

# COUNSELOR TRAINING MANUAL



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## INTRODUCTION

Following the ethnic violence in Kyrgystan in the early summer of 2010, Médecins Sans Frontières quickly set up a mental health project to support the local population. An important goal for the mental health activities was to recruit local candidates for a counselor training that would enable them to work with the traumatized population. During my three-week visit, I was able to develop a training manual that could be used by successive psychologists.

The program for this 10-day counselor training manual has been structured so as to motivate the trainees for the training and make them confident that they will be able to master the skills and learn the attitudes that are expected of them. I particularly wanted to avoid the cultural expectations of being the expert/teacher and using one-way communication, so the methods used in this training aim to actively engage the trainees in the training as much as possible.

The first days of the program are devoted primarily to listening skills, and the concepts of trauma are not introduced until Day 4. In this way, the trainees will have time to become comfortable with each other and not be overwhelmed by the difficult emotions involved in working with trauma survivors.

This training centers around Guus van de Veer's Five Types of Psychosocial Problems. However, I have made some adaptations. Assuming that the gradation of Types of Psychosocial Problems should reflect both the severity of the problem and consequently the skills required of the counselor, I have adjusted the order as problems:

1. Practical problems
2. Lack of Skills / Knowledge
3. Inner problems/struggling with choices
4. Overwhelming feelings
5. Trauma symptoms
6. Psychiatric problems

The above order is based on the following considerations:

- My impression is that Van de Veer categorized Inner Problems at level (5), just above Psychiatric Problems at level (6) because Inner Problems usually involve long-term psychoanalytic treatment (by a psychiatrist). However, psychoanalysis is not a common option in underdeveloped countries. In a post-emergency context, Inner Problems can be dealt with effectively through short-term directive counseling. For this reason, I have placed Inner problems one level below (2) Lack of Skills/Knowledge.
- There is overlap in both the symptoms and the interventions involved in Overwhelming Feelings (e.g. depression) and Trauma Symptoms. For this reason I felt that Overwhelming Feelings should be at level (4), to be discussed before Trauma Symptoms at level (5). I have also recommended some additional interventions that may be used with the latter.

- In the context of post-disaster mental health, counseling is generally considered appropriate for Type (5) Trauma Symptoms. However, if there are indications that the symptoms qualify for a PTSD diagnosis (i.e. at least 3 symptoms which have lasted at least 4 weeks, and these symptoms interfere with daily functioning), the counselor should consider psychiatric and/or medical referral and discuss this with the expat supervisor. For this reason, I have placed Type (5) Trauma Symptoms one level above Type (6) Psychiatric Problems.

In this training program, each day ends with relaxation exercises. The aim is that trainees first do several group relaxation exercises, so that they experience a variety of ways to do relaxation and learn that relaxation can be effective in helping them cope with the stress of counseling work. Starting on Day 3, trainees try out relaxation exercises with each other, so they have ample opportunity to practice and become comfortable in using relaxation effectively. Relaxation exercises can be taken from various sources (Van de Veer, MSF-OCA). I would recommend that a selection of relaxation texts be translated so that the material is available for use by the counselors.

Training local counselors usually requires that an interpreter works on behalf of the trainer. I have indicated that some parts of the training, namely, the group discussions, do not require translation, I felt that this would be a more efficient use of time, since translation slows down the communication process. Also, it encourages the group to exchange views freely and to work together as an independent (peer) group. After the untranslated group discussions, the group presents the findings in a plenary, translated by the interpreter.

I have aimed to provide a clear and structured setup for a 10-day program. Naturally, trainers will want to adapt the program for specific contexts and needs. I suggest that the trainer notes which parts have been included in the training, to be included in the certificates that counselors receive at the end of the training. In this way, it will be clear to future trainers and/or supervisors which topics may need attention.

I would appreciate receiving feedback from any trainers who make use of this counselor training manual!

Nicky Cohen de Lara-Kroon  
Kyrgystan, July 2010.

## WEEK 1

		MORNING	AFTERNOON
DAY 1	Mon.	Introduction Ice breaker  Rules for listening  Active listening	Types of Psychosocial Problems (1) Practical Problems (with role play)  Group relaxation exercise
DAY 2	Tue.	Demonstration listening skills (clinic case)  Case discussion	Types of Psychosocial Problems (2) Lack of Skills / Knowledge (with role play)  Group relaxation exercise
	Wed.		-
DAY 3	Thu.	Dealing with difficult clients; non-verbal communication; touchy subjects	Types of Psychosocial Problems (3) Inner Problems / Struggling with Choices (with role play)  Group relaxation exercise and tryouts
DAY 4	Fri.	Psychological process following a traumatic event  Care for counselors	Types of Psychosocial Problems (4) Overwhelming Emotions (with role play)  Group relaxation exercise and tryouts
DAY 5	Sat.	Looking back: what have we learned?	-

## WEEK 2

DAY 6	Mon.	Special groups: working with parents of young children	Types of Psychosocial Problems (5) Trauma Symptoms (with case presentation)  Relaxation exercise tryouts
DAY 7	Tue.	Demonstration counselor interventions (clinic case)  Case discussion	Types of Psychosocial Problems: Psychiatric Problems (with case presentation)  Relaxation exercise tryouts
	Wed.		-
DAY 8	Thu.	Working as a counselor: client files; supervision; peer support	Preparing for counseling work: community activities; psychoeducation  Relaxation exercise tryouts
DAY 9	Fri.	Special groups: working with families  Sexual violence	Preparing for counseling work: clinic activities  Medical presentation of psychosocial problems  Relaxation exercise tryouts
DAY 10	Sat.	Review  Certificates!	-

## DAY 1

## INTRODUCTION

## TRAINER

Introduce yourself to the group.

Provide some brief info about MSF and why MSF offers MH as well medical aid.

## ICE BREAKER: INTERVIEW ABOUT HOBBIES

## DYADS

Trainees interview each other about activities that s/he enjoys doing, what s/he likes about these activities, when s/he does it, when did s/he first started doing it, etc. "The interviewer will then introduce you to the group so that we get to know you better."

## PLENARY

Each trainee reports on the interview.

## TRAINING PROGRAM

## TRAINER

Deal with practical questions (salary, info from HR, etc.); participant must fill in HR forms, bring copy passport.

Explain training program; counselors will work under supervision of expat psychologist after training.

## LISTENING SKILLS

## TRAINER

Explain that the "core activity" of counseling is listening; what did your interviewer do/say to encourage you to talk? → trainer summarizes, using pointers from SHEET 1: HOW TO LISTEN/TALK.

## DYADS

Trainees interview each other about a *positive* childhood experience.

## PLENARY

Trainees report on how their interviewer listened: "what did you like, what did you not like?" → trainer summarizes, leading on to pointers from SHEET 2: ACTIVE LISTENING.

## DYADS

Trainees interview each other about a *negative* childhood experience ("if you prefer, you may role play an imagined experience").

## PLENARY

Trainees report how their interviewer listened → trainer

summarizes, leading on to the basic principles of counseling, using  
SHEET 3: PRINCIPLES OF COUNSELING

## LUNCH BREAK

TYPES OF PSYCHOSOCIAL PROBLEMS (V.D. VEER)

TRAINER

ROLE PLAY (1) PRACTICAL PROBLEM

Trainer roleplays the client, trainee explores the client's practical problem (Practical problem: client can't sleep because the neighbors make so much noise every night). Other trainees observe.

GROUP DISCUSSION (no translation needed)

What was the problem presented by this client? How can the counselor help someone with this kind of problem?

PLENARY

Group reports findings → trainer watches for judgmental attitudes and/or emotional reactions of trainees.

