis with paranoid features may change drastically in meaning for the client. This must be kept in mind by the helper while working in a helping setting.

The indications for social work outlined below do not differentiate among the different mental disabilities; rather they involve a problem-solving view and a tested strategy to address the problematic case. The helper must tailor the general situation on the specificity of the case s/he's working on.

As we have discussed previously, Psychosocial Counselling is one of the techniques useful to help client with psychosocial distress to empower and find a personal way for improvement to full psychosocial well-being. In a holistic rehabilitation plan with a client, counselling may be one of the helping methods to be used, probably not the only one. For some client moreover counselling is not the best way to help him/her, while other kinds of interventions can gather better and stable results. It is a matter of precisely analyse the contest, assess the problems, in a holistic approach, and address the problems through the most appropriate helping skills.

The cases we will discuss in the last module are some of those, they are not in opposition to counselling and rather they can be part of the same rehabilitation plan with a person at different stages or at the same time. The counsellor, nurse, social worker and any other helping professional involved in a rehabilitation strategy for clients has the responsibility to define the better solution(s) for the problem.

Unit 2. Psychosocial rehabilitation plans

Exercise 1. Before going into details and work on case studies, ask the participants what is their understanding for the words "Psychosocial Rehabilitation Plan". Engage a brief class discussion.

Note for the trainer:

Psychosocial Rehabilitation is a broad term encompassing a group of practices, including skills development, social skills training, family education, self-management, peer support, coping skills, self-monitoring training, vocational rehabilitation, education, and social and recreational development.

The psychosocial rehabilitation plan is focused, among others, on facilitating the development of an individual's skills in living and learning in social and work environments; on developing the individual's ability to make decisions regarding self-care, and on self-management of symptoms and medication (side effects).

Psychosocial Rehabilitation Plan (hereafter PRP) is assessing, defining and implement of series of rehabilitative and therapeutic actions having the main goal in the attainment of psychosocial well-being of individuals and their families.

The ability to plan and intervene collaboratively with the individual in their environment that utilizes their strengths and promotes empowerment is essential for social work practice.

In many countries there is the availability of a number of social services, vocational training spaces and other offering to the social workers a variety of opportunity for rehabilitation of patients. In Somalia-Somaliland-Puntland, these kinds of services are available only at a very minimum level and often sporadically (project based). If this can be seen as a limitation for social works, and to many extend it is, the trained social worker will learn how to find *opportunities* where s/he hasn't seen it before.

In the Somali context there are, in fact, many opportunities (which may sometimes hide behind a veil of despair or lying because never used before) starting from familiar social support that, even if in poor economic conditions, may generously offer more than what in other richer environment is offered to people.

The social worker may start from here to understand where s/he can find key resources useful for the client's rehabilitation. A lot of efforts has to be invested on the relational level, as a positive (and free of cost) resource for empowerment of people.

Exercise 2. Read the following case study and ask the participants from where they would start if they were asked to begin a psychosocial rehabilitation plan with Maxamud.

Case Study 'Maxamud'.

Maxamud is a 25 years old man, he lives in a house with part of his family (father, mother and younger brother) in town. At the time of first visit is chained. He is brought at the Psychosocial Centre by the father, which refers about a situation disparate and with no improvements in the last 4 years. According to the father, Maxamud is aggressive, reason why is sometimes chained, talking nonsense and he tried several times to escape from home. He complaints always about the lack of clothes and is afraid about the possibility to be killed by someone from the "security services" in his house. He also thinks that the president of Somalia wants to see him death and is arranging a strategy together with the father who everyday tries to poison him.

Note for the trainer:

Steps in PRP are:

- Assessing the situation
- Identifying problem(s) and resources
- Define a strategic long—term plan and goals
- Implement the plan (social work)
- Permanently monitor progresses
- Re-adjusting the plan (if necessary)
- Ending the intervention
- Setting objectives for prevention of relapses
- Evaluate the intervention

A PRP is a *circular process*; it doesn't have a linear cause-effect development. The worker must be ready to put under evaluation and discussion its own assumption at any time and possibly to change the intervention style, if needed.

The approach for PRP is holistic; it involves the person and close family as well as "enlarged" families and the communities as a whole.

Nowhere, and we could say especially in the Somali context, the patient/client can be isolated from his/her socio-cultural environment; a psychosocial rehabilitation of individual is useless if a serious work is missing at family level and, to a different extend – which is beyond the discussion in the present manual- at community level. For many patients rehabilitation means reintegration into the socio-cultural environment, if the context is at a certain level and for any reason creating itself the conditions for accumulating stress or enables misbehaving toward vulnerable people, the risks for relapsing is very high.

In the following Units we will deepen some aspects of the PRP in the Somali context.

Unit 3. Interviews, listening: (first) meetings with mentally ill patients and their families

Note for the trainer:

This Unit refers to the first steps of the psychosocial work; in line with the above PRP steps definition they mainly-but not exclusively- refer to:

- Assessing the situation
- Identifying problem(s) and resources

The first step in any helping relationship is the moment of the first meeting with the patients and/or their family. Any helping relation must be based on trust that has to be built during the process (see previous units).

We have already seen some key aspects for establishing a proper setting for communication and for better direct the verbal and non-verbal communication; we will discuss now some problematic aspects of communication and gathering information process.

Exercise 1. Divide the participants in small groups. Recall the case study described before and imagine the situation of the first interview:

Case Study 'Maxamud'/bis. The father of Maxamud brings him chained at the psychosocial centre for a visit. It's the first time and they had taken an appointment in advance. You welcome them and sit together on a plastic mats in the veranda (the other rooms are not available). Now imagine yourself opening the meeting. Maxamud doesn't want to sit and the father is a bit nervous and pulls him with the chain holding tight his ankles.

Ask each group to answer the following questions:

- What would you do first?
- How do you start the meeting?
- Which kind of information is relevant?
- How will you gather the information?

Give them 15-20 minutes to complete the assignment, and then ask each group to detail the answers to the class. The trainer will list (summarizing) the outcomes and discuss them with the participants.

Note for the trainer:

- Introduce yourself and your role. It is important for the clients to understand who is in front of them: a doctor? A nurse? A social worker? Not only the role is important, most important at this stage is to clarify which is you role for the well-being of the client. You can be a nurse working only (in this stage) at the social rehabilitation of the patient (maybe there is no any medical service available in your town) so, not properly acting as is the common understanding for what is a nurse.

  According to the setting where you are currently working (in a psychosocial centre in the example) and what can be offered to the clients in the future, you should clarify which are the *limits* of your intervention and if there is the possibility of cooperation with other professionals.

  Note that not all these information may be given at the beginning; some will be told to the patients during the meeting in case of need.

  The output of this first introduction must be: *the patient and familiar have a clear idea of what they are doing there and an initial idea of what they can expect from you.*

- Setting and first observation. Is the place where you sit suitable for the purpose of the meeting?

  The patient is restless and chained, are there disturbances around that may increase the anxiety of the father and the restlessness of the patient? Are these disturbances related to the setting or independent from it?

  If you understand that the environment around you is not suitable for the situation and if you have the possibility to make changes, this is the moment when to do it. If you don't have this possibility just proceed with the meeting; sometimes if the situation is particularly tense it can be useful to express verbally that you (all together) will do your best to avoid being distracted by the poor setting and concentrate (demonstrate to them that you are *caring contextually*).

  The case study proposed addresses an immediate challenge to the social worker; the patient is, in fact, chained. What will you do? Do you deal with this problem (if you think is a problem…) or let the situation flow normally?

  See Unit 5 for details about the chain issue.

- Beginning the interview. During the first interview you have to gather as much information as you can; in the majority of the cases you don't know the person but even if you know the person the kind of information you need and the way you are going to collect them are different to what you already know and to the way you are going to put them together.

  Normally you will collect clusters of information such as:

  - Biographical data (patient and family);
  - Personal history of the patient (including past-present history; significant or traumatic life events, family and social relationships, reason for referral, skills, resources, education and work background…);
  - History of illness (from a psychosocial point of view and not medical unless is required by the situation);
  - Use of substances;
  - History of present and past treatments sought (traditional, religious, western, use of chains…);
  - Expectations;

  You don't have to gather all the information above at once if the situation doesn't allow it and don't have to follow the order as it is in the list.

  Since you are collecting a lot of information it would be better if you have the possibility to write them down; to this scope you may use a format for the interview that you will have prepared in advance. Example of useful semi-structured format for psychosocial interview is in Annex I . In Annex II you will find the Medical record format currently in use at the Mental Health Department of the Bosaso General Hospital. The record is organized in three main sections: the *social section* (first two pages, normally compiled by the social workers/nurses/counsellors), the *medical section* (third and fourth pages; normally compiled by the doctor or nurse in charge; this section include the psychiatric mental status examination) and the *diary* (the last two pages; it refers to information of follow-up visits, social activities, home visits, rehabilitation progresses; it is compiled independently by social worker, nurses, counsellors, doctors, etc. according to the situation). The medical record is organized in a way that enable an easy data entry process of the data into an electronic database.

  Note. *Interviewing is not interrogating someone*, thus you absolutely have to avoid giving this impression to the interlocutor; check the way you are using pen and paper, your posture, attitude and communication style. If the client or family have this impression they will probably will not share

openly their information and feelings having the impression of being potentially under accuse and liable to of negative judgement.

- Be open to the unexpected. In this field the most relevant information are often gathered when you less expecting them, sometimes they are whispered or even more often they are achieved indirectly while talking of something else. The client or the familiar may also, this is quite common, avoid giving you some information if they think that are *not relevant* to the discussion. The social worker must help the family and guide them, letting them feel free to explore unexplored part of their lives, feelings, and ideas. Since some of the information and life events you are asking for might be very sad, source of frustration, emotionally overwhelming the social worker has to be perceptive to do no hurt the sensitivity of the persons involved. At the same time s/he also has to learn with the practice how to get information indirectly if s/he understands it can touch emotional chords of the person, using a *longer* path.
- Relevant Information. Not all the information are relevant first of all it has to be clear which is the mandate of the helper, its role, limits, possibility to work for rehabilitation, which are other professionals available etc. You won't ask for a detailed explanation of the activities of all the friends of a patient; rather you might ask for the some info related to what he perceived to be his best friend, especially if some of there is any link between the actual condition of the client and activities carried out by the friend.

*Example*s of relevant information's are:

- stressful life events of the family/patient (note that some events may be relevant for you an not for the patients and vice versa);
- relevant changes in life (i.e. dislocation);
- contradictions emerging from tales of different element of the family;
- information about the loved ones (peer, familiars, friends…);
- economic information (including losses);
- life events in the proximity of onset of illness and in any change of the course of illness.

Little by little both during each interview/meeting and during the development of rehabilitation plan it will be clear which are the relevant information and which are not; they may also change and some information considered not relevant at the beginning of the process may became relevant later on.

Examples of relevant information at the first interview with Maxamud (case study).

Maxamud's case study shows a quite common scenario a social worker has to face. S/he has welcomed Maxamud and his father and that are the information gathered in the first 10-15 minutes of the meeting. The social worker has a general background of the situation and will start to investigate following the list of relevant information listed before and having the format for semi-structured interview with him/her or well memorized in his/her mind…

Relevant directions where to investigate are:

- "*no improvements in the last 4 years"*; what happened 4 years ago?; what have been happening in the last 4 years to Maxamud? (exploration is possible in many directions);
- Why Maxamud is chained? They said because is aggressive, but what does this mean? What Maxamud does to be described as aggressive? Does the father think that chaining him can help him, in which way?

- Are there particular events, attitude of others, situations that rend Maxamud aggressive?
- Who is the responsible for him? Who has physically chained him? Do the other members of the family agree on that?
- Why did they decide to come to the Psychosocial Centre, what do they expect?
- Is there anything in the story of Maxamud or in the story of the family linked in any form to the "security services" mentioned by him?
- When he talks nonsense, what does he talk about?
- What was Maxamud doing before being chained? At the time of chaining was 26… was he working? Studying?
- Have they sought other kind of treatments before? Did they get any improvement?

These are just some examples from where to start an interview, in relation to the answers and the story that will gradually take form, the social worker will be able to drive the conversation in the most appropriate directions.