TRAINER

Explain types of psychosocial problems, using SHEET 4:

PROBLEM TYPE 1 (=v.d. Veer, first row only). Indicate that each day will deal with another type of psychosocial problems: Lack of skills/knowledge (type 2), Inner problems / struggling with choices (Type 3), Overwhelming feelings (Type 4), Trauma symptoms (Type 5) and Psychiatric problems (Referrals).

RELAXATION

TRAINER

Explain how relaxation works, why it is used. Exercises will be done every day to make trainees familiar with relaxation.

Use relaxation exercise with whole group.

NB For many cultures it is important to indicate that eyes may be closed while I am talking (i.e. not impolite towards me).

Reactions?

CLOSE DAY 1

Questions, remarks?

## DAY 2

***Before you start: arrange for a patient/client to be available for a case demonstration in the morning.***

### LOOKING BACK

Questions, thoughts about yesterday?

### RULES FOR COUNSELING

#### TRAINER

Discuss issues concerning confidentiality:

- how and why you must ensure confidentiality; no surname, no address in client file;
- why you must break this rule when there are life-threatening client issues (suicide, threat to others); what you should do in such cases.

### CASE DEMONSTRATION

Trainer does a consultation with a patient/client, including a relaxation exercise (if appropriate); trainees observe the session and make notes.

### CASE DISCUSSION

What did you observe in the client? What did you observe in the counselor? Which type of problem did the client present? → trainer refers to Types of Psychosocial Problems listed yesterday.

### CONDUCTING THE FIRST SESSION

#### GROUP DISCUSSION (no translation needed)

Which info do you need, how do you ask for this info, in which order?

#### PLENARY

Group reports → trainer adds pointers, using SHEET 2-1: FIRST SESSION. First session forms are handed out to the trainees for future use.

## LUNCH BREAK

### CONDUCTING THE FIRST SESSION

#### ROLE PLAY (2) LACK OF SKILLS/KNOWLEDGE (no translation needed)

One trainee roleplays client with sleeping problems not related to trauma (Lack of skills/knowledge: client's ex-husband is unemployed and is demanding money from her; she needs to

learn how to be more assertive). Other trainees take turns in roleplaying the counselor for approx. 5 minutes

GROUP DISCUSSION (no translation needed)

What type of problem did the client present? What does the client need? What is your role of counselor? What kind of interventions are appropriate for this type of problem?

PLENARY

Group reports findings → trainer adds row 2 to table, using SHEET 2-2: PROBLEM TYPE 2.

RELAXATION

TRAINER

Use relaxation exercise with the whole group.

Reactions? → trainer explains how relaxation works, why it is used.

CLOSE DAY 2

Questions, remarks?

## DAY 3

### LOOKING BACK

Questions, thoughts about yesterday?

### DEALING WITH "DIFFICULT" CLIENTS

#### TRAINER

Compliment trainees that they are quickly learning to use new listening skills and show a caring attitude. Now we will make it little bit harder for them: how to deal with difficult clients.

#### ROLE PLAY "DIFFICULT" CLIENTS (no translation needed)

Trainees take turns in roleplaying the counselor in various roleplays with "difficult" clients (client who talks too much, client who talks too little, etc.). Other trainees observe.

#### GROUP DISCUSSION (no translation needed)

What made the session with each client so difficult? What can the counselor do?

#### PLENARY

Group reports → trainer looks out for counselors' emotional reactions (irritation, contempt); explains how one's own reactions can get in the way of good counseling, gives some pointers about how to be more accepting and understanding of the client's difficult behavior, and emphasizes that counselors need to be calm and relaxed at all times (how can you achieve this?).

## LUNCH BREAK

### TYPES OF PSYCHOSOCIAL PROBLEMS: TYPE 3

#### GROUP DISCUSSION (no translation needed)

The aim is to increase the trainees' awareness of issues that the beneficiaries are experiencing. Therefore, instead of roleplay, the group is asked to discuss:

1. What kind of inner problems / choices do people struggle with in general (your own examples, that of your friends)?
2. What kind of inner problems / choices are many people struggling with since the violence erupted?
3. In which ways can people be affected by inner problems / struggling with choices?

NB This exercise in particular may trigger the counselors' own inner struggles and doubts about their situation.

#### PLENARY

Group reports → trainer adds pointers using SHEET 3-1:

PROBLEM TYPE 3.

RELAXATION

TRAINER

Use relaxation exercise with whole group.

Reactions?

DYADS

Trainees do simple relaxation exercise focused on breathing.

CLOSE DAY 3

Questions, remarks?

## DAY 4

### LOOKING BACK

Questions, thoughts about yesterday?

### PSYCHOLOGICAL PROCESS AFTER A TRAUMATIC EVENT GROUP DISCUSSION (no translation needed)

The group is asked to discuss what they have seen in people who have experienced the violence: how do people react in terms of behavior, emotions and what they say?

#### TRAINER

Explain that people who have experienced a traumatic event usually go through some typical phases (The concept of PTSD will be presented on Day 6. Here the emphasis is on the "normal" process that can be seen in the general population.)

Explain how counselors can recognize these phases by observing emotions and the way the client talks (thoughts, cognitions), using SHEET 4-1: PSYCHOLOGICAL PROCESS.

Explain vicarious traumatization. Vicarious means "as if you were there yourself", i.e. people can be traumatized by hearing the stories, watching the images on TV, etc.

NB Watch out for trainee reactions reflecting their personal traumatic experiences.

### CARE FOR COUNSELORS

#### TRAINER

Explain the importance of peer support for counselors.

#### DYADS

Trainees select a personal traumatic experience they wish to talk about. "This should not necessarily be your most extreme traumatic experience, i.e. not the worst thing that you ever experienced!" If preferred, trainee may roleplay someone else's traumatic experience.

#### PLENARY

Reactions? NB Do not require trainees to discuss the content of their dyad talks in the plenary! Aim is to encourage peer support.

## LUNCH BREAK

### TYPES OF PSYCHOSOCIAL PROBLEMS: TYPE 4

#### ROLE PLAY (no translation needed)

One trainee plays the role of a client presenting overwhelming emotions (e.g. grief), another plays the role of counselor. NB

Roleplaying overwhelming emotions related to the recent violence may be too stressful for the trainees if they have experienced the violence themselves. In that case, the trainer can suggest roleplaying a traumatic event not related to the violence, e.g. a car accident.

GROUP DISCUSSION (no translation needed)

Group discusses observations: what type of interventions did the counselor use, what helped, what didn't help?

PLENARY

Group reports → trainer explains Type 4 Overwhelming Emotions, using SHEET 4-2: PROBLEMS TYPE 4.

RELAXATION

TRAINER

Use relaxation exercise with whole group.

Reactions?

DYADS

Trainees do simple relaxation exercise focused on muscle relaxation.

CLOSE DAY 4

Questions, remarks?

## DAY 5

### LOOKING BACK

Review what we have learned the past week.

### HOW TRAINING AFFECTS THE COUNSELLOR TRAINER

Explain that learning to be a counselor affects you:

- At the start of the training, participants are often afraid to share their own emotions and often they become anxious when they hear the emotions of other people. (Uzbek men don't talk about emotions, even brothers don't.) Talking and listening can be learned.
- Working as a counselor can be draining. Importance of taking good care of counselors. This is done in three ways: supervision by expat psychologist, peer support by regular meetings, self-care (regular breaks). Make sure that all three are provided.

### DYADS

Trainees talk about the meaning of working as a counselor: how will it affect me, what are my plans, what do I expect from the job, what do I want to achieve, etc?

### CLOSE DAY 5 (NO AFTERNOON SESSION)

Questions, remarks?

## DAY 6

## TRAINER

Note that the topics are steadily becoming more difficult and challenging for the counselors.

## SPECIAL GROUPS: WORKING WITH PARENTS OF YOUNG CHILDREN

## TRAINER

Present CASE ROSHANNA. (Role play is not considered appropriate here, because it is difficult to roleplay a young child.)

## GROUP DISCUSSION (no translation needed)

- What is the parent's Type of Problem (vd Veer)?
- What is the "cause" of the problem (hypotheses)?
- Which counselor interventions may be appropriate?

## PLENARY

Group reports findings → trainer adds pointers using SHEET 6-1: WORKING WITH PARENTS.

For further reading, trainer is referred to: *WHO MHPS Care for Children Affected by Disasters*.

## LUNCH BREAK

## INTERVENTIONS WITH TRAUMA SURVIVORS

## TRAINER

Refer to discussion of how people are affected by traumatic events, presented on Day 4. Present Traumatic Symptoms belongs to Type 5 Psychosocial problems, using SHEET 6-2: TYPES OF PROBLEMS 5.

Explain that interventions for Traumatic Symptoms (Type 5) largely overlap with interventions used with Overwhelming Emotions (Type 4), with some extra interventions that are specifically appropriate for trauma survivors, using SHEET 6-3: INTERVENTIONS TYPE 5.

## TYPES OF PSYCHOSOCIAL PROBLEMS, TYPE 5

## TRAINER

Explain that after traumatic events, most people go through the psychological process discussed on Day 4. In a small percentage of people, the symptoms are severe and long-lasting.

## CASE PRESENTATION

The trainer presents a case in which the client reports PTSD symptoms lasting longer than 3 months. (If roleplay is preferred, it

is advisable that the trainee who roleplays the client shows his/her distress by covering his/her face, instead of attempting to roleplay weeping and other signs of severe distress.)

#### PLENARY

Group discusses the case in terms of presenting symptoms → trainee clarifies the concept of PTSD as a diagnosis, using SHEET 6-4: PTSD.

NB Counselors should (obviously) not attempt to make a diagnosis, but need to know which traumatized clients require referral. Referral is required if (1) the traumatic symptoms are severe, AND (2) these symptoms have lasted longer than 4 weeks, AND (3) the symptoms interfere with the client's normal functioning (i.e. the client is not able to work or function as a housewife).

#### RELAXATION

##### DYADS

Trainees take turns to try out relaxation exercises (e.g. using translated relaxation texts from v.d. Veer, chapter 5).

#### PLENARY

Discuss how the exercise went.

#### CLOSE DAY 6

Questions, remarks?

## DAY 7

***Before you start: arrange for a patient/client to be available for a case demonstration in the morning.***

## LOOKING BACK

Questions, thoughts about yesterday?

## DEMONSTRATION CASE CLINIC

Trainer does consultation with a clinic patient referred by a doctor. Trainees observe the session and take notes about the following questions:

- Which Type of Problem (v.d.Veer) is the client presenting?
- Which interventions are relevant to this type of problem?
- Should there be a follow up and/or further counseling? If so, what is the plan / goals of further counseling?

## CASE DISCUSSION

Group discusses findings → trainer adds pointers

## LUNCH BREAK

TYPES OF PROBLEMS: PSYCHIATRIC PROBLEMS  
TRAINER

Present CASE SEVERA. (A case presentation is proposed because it is difficult to roleplay psychotic behavior.) NB Describe problems and observations only; do not state the Hypothesis or Interventions!

## GROUP DISCUSSION CULTURAL ISSUES (with translation!)

Trainees discuss observations regarding Severa's behavior. How is this kind of behavior explained according to his/her culture or religious beliefs? → trainer identifies the problems as Acute Psychosis to explain the Westernized approach to mental health. The aim of this discussion is to promote understanding between trainees from different cultures / religions.

What kind of interventions are required? → trainer emphasizes need for referral, using SHEET 7-1: TYPES OF PROBLEMS 6. Counselor interventions are focused on motivating the family to pursue referral and supporting the family in dealing with the client.

PSYCHIATRIC PROBLEMS: SYMPTOMS CHECKLIST  
TRAINER

Present SHEET 7-2: CHECKLIST PSYCHIATRIC SYMPTOMS

and hand out copies to trainees. Explain that the checklist can make counselor aware that the client may be presenting a psychiatric problem and may require referral to psychiatric care. NB The checklist is NOT intended to be used as a questionnaire, i.e. counselors should not inquire about all these symptoms!

Emphasize that the two criteria for referral are:

(1) these symptoms are chronic, i.e. they were present before the violence, OR

(2) these symptoms interfere with daily functioning.

Therefore, counselors should always ask:

- whether the problems were present before the violence; and
- whether or not the client is able to do his/her daily activities.

Obviously, the checklist only provides an indication of a possible psychiatric problem, and counselors cannot provide any kind of diagnosis (even if asked by the client).

## RELAXATION EXERCISE

### DYADS

Trainees take turns to try out relaxation exercises (e.g. using translated relaxation texts from v.d. Veer, chapter 5).

### PLENARY

Discuss how the exercise went.

## CLOSE DAY 7

Questions, remarks?

## DAY 8

### LOOKING BACK

Questions, thoughts about yesterday?

### WORKING AS A COUNSELOR: CLIENT FILES

#### TRAINER

Explain the need for recording some information from each session. Note that, in view of security, the recording of the client's personal info must be limited, i.e. the client should not be traceable: no surname, no address (note district only).

Discuss the information from the first session that needs to be recorded, using FILE FIRST SESSION.

Discuss the information from subsequent followup (FU) sessions that needs to be recorded, using FILE FU SESSION.

Hand out copies of both forms to the trainees.

NB The current MSF-B forms are extremely complicated, partly because they are intended for data collection. Since we have had no indication that the counselors need to contribute to data collection, I have simplified both forms.

### WORKING AS A COUNSELOR: PEER SUPPORT

#### TRAINER

Explain that counselors are be supported in two ways:

- Supervision by the expat psychologist. Inform the trainees how the supervision will be organized, how they can prepare for supervision meetings, etc.
- Peer support. Explain why peer support is important, using SHEET 8-1: PEER SUPPORT

#### GROUP DISCUSSION (no translation needed)

Trainees to discuss how they want to organize their peer support, where/when to hold meetings, whether they want to appoint a group leader, etc.

#### PLENARY

Trainees report on concrete plans for peer support activities.

## LUNCH BREAK

### PREPARING FOR COUNSELING WORK: COMMUNITY ACTIVITIES

#### TRAINER

Ask trainees what the advantages and disadvantages are of group work, i.e. a group of people with a similar problem or situation (e.g.

IDP's in a tent camp, mothers of young children).

GROUP DISCUSSION (no translation needed)

Trainees discuss how they would organize a group discussion for a group of IDP's located in a tent camp, what kind of information would be useful to this traumatized group, and how they would provide this information.

PLENARY

Group reports findings → trainer adds pointers to clarify rules for group work and the role of the counselor, using SHEET 8-2:

PSYCHOEDUCATION

RELAXATION EXERCISE

DYADS (no translation needed).

Trainees take turns to try out relaxation exercises using translated relaxation texts from v.d. Veer (chapter 5).

PLENARY

Discuss how the exercises went.

CLOSE DAY 8

Questions, remarks?

## DAY 9

***NB Bring large sheets of paper for the drawing assignment!***

## LOOKING BACK

Questions, thoughts about yesterday?

SPECIAL GROUPS: WORKING WITH FAMILIES  
TRAINER

Explain that each family has its own dynamics, in which family members have different roles and relationships. To understand family dynamics, ask trainees to make a drawing of their own family in the past (i.e. from their childhood, when they lived at home) with themselves included in the drawing.