- The patient's point of view (see also "Explanatory models" at Module 1, Unit 3). An important methodological aspect is to always ask the point of view of the patient. Some can assume that asking directly to the person who is in need for help is implied, but the reality is far different. Indeed, the kin of the person with mental health problems usually avoid asking his/her opinion (because since they think is mentally sick they assume that s/he can't think and answer properly) but the same attitude is often present among help workers.

  Of course according to the mental state of the person there is a different range of understanding and possibility for exchange but in many cases the reason why the patient is not involved is only because of prejudice. The prejudice is then reinforced by the practice of never ask him/her opinion and thus be gradually isolated from the other significant persons of his/her life.

  On a different note asking the opinion of the person, directly, openly, in front of other members of the family has the therapeutic meaning of creating a positive background for future reintegration and acceptance; with this act you show to the family that the opinion of the "sick" person is worth to be listen as well as the voice of the "sane" member of the family, it helps to gradually open the relatives for accepting their presence, feelings, needs.

- Giving a "*prescription*"; closing the meeting and prepare the following.

  At the end of each session is a good praxis to "give" something to the person involved, as a sort of ritual and mutual exchange and as a way to giving them the sense (which is actually real) of caring. When you work for the psychosocial rehabilitation of a person, which is a long –and sometimes a very long- process, sometimes you will have non positive feedbacks from the interlocutors. The last may directly or indirectly accuse of doing nothing, simply talking, simply listening… having thus the perception of loosing their time. This happens when the "contract" (see next Unit) is not clear or not well understood, but also when the situation is protracting for long (even before going to the social staff) and family experience lack of hope or for many other reasons.

Giving a prescription doesn't have to be read in medical terms; it doesn't mean to give a medical prescription of medicines or other treatments. It means to give an assignment to do to the family or patients or at others, which is relevant and part of the therapeutic process.

Examples of prescriptions are:

- a specific exercise to do;
- a diet to follow;

- some behaviours to avoid in specific circumstances;
- a referral to other specialists;
- something to bring the next session;
- something to think about and to be discussed in the next meetings;
- something to physically do (a telephone call to significant actor of the life of patient; bring something to others; help someone in the family; help in house working…).

The *prescription* is also a way to link the different session of a therapeutic program and create continuity and fluidity in the whole process; it doesn't have to be seen as pure instrumental fact, in fact the *things to do* a re assignment with a specific therapeutic meaning that the social worker identifies as relevant during the session.

At the end of the session, especially after the first meetings, much information will be on the table of your established relationship and the social worker might decide to need verification or to investigate deeply. It often happens that some of the information collected are partial and that other actors, different from those involved in the first interviews, are needed to get the missing information. It is not uncommon that the social workers decide to go and visit the patient at home, or to ask for an appointment with other members of the family or with other friends, or with a professor or the employer of the patient. This is part of a normal assessment and therapeutic process. The social worker should enlarge the investigation as much as s/he think is necessary for better define the case and better work for the developing of a psychosocial rehabilitation plan tailored to the client' needs.

Unit 4. Implementing a Psychosocial Rehabilitation Plan

Note for the trainer:

In this Unit will be discussed some relevant methodological aspects concerning the implementation of psychosocial work, mainly referring to the following steps:

- Define a strategic long—term plan and goals
- Implement the plan (social work)

Exercise 1. Read the following case study and ask the participants in small groups to try to draw a framework for a psychosocial rehabilitation plan for Maxamud. The following information are those hypothetically gathered during the first meeting with Maxamud and his father (see previous Unit).

Case Study 'Maxamud'/ter (additional information)

Ismail, the older brother of Maxamud died 4 years and half ago shot by bandits in the road to Qardo, while he was coming back to Bosaso from south Galkayo. He was there for business purposes, in which also Maxamud was involved.

The younger brother of Maxamud is Khat addicted and, according to the information received is 'not normal'. The father doesn't work, while the mother sells foods at the market. Maxamud and Ismail had planned for long about the business. Though at the time of the accident Maxamud did not have the means and, according to the father' information, the genius for starting the business alone.

Few months after the killing of Ismail, Maxamud lost a sum of money of the family in a non clear fraud perpetrated by a Somali businessman living in Saudi Arabia. According to the family there is nothing to do with that amount of money, which is lost.

They are from a minority clan.

Maxamud did not complete the school in Mogadishu, where the family had lived up to the collapse of the Somali Democratic Republic, because of the war. They were forced to flee to a refugee camp in Kenya. After four years they moved to Bosaso. He was a good pupil and in Bosaso he completed the intermediary and secondary school (one year before Ismail died).

In the two years before the death of his brother he used to help a carpenter, and get some small amount of money that he normally gave to the family.

He was chained 3 years ago by the father with the consent of the mother. They sought the help of Koranic healers, several times, both at a Koranic camp and at home.

Two years ago a Somali doctor leaving in Sweden, who was one month in Somalia for visiting patients free of charge, made a diagnosis of schizophrenia and prescribed two medicines (they don't remember the name); one of which was very helpful according to the father. They stop the treatment for lack of money after 2 months.

Maxamud is chained in one small room inside the parents house (there are also other 2 families in the same house).

Note for the trainer:

There is no one, unique, way of defining and draw psychosocial plan with patients. There could be different manners to reach the same goals but some general, and always valid, rules can be summarized as follow:

- gathering relevant information;
- respect the patient and his/her own *world* ;
- have the focus on patient situation and work for patients psychosocial well-being;

- do not judge negatively attitudes and behaviours of patients and familiar at first sight;
- reflect on the marginalized position of the patient (in the majority of the cases)
- do not isolate the patient from its closest world and in general from the socio-cultural environment;
- do not create/augment distances between
- coordinate with other professional involved in the case;
- be respectful, trustful and clear at any stage with all the persons involved;
- define clearly objectives, priorities and specific goals of the therapeutic plan;
- share the plan with the persons involved and define clearly roles and limits;
- be creative!

- Drawing "contracts". In organization settings a psychological contract is defined as the mutual expectations, beliefs, perceptions, and informal obligations in the employer-employee relationship, plus setting the dynamics for the relationship and defining the detailed practicality of the work to be done.

In every help relationship a psychological contract is implied and active, though unfortunately not always it is clear to each of the parties involved.

A psychological contract is not a written contract as we are accustomed to know. It rather involves a set of expectations and obligation set during the first phase of the helping relationship.

At a very basic level we could say that the psychological contract start at the first acknowledgement and it's "drawn up" by a client (patient and/or familiars) who is seeking help and a helper (social workers, counsellor, nurse…) who is willing to help (for what refer to its competencies) the client.

Detailing more we can assume that, in general, a first set of mutual obligations can be as follow:

- The client and familiar will provide all the relevant information to the helper, honestly and openly, as required and they will follow the prescription made by the helper;
- The helper will listen attentively at the case, will care about it and will use all the competencies and skills, as per its professional role, to help the client reaching the psychosocial well-being.

These kind of mutual obligations are typical of any helping relationship and often taken as assumed. It is, nevertheless, a good habit to verbally express believes, expectations, perceptions and obligations between the parties. The contract should be *clear since the first steps of the relationship*, although it can be partially modified in some aspects (normally when you get new information or if you need to detail better a specific component of the contract). If some changes are needed during the rehabilitation plan these have to be clearly verbally expressed and agreed between the parties.

The *boundaries* of the contract must also be clear. The contract should be *feasible* and its limits should be understood. This imply that unattainable expectations must be highlighted and excluded: if the contract is not clear one of the parties may expect the other to do something that is beyond its possibilities thus generating an unstable relationship, source of frustrations on both sides, that will negatively affect the realisation of the plan.

In the *case of Maxamud* the contract will be based on the general assumptions, as outlined before, gathered in the first stages of the meeting.

Exploration of the expectation of clients and role of helper has also to be done at the beginning to better addressed needs and define a participate contract. The helper will, for instance, explain to the client that s/he will take care mainly of the social aspects of the rehabilitation without prescribing medicines – if

needed- because beyond its role. S-7he will also explain that medical , psychological, social aspects all contributes to the well-being of the person and are all relevant and non disjointed, thus s/he will coordinate with other professional involved in the rehabilitation plan (i.e. nurses, doctors, religious healers) to share and define a common strategy.

Deepening the contract (imagine that you have already identified some key aspects of the plan and started to work on them) a possible mutual agreement may include the following:

The *patient* avoid attempts of escape; try to control anger avoiding to verbally attack the mother; goes once in a week at the psychosocial centre; follow therapeutic indication; regularly take medication prescribed;

- The *father* unlocks the chain, setting M. free; the *family* involves him in small domestic scale affair; they help M. in taking regularly the medications; they accompany him at the follow-up visit in the clinic and are available to go to the Psychosocial centre whenever required;
- The *helper* attends every week M. at the centre and monitors the situation with him; in case of need (only for major issues, since he will be free from the chains) s/he will go for home visit; helper is available to meet relatives of M., via appointment, at any time; s/he coordinates with other professionals for general rehabilitation plan; will explore with M. possibility of external activities (i.e. carpentry), supervising and monitoring progresses.

It should be clear that this three-fold contract (as all the types of contracts) implies that all parties fulfil their commitments; the *contract* is drawn up on a *systemic* way so if one part of system fails in its obligations the contract is broken and, after an evaluation of causes, re-adjustments are needed.

Assessment of abilities, definition of objectives. Important task of the social worker is the ability of assessing the psychosocial world of the client and to define objective of work. To facilitate this assignment, formats may be used by the helper. In Annex III you will find one of the possible format, a Somali adapted version of the Italian *VADO – Valutazione Abilità e Determinazione Obiettivi.*

The key features of the VADO format are the following:

- *Identification of abilities & difficulties.* In identified areas the social worker assesses and gives a code to the ability of the person in the area; this exercise –which is always in place during the social work- is formally repeated in different moments (i.e. every 1/2/3 months; or after significant changes in the life/rehabilitation plan of the individual) in order to clearly evaluate the progress made;
- *Identification of resources.* Assessment of specific resources in 5 key areas –*Familial, Social network, Economic, Housing, Therapeutic continuity-* in order to identify possible levels for rehabilitation plan and to complete the general assessment of the patient current situation.
- *Identification of early signs of crisis*. The social worker takes notes, with the help of the family, of possible signs of crisis that may anticipate a relapse or an acute crisis of the patient. It has a preventive purpose and helper and family have to be trained on that (some signs may come from a medical realm).
- *Sharing of therapeutic project between patient and relatives.* Level of sharing of the rehabilitation project. As explained before you will hardly have positive achievements in the therapeutic process if there is no sharing of the overall projects among significant actors involved.

Short term objective (specific). It refers to the definition of short-term therapeutic verifiable objective (s), toward the achievement of which, the social work is focused. Many short terms objectives may be identified on a linear or parallel sequence.

Long term objective (general). It is the overall, long-term, objective of the therapeutic plan which ends with the improvement of the psychosocial wellbeing of the client and it is tailored on the client' general conditions.

It is worth to notice that the VADO approach underlines a positive regard to the clients and families, focusing mainly on the resources rather than on the dysfunctions.

As a *methodological note* we would like to highlight that the *key* of any therapeutic plan resides in the relationship. The formats are useful tools which help the social workers to have a clear updated picture and to share information with others who might not know the client and may substitute the social workers or cooperate on the case. The formats have the positive aspect of summarizing features and give a synthetic overview, based on direct observation, but they have to be understood as *tools* and *not* as *means* for rehabilitation. The rehabilitation of the person passes through the relationship established face to face, in the community, at work, with the family etc., and not through the numbers of a format.

Home visiting and working in the community. Social workers and other professional figures involved in social rehabilitation programs with patients will occasionally/regularly do home visiting. This is a specific way of caring and a therapeutic tool, as part of an overall long-term rehabilitation plan, which brings the helper inside the social/familiar world of the patients.

Home visiting are necessary and useful in many situations, some listed below:

- It is impossible for the client to move from home (i.e. psychical disability, is chained at home, familiar doesn't allow him/her to leave house, etc.);
- There is a need for observing the familial setting;
- There is a need for further investigation with relatives or friends;
- Implementation of specific aspects of the rehabilitative process has to be undertaken in a familiar environment or are specifically designed to be done at home).

Note. We have generally talked about *house* but the meaning here is broader, including IDP settlements (huts), informal housing, other settlements/areas in the community. To simplify we are referring to all the actions that will be undertaken by a helper and clients outside structured helping facilities (i.e. hospitals, psychosocial centres, clinics, etc.) where the helper is identified with the *host*.

Use and Misuse. Home visiting brings the immediate message of caring that, particularly in an environment where people is not used to feel that someone is caring at them, it helps to increase the positive acceptance of the helpers and their works.

As we have seen from the list above, in some cases home visiting is the only mean through which we can be in a relationship with the client. In such cases it is mandatory to do home visiting, whereas the helper should not overuse/misuse this important tool when is not necessary. An excessive use of home visiting when it is not strictly necessary for the rehabilitation path, could affect negatively the therapeutic process, relegating the client and family in a passive position, waiting for the help to come.

The Home visits must be planned in advance and agreed with the family. Although in the Somali context is not unfrequented that unexpected home visits are welcome by the clients, it is a professional habit to prepare and be prepared (from both sides) to the visit. Social workers and the clients may agree on a scheduled plan of visits (i.e. once a week at beginning of relation if home visiting is the only solution for working on the helping relationship). The social worker will be punctual and in case of impossibility to fulfil the appointment will inform in advance the family. If a certain foreseeable requirement is needed during a home visit, it should be discussed and agreed in advance, normally during the precedent home visit.

Significance of home visiting. During home visit the helper can gather an important amount of information, and clarify some incongruence emerged during meetings in formal settings. It gives the unique opportunity to discover patterns of behaviour among the family members (or in different settings, depending where the home visit is taking place) which are not visible in other settings; you can better understand which are the roles of different members of the family from a systematic perspective and acquire new and unexpected information.

On a different note it is a place where to implement part of the therapeutic path which can only be implemented at home (for the reasons discussed before). *Examples* are: educational activities with familiar/clients, recreational activities with client, giving of medicines if client not able to leave the house (i.e. injections by nurses); working on *chain* issue and many others.

Home visit in its broader meaning include also all the activities done jointly by the social workers and the client in the community as part of the therapeutic project; examples are supervision/monitoring of vocational activities/trainings, accompany to clinical visit, helping in using community facilities, accompany the client in doing anxiety generating tasks with others, visiting new areas, etc.

Unit 5. The practice of containment with *Chains*

Note for the Trainers:

The use of metal chains to physically contain people with mental health problems is unfortunately a known and quite common praxis in the Somali context, as well as in other low-income context.

Not many data on the phenomena are available at present since very few are the INGO (mainly G.R.T./ UNA) or International Agencies (in particular WHO – that runs a short term *chain free program*- and UNHCR) devoted to mental health related interventions in the area.

G.R.T. opened, in 2003, the first Mental Health Intervention in the Puntland State of Somalia, which counts now on Mental Health Department (hereafter MHD) within the Bosaso General Hospital with a multidisciplinary psychiatric team providing mental health services to the population of Puntland (including free medical and social care, provision of psychotropic drugs, awareness campaigns, home visiting in town and IDP camps, and other specialized and support activities).

According to G.R.T. sample data[16] on the use of chains we have the following figures:

- in the period from 08/06/2003 to 26/06/2004 the percentage of people who was brought chained at the time of first visit at the MHD in Bosaso was: 28.4 %
- in the period from 01/07/2004 to 26/03/2005 the percentage of people who was brought chained at the time of first visit at the MHD in Bosaso was: 12.2 %

These data refer only to the patient brought (literally) chained at the Hospital, meaning, without any doubt, that a higher number of patient is chained at home, at a tree or in a hut. The percentage of people chained at the time of first visit testifies, in any case, the existence of a serious problem: 28.4% of the persons with mental health related problems was kept chained at home.

The second data (referring approximately to the year after the opening of the clinic and related mental health services) shows a significant decrease in number of person chained, from 28.4% to 12.2%, mainly due to the availability of a professional Mental Health clinic and services in town.

A different data is also significant for understanding the extent of the *chain issue* in the Somali context*:* if we have a look at the global data of patients been visited at the MHD from 08/06/2003 to 26/03/2005, the *percentage of patients who has been chained at least once in their life is 29.5%.*

One in every three persons with mental health problems (or so presumed) has been chained at least once in their lifetime!

Being chained once for some person means to have been chained for 1 day or 1 week, for many more from 1 to some months up 13 consecutive years (which is the longest range found by GRT staff in Bosaso).

In general these data testify that the use of chains is one of the means most commonly used by familiar of persons experiencing mental health disorders.

Exercise 1. Ask the participants if they know any person who has been chained for mental health related problems and than engage a discussion on the following:

- Which are the reasons for chaining people with mental disorders?
- Which are the effects of chaining people?
- Do you think is useful to chain people affected by mental health problems?

16 See for details: GRT "Mental Health Intervention in Bosaso, Puntland – NE Somalia" Final Report. The Project was co-funded by Italian Government and European Commission in the period 01/05/2003 – 30/04/2005; Contract No SO/0031/IT-COF/02

Note for the trainer:

The practice of containing disabled people with chains consists in capturing the persons chained tightly on their ankles with a padlock, at home, in the market and along the streets. A chained person has no possibility to move or to walk and in many cases they are not allowed even to go to toilet. Persons living chained are normally in desperate conditions separated from the community and will bring this stigma with them for long.

This brutal practice is persecuted all over the world and in the majority of the countries laws consider such as a *reduction in slavery* and treated as a criminal act. Unfortunately in many impoverished countries, as we have seen, is still spread although not with criminal intentions.

Instead of criminalizing *tout court* such terrible act it is important to understand deeply the reasons why such terrible form of freedom deprivation happens in a certain community at a certain historical moment.

The following are some of the explanations most commonly reported by patients and relatives in the Somali context when asked about the *rationale beyond the use of chains:*

- To ensure the mentally ill does not injure him/herself (since they are considered to have lost contact with reality);
- To ensure that the mentally ill does not injure others (consider also the economic reason beyond this explanation and the *dya payment* [17] due in case of damages caused to others);
- Because s/he's aggressive and can not control him/herself;
- To avoid attempts of escaping the house (and potentially be lost or create problems);
- To let him/her rest and/or calm down.
- Because is not understandable (i.e. talking nonsense, flight of ideas, hallucinations);
- To prevent her from undressing (women only);
- To avoid the patient to be injured/attacked by others because of his/her mental state (children may deriding the person and throw stones against him/her).

It is quite evident from the above statements, and confirmed by direct observations of professionals in the field, that the main reasons beyond chaining have less to do with any idea of therapeutic efficacy of such containment, rather is mainly *based on preventive strategies and is a direct consequences of the lack of any service addressing mental health issues in the area.*

Moreover, other data collected in Bosaso demonstrates that before seeking help at the MHD almost the totally of patients was brought to other healers according to availability in the area and personal beliefs. This means that when there is a sign of crisis the family usually tries to do their best (and what is affordable) to help the kin to improve. In many cases more than one treatment is sought.

The following table[18] gives an idea of the treatments sought in the Somali context (Puntland in particular) when a mental health problem arise in the family (sample of 793 patients).

17 Ref. I.M. Lewis, 1961
18 GRT "Mental Health Intervention in Bosaso, Puntland – NE Somalia" Final Report

Healing System	Number	Sample	Percentage
Dawo-Somali	136	793	17%
Koranic	577	793	73%
Saar-Minghis	81	793	10%
Psychiatrist	40	793	5%
Neurologist	301	793	38%
Other	156	793	20%

Table 1. Percentage of contact with different healing systems

In the majority of the cases chains are the direct consequences of the following reasons:

- no services available;
- no services able to alleviate negative symptoms of illness;
- extreme poverty and lack of resources;

The extreme burden experienced by the family when a person gets mentally sick is thus solved through the use of chains mainly because of the lack of alternatives rather than for the proved efficacy of such practice (although a minority have some believes about the positive effect of chains, especially with aggressive patients).

From an effectiveness point of view, the use of chains has no positive consequences at all, in no circumstances. The psychological, social and medical consequences of the use of chains are devastating for the individual and for the family. The more a person is forcibly contained, the more his/her mental conditions will deteriorate at all levels.

The containment will expel gradually the possibility of reintegration of the person, stigmatizing him/her, damaging the feelings of trust toward the relatives and the external world; isolating him/her from the community; the chains only make any hypothesis of future rehabilitation harder relegating the person with mental health problems in a deteriorating vicious cycle.

The person is experiencing an acute crisis -> no solutions are found by the family to cope with the crisis -> parson is contained with iron chains -> the more the person is chained the more is isolated -> the more is isolated the more his/her condition deteriorates -> more deterioration means more stigmatization from the community -> more stigmatization lead to more isolation and so on….

Managing a visit/interview with chained people. It is frequent for a helping professional working with mentally ill people in the Somali context to face the issue of containment with chains.

In the *exercises* in Unit 3 this kind of scenario was addressed. We have asked the participants to imagine themselves while meeting for the first time (regardless of the location, Psychosocial Centre, Mental Health Department, private house) a patients brought chained by relatives. *What will you do? Will you address the chain issue during the session?* These, as outlined before, are some crucial aspects the workers will have to face immediately and which have consequences.

If you ask the relatives to remove the chains during the interview, they will complain about: the risk of setting the patient free, safety, that *patient is sick*, aggressive etc.

Experiences from the field have shown that removing chains during such settings, normally, does not create any "security" problem. No accidents have been reported by the Bosaso MHD staff in the first years of activities concerning this specific matter.

Opening the chains is a complex action, involving lots of psychological and emotional meanings for the patients as well as per the family members. It has also to be considered that removing the chains in front

of the therapist/counsellor/doctor, doesn't imply automatically that the patient will be set free at home in its daily life, and this is the main goal concerning the chain issue: to *guarantee that chains once removed are not tight again on the person' ankles or hands.*

Removing the chains at the time of visit has the following immediate benefits:

- To show to the parents that unchain the patient is possible;
- To demonstrate that the positive atmosphere generated by the removing of chains, sets a constructive background feelings that enable a more fruitful cooperation among the actors (in particular patients and familial);
- To demonstrate willing of caring to the patient (mainly) and to the relatives;
- To create a setting perceived as more equal (in particular by the patient).

In case of resistance from the parents and especially when their fears are not justified (the extreme majority of cases), you can explain that an inescapable rule for starting the meeting and any intervention with them is to remove the chains.

The chains should be removed by the person who chained the patient first or by a relative; if this is not possible the social worker can open the padlock, always after having received the consent of caregiver.

As discussed before removing the chains is a significant action that will have consequences in the familial system as well as in the helping relationship. It is a part of an unwritten agreement – contract-, thus it implies other actors to do something in relation to it. As we have seen discussing the *psychological contracts,* if you ask the father to open the chains he has to "receive something" as part of the mutual obligations of the contract. "Something" depends on the situation (of course does not include any kind of monetary exchange); an example is in Unit 4 page 53.

A medical prescription (if there is a clinical need and psychotropic drugs are regularly prescribed by a specialized doctor) is one of the actions that, in the mutual processes of contract obligations, constitute an immediate key for removing chains.

Some of the effects of benzodiazepines and neuroleptics commonly used in Somalia-if available-, include reduction of anxiety, agitation and mental confusion. For what is strictly of interest for the present discussion these effects have the positive result of enabling an immediate acceptance of therapeutic intervention by the family and to accept to open the chains.

Moreover in this circumstances you can stress the fact the "removing of chains" is an essential rule for starting the therapy, a pre-condition.

Although when psychotropic drugs are involved in the therapy removing of chains is easier, this doesn't mean that a medical prescription is always necessary; this evaluation has to be firmly delegated to a doctor specialized in psychiatry.

There are cases when people chained don't need a medical intervention and the process of removing chains passes through socio-psychological work with the family and the patient with a systemic approach.

The social worker has always to evaluate every singular situation addressing properly the issue and working fro removing chains as soon as possible.

We now address a last important aspects involved in the practice of containment: the *vicious cycle of aggressiveness and containment with chains*.

Many relatives state that a family member is chained because of his/her aggressiveness; at the same time a chained person often react in aggressive manner towards those (not only) who have chained him/her and, again, if s/he is released or escapes his/her confrontation with the family members will be probably based on hostility.