## PLENARY

Each trainee shows his/her drawing to explain some of his/her family dynamics. The trainer may probe, e.g. "why have you drawn yourself standing next to your father?"

## GROUP DISCUSSION (no translation needed)

Trainees discuss the advantages and difficulties of group work with the whole family, how they would organize the group and possible interventions.

## PLENARY

Group reports findings.

For background information, read v.d.Veer Appendix 2: The problems of families.

SPECIAL GROUPS:  
WORKING WITH RAPE SURVIVORS  
TRAINER

**NB Use the term "rape survivor"!** ("Rape victim" is considered inappropriate, because it has passive and negative connotations.)

Explain that rape is a very difficult issue in every culture.

Emphasize that we do not expect counselors to quickly learn how to work with rape survivors. If the counselor suspects that the client has experienced sexual violence, s/he **MUST** discuss the case with the expat supervisor, and explain to the client that the support of the supervisor is needed to work with the client.

Counselor and supervisor should discuss whether to refer the rape survivor for treatment elsewhere.

Use SHEET 9-1: SEXUAL VIOLENCE to provide some basic information. Discuss the possibilities for referral or transfer to a different-sex counselor.

For background info, read v.d.Veer Appendix 2: Sexual Violence.

## LUNCH BREAK

### PREPARING FOR COUNSELING WORK: CLINIC ACTIVITIES TRAINER

Explain that the plan is for some of the counselors to work at the clinic on certain days.

Explain how patients may present their mental health problems to the doctors at the clinic in different ways, and that the counselor needs to approach these patients accordingly, using SHEET 9-2: MEDICAL PRESENTATION OF PSYCHOLOGICAL PROBLEMS.

### GROUP DISCUSSION (no translation needed)

Trainees discuss how the group would want to plan counseling work at clinic and in community: which counselors would work in which areas and/or in the clinic, on which days, etc. Planning should also include the peer support meetings and meetings with the expat supervisor.

### PLENARY

Group presents findings. Trainer discusses the feasibility of the plans and, if possible, makes arrangements for counselors to start work after the training.

### RELAXATION EXERCISE

#### DYADS (no translation needed)

Trainees take turns to try out relaxation exercises using translated relaxation texts from v.d. Veer (chapter 5).

### PLENARY

Discuss how the exercise went.

### CLOSE DAY 9

Questions, remarks?

## DAY 10

### LOOKING BACK

#### GROUP DISCUSSION

Trainer and trainees review what they have learned over the past two weeks.

### PRESENTATION OF CERTIFICATES

An example of a certificate has been provided (CERTIFICATE).

### CLOSE DAY 10 (NO AFTERNOON SESSION)

## ANNEX

SHEET 1-1	How to listen, how to talk
SHEET 1-2	Active listening
SHEET 1-3	Principles of counseling
SHEET 1-4	Types of Psychosocial Problems (1)
SHEET 2-1	First session
SHEET 2-2	Types of Psychosocial Problems (2)
SHEET 3-1	Types of Psychosocial Problems (3)
SHEET 4-1	Psychological process following a traumatic event
SHEET 4-2	Types of Psychosocial Problems (4)
SHEET 4-3	Interventions Type 4
SHEET 6-1	Working with parents
SHEET 6-2	Types of Psychosocial Problems (5)
SHEET 6-3	Interventions Type 5
SHEET 6-4	PTSD
SHEET 7-1	Types of Psychosocial Problems: Psychiatric Problems
SHEET 8-1	Peer support
SHEET 8-2	Psychoeducation
SHEET 9-1	Sexual violence
SHEET 9-2	Medical presentation of psychosocial problems
CASE 1	Roshanna
CASE 2	Severa
FILE	First Session
FILE	Follow-up session
CERTIFICATE	
CERTIFICATE Appendix	
SHEET 7-2	Checklist Psychiatric Symptoms

## SHEET 1-1 HOW TO LISTEN, HOW TO TALK

- Sit (indirectly) facing the person
- Make eye contact regularly
- Your body "talks": show that you care by sitting near the person (not too close), leaning towards the person
- Show concern through your facial expression
- If appropriate, show concern by touching the person (→ discuss "where can you touch?")
- Give your full attention, do not let yourself be distracted
- At times, nod your head or say something to show you are listening (e.g. "I understand")
- Use a gentle, calm voice
- Do not interrupt (if you must, ask permission)
- Do not give orders
- If the person is overwhelmed by emotions, ALWAYS offer to stop for a pause (→ discuss "why should you offer to stop?")

## HOW TO ASK QUESTIONS

- Ask questions calmly and slowly. Don't insist, i.e. avoid sounding like an interrogator.
- Before you ask a question, think about how the question will make the person feel.
- Avoid yes/no questions. Closed questions such as "Are you afraid?" provide little information. Open statements are more useful i.e. "Please tell me about what is frightening you."

## SHEET 1-2 LISTENING

Never assume that you already know how a person feels, always listen to what the person has to say so that you can fully understand his / her problem.

ACTIVE LISTENING  
=  
LISTENING TO THE WORDS TO FIND THE EMOTIONS  
AND THOUGHTS *BEHIND* THE WORDS.....

### HOW TO FIND THE EMOTIONS AND THOUGHTS *BEHIND* THE WORDS:

- attend to the person's body language
- listen to the person's tone of voice and way of speaking
- guess (through empathy) the emotions *behind* the words
- if necessary, check whether you have understood the emotion correctly by asking

Many people do not directly ask for help for their emotions. Instead they describe a problem. Often, it can

be quite easy to guess which emotion lies behind the problem:

*My child refuses to go to school → I am very worried*

*I cry all the time → I feel sad and depressed*

*I cannot leave the area → I feel trapped, this makes me angry.*

Many people describe a problem that does not seem to be connected to any emotion. In that case, just ask for more details:

*I have a headache → Please tell me about your*

*headaches → My son had to flee to Russia, and when he calls me, I always get a headache afterwards → you feel worried, you miss your son.*

NB When asking for more details, use when-where-how-questions, but always avoid using why-questions!

## SHEET 1-3 FUNDAMENTAL PRINCIPLES OF COUNSELING

- I am ready to listen to you → availability
- I want to understand you, what you feel and say is important to me → validation
- I respect you → confidentiality
- I respect your views and the ways you express your views → non-judgmental attitude
- I want to help you to find ways to become better and solve your problems → support and partnership

Why are these principles important? They are the prerequisites for building a trusting relationship with the client; change can only be achieved through trust!

## CONDITIONS FOR A COUNSELING SESSION

- find a quiet, safe place for the session
- make sure you are undisturbed during the session
- be clear about who you are, what you can do for the person
- be clear about how much time is available (gently remind person near the end)

## SHEET 1-4 PROBLEMS TYPE 1

TYPES OF PSYCHO-SOCIAL PROBLEMS	CLIENT NEEDS....	COUNSELOR ACTS AS	COUNSELOR INTERVENTIONS
Type 1. Practical problem	... to explore possible solutions  .. to be supported in achieving solutions	“extra brain”	<ul style="list-style-type: none"> <li>- explain</li> <li>- advise</li> <li>- assist in problem solving thinking</li> <li>- suggest referral</li> </ul>

## SHEET 2-1 CONDUCTING THE FIRST SESSION

### 1. Introduction

Explain who you are (i.e. not a medical doctor).  
Thank the client for coming to see you.

### 2. The problem

What is the problem / what is troubling you / how  
can I help you?

Tell me more about the problem (e.g. when does it  
occur, when did it start)?

How is it affecting you?