What is important to understand here is that *chains produce aggressiveness*. Chaining a person is a total deprivation of freedom, of any kind: freedom to move, to act, to be responsible of oneself, to love and at the end also to think, to dream. In one word the person stop to exist as a social actor, as part of the community, becoming a non-person. It is easily understandable how such situation creates an enormous stress on the person, frustration and anger, which have very few ways to be expressed, the most common is trough aggressiveness (or through withdrawal, which in such situation often hide a huge dose of repressed hostility).

The only way to reduce aggressiveness generated by the chains is to remove them; working at the same time, as discussed before, to develop a therapeutic plan which involves all the parties of the system and that have, as main goal, the well-being of the patient via the conservation of its permanent physical freedom.

Part 3

Gender-Based Violence and Psychosocial Counselling in the Somali context

Written by: Asia Abdulkadir

Introduction

Part 3 of the current handbook, is drafted to improve the awareness, knowledge and skills of social and health professionals on gender-based violence (GBV) in Somalia. It is designed for use by volunteer counsellors, non-professional counsellors, and professional counsellors who do not have extensive experience in counselling in the context of gender-based violence. Others may also find the material of use.

This is a four-day training. The first two days are designed to increase participant's knowledge and understanding of the concept of gender, and gender-based violence. The second two days takes a closer look at psychosocial counselling and counselling guidelines. However, time permitting; extending the training over a five-day period is preferable to allow for deeper discussion and to alleviate participant and facilitator fatigue.

Gender-based violence has long remained a feature of family and social life, about which society has preferred to remain silent. GBV takes in Somalia many forms and affects a large number of women at different points in their life cycle, from infancy and childhood to adulthood and old age.

Discussions of gender-based violence can be emotional, as so many people may have personally experienced gender-based violence or are close to someone who has. If someone becomes extremely upset, you should have a plan to deal with this – for example, stop the workshop and know how to refer the person to appropriate support structures.

However – regardless of participants' views on the treatment of women and children in Somalia and their consideration of GBV and SBV, facilitators should make clear that SGB and GBV are non-negotiable facts and a 'zero tolerance' must be a shared agreement of all participants.

An important part of your role is to listen and to provide a safe space for discussion and reflection. You should be ready to reinforce a sense of respect for all participants. There may be a need for flexibility in the timing of exercises. Try to go with the dynamics of the group (taking a break where it most naturally fits) but also be aware of the need to cover a lot of material. For Somali participants, it is advisable to fit the break during the prayer time. If there are expectations of a final report, this should be clarified in advance and planned for.

Module 1
Gender and Gender-based Violence

Learning objectives for Module 1

- Increase participant's knowledge and understanding of the difference between sex and, and gender-based violence.
- To identify the many forms of gender-based violence.
- To understand causes and consequences of gender-based violence.

Methodology (20 minutes):

- After introduction ask each participant to write down on two different cards, one expectation and one fear for the workshop.
- In a short discussion mention the language difficulties for the majority of the participants and therefore to not interrupt while other are speaking, speak slowly if needed.

Materials: Flipcharts, pens, case studies, discussions, ppt presentations

Unit 1 Introduction to the term 'Gender'. How to perceive the world with 'Gender' perspective'

Objective: To have an understanding on the difference between sex and gender.

Exercise:

- Ask participants what they know about the differences between 'sex' and 'gender'.
- Explain the difference quickly and simply.

  For example you can the following definition:

  Gender is the concept used to identify a human being as male, female. Usually it is used to highlight the social distinctions between men and women; for example the positions they occupy the roles they play and the social status they have are socially constructed. Sex is biologically determined.
- Divide the group into small groups, and distribute the Gender Game handout to each group.
- Ask them to read the statements one by one in their groups, and to discus among themselves whether they think the statements refer to sex or to gender, writing a 'G' for those they think refer to gender, and 'S' for those they think refer to sex. If there is disagreement or uncertainty among the group, they may make note of that.
- Read the answers and discuss them with the whole group.

Handout

- Women give birth, med do not (S)
- Little girls are gentle, boys are tough. (G)
- In traditional Somali society a husband is responsible for the family's wealth and security and a wife is responsible for the day-to-day management of domestic affairs. (G)
- Women can breastfeed babies, men can bottle-feed babies. (S)
- The average of Somali women married for the first time at 21 years of age, while men tended to marry the first time at between 25 and 30 years of age. (G)
- In Somaliland the number of female- headed households has increased considerably as a result of the civil war and continuing conflicts. (G)
- Men's voices break at puberty, women's do not. (S)
- In one study of 224 cultures, there were 5 in which men did all the cooking, and 36 in which women did all the house-building. (G)
- According to UN statistics, women do 67 per cent of the world's work, yet their earnings for it amount to only 10 percent of the world's income. (G)

Notes for trainers

This is an activity to be used with participants, who have very little, or no understanding of gender, or who feel that they need to go back to basics to be sure of their grasp of the concept.

Unit 2. Exploring Gender-based Violence: Root Causes & Consequences

Objectives:

- To identify the many forms of gender-based violence.
- To understand the causes and consequences of gender-based violence.
- To understand the differences between root causes and contributing factors
- To recognize that gender inequality is the root cause of gender-based violence.

Step 1: Types of gender-based violence

- Ask participants what we mean when we say "Gender-Based Violence"?

  Note for the trainers: Explain that gender-based violence is Physical, mental, or social abuse (including sexual violence), which is directed against a person because of his or her gender or gender role in society or culture.

- Ask participants to identify some forms of gender-based violence.
- Ask participants what are the differences between contributing factors and root causes of gender-based violence.

Note for the trainers: Encourage all ideas and examples. Make sure that all forms of gender-based violence are covered.

It is also important to explain that men and boys can also be the target of sexual abuse, usually committed by other men, but that women and girls are affected disproportionately.

Types of GBV that should be identified are:

1. Physical violence: domestic violence; physical assault; physical harassment in public; attempted murder; denied access to medical treatment; murder; female infanticide, harmful traditional practices (i.e. FGM).
2. Sexual violence: Forced marriage; child marriage; forced engagement; forced prostitution; rape; forced sexual intercourse with husband; incest; sexual assault; refusal to grant divorce.
3. Psychological/emotional violence: denial of food or basic needs; prevention of education, refusal to communicate; preventing maternal contact with children; using children as threats; physical threats to other family members; verbal insulting; threats to kill; intimidation; restrictions on movement outside the home i.e. to visit own family, talk to neighbours, etc; forced to divorce/ separate; abandoned to own parents.
4. Other types of violence: other traditional and cultural practices i.e. honour killings; kidnapping; attempted kidnapping and trafficking.

Conclusion

- Emphasize that although violence takes many different forms, gender-inequality is the root cause.
- Stress that although culture is often used to justify the use of violence toward women, the right to be free from abuse is a fundamental and universal right.
- Emphasize that violence/assault need not always be present. Threats and coercion are also forms of violence.

Gender-based violence in Somaliland/Somalia

According to UNICEF SOMALIA REPORT 1998:

- The Practice of FGM is almost universal. It is estimated that 95-98% of women have been circumcised.
- SGBV is common, particularly in IDP Camps and most of the time against women and girls of rival clans and those of minority groups.
- It has been estimated that 86% of all adult Somali women are illiterate

Step 2: Consequences

- Explain that the consequences of GBV can be scattered into four general areas:
  - Health
  - Emotional, social and psychosocial
  - Legal/justice system
  - Community and physical safety and security.
- Divide participants into 4 groups representing each of the 4 sectors and ask the participants in their groups to:
  a) Review the various forms of GBV from step one.
  b) List and discuss all of the consequences/outcomes of GBV for their sector. Include individual consequences to the victim, and also outcomes for others – community, family, government, etc.
  c) Prepare a flipchart paper with your group's list of consequences.
  d) As each group reads their lists, the facilitator writes the example on flipcharts.

Notes for Trainers: Some consequences of gender-based violence

Health:

Individual consequences to the victim:

- Injury, disability, or death. STDs and AIDS. Injury to the reproductive system including menstrual disorders, childbearing problems, infections, miscarriages, unwanted pregnancies, unsafe abortions. Depression, leading to chronic physical complaints and illnesses. FGM, resulting in shock, infection, excessive bleeding or death, and longer-term affects such as emotional damage, including anger, fear, resentment, self-hate and confusion. Loss of desire for sex and painful sexual intercourse. Difficult pregnancy and labour, chronic pain and infection, infertility.

Impact on wider society: Strain on medical system

Emotional/Psychological:

Individual consequences to the victim:

- Emotional damage including anger, fear, resentment and self-hate.
- Shame, insecurity, loss of ability to function and carry out daily activities. Feelings of depression and isolation. Problems sleeping and eating. Mental illness and thoughts of hopelessness and suicide. Judgments made about the victim, blaming the victim, treating the victim as a social outcast.

Impact on wider society:

- Expensive, drain on community resources; family, friends, community leaders, social service agencies, etc.
- Victim unable to continue as contributing member of society; unable to keep up with child care, unable to earn an income. If perpetrators not apprehended or arrested, this sends a strong message that the behaviour is somehow acceptable, leading to further incidents of violence.

Legal/Justice System

- Lack of access to legal system, lack of knowledge of existing laws, confusion regarding the most appropriate channels i.e. criminal, traditional etc.
- Victim reluctant to report due to heavy stigma attached to sexual abuse.
- Lack of sensitivity to the issues expressed by judges.
- Costs incurred by the victim.

Impact on wider society: Strain on police/court resources already challenged and overburdened.

Security, Physical Environment of the Community

- Victim feels insecure, threatened, afraid, Climate of fear and insecurity impacting women's freedom and perception of personal safety.

Impact on wider society: Lack of female participation in the community life. Fear of going to school and work.

Step 3 Root Causes and Contributing factors

What are the differences between root causes and contributing factors of Gender-based violence?

Contributing factors are those that perpetuate GBV or increase risk of GBV (family, community and state violence). Contributing factors do not cause GBV although they are associated with some acts of GBV.

Some examples:

- Khat, Alcohol/drug abuse is a contributing factor - but not all drunks/drug addicts beat their wives or rape women.
- War, displacement, and the presence of armed combatants are all contributing factors, but not all soldiers rape civilian women.
- Poverty is a contributing factor, but not all poor women are victimized by forced prostitution or sexual exploitation.
- Many contributing factors can be eliminated or significantly reduced through prevention activities

Unit 3 . Exploring the terms power, force and consent

Objectives	• To identify the relationship between abuse of power and GBV. • To Understand that the term "violence" in the context of GBV means using some type of force, which may or may not include physical force. • To understand the meaning of "informed consent" and its relationship to GBV.
Notes for trainers In all cases of GBV three important concepts underpin all acts and actions between the victim and perpetrator. It is crucial for participants to understand how this inter-plays in abusive situations and why women maintain silences or make the choices they do make.	

Key discussion points

Raise discussions to highlight how all these acts are violations of the women's human rights

Power

Perpetrators can have "real" or "perceived" power. Some examples of different types of power and powerful people:

- Social – peer pressure, leaders, teachers, parents, etc.
- Economic – the perpetrator controls money or access to goods/services/money/favours; sometimes husband or father.
- Political – elected leaders, discriminatory laws.
- Physical – strength, size, use of weapons, controlling access or security; soldiers, local commanders, police, robbers, gangs, mafia, etc.
- Gender-based (social) – males are usually in a more powerful position than females.
- Age-related – often, in traditional societies status/power is granted with age.
- Power is directly related to choice. The more power one has, there are more choices available.
- The less power one has, fewer choices are available.
- Disempowered people have fewer choices and are therefore more vulnerable to abuse.
- Gender-based violence involves the abuse of power. Unequal power relationships are exploited or abused

Do all people with power abuse their power? (No)

Violence - use of force

1. "Force" might be physical, emotional, social or economic in nature. It may also involve coercion or pressure. Force also includes intimidation, threats, persecution, or other forms of psychological or social pressure. The target of such violence is compelled to behave as expected or to do what is being requested, for fear of real and harmful consequences.
2. Violence consists of the use of physical force or other means of coercion such as threat, inducement or promise of a benefit to obtain something from a weaker or more vulnerable person.
3. Using violence involves forcing someone to do something against her/his will - use of force.