What do you think has caused the problem?

### 3. Tell me more about yourself

Ask only for information you think may be relevant  
to the problem. It is not essential to know  
everything about the client, i.e. you don't have to  
take a complete anamnesis (age, marital status,  
children, past experiences, childhood, schooling,  
etc.).

You need to obtain information that will clarify how  
the problem is related to certain factors in the  
client's life or past history.

Also, this information is important to formulate adequate  
interventions (advice, homework, etc.) and to use  
appropriate relaxation exercises.

## SHEET 2-2 PROBLEMS TYPE 2

TYPES OF PSYCHO-SOCIAL PROBLEMS	CLIENT NEEDS....	COUNSELOR ACTS AS....	COUNSELOR INTERVENTIONS
Type 1. Practical problem	- to explore possible solutions - to be supported in achieving solutions	"extra brain"	- explain - give advice - assist in problem solving thinking - suggest referral
Type 2. Lack of skills / knowledge	- to become better informed - to gain increased skills	"teacher / trainer"	- explain - demonstrate (modeling / roleplay) - arrange exercise (homework)

TYPES OF PSYCHO-SOCIAL PROBLEMS	CLIENT NEEDS....	COUNSELOR ACTS AS....	COUNSELOR INTERVENTIONS
Type 1. Practical problem	- to explore possible solutions - to be supported in achieving solutions	"extra brain"	- explain - give advice - assist in problem solving thinking - suggest referral
Type 2. Lack of skills / knowledge	- to become better informed - to gain increased skills	"teacher, trainer"	- explain - demonstrate - arrange exercise
Type 3. Inner problems / struggling with choices	- to increase self-knowledge, self-esteem, & autonomy - to clarify choices	"mirror, analyzer"	- explore issues (listening, reflecting) - use relaxation with metaphors

PSYCHOLOGICAL PROCESS FOLLOWING A TRAUMATIC EVENT (from N. Cohen de Lara: Debriefing Protocols)			
PHASE	BEHAVIOUR	EMOTIONS	COGNITIONS
Outcry	Dazed, confused perception and memory	Shocked, numb, helplessness	This can't have happened to me. I can't believe it, how can this be true?
Denial	"Macho" stance; focus on work, "auto-pilot"	Elation	It wasn't that bad. It hasn't really affected me.
Intrusion	Repetitive talking, easily startled	Anxiety, shame, guilt	Will it happen again? Did I do the right thing? What will others think of me? How can I live with these memories?
Working through	Crying, depressed, shouting, harassing others	Grief, anger	I have lost something/someone precious. My life will never be the same. They should not have let this happen, they let me down.
Completion	Relaxed, appropriate range of behaviour	Calm; appropriate range of emotions	I have survived. I am safe now. I have become a stronger person.

TYPES OF PSYCHO-SOCIAL PROBLEMS	CLIENT NEEDS....	COUNSELOR ACTS AS....	COUNSELOR INTERVENTIONS
Type 1. Practical problem	... to explore possible solutions .. to be supported in achieving solutions	"extra brain"	- explain - give advice - assist in problem solving thinking - suggest referral
Type 2. Lack of skills / knowledge	...to become better informed ...to gain increased skills	"teacher, trainer"	- explain - demonstrate (modeling / roleplay) - arrange exercise (homework)
Type 3. Inner problems / struggling with choices	...to increase self-knowledge, self-esteem, autonomy ...to clarify choices	"mirror, analyzer"	- explore issues (listening, reflecting) - use relaxation with metaphors
Type 4. Overwhelming emotions	..to stay in control of emotions ...to be supported in resolving emotions / issues	"mother, comforter"	-reassure -use grounding techniques -teach relaxation to gain control of emotions encourage use of coping mechanisms

## SHEET 4-3 INTERVENTIONS FOR CLIENTS WITH OVERWHELMING EMOTIONS (TYPE 4)

Remain calm yourself! Make sure you are breathing comfortably and continue to do so.

Allow yourself to pause. You don't have to react immediately!

Always retain your confidence in your client: the client has the inner strength to survive and overcome his/her problems!

Say something simple and short: "I understand how sad you must be feeling."

When the client is overwhelmed by the emotions, use the following:

- Ask the client to pause: "I want to ask you to stop here for a while, please take a little time to become calm again."
- Reassure the client: "You are safe now." "It has passed."
- Make suggestions that will help the client to become calm: "I want to ask you to let go of these images that are so disturbing. Imagine that they are like photographs in a book; in your mind, you may close that book now, so that you can take a deep breath and become calm again."

SHEET 6-1  
WORKING WITH PARENTS OF YOUNG CHILDREN

HOW YOUNG CHILDREN MAY BE AFFECTED BY  
TRAUMATIC EVENTS: TYPICAL SYMPTOMS

PRE-SCHOOL CHILDREN (0-5 YEARS):

- CRYING
- CLINGING BEHAVIOR
- WITHDRAWAL
- REGRESSIVE BEHAVIOR (e.g. THUMB-SUCKING,  
BEDWETTING, FEAR OF DARK)

CHILDREN (6-12 YEARS):

- SLEEPING PROBLEMS
- NIGHTMARES
- IRRATIONAL FEARS
- IRRITABILITY, OUTBURSTS OF ANGER, FIGHTING
- REFUSAL TO ATTEND SCHOOL

## WHAT PARENTS / CAREGIVERS NEED TO KNOW:

- A HEALTHY CHILD, i.e. A CHILD WITH A NORMAL DEVELOPMENT, DOES WELL IN THREE AREAS:  
AT HOME, AT SCHOOL AND WITH PEERS
- HEALTHY CHILDREN ARE EXTREMELY RESILIENT
- TRAUMATIC SYMPTOMS IN CHILDREN WHO WERE HEALTHY PRIOR TO THE TRAUMATIC EVENTS CAN BE EXPECTED TO DECREASE OVER TIME
- PARENTS' REACTIONS DETERMINE TO A LARGE EXTENT HOW WELL CHILDREN RECOVER AFTER TRAUMATIC EVENTS

## SUGGESTIONS FOR PARENTS / CAREGIVERS:

- YOUR CHILD'S SYMPTOMS WILL DECREASE OVER TIME
- DO NOT IMPOSE YOUR HELP (i.e. do not push your child to talk, avoid flooding the child with advice)
- BE AVAILABLE WHEN YOUR CHILD WANTS TO TALK, CREATE SPACE / TIME FOR TALKING
- MAKE EXPRESSIVE PLAY MATERIALS AVAILABLE TO YOUR CHILD
- OFFER REASSURANCE; SHOW THAT YOU ARE OPTIMISTIC ABOUT THE FUTURE
- ENCOURAGE YOUR CHILD TO PARTICIPATE IN

CHILD-APPROPRIATE RITUALS (e.g. lighting a candle for the deceased)

- NORMALIZE DAILY ROUTINES AND ACTIVITIES (i.e. exercise, sleep, meals)
- MAKE SURE THAT BEDTIME ACTIVITIES ARE CALMING
- TOLERATE REGRESSIVE SYMPTOMS (e.g. thumb-sucking, bedwetting, clinging behavior) FOR A REASONABLE PERIOD OF TIME
- AVOID INVOLVING YOUR CHILD IN FAMILY TENSIONS OR DISCUSSIONS RELATED TO THE TRAUMATIC EVENT
- MAKE SURE YOU ARE MODELING HEALTHY COPING STRATEGIES