Consent

1. Consent means saying "yes," agreeing to something. Informed consent means making an informed choice freely and voluntarily by persons in an equal power relationship.
2. Acts of gender-based violence occur without informed consent. Even if she says "yes," this is not true consent because it was said under duress - the perpetrator(s) used some kind of force to get her to say yes.
3. Children (under age 18) in most countries are deemed unable to give informed consent for acts such as marriage, sexual relations, etc. In Somalia girls under 16 are considered minor.

Exercise: Divide participants into two groups and distribute the handout with the case study below.

Case study: The case of an arranged marriage

Learning Objective: To understand the meaning of "informed consent" and its relationship to Gender-based Violence

Nimco's father says he has some very important matters to discuss with her and her mother. He then proceeds to tell Nimco that since she is now 18 years old he has arranged her marriage to a man who is the son of a very good friend of him from long time ago. Her father says this man comes from a good family, has a good job and the family has a good reputation and this is a good match for her. Nimco's mother (Zahra) tries to ask more questions about the man, but the father says the marriage is arranged and he has complete trust that the marriage will be a good one. Nimco has never seen or met this man, who is considerably older than her. Nimco does not raise any verbal objections to the marriage and her silence is taken that she is in agreement of the marriage. In Somali society, young girls do not usually give their opinions or views to their fathers on partners for marriage; being too forward is not seen as a good quality for girls, the more shy or embarrassed a young girl appears the more she is perceived as being innocent and having good virtue.

Ask them to read the case study carefully and ask them to discuss the following questions:

1. How common is this kind of situation in Somali society?
2. Did Nimco give her informed consent to this marriage?
3. Was there any force used in this incident?
4. Who is more powerful in this example – father or daughter?
5. What kind of power does this father have?
6. What kind of power does the daughter have?
7. What kind of power does the mother have?
8. How does power relate to choice in this example?

Note for trainers: Discuss the meaning of "informed consent and its relationship to Gender-based violence.

Exercise 2: Handout these case studies and ask participant to read them in a group out of two or three persons. When they finished reading they should discuss the questions among themselves before the large participant's discussion.

Case on violence against girl child (30 minutes)

Parents brought their 2-year-old daughter to Hargeisa Group Hospital who had been raped by a 45- year-old man. Soon after her admition the little girl died from internal bleeding. No one could say how this could have happened. The father does not want any support and wants to keep the rape a secret, if known would be a source of shame for the family.

Case on raped women (30 minutes)

Ifrah was admitted to the clinic accompanied by her sister-in-law. She complained about stomach pain, sleepless nights due to pain in her entire body. Ifrah refused to be examined in the presence of her sister-in-law but her stomach looked suspiciously big. The nurse asked whether she was pregnant. The sister-in-law laughed "God no, her husband went to Ethiopia two years ago. She can't possibly be pregnant."

The nurse asked her to go and see the doctor for laboratory examinations. On their way out, Ifrah confided in her quietly that she had been raped and was pregnant now. Around noon,

Ifrah asked her sister-in-law to wait outside the toilet door because she didn't feel well and needed to use the toilet. There she gave birth to the child and tried to flush it down the toilet.

In the process, the baby died. When the sister-in-law realised what had happened she was desperate because she didn't know how to explain this to their family.

Group - discussion and questions

1. What do you feel when you listen to such cases?
2. Have you heard of similar cases in your community? What do they tell you about sexual violence in society?
3. Do you think sexual violence is a big problem in Somali society? Is the problem largely caused by strangers/unknown men or by men who are family/relatives?
4. Why are sexually abused women unable to discuss or report such kind of cases? What are the barriers?
5. Why is sexual abuse such a taboo subject in Somali society? What are the reasons for maintaining the 'silence'? What purpose does it serve and for whom?
6. What do you think girls/women who have been sexually abused feel about never being able to talk about what happened?

Unit 4. Conclusion of this part of the training

Notes of trainers

- Finally close the this part of the training by making the following conclusions:
- Although violence takes many different forms, gender- inequality is the root cause.
- Although culture is often used to justify the use of violence towards women, the right to be free from abuse is a fundamental and universal.
- Violence/assault need not always to be present. Threats and coercion are also forms of violence.
- Gender-based violence includes any physical, mental or social abuse which is directed against a person on the basis of gender or gender role within the given society and has its roots in gender inequality. It is therefore important to integrate a gender perspective to effectively prevent and respond to gender-based violence. This means looking at what causes gender-based violence, analyzing what happens to women and girls because of gender discrimination, etc.
- The impact of gender-based violence is far-reaching both for the victim, and for society at large. Strategies to respond to the many forms of gender-based violence must adopt a holistic approach and extend to all sectors.
- Systematically addressing gender inequality at all levels is decisive.

Module 2.

Psychosocial Counselling and the need for effective counselling

This part of the manual is designed to improve the knowledge and skills of social workers, health professionals and other service providers on psychosocial counselling and gender-based violence (GBV). These service providers are in a unique position to identify the problem, contribute to its prevention and assist victims. This is because social workers and health facilitators are probably one of the few public institutions that most women interact with at some point in their Lives.

Unit 1. Introduction to Psychosocial Counselling on GBV

Notes for trainers

In case there are some participants who have not been part of the previous training, ask participants to introduce themselves to each other.

Summary and review of the first part of the training

At the beginning of this session, the group facilitators should ask some of the participants to summarise the previous training sessions on Gender-based violence.

Afterward the facilitator should summarise and review the main learning points on gender-based violence such as:

1. GBV, no matter what form it takes is never the victims fault - even though the victim may feel that she is somehow responsible for the abuse and violence they suffer.
2. Women maintain silences on abuse/violence for different reasons - understanding the pressures placed on women not to disclose the abuse does not mean she does not want to seek help or change the situation, rather it reflects the barriers raised by family and societal 'norms'.
3. The risks in some societies for disclosing sexual violence i.e. rape can have severe consequences for women such as imprisonment, death or honour killing.

   It takes courage and strength for women to break social taboos of society to publicly disclose abuse and to seek justice.
5. GBV can affect any woman regardless of her education, social class, ethnicity and wealth.

In Somalia, there is a view if you are educated or married into a reasonably well off family, the women is unlikely to be abused, this is simply not true. Statistics from all over the world show that any women can become a victim of GBV.

Types of helping professionals: differences and similarities

Despite the need for support, many survivor of GBV feel unable to tell to relatives and friends about their experiences. The reasons are various: They may be under treat from the perpetrator. They may fear that other won't believe them, will not take them seriously or blame them for the situation. They may be concerned about harm to their children or other family member. A counsellor can help them to talk about their problem in a confidential environment.

Gender-based violence situation are often complex. There are many factors to consider helping ensure the safety of the clients and other family members. This is why a psycho-social counselling is essential.

Note for the trainers: This session explains the differences of the main types of professionals who undertake Gender-based violence (GBV) cases including those with mental health problems. While, counselling skills can be learned by most staffs who deal with GBV cases – they do need to realise that some cases will require specialised interventions.

Objectives:

- To learn the similarities and differences between different types of professionals undertaking social work, community work and mental health.
- To become aware that for interventions and practice to be safe, staffs must be trained in counselling and casework methods.

- To think about what kind of future trainings and professional qualifications are required for social and community workers to work on Gender-based violence (GBV) and other social problems.

Exercise: Ask participants how many types of helping professional do they know.

Notes for trainers:

As described in the introduction of previous modules the group facilitator can use different ways to conduct each of the sessions to match their own personal style of training. By now the group facilitators will know the participants and should have established a relationship with each other. It is advised that you go through the four areas below as in previous sessions.

Background Information on the different types of professionals who undertake GBV cases

Social work and community work are new activities being introduced in Somali society. These terms generally describe a professional activity that is concerned with the enhancement of human well-beings - , it attempts to relieve, prevent hardship, violence and suffering. Generally, individuals who work in social work field are called 'the helping profession'. Usually, they are known as social workers, community workers, youth workers or counsellors. They can be qualified or unqualified; those who are unqualified are not allowed to work as specialists that require professional training such as child protection and mental health. This is because these areas require a deeper knowledge.

The difference between social worker and community workers is:

Social workers usually work in a defined setting such as an agency context, hospital or residential environment and work with clients (individual, family or groups) also called caseworker and work in areas listed above. Social workers have a responsibility to help individuals, families, groups and communities through the provision of various services. It does this by providing support either directly to, or in co-ordination with other agencies or through a range of service provisions. Social workers have legal obligations to protect individuals and society, and have power to take away the liberty of a person such as remove children from abusive parents or admit an adult with mental health problems (who are either dangerous to themselves or to others) for admission to a hospital or other safe residential setting.

Unqualified social workers can work in all the same areas in social work but do not have the same power base, and they are required to have some basic training such as interviewing skills or basic counselling skills.

Community workers work in less defined setting such as in the community, specific location or specific groups within that community. The kind of work they do is usually dependent on issues or problems facing the whole community, or a specific group within a community. Usually, they engage the community in finding solutions to problems. The work is wide ranging such as outreach activities, mobilization, capacity building, running specific activities, linking communities to resources, running specific programmes, mediation between community groups and government, etc. They also work with individuals and families. They may or may not be qualified social workers.

In developing countries, those working in social work, have names that are accepted or familiar to their communities such as family mediators, community activists, youth workers, community volunteers or community mobilisers.

In Somalia, these terms are used inter-changeably.[19] It is useful to think long term as experiences from different countries have shown – that social work can become an overused term for dealing with all types of social problems and if formal education/training will one day be developed in universities – it is better to limit its usage.

19 In Somali language Shaqaale bulsho is the most used term for the helping professionals. It refers to both to community workers and social workers.

In Somalia, many people are keen to work on individual cases of GBV. I strongly recommend that staffs are trained in casework and counselling before they commence counselling. It might seem as if it is easy to solve problems by telling victims what to do, but to be really effective you need skills to intervene in a way that is helpful and empowering to women.

Understanding the difference: psychologist, psychiatrist, psychotherapist and counsellor

Many survivors of Gender-based violence, and others in the community, may have severe mental health problems that will need more specialised interventions than can be done by social or community workers.

These are:

A psychologist is a mental health professional who has received extensive schooling and a degree from a credible university to work with clients who have mental health problems and mental health illnesses. In most cases a psychologist is trained in one or more approaches in psychotherapy and is registered with a professional organisation. Psychologists usually have additional training in certain forms of psychotherapy to be able to work with more seriously ill clients.

A psychiatrist is a specialised medical doctor who has received training in the diagnosis, treatment and research of mental disorders. Because psychiatrists are medically trained, they take the point of view that a woman with serious emotional and behavioural problems is mentally ill. Therefore, not many psychiatrists are trained as counsellors or psychotherapists, but rather focus on the prescription of medications.

A psychotherapist is a specialised counsellor extensively trained in one or more specific approaches or techniques that are regarded as psychotherapeutic interventions. It is a more developed approach than when it is offered through counselling. The word psychotherapy is often used to describe counselling and other psychological interventions. It is a form of counselling but it means that a trained professional is using specific procedures and techniques to help someone with a mental, emotional or behavioural disorder.

A counsellor helps clients to identify their problems and helps them find their own solutions.

Counselling takes place when a counsellor sees a client in a private and confidential setting to explore a difficulty the client is having, distress/violence they may be experiencing or perhaps their dissatisfaction with life, or loss of a sense of direction and purpose. It is always at the request of the client as no one can properly be 'sent' or 'forced' for counselling. Professionals trained in counselling can be nurses, social workers, youth workers, safe house staff, midwives, and other professionals.

Exercise: Match problems with relevant professional who can help

Time: 30 minutes

This activity can be done in two ways:

- Explain the main points from the background information and then do the quiz, or do the quiz first and than cover gaps with an explanation from the background information.
- Participants should try to match the problems with the relevant profession – sometimes the cases overlap with two or more professionals.

Instructions for trainers to conduct the exercise :

1. On different colour cards write down the professions:

   Social worker, community worker, psychologist, psychiatrist, psychotherapist, counsellor and other. Stick them on a wall.

2. On the different coloured cards write down different GBV and mental health scenarios such as:
    1. A woman is depressed with problems in marriage.
    2. Sheiks are advising women not to work in foreign NGOs.
    3. A woman has had a nervous break down.
    4. A girl has panic attacks after witnessing a bombing incident.
    5. A man is acting and talking strangely, suicide attempt.
    6. A refugee woman has become separated from her husband and children.
    7. A woman was attacked by armed men and is suffering Posttraumatic Stress Disorder (PTSD).
    8. High numbers of child marriages in community.
    9. A man believes he is possessed by jinns, etc

Ask participants to explain their choice.

Unit 2. Exploring Counselling

What do we mean when we say counselling?

This section will review some of the contents already explained in Part 2, Modules 3 and 4.

Learning objectives

- To establish an understanding of counselling
- To increase participant's knowledge and understanding of difference between the models of traditional counselling and the models of contemporary counselling

Note for trainers: provide the definition below

Counselling is a process in which the helper (counsellor) expresses care and concern towards the person with a problem. The purpose for counselling is to create an environment of trust where the client can learn more about their thoughts, their feelings, and their life. Through this process, the client is able to take action to achieve their goal or to solve their problem(s).

Exercise: Ask participants how many types of counselling do they know?

Counselling can be categorised in two main types:

Traditional Counselling

Traditional Counselling: People seek help from others in order to solve their problems. In the traditional set-up, parents, uncles, aunts, siblings and grandparents are readily available to render assistance to others. Much of traditional counselling is based on advice-giving and wisdom.

Professional Counselling

Professional Counselling: is a help for clients to identify their problems and to find their own solutions. Professionals trained in counselling can be nurses, social workers, youth workers, safe house staff, midwives, and other professionals enable assistance.

Characteristics of the two main types of Counselling:

Traditional Model of Counselling

1. Counselling in the traditional set-up is done through the following:
   Family, Parents, Uncles, Aunts, Grandparent, Elders, Traditional leaders, Religious leaders.
2. Problems Handled by traditional Counsellors are:
   Family Problems, Family disputes, domestic violence, marriage problems and inheritance.
3. Characteristics of the tradition Models are: It tells someone what to do; An authority figure or elders gives advice; It teaches rules/expectations of the society; It maintain social and cultural norms of the society

Professional Model of Counselling

1. Counselling in the professional set-up is done through the following:
   Professionals such as social workers, community workers, psychosocial therapist, doctors and nurses etc.
2. Problems Handled by professional Counsellors are:
   It deals with problems of the family, individuals and society.

3. Characteristics of Professional Counselling are: Client creates own norms unless life-threatening issues arise; Client and counsellor decide how long the client will stay.

Methods of the Professional Counselling

Professional Counsellors should:

- Help the client to speak freely about what is in their hearts.
- Let client define their problems
- Ask "what brings you here today?" or "so you are visiting us today?" or "may I help?"
- Find out what is going well on his/her life and what is difficult.
- Find out what is the client's most immediate need?
- Repeat the definition of the problem to the client.
- Get confirmation or correction.

Guiding questions for the counsellor:

Find out all the causes of the problem, e.g. How are the followings contributing to the problem:

- Parents
- Extended Family
- Peers
- School
- Health problems
- Finances?

Note for trainers: Professional counsellors should:

- Ask client what will solve the problems (How can the items above help with the solution?)
- Ask how each of the above actions can make the problem better. What could they do? What could the client do?
- Ask how the client has started to overcome his/her situation in life, even in small ways.
- Ask what are their hopes for the future?

The Counselling Attitude

Professional Counsellors should.

- Give emotional support, even if doubtful or critical about what client saying. Example: some clients may not say the truth.
- Create a warm, permissive atmosphere where client feels free to discuss problems.
- Reflect back, like a mirror, what the client is *saying* and how the client is *feeling.*
- Not be superior to the client.
- Not tell clients what to do. It is finding out what works best for the person.
- Maintain confidentially
- Avoid Advising
- Avoid being judgmental

It is important to emphasise that the counsellor believes the client can sort out his or her own problems.

Unit 3. Advantages and disadvantages of traditional vs professional counselling

Advantages and disadvantages of traditional counselling

Notes for trainers: Ask participants if they know some more advantages and disadvantages of traditional counselling to be listed.

Advantages:

- A person known to the Client

Disadvantages:

- It tells someone what to do.
- Traditional counsellor is superior to the client (in traditional societies parents and grandparents are superior to younger persons).
- Creates dependent relationship between clients and counsellor.
- It involves giving an opinion, making a judgment and a recommendation.

Listening Exercise: Read out each statement and participants should give their answers to the statements.

	Listend to	Not listend to
You cut me off and started telling me about your experience.		
You want to solve my problems for me.		
You allow me to express my negative feelings towards you without becoming defensive.		
You give me your undivided attention.		
You make judgements about me because of my language, grammar and accent.		
You trust me to find my own solutions to my problems.		
You allow me time to think, feel and express.		
You choose an appropriate time to respond.		
You do not looking at me when I am speaking.		
You enable me to make my experiences feel important.		
You keep looking at your watch.		

Advantages and disadvantages of Professional Counselling

Advantages:

- Talking done by client.
- Define problem from client's point of view.
- Works toward interests of client.
- Openness; it is a two-way communication system.
- Client decides solution.
- Builds self image.
- Equality between counsellor and client.
- Self-expression.
- Empowers client.

Disadvantages:

- Needs a lot of time.
- Questions might put client off.
- Constraints on meeting places.
- Restricted to clients views.
- Solution from clients only demoralises client (Clients could expect solutions from counsellor).

Notes for trainers: After presenting pros and contra, discuss with participants which types of counselling do they prefer for their own work with clients and ask them to give a reason for their choice.

Case study: unhappy marriage

Fadumo has been very unhappy with her marriage of a few months. It was a forced marriage with a cousin who is a few years older than her. Her husband Ismail is a kind, reasonably good looking, educated man with a good job. There are no particular problems in the marriage, but Fadumo just does not like him, does not feel she can love him, does not want him to touch her and just wants a divorce. She feels depressed.

Instruction for trainers:

1. Introduce to all participants the case study of unhappy marriage, chose two persons from them, and ask the one to play a role of Fadumo and the other one should play a role of a counsellor. (15-20 mins)
2. All other participants should observe the counselling process and make some notes for the discussion later.
3. Now, ask participants to give their feedbacks from what they have observed during the counselling process.

Unit 4. Understand and identifying the primary client and client groups for counselling

Learning objective: To understand and identify the primary client in terms of professional responsibility

Notes for trainers:

1. Provide participants with the following background information on the primary client in form of presentation.
2. Ask participants if they sometimes experience difficulties in identifying the primary client and discuss with them how to overcome the difficulties.

In general, client refers to the person who has problems and seeks support. They can also be referred to as cases, service users or customers. Some agencies and professionals do not like the term client as it reinforces the power difference between clients and professional - with the professional being the expert, powerful, able to limit or restrict resources/support. Some prefer a more neutral name.

As a professional worker it is important to be clear about who the primary client is and the professional's obligations and responsibilities to her. In GBV cases the primary client is the woman coming for help and support, not her family members or husband. This means we cannot share information about her with them or try to work with her family members without her informed consent, even though they maybe contribute to the problems she has.

Good practice means there should be a contract agreed between the client and counsellor through consensus. This is usually an agreement on how often you will meet, where, for how long, what you want to change, areas to develop new skills and when it will finish.

When a client is under 18 years old (in international law) and under 16 years old (Somali national law) – the parents have parental responsibility (unless this has been taken away from them legally such as with a parental rights deprivation order) - in these situations a representative of the government or another relative will be granted parental responsibilities. This means professional interventions must be made with parental permission or someone who has acquired parental responsibility legally. In an emergency, interventions are allowed without parental permission as stated in the laws of the country relating to child protection issues. Nevertheless, parents should be involved and informed of what the interventions are – as parents hold the responsibility for their child. Parents in most families will want to support and do their best for their child and they can also help with reassuring the child and in the follow up actions.

Working with girl children is again dependent on the agency context and requires specialist training.

In Somalia, due to the lack of trained people, this often means that women working in different communities and agencies will be asked to work with girl children experiencing violence as there will be no one else to help.

Unit 5. Understanding the limitation to Counselling

One of the issues confronting counsellors and social/community workers are they want to be seen by their clients as being helping and supportive. This can sometimes lead us to promising to help with all sorts of problems that are not possible to resolve. This may be because the counsellor wants to be liked and seen as good and helpful person. This is natural. We all want to be liked and seen as doing something useful but this is creating dependency and also not being realistic. Clients will come with a range of problems alongside Gender-based violence issues such as economic difficulties, poor housing, poor relationships, no money for food, etc. It is unrealistic for the counsellor to think they can resolve all of these for or on behalf of the client. It will make both the counsellor and client feel 'helpless' and 'hopeless', leading to the client going away feeling that no one can help her with her problems. In some ways it makes the problems appear unmanageable.

As a counsellor or social/community worker you will be able to refer clients to other agencies or communities for support, depending on what projects or activities are being offered. Nevertheless, finding jobs and eradicating poverty are not easy to solve as they require long term policies, funding and investment from the central and local government.

In this sense, counsellors cannot deal with the external problems the client has such as: economic difficulties, or leaving the country. The counsellor can only empower the client by helping her/him gain insights and self-awareness to the problems, and enable her/him to acquire skills to deal with these situations. The counsellor can help her/him deal with her mother-in-law problems by being assertive and putting limits on the relationship; can support her/him to manage finances through budgeting skills; can help her/him with how/where to look for a job and how to present herself/himself positively to employers. It is important to recognise these limitations and not make unrealistic promises and plans that the counsellor cannot fulfil. This builds false hope and expectations – leading to disappointment and feelings of 'hopelessness'.

Notes for trainers:

1. Now ask the participants to list the usual problems clients ask for support and help with. Write all these problems on the flip chart.
2. Now ask the participants whether it is realistic for the counsellor to resolve all these problems? Circle all the ones that cannot be resolved or changed through counselling with a different colour.

Key discussion points

- The counsellor needs to make clear to the client what counselling is by explaining the limits of the counselling relationship (what is possible and what is not).
- Counsellors will want to have a good relationship with their clients, which is open and honest. In such a relationship you can challenge and manage to discuss difficult issues with a client because there is respect, trust and mutual understanding.
- You can only empower the client to make the changes in her/his life.
- Change is only possible if the client truly wants to make a difference in her own life. This requires her/him to give time, commitment and to be motivated.

When counselling is not appropriate

There will be situations when counselling is inappropriate or not suitable when dealing with clients who are vulnerable or at risk. Sometimes their mental state is such that they are not in control of their mental state to engage appropriately with counselling. Nevertheless, they would still require different kinds of support and help, these are:

1. Girls/Women with severe mental health/illness such as schizophrenia, mental retardation, psychosis, and schizophrenic post partum psychosis. The client would require support and care, and with medication, would be able to function normally. But counselling may be inappropriate even when their condition is stable and would require careful consideration of their past medical history to assess suitability to counselling support.

2. Girls/women with a history of suicide attempts or at high risk of suicide. Again, they would require support and help and counselling may be appropriate at a later stage.

3. When counselling will place a girl/woman at risk of further abuse and violence within her family due to restrictions and hostility to outside 'support'. Once, the situation is calm and stable counselling can be offered.

4. Girls/women who are currently drug or alcohol addicts are unable to function normally.

5. In general, a counselling session should be cancelled if the client is under the influence of drugs, or threatening violence towards the counsellor. In such situations counselling is not likely to be effective with the clients not being in control or responsible for their behaviour and actions.

Unit 6. Distinguishing between an emergency and a crisis

Learning objectives:

- To learn to understand what crises are and their impact on an individual life.
- To differentiate between crises and emergencies and plan appropriate responses and interventions

Notes for trainers:

Explain briefly to participants the difference between an emergency and a crisis.

For e.g.

A crisis is not necessarily immediate or urgent, although it may be perceived as such by an individual.

Crises are often confused with emergencies.

Emergencies are external threats to individual's life which are seen as overwhelming, and depend on who is doing the defining.

1. Handout the following case study to participants and ask them afterward to discuss the questions.

Case study: Urgent referral

Saadia is a mother with five children aged between 7 - 15 years old. She has run away from home in Hargeisa and arrives in Bosaso where she shows up at 3 p.m. in your office. She tells you that her husband has been abusive to her for a long time, physically and psychologically and she cannot live with him any longer. She cannot go anywhere, do anything or spend any money – he watches her all the time, criticising her all the time. Her husband has problems with her family over land issues and has threatened to kill her family members if she seeks help from them. She has not been in touch with her family for some time now. On questioning how she got to Bosaso, she tells you that she left early in the morning and got the 8 a.m. shared taxi, and the taxi driver dropped her here. When you ask her why she left the children behind, she responds by telling you, they have only two rooms in the house and he sleeps with the children in the same room. She did not want him to know she was leaving – she was confused and did not know where she would go. She first went to her cousin's house; she gave her money, but said she would not allow her to stay because her husband is unpredictable and would cause her many problems. Her cousin promised not to say anything to anyone.