PSYCHO-SOCIAL PROBLEMS	CLIENT NEEDS...	COUNSELOR ACTS AS....	COUNSELOR INTERVENTIONS
TYPE 1. Practical problem	..to explore possible solutions ..to be supported in achieving solutions	“extra brain”	- explain - give advice - assist in problem solving thinking - suggest referral
TYPE 2. Lack of skills / knowledge	..to become better informed ..to gain increased skills	“teacher, trainer”	- explain - demonstrate - arrange exercise
TYPE 3. Inner problems / struggling with choices	..to increase self-knowledge, self-esteem, autonomy ..to clarify choices	“analyzer, mirror”	- explore issues - use relaxation exercises with metaphors
TYPE 4. Overwhelming feelings	..to stay in control of emotions ..to be supported in resolving emotions / issues	“mother, comforter”	- reassure - use grounding techniques - teach relaxation techniques to gain control of emotions - structure behavior related to emotions
TYPE 5. Trauma symptoms	..to stay in control of emotions ..to strengthen coping mechanisms ..to be supported in resolving trauma issues (e.g. trust)	“trauma specialist”	- reassure and psychoeducate - use grounding techniques - teach relaxation techniques to gain control of flashbacks - encourage use of coping mechanisms

SHEET 6-3  
INTERVENTIONS WITH TRAUMATIZED CLIENTS  
(TYPE 5)

REASSURE / USE PSYCHOEDUCATION

REINFORCE GOOD COPING AND ENCOURAGE  
SOCIAL SUPPORT

SUPPORT THE CLIENT IN RESTORING DAILY  
ROUTINES AND ACTIVITIES

WHEN THE CLIENT DESCRIBES THE TRAUMATIC  
EVENTS, ENCOURAGE HIM/HER TO ALWAYS  
CONTINUE UP TO THE "SAFE POINT" (TO AVOID  
RECONDITIONING THE ANXIETY RESPONSE)

*A client described how he had been ambushed by two young men holding rifles. They stopped him on a narrow road and demanded his car. In tears, he said that he was certain he was going die when he refused their demand. The counselor asked him to continue and tell him what happened next. The client said that he had driven to a friend's house in a dazed state, and that he burst into tears when his friend opened the door. Prompted by the counselor, the client went on to describe how his friend had made him a cup of tea and sat with him. At this point in his story, the client's face relaxed, and he smiled.*

WHEN THE CLIENT IS OVERWHELMED OR BECOMES  
DISSOCIATED, USE GROUNDING TECHNIQUES:

- Formulate positive cognitions (“*you are safe now;*”  
“*you have survived;*” “*you did the best you could*”)
- Shift the client's attention to the present (“*let go of the  
images you have been describing and focus on  
the room you are sitting in right now*”)
- Suggest physical relaxation or calm (“*take a deep  
breath and let some of the tension go*”)

## SHEET 6-4 POST TRAUMATIC STRESS DISORDER (PTSD)

DSM = a manual that categorizes mental health disorders, listing the defining characteristics of each disorder.

### **FOR THE DIAGNOSIS OF PTSD:**

A traumatic event = a life-threatening event in which the individual experienced intense fear, helplessness, or horror (i.e. death of a loved one through illness is not considered a traumatic event).

NO LESS THAN **THREE** CRITERIA MUST BE FULFILLED.

#### **CRITERIA 1:**

#### **AT LEAST 3 OUT OF 4 SYMPTOMS ARE PRESENT:**

- DISSOCIATIVE SYMPTOMS (sense of numbness, detachment, absence of emotions, decreased awareness of surroundings, depersonalization)
- RE-EXPERIENCING THE TRAUMATIC EVENT (nightmares, flashbacks)
- AVOIDANCE OF REMINDERS (avoids thinking about event, avoids places or people related to event)
- MARKED ANXIETY OR INCREASED AROUSAL (sleeping problems, poor concentration, hypervigilance, easily startled, motor restlessness)

#### **CRITERIA 2:**

**ABOVE SYMPTOMS HAVE LASTED AT LEAST 4 WEEKS**

**CRITERIA 3:  
ABOVE SYMPTOMS INTERFERE WITH DAILY LIFE**

**ALSO, THE FOLLOWING MUST BE RULED OUT:**

- pre-existing mental disorder
- medical condition
- psychosis, depression, substance abuse

PSYCHOSOCIAL PROBLEMS	CLIENT NEEDS ...	COUNSELOR ACTS AS....	COUNSELOR INTERVENTIONS
Psychiatric problems	..to understand the need for psychiatric care	"motivator / supporter"	- refer to psychiatric care - motivate for referral

## SHEET 8-1 COUNSELOR PEER SUPPORT

Adapted from v.d. Veer Annex 1, point 9 (The consequences of working with victims of armed conflict for the counselor).

As a counselor, you need the support of your colleagues for various reasons:

1. Listening to emotional stories of his clients can bring about strong emotions in any counselor. Because you want to understand a client, you may feel some of the client's feelings yourself (e.g. helplessness, sadness, anger). This can be very confusing.
2. The stories of some clients may remind you of some personal experiences that were painful and may trigger some strong emotions connected to these painful experiences. This could lead to sleeping problems and nightmares.
3. The client's stories are confidential. This means that you cannot talk with others about what you have heard and that you cannot share these experiences with family or friends. So if you are tense because of the stories you have heard, you cannot tell others exactly what has made you so tense.
4. Counselors are human beings who have their own personal problems. Without being aware that it is happening, your personal problems may get in the way when you want to help the client.

Counseling can be a heavy task at times and therefore every counselor, experienced or not, needs the support of his/her colleagues. In peer support groups, counselors can discuss their clients, as well as the feelings and difficulties they are experiencing.

SHEET 8-2

SHEET 2 PSYCHOEDUCATION

Adapted from MSF-H Kosovo Training Manual (1988)

## **Psycho-education**

For many people, admitting to needing psychological help is very difficult. They feel that it is a taboo subject that will stigmatize them. Their perceptions of mental problems is often associated with extreme cases of insanity, where people are locked up in dark cells or other stereotypical images. This is one of the reasons that one finds much denial and avoidance in the community whereby they suppress their feelings and reactions as though they do not exist. The other common response is somatisation. People accept physical illness far more easily than mental illness. But in the case of somatisation, even this can become more and more frustrating as people seek desperately for a physical cause to their illness. However, if left untreated, these reactions can lead to much greater problems which are more long term and difficult to treat. It is here that the needs are shifted from preventive to curative.

One of the greatest problems for counselors, therefore, is that people misunderstand mental health and psychosocial needs. They do not have a notion about normal reactions to abnormal conditions. In chronic traumatic situations, common individual reactions such as depression and anxiety become more decentralized, turning it into a normal group reaction. As such, individuals who may well be disturbed by their own reaction dare not mention it, as it could be taken as a sign of weakness. This is often one of the main reasons for common avoidance and denial behavior. However, instead of this helping anyone, this often leads to the community as a whole feeling frustrated, debilitated and unmotivated. In such situations, one will often find that those who have been able to seek help have been able to overcome their problems more easily and fare better in their daily lives afterwards.

Therefore, one of the most important first steps to take in a community is to educate them on mental health. Just as you have been educated in the principles of causes, common reactions and preventive or curative measures, so should the community have a basic understanding of them. This is where psycho-education becomes important.

Psycho-education is the process of educating individuals and community groups about stress related issues, the normal reactions to the various levels of stressors, the importance of social support through friends, family and the community, the dangers of denial and avoidance, how to increase protection and reduce vulnerability, where to look for help and what help services exist. The intention is to encourage people to understand their reactions better, and to improve their coping strategies as individuals and through the community.

When implementing a mental health program, psycho-education is very useful at many different levels. At first it helps to raise awareness about the existing services, when and where they can be accessed, and their benefits. Psycho-education is also important with individuals and/or groups during counseling sessions. It helps the clients to get a good idea of what to expect from the sessions, as well as what both their role and that of the counselors are. Knowing this helps to guide them in between sessions and even after counseling sessions are over and they start coping in life's larger context.