Exercise: Group discussions

1. Is this case a crisis or emergency? Explain your reasons.
2. What are the actual and potential risks for Saadia? Currently, if she returns to her husband?
3. What additional information would you require to understand and analyse the case before taking any further actions? Where would you get this information?
4. What actions would you take now on the case?
5. Who else should be involved in the case for further inventions and state reasons for their involvement? Immediate and the short term?

Conclusions

Counselling does not mean that advice and guidance are not suggested in counselling relationships such as advising a client to do relaxation exercises to relieve stress. The key difference is that counselling is based on respecting the personal freedom of the client and principles of self-determination – meaning the client decides what she/he wants to do and what feels like a right solution to her/his problems. It is the clients' choice and decision at all times.

In the Somali culture, girls/women are restricted in what they can and cannot do as well as what they can think and say. Frequently they have no choice or control over their lives, let alone being consulted or asked what they would like to do. The counselling relationship should try not to recreate similar kinds of conditions that already exist for girls/women in their family environment which are dependent relationships - it should be one that empowers her, and helps her feel she has control and choices in her life.

Annex I: GRT Inception semi-structured Interview format

MENTAL HEALTH ASSESSMENT

PSYCHOSOCIAL ASPECTS

1. A. GENERAL DATA

Serial No of interview……..
Date……

Location of settlement ……..…….

Type of settlement: ….. IDP camp …… Concrete house …… Other ….……

1. B. INTERVIEW

Biography

Full Name …… Age (or date of birth) …….. Sex ……

Marital status……..……..

Current Occupation …….. School attendance ……..……

Previous Occupation(s) ……..……

Nomadic/settled ……..…….

Parents still alive ……..……

Family/Caregivers (collect information) ……..……

……..……

……..……

Where s/he her/his family comes from?……..……..

Why they left their previous town?……..…….

……..……

……..……

Treatments

Has s/he never been for… :

Dawo-Somali treatment ……..…… Koranic treatment ……..……

Saar-Mingis treatment…..…….. Psychiatric unit (abroad?)……..……

Other .....

When (specify for each treatment) .....

.....

Where (same, as above) .....

.....

How many times ((same, as above) .....

.....

How long (same, as above) .....

.....

Why (ask about the choice) .....

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.....

Expectation about treatment (before treatment) .....

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Results (after treatment) .....

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.....

Use of substances

Use of Khat ..... alcohol .....

hashish ..... other .....

Remarks about use/abuse .....

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.....

Chains

Currently Chained? ..... For how long has s/he been chained (this time)? .....

Has s/he been chained in the past? ..... How many times and where? .....

.....

For how long has s/he been chained in the past (write about every time)? .....

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Why is s/he chained? (patient opinion) .....

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Relatives' opinion .....

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Personal history (past-present history, significant or traumatic life events, family and social relationship, history of the present illness, skills, resources, etc.) .....

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1. *REMARKS and OBSERVATION*

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Name of Social Worker:……

Annex II: GRT Medical Record (See, in particular, the *social section*)

BENDER QAASIM GENERAL HOSPITAL

MENTAL HEALTH WARD

MEDICAL & SOCIAL FORM

Serial No …….. Date……..……

BIOGRAPHY

Full Name……..Age (or date of birth)…..… Sex: M ☐ F ☐

Mother's name…….

Responsible (name, address, phone)....……..……..

Marital status: single ☐ married ☐ divorced ☐ widow/er ☐ abandoned ☐

School attendance: none ☐ primary ☐ koranic ☐ intermediate ☐ secondary ☐ university ☐

Occupation [Current]……..

Occupation(s) [Previous]……

Family: total members…….residents: M…… F…..workers with income: M ..... F…….
Family income (US$/month):.....…….....Remittances (US$/month):……....

Nomadic ☐ Current Area……..……..

Settled ☐ IDP camp ☐ Concrete house ☐ Current residence…….

Originally from……..……..

Reason of movement: Civil war ☐ Economic ☐ Temporary (visit) ☐ Other☐……

TREATMENTS

Dawo-Somali ☐ When…….Where…….How many times……...Cost…..

Koranic ☐ When…….Where……How many times……..Cost…..

Saar-Mingis ☐ When…….Where……How many times……..Cost…..

Neurologist ☐ When…….Where……How many times……..Cost…..

Psychiatric ☐ When…….Where……How many times……..Cost…..

Other ☐ When…….Where……How many times……..Cost…..

SUBSTANCES

Khat ☐ Weekly use 1 time ☐ 2 times ☐ 3 times ☐ ≥4 times ☐

Daily use 1 michin ☐ 2 michins ☐ 3 michins ☐ ≥4 minchis ☐

Cost per day…… Duration of use……..

Alcohol ☐…….. Hashish ☐…….. Other ☐……

CHAINS

Chained at present ☐ How long has s/he been chained ……..

Chained in the past ☐ How many times …… For how long (total)……..

SOCIAL EXPLORATION

Personal history (past-present history, significant or traumatic life events, family and social relationship, reason for referral, skills, resources, etc.)……...

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Current Level of burden on the family: Mild ☐ Moderate ☐ Severe ☐

Current Level of Disability due to illness: Mild ☐ Moderate ☐ Severe ☐

What does the family attribute the patient problem to: Jin ☐ Magic ☐ Injury/Accident ☐

Stressful event ☐ Other ☐

Specify:……
……
……

Compiled by: ……

MEDICAL INVESTIGATION

Familiar Medical History (psychiatric/medical history of parents and close family members) …………..
………………………………………………………………………………………………………
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ANAMNESIS

Previous medical illness ……………………………………………………………………………………

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Previous and Present psychiatric illness (Specify Onset, Diagnosis and previous psychotropic drugs if any)

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GRT – Mental Health Intervention in Bosaso, Puntland – NE Somalia

MENTAL STATUS EXAMINATION

General description

Appearance ……

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Behavior and psychomotor activity……

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Attitude toward the examiner……

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……

Speech

Rate (e.g. rapid, slow, halting)……

Amount (e.g. taciturn, lacking spontaneity, grandiose)……

Tone (e.g. monotone, singsong, slurred)……

Speech impairment……

Thought process (Loose associations, Tangential thinking, Blocking, Perseveration, , Flight of ideas)……
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Contents of thought (Delusion, Obsessions)……

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Mood and Affect, Appropriateness (e.g. Depression, Elation, Irritability, Sadness, Anxiety)

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Perceptual disturbance (Illusion, Hallucination)……

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Sensorium and Cognition (alertness and level of consciousness, orientation, memory, concentration, abstract thinking, intelligence)…….

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Impulse control ……

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Insight about the presence of illness……

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Diagnostic Description……

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First Prescription……..……

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Signature: Doctor……

DATE	DIARY

Full Name……..……

DATE	DIARY

GRT – Mental Health Intervention

Annex III: VADO Form

Valutazione Abilita' Determinazione Obiettivi (VADO)

Somali Adapted Version 2004

Mental Health Ward – Bosaso General Hospital

Name of patients: …… Report No.: ……

Identification of abilities & difficulties

Date …… ..... | …..…… |…..…

1. Self Care (eat, wash, dress, clean, drink)
   1 2 3 4 |1 2 3 4 |1 2 3 4
2. Social relationships (friends, peers, neighbors)
   1 2 3 4 |1 2 3 4 |1 2 3 4
3. Familiar life (contacts with relatives, neighbors)
   1 2 3 4 |1 2 3 4 |1 2 3 4
4. Housing (kind of house)
   1 2 3 4 |1 2 3 4 |1 2 3 4
5. Capacity of independent displacement (orientation, use of landmarks)
   1 2 3 4 |1 2 3 4 |1 2 3 4
6. Use of facilities (telephone, radio…)
   1 2 3 4 |1 2 3 4 |1 2 3 4
7. Capacity of understanding money' value and use.
   1 2 3 4 |1 2 3 4 |1 2 3 4
8. Insight about mental problems
   1 2 3 4 |1 2 3 4 |1 2 3 4
9. Physical, Intellective, language skills
   1 2 3 4 |1 2 3 4 |1 2 3 4
10. Ability of physical self-care (physical illness)
    1 2 3 4 |1 2 3 4 |1 2 3 4

11. Ability of Psychological self-care (mental illness)

1 2 3 4 | 1 2 3 4 | 1 2 3 4

13. Ability to take care of others (children, parents…)

1 2 3 4 | 1 2 3 4 | 1 2 3 4

13. Ability to ask for Help

1 2 3 4 | 1 2 3 4 | 1 2 3 4

14. Work, study

1 2 3 4 | 1 2 3 4 | 1 2 3 4

15. Hobbies

1 2 3 4 | 1 2 3 4 | 1 2 3 4

16. Ability to cook (for women only)

1 2 3 4 | 1 2 3 4 | 1 2 3 4

17. Sexual functioning

1 2 3 4 | 1 2 3 4 | 1 2 3 4

18. Capacity to cope with stigma

1 2 3 4 | 1 2 3 4 | 1 2 3 4

19. Ability to follow religious duties

1 2 3 4 | 1 2 3 4 | 1 2 3 4

Legend

Tic numbers from 1 to 4 if the characteristic is:

1. absent / poor 2. slightly present 3. enough present 4. present /good

Identification of resources in the following areas

a. Familial .....

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b. Social network.....

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c. Economic .....

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d. Housing .....

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e. Therapeutic continuity .....

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Identification of early signs of crisis

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Sharing of therapeutic project between patient and relatives

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Short term objective (specific)

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Long term objective (general)

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Remarks

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GRT – Mental Health

Annex IV: Agreement on Ground Rules for the Training

Objectives:

To arrive at commonly agreed upon and mutually respectful norms of behaviour during the course of the workshop

Method:

- Explain to the participants the need for having a set of rules for behaviour.
- Ask the group for suggestions for rules that should be adhered to, and make it clear that the rules should be agreed upon by the entire group.
- Write the agreed rules on the flip chart and keep them in full view throughout the workshop.

Notes for trainers: A sample of some common group rules

- Starting and finishing on times agreed, including at tea and lunch breaks and full attendance during workshops.
- Respect individual opinions and views, even when they are different to yours or if you disagree with them.
- Everyone is equal in the group regardless of age and status.

Mobiles must be switched off

Annex V: Evaluation Form

1. In one word/sentence, the training workshop was:
2. In one word/sentence, the participants were:
3. In one word/sentence, the facilitator/s was/were:
4. Will you be able to apply what you learned during this workshop in your work?

   Definitely not probably not Not sure Most likely yes definitely yes
5. Do you think the group will be able to apply what they learned?

   Definitely not Probably not Not sure Most likely yes Definitely yes
6. What elements of the workshop were the most useful?
7. What elements of the workshop were the least useful?
8. Would you feel comfortable counselling on gender-based violence? Why or why not?
9. Additional comments and suggestions are most welcome!

GLOSSARY

Active listening

To listen actively is not only paying attention to what is being said. It is also about communicating an understanding of what the speaker means. This includes responding both non-verbally (e.g. by attending, nodding and affirming) and verbally (e.g. by saying "I see", "right", "please continue" and "I would like to hear more about that"). Using the same terms and words as the person speaking will give a message of understanding and following what the speaker is saying.

Advocacy

The active support of an idea or cause, especially actively speaking in support of a person or group.

Anxiety

A vague, unpleasant emotional state characterized by distress, uneasiness, general nervousness or sometimes panic, especially when faced with reminders of a crisis event; concerns of losing control or not being able to cope; worries that the situation may happen again. It is common for people who suffer from anxiety to be constantly watchful and easily startled by loud noises, sudden movements, etc.

Attempted rape refers to efforts to rape someone, which do not meet with success, falling short of penetration.

Bipolar Disorder (also called manic-depressive disorder) is one of the most severe forms of mental illness and is characterized by recurrent episodes of mania-high mood- and (more often) depression-low mood.