There are various different methods to educate individuals and the community on mental health and psychosocial needs. For example, some groups have different interests with regard to psychosocial needs depending on the issues which concern them, and how they are organized. Also, different groups have different roles with regard to providing psychosocial support, and it is helpful to encourage their role through psychoeducation. Therefore, the most appropriate strategy for providing psycho-education in the community is to identify target groups, decide on the relevant content and devise an appropriate approach. Below are some ideas on some of the different methods:

Conferences: Conferences are one of the most common ways of informing a group of people about a certain topic quickly. A conference is when a group of people meets to learn about and discuss a relevant topic. They are especially useful for two-way information gathering. Those calling the conference are able to share important information and receive feedback, which can assist them as well. Conferences usually take place over a couple of hours and include lectures and discussion. It is seldom that any practical activities will be held. In the case of psycho-education,

conferences are useful for spreading the principles of mental health and psychosocial needs, and to discuss how best to implement them within the local context.

Workshops: Workshops are similar to conferences in that they also require one to call together a group of people to provide and share information. With both, the way they are selected is by identifying some common feature, such as members from the same community, social groups, doctor's, etc., so that the content can be directly relevant to them. Workshops are usually scheduled over a period of a few days in which there is a period for lectures and discussion as in the conferences, but also more practical group work and activities are planned, directed at the specific needs of the target group in question. This is in view of giving a more tangible idea of how to implement useful strategies.

Door-to-Door: Door to door literally means that those spreading information about a certain topic, visit people in their homes by going from one home to the next ("door to door"). Usually the individuals to be visited will be identified before hand through a concerned source who may feel that an individual or family may need the information. In the door-to-door method one usually describes the principles of psycho-education, but this also allows for a more intimate discussion on the needs of the specific situation in the house visited.

Local officials: In many communities the local officials play an important role in the spreading of useful information, especially as they are often good role models and admired by many. In order to get the local authorities involved, it is useful to find methods through which to educate them as well. Often using conferences and group discussions are the most helpful for this. During such encounters it is a good idea to discuss the most appropriate strategies.

## SHEET 9-1 SEXUAL VIOLENCE

- MALE CLIENTS MAY BE SURVIVORS OF SEXUAL VIOLENCE (NOT ONLY FEMALE CLIENTS)
- SEXUAL VIOLENCE INCLUDES: RAPE, FORCED SEXUAL ACTIVITY AND GENITAL TORTURE
- SEXUAL VIOLENCE MAY HAVE SERIOUS PHYSICAL CONSEQUENCES (e.g. HIV/AIDS, pregnancy, genital damage)
- SEXUAL VIOLENCE MAY HAVE SIGNIFICANT SOCIAL CONSEQUENCES (e.g. stigmatization, abandonment)

### COUNSELOR INTERVENTIONS:

- ALWAYS DISCUSS WITH YOUR SUPERVISOR!
- CONSIDER REFERRAL
- OFFER TRANSFER TO DIFFERENT-SEX COUNSELOR
- IF APPROPRIATE: EDUCATE AND REASSURE
- IF APPROPRIATE: SUPPORT IN SEEKING MEDICAL PROCEDURES
- USE INTERVENTIONS FOR TYPE (5) TRAUMA SYMPTOMS
- FOCUS ON EMOTIONS RELATED TO SEXUAL VIOLENCE (shame, anger, low self-esteem, etc.)
- INCLUDE INTERVENTIONS TO IMPROVE MARITAL RELATIONS AND/OR FAMILY DYNAMICS (e.g. husband-wife sessions)

## SHEET 9-2 MEDICAL PRESENTATION OF PSYCHOLOGICAL PROBLEMS

PATIENTS PRESENT THEIR PSYCHOSOCIAL PROBLEMS TO THE DOCTOR IN THREE DIFFERENT WAYS:

1. PHYSICAL COMPLAINT IS CAUSED BY PSYCHOSOCIAL PROBLEM: "Doctor, I have sleeping problems because of my traumatic experiences."

= PATIENT IS AWARE THAT S/HE HAS A PSYCHOLOGICAL PROBLEM AND ATTRIBUTES IT TO THE TRAUMATIC EVENT

Therefore;

- the patient understands the need for counseling
- the patient is motivated for counseling

→ PROCEED WITH COUNSELING

2. PHYSICAL COMPLAINT + PSYCHOSOCIAL PROBLEMS:

"Doctor, I need medication for my asthma. Also, I feel tense since the violence."

= PATIENT IS AWARE THAT S/HE HAS A PSYCHOLOGICAL PROBLEM

Therefore;

- the patient understands the need for counseling
- the patient may not be motivated for counseling.

Counselor needs to motivate the client for counseling

→ FOCUS ON BUILDING TRUST

3. PHYSICAL COMPLAINT ONLY: "Doctor, I need medication for my sleeping problems."

= PATIENT IS NOT AWARE THAT S/HE HAS A PSYCHOLOGICAL PROBLEM

Therefore;

- the patient does not understand the need for counseling
- the patient is not motivated for counseling

Counselor needs to explain the need for counseling

Counselor needs to motivate the client for counseling

→ FOCUS ON PSYCHOEDUCATION

## CASE ROSHANNA

### CASE DESCRIPTION

Mother Nadja (42 yrs.), nurse, single, comes in together with her daughter Roshanna (4 yrs.)

#### Problem:

Since the violence, Roshanna is very scared and clings to her mother all the time. This is very difficult for her mother, who needs to go to her job as a nurse. During the day, Roshanna stays with grandmother (mother's mother), and cries when mother leaves. This depresses mother.

During the violence, the family had to stay in the basement for 4 days. Since then, Roshanna does not eat well, she is easily startled, and cries frequently. Sometimes she cries while playing with her doll. She often wakes up at night (she sleeps in mother's bed) and has to take a nap in the afternoon because she is so tired.

Roshanna is the youngest of mother's 4 children. The other children are aged 18, 15 and 12. Mother did not expect to have a fourth child. The marriage was not good, but the parents decided to stay together when mother found she was pregnant. When Roshanna was aged 2 yrs., father left the family. Mother was severely depressed during approx. 1 year after his departure, "I could not have managed to get through this period if I had not had Roshanna." Roshanna has slept in mother's bed since father left.

The other children are all doing well at school. Schools are now closed for the summer vacation. Everyone is anxious about the current situation, so the children stay at home a lot, in the house. At dinner time, the older children take turns to feed Roshanna when she refuses to eat.

### OBSERVATIONS DURING THE SESSION

When they come into the room, Roshanna clings to her mother, hides her face in her lap and doesn't allow mother to seat her in a separate chair. However, during the interview, she takes secret looks at the counselor. When she thinks that mother and the counselor are not watching, she takes some crayons from the table and starts to draw on a piece of paper. As soon as she sees that the counselor is watching her, she immediately clings to mother again. Roshanna looks slightly underweight for her age/length, but otherwise appears to be a healthy child.

### HYPOTHESES

The problems may be designated as Separation Anxiety. There are two hypotheses:

1. Roshanna's separation anxiety is related to the traumatic events she and the family have experienced.

2. Roshanna's separation anxiety is age-inappropriate behavior that is being reinforced by mother. Mother seems to have become emotionally overly dependent on Roshanna when she was depressed following father's departure, and this is being repeated because of mother's anxiety following the traumatic events.

#### SUGGESTED COUNSELOR INTERVENTIONS

Counselor interventions should be in line with both hypotheses.