Bio-psycho-social model highlights the interdependence between physical, psychological and social well-being in creating a positive health condition of the person.

Client refers to a beneficiary who has been admitted into a mental health or psychosocial programme to receive care, and is involved in a therapeutic relationship with a counsellor/mental health practitioner. The client is not called patient (as in the medical setting) because psychosocial or mental health support is not necessarily restricted to medical disorders.

Crisis

Any sudden interruption of the normal course of events in the life of an individual or a society that makes re-evaluation of modes of action and thought necessary. A general sense of loss of the normal foundations of day to day activities.

Complex emergencies: An emergency situation (life and/or property threatened) that impacts communities on multiple levels, i.e.: safety threatened, infrastructure damaged, civil unrest, health systems challenged

Comprehensive health care approach assumes a holistic interpretation of the human being as being physical, mental, social, spiritual and moral in nature.

Coping is a process in which the individual (or group) deals with situations by managing them adequately without necessarily mastering them completely. After a traumatic experience, new information needs to be processed, assimilated and integrated into a new 'worldview'. According to cognitive processing theories the two most common elements of the coping processes are intrusion and avoidance.

Counselling is a relationship in which a helper assists a client to understand himself and his problems better. Where appropriate, the helper uses various strategies to clarify and expand the clients' understanding, to assist him to develop and implement strategies for changing how he thinks, acts, feels so he can attain life-affirming goals.

Confidentiality. All the information emerging in a helping relationship is confidential; from the beginning this has to be made clear and explicated to the client.

Congruency. Quality and attitude of genuineness, of spontaneous expression in constructive way, of the helper personality.

Cultural sensitivity: An awareness and respect for the differences in per-spective, rituals, priorities, traditions and taboos from one group of peo-ple to another.

Depression in moderate manifestations is a condition characterized by negative feelings about the self, pessimism about the future, a general sense of inadequacy and a slowed activity rate. More extreme forms involve withdrawal into the self, possible development of the sense of hopelessness and perhaps delusions of guilt and inadequacy. Transcultural psychiatry emphasizes that local definitions of 'self ' affect a client's experience of depression, and how he expresses emotions and symptoms. Causes and symptoms of depression therefore differ according to cultural context and behavioural norms.

Disease refers to the way practitioners recast illness in terms of their theoretical models of pathology.

Distress: A type of stress that is experienced as unpleasant, and causes various stress reactions in the person.

Empathy To be able to identify with and understand another person's situation, feelings, and motives.

Empowerment: Gaining control of the decisions that impact one's life – as an individual or as a group. This is mainly achieved by acknowledging people and by setting up structures that allow people to participate in community activities. Engagement, whether it is in daily activities, recreational or educational activities, helps promote psychosocial well-being and empower people so that they regain a feeling of control over some aspects of life, a feeling of belonging and of being useful.

Family therapy can help family members resolve issues among each other. It also can help them adopt ways to help another family member to get well. Family members can learn how actions and ways of communicating can worsen problems. With help, new and improved ways of communicating can be explored and practiced. In western settings family therapy is often used when an adolescent has a problem with alcohol and substance abuse.

Forced Marriage occurs when parents or others (can include perpetrator) force someone to marry another against her/his will. This includes exerting pressure, ordering a minor to get married, for dowry-related purposes, or in other circumstances.

Gender-analysis: An evaluation process that seeks to determine the roles of genders and the consequences of those roles.

Gender-balance: The ratio of males to females. In relief work, the staff should reflect the gender balance of the recipient population. Decisions should be made with input reflecting this gender balance.

Gender Based Violence is physical, mental, or social abuse (including sexual violence) – including acts, attempted or threatened, done with force or without force and without consent of the person/survivor – which is directed against a person because of his or her gender or gender role in a society or culture. In circumstances of gender violence, a person has no choice to refuse or pursue other options without severe social, physical, or psychological consequences. Forms of gender-based violence include sexual violence, sexual abuse, and sexual harassment, sexual exploitation, early or forced marriage, discrimination, denial of education, food, freedom, etc., forced prostitution, domestic violence, female genital mutilation, and incest.

Giving advises is telling someone what you think they should do and how you think they should do it; it is giving your personal opinion, implying that you propose your own personal view of the situation and suggest the best way to solve it.

Giving information is telling someone facts so they can make an informed decision about what to do.

Health

In the WHO Constitution is "not merely the absence of disease or infirmity", but rather, "a state of complete physical, mental and social well-being".

Illness refers to the client's perception, experience, expression and pattern of coping with symptoms. Because language, illness beliefs, personal significance of pain and suffering and socially learned ways of behaving when ill are part of that process of mediation, the experience of illness (or distress) is always a culturally shaped phenomenon.

Insomnia is the inability to fall or stay asleep. Insomnia can be classified as transient (short term), intermittent (on and off) and chronic (constant). Chronic insomnia is more complex and often results from a combination of factors, including underlying physical or mental disorders.

Key informant interview is a qualitative tool for acquiring detailed information about beneficiaries' perspectives. There are several types of key informant interviews including: in-depth, individual or group and case study interviews. Key informant interviews are obligatory in psychosocial assessments.

Mental health: An emotional state in which the individual is able to enjoy significant social relationships, attend to responsibilities such as work or school, care for oneself as appropriate to age and manage normal pleasures and disappointments. It consists of a series of different psychological processes that enhance a person's psychological, emotional and social functioning.

Mental health disorders are disturbances in the biological and/or psychological functioning. They are diagnosed according to a standard system of criteria that allows a generally accepted definition of the condition. The definition of mental health problems is culturally defined. Consequently various categorical systems can be described. However, it is universally accepted that mental health problems are medical.

Mental Retardation is not a Mental Illness in the strict sense of the term. Mental Retardation is rather a state than an illness, a condition which is present from very early childhood and remains during the course of one's life. It means that the brain development of the child is slower or delayed compared to other children (see also IQ).

Non verbal communication

All communication without words, i.e. body movements, facial expressions and non-verbal sounds like sighs or gasps. Culturally specific in nature.

Post-Traumatic Stress Disorder (PTSD) is a psychiatric disorder that can occur if people are unable to integrate their traumatic experience in their present life. PTSD is marked by clear biological changes as well as psychological symptoms. PTSD is complicated by the fact that it frequently occurs in conjunction with related disorders such as depression, substance abuse, problems of memory and cognition, and other problems of physical and mental health. PTSD can be diagnosed three months from the traumatic incident. Before this most of the problems are regarded as part of the normal coping process.

Protective factors

Factors that give people a psychological "cover" and therefore reduce the likelihood of severe psychological consequences when encountering hardship or suffering. Protective factors can be the belonging to a caring family or community, maintaining traditions and cultures, and having a strong religious belief or political ideology which gives the feeling of belonging to something bigger than oneself. For children, some protective factors are a stable emotional relationship with adults, and social support both within and from outside the family.

Psychosis is a mental disorder sufficiently severe to result in personality disorganisation and a loss of contact with reality

Psychosocial refers to the dynamic relationship between the psychological and social dimension of a person, where the 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. Psycho' refers to psychological, that means problems of behaviour or needs of personal emotions, thoughts and feelings like fear and despair. 'Social' refers to the interaction between the individual and a larger group such as family, community and/or its environment (physical, moral, spiritual).

Psychosocial health indicates the presence of life or personal problems that undermine daily normal functioning. The definition of what constitutes normal varies cross-culturally and between individuals.

Psychosocial illnesses are conditions of not well being, common in the community. The relationship between psychological and social effects is dynamic, mutual and ongoing. Social problems can easily affect the psychological status of the individual. Psychological problems can affect the individual's social (e.g. interpersonal relations) well being

Psychosocial Rehabilitation is a broad term encompassing a group of practices, including skills development, social skills training, family education, self-management, peer support, coping skills, self-monitoring training, vocational rehabilitation, education, and social and recreational development.

Psychosocial Rehabilitation Plan is assessing, defining and implement of series of rehabilitative and therapeutic actions having the main goal in the attainment of psychosocial well-being of individuals and their families.

Psychosocial support refers to the actions that address both the psychological and social needs of individuals. It should be integrated both in emergency response operations and in long-term development programmes. Psychosocial support activities should seek to facilitate communication and re-establish the social support in the community, and support people's efforts to actively respond to the impact of critical events.

Psychosocial well-being describes the positive state of being when an individual thrives. It is influenced by the interplay of both psychological and social factors.

Psychotherapy: A healing process that addresses emotional and social problems from the perspective of the individual. A number of modalities may be used including talking, medication, group work etc.

Rape is an act of non-consensual sexual intercourse; where one person forces another to have sex. Any penetration (anal or vaginal), regardless of the level of force used, is considered rape, and may include: statutory rape (sex with a person considered a minor by law regardless of consent of the survivor); gang rape, if there is more than one assailant; male rape, sometimes known as sodomy.

Resilience is the capacity to restore a new balance when the old ones are challenged or dysfunctional. Resilience is defined through physical, mental, social, spiritual and moral systems.

Sexual Assault includes acts of violence not involving anal or vaginal penetration. Examples include: forced or coerced oral sex, insertion of objects in the vagina, etc.

Sexual Harassment is unwanted sexual bothering of someone for sexual purposes or using sexual acts, words, sounds, or implications. It may include low-level physical contact, like touching. Sexual harassment can include threats of a sexual nature, or the use of authority to achieve sexual favours.

Sexual violence is any act, attempted or threatened, that is sexual in nature and is done with force or without force and without consent of the person/survivor. This includes acts of forcing another individual, through violence, threats, deception, cultural expectations, weapons, or economic circumstances, to engage in behaviour against his or her will.

Although rape and attempted rape are the crimes most often associated with sexual violence, there is an abundance of sexual crimes committed during flight, in the refugee camps and after repatriation. Wars

have resulted in massive amounts of abductions, forced pregnancies, rapes and sexual torture. Refugees fleeing their countries have also experienced sexual harassment and been forced to exchange sex for favours (such as food and resources) or prostitute themselves. Ongoing issues in refugee camps and settlements include early and forced marriages, female genital mutilation, and domestic violence.

Sickness can be defined as a social meaning of distress or a process for socializing disease and illness

Stressful events and traumatic stress have not been distinguished successfully yet. The qualification of an event being traumatic or stressful is bound individually. Events that do not involve extreme stress (immediate survival) can be perceived as challenging by some or as threatening by others. Traumatic stress is often associated with wars, captivity, torture, disasters and racial discrimination.

Support group/self-help group

Forums where participants can provide each other with emotional as well as practical support. They should not be used as therapy. Support groups can be facilitated by someone who has received some elementary training in psychosocial support, who has empathy and patience and feels comfortable taking such a responsibility.

Supportive communication

Communicating empathy, concern, respect and confidence in the abilities of the other person.

Transcultural Psychiatry combines anthropological information about culture and social groups with epidemiological and psychiatric studies of the aetiology of health and illness. It employs the anthropological assumption that patterns of thought and behaviour are learned through one's cultural environment. Therefore while people experience the same types of psychiatric and psychological disorders worldwide, they express mental disorders in varying ways cross-culturally.

Trauma: Used commonly to describe either a physical injury or a psychological injury caused by some extreme emotional assault. Definitions of what constitutes a trauma are subjective and culture-bound. Sometimes the term, collective trauma, is used. This term refers to a situation where an entire community is suffering and its cohesion is lost due to a crisis event.

Traumatic experiences: Events in a person's life that are beyond the experience or imagination of most people and beyond any one person's ability to control, that causes great fear, horror, helplessness, terror or threatens life.

Vulnerability in the context of traumatic experiences refers to an individual's ability to cope with distress experiences e.g. living in poverty, mental or physical health disabilities, lack of social network, lack of family support and previous traumatic experiences. In the context of mental health and psychosocial programmes, vulnerability is further defined in terms of morbidity (e.g. the presence of symptoms), mortality (e.g. suicide), access to care, lack of dignity and specific conditions that increase vulnerability (e.g. being in a psychiatric institutions).

Vulnerable groups

Often used to describe groups of people living with health challenges (e.g. HIV and AIDS, TB, diabetes, malaria, and cancer), people with physical disabilities and/or mental illness, children and adolescents, older people, women, unemployed persons, people living in poverty, IDPs, refugees, and minority groups.

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