1. Interventions to help Roshanna (and mother) work through the traumatic experience and deal with trauma symptoms, e.g. advise mother to encourage drawing and play, so that Roshanna can express her fears related to the trauma.
2. Interventions to help mother stop reinforcing age-inappropriate behavior, e.g. advise mother how to address the sleeping problems (no daytime sleeping, not paying attention to R waking up, gradually teaching Roshanna to sleep in separate bed, and eventually in separate room); support mother in learning to share her emotional problems with others instead of relying on the relationship with Roshanna.

## CASE SEVERA

### CASE DESCRIPTION

Mamlekat (50 yrs.) and her sister Zukumor (48 yrs.) come in together with Mamlekat's daughter Severa (16 yrs.)

### PROBLEM(S)

"We were at home when the violence started. We fled from our house, saw crowds with men carrying weapons. They were attacking people on the street. When Severa saw what was happening, she was so scared that she wet her pants. We thought the military would help us, but they didn't. We were able to get into a minibus (with about 20 other people), which took us to a safe place. There were about 1000 people there. We stayed there for 5 days. Severa was extremely frightened all the time, she could hardly sleep at all."

Prior to the violence:

Severa was doing very well at school. She had many friends. She was always very helpful at home. Her childhood was normal. No medical problems. No family problems.

### OBSERVATIONS DURING THE SESSION

Mamlekat talks about the problems, her sister occasionally adds some information. While she talks, Mamlekat is tearful.

Severa briefly says she does not speak English and laughs wildly, gesturing with her hands. She continues to use her hands, often mimicking the gestures of others. For a while she stares at the translator, making him feel very uncomfortable. Then, she again laughs in an uncontrolled manner, drooling as well. She becomes very restless, and starts to tug at her head scarf. She stands up, removes the scarf with loud sighs. Mother tries to calm her down, tells her to sit down again and put her scarf back on, which she does. Mother explains that she has behaving in this manner since the violence.

### HYPOTHESES

The problems described by mother and the observations during the session indicate that a diagnosis of acute Psychosis is highly probable.

### COUNSELOR INTERVENTIONS

- Refer: advise mother to go to the psychiatric clinic.
- Educate: explain that there is a possibility that Severa will be diagnosed with a serious mental disorder; explain what treatment may entail (hospitalization, medication)
- Motivate: urge mother to proceed with referral. If there is resistance to the referral, explore reasons and try to address these reasons.

## FIRST SESSION

**Counsellor:**..... **Date:** .../...../.... **Location of consultation:**

.....

**Name client:** ..... **Sex:** M / F **Age:** .....

**Nationality:** .....

**Residence:** ..... **If IDP: original**

**residence:** .....

**Children (age/sex):** .....

.....

**Others present:**

.....

**Referred by:** .....

**Presenting problems** (In patient's own words):

**Relevant client history (childhood, education, etc):**

**Coping methods:**

**Support system** (family, friends, colleagues, community):



**Type of Problem:**  
**Hypotheses:**

**Date of next appointment:**

## FOLLOW UP SESSION

**Counsellor:**..... **Date:** .../...../.... **Location of consultation:**

.....

**Name client:** ..... **Sex:** M / F **Age:** .....

**Others present:**

.....

**Type of problem:**

**Development of problem(s) since last session:**

**New developments / information:**

**Counselor interventions:**



**Date of next appointment:**

**Reason of termination of counseling:**

- improvement, no further counselling needed
- no improvement, client ends counselling
- no improvement, counsellor advises referral
- client does not show up.

~~~~~**CERTIFICATE**~~~~~  
~~~~~

THIS IS TO CERTIFY THAT

.....

HAS COMPLETED A 9-DAY GROUP TRAINING IN

**COUNSELOR SKILLS**

AND HAS DEMONSTRATED  
THAT S/HE HAS MASTERED THESE SKILLS  
TO A SATISFACTORY LEVEL

SIGNED .....  
NAME .....  
POSITION .....  
DATE .....

NAME ..... DATE .....

	Topic	Comments
Day 1	Rules for listening	
Day 1	Active listening	
Day 3	Dealing with difficult clients; non-verbal communication; touchy subjects	
Day 1	Types of Psychosocial Problems (1) Practical Problems	
Day 2	Types of Psychosocial Problems (2) Lack of Skills / Knowledge	
Day 3	Types of Psychosocial Problems (3) Inner Problems	
Day 4	Types of Psychosocial Problems (4) Overwhelming Feelings	
Day 6	Types of Psychosocial Problems (5) Trauma Symptoms	
Day 4	Psychological process following a traumatic event	
Day 7	Types of Psychosocial Problems: Psychiatric Symptoms	
Day 7	Cultural issues in mental health	
Day 7	Checklist Psychiatric Symptoms	
Day 6	Special groups: working with parents of young children	
Day 9	Special groups: working with families	
Day 9	Special groups: Sexual violence	
Day 8	Working as a counselor: client files	
Day 8	Care or counselors; supervision; peer support	
Day 8	Preparing for counseling work: community activities	
Day 8	Psychoeducation with groups	
Day 9	Preparing for counseling work: clinic activities	
Day 9	Medical presentation of psychosocial problems	

No. of group relaxation exercises experienced: .....

No. of relaxation exercise tryouts in dyads: .....



## SHEET 7-2 CHECKLIST PSYCHIATRIC SYMPTOMS

GENERAL	BEHAVIORAL	ANXIETY	DEPRESSION	PTSD	PSYCHOSOMATIC	PSYCHOSIS
<ul style="list-style-type: none"> <li>○ Insomnia</li> <li>○ Concentration</li> <li>○ Loss of appetite</li> <li>○ Sexual problems</li> <li>○ Low energy</li> <li>○ Irritable/angry</li> <li>○ Enuresis</li> </ul>	<ul style="list-style-type: none"> <li>○ Aggression</li> <li>○ Delinquency</li> <li>○ Substance abuse</li> <li>○ Anorexia</li> <li><b>Children</b></li> <li>○ Hyperactivity</li> <li>○ Autism</li> <li>○ Selective mutism</li> <li>○ Developmental regression</li> </ul>	<ul style="list-style-type: none"> <li>○ Fearful / anxious / worried</li> <li>○ Hyperventilation</li> <li>○ Panic attacks</li> <li>○ Phobia</li> <li>○ Obsessive behavior</li> <li><b>Children</b></li> <li>○ Separation anxiety</li> </ul>	<ul style="list-style-type: none"> <li>○ Depressed / sad</li> <li>○ Cries easily</li> <li>○ Loss of interest</li> <li>○ Feelings of hopelessness</li> <li>○ Feelings of guilt / shame</li> <li>○ Feeling distant from others</li> <li>○ Low self-esteem</li> <li>○ Suicidal thoughts</li> <li>○ Expects no future</li> </ul>	<ul style="list-style-type: none"> <li>○ Flashbacks</li> <li>○ Nightmares</li> <li>○ Sense of detachment / numbness</li> <li>○ Depersonalization</li> <li>○ Avoidance of reminders</li> <li>○ Easily startled</li> <li>○ Hypervigilance</li> <li>○ Sleeping problems</li> <li><b>Children:</b></li> <li>○ Repetitive replaying of event</li> </ul>	<ul style="list-style-type: none"> <li>○ Heart palpitations</li> <li>○ Hypertension</li> <li>○ Headache</li> <li>○ Stomach ache</li> <li>○ Pain in chest/heart</li> <li>○ Other .....</li> </ul>	<ul style="list-style-type: none"> <li>○ Bizarre behavior</li> <li>○ Disorganized thoughts</li> <li>○ Disorganized speech</li> <li>○ Delusions</li> <li>○ Hallucinations</li> </ul>

