BelSalameh

The MHPSS Training Pack

THE MENTAL HEALTH MANUAL

أبعاد abaad

This project is funded by the European Union

بالسلامة

BelSalameh

strengthening resilience and peace in syria

تعزيـز السلام وإرادة الحيـاة في سوريـا

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Mental Health (MH Manual)

CONTENTS

THE MHPSS TRAINING PACK

Introduction to the MHPSS Training Pack

Welcome to this combined Mental Health and Psychosocial Support (MHPSS) Training Pack for personnel working in emergency settings. This Training Pack has been devised by ABAAD with support from the European Union. Many professionals from Syria, the wider region and across the globe have contributed to this project.

This work is a joint effort arising from an assessment of needs of professionals working in Syria and constructive contributions from and training of a group of MHPSS workers involved in day-to-day service delivery within the region. Some of the contributions from the authors were utilised in a number of pre-launch training exercises and the feedback from these trainers and trainees has been incorporated into some of the final versions of the various chapters contained within this Training Pack. This combined "top-down" (experts and professionals) and "bottom-up" (clinicians and practitioners) approach was used in an effort to produce a Training Pack which is based on local needs, adapted to the local context and more suited to the relevant target audiences working within the MHPSS framework of services that operate in Syria and the region.

This comprehensive MHPSS Training Pack is divided into two separate, complementary, and related components with different target professional audiences, groups of beneficiaries and MPSS issues in mind. There are two manuals in this Training Pack series:-

- **Mental Health (MH Manual)**
- **Psychosocial Support (PSS Manual)**

The primary intended targets of the content these two manuals are represented in the diagram below which is discussed in the following "Introduction to MHPSS in Emergency Settings":-

	MHPSS Problems	Pyramid Layers	Services Required
MH Manual	Severe psychological disorders	Specialised Services	Professional treatment for individuals or families
PSS Manual	Mild to moderate mental health disorders	Focused non-specialised support	individual familyor group interventions
	Mild psychological distress (natural reactions to crisis)	community and family supports	Psychosocial support activities
	General population affected by crisis	Basic services and security	Meeting basicneeds and providing security

The MHPSS Training Pack Content

The Mental Health Manual

The material contained within this publication is primarily intended for a range of Mental Health (MH) staff working in specialised emergency settings and contains information and some MHPSS interventions perhaps more suited to the "specialised service" layer of the IASC Intervention Pyramid [1] (*see diagram on the left and in the Introduction section for more details)

MH Manual	Contents
Introduction:	Mental Health and Psychosocial Support in Emergency Settings
Chapter One:	Mental Health: General Concept and Mental Disorders
Chapter Two:	Primary Counselling
Chapter Three:	Narrative Exposure Therapy (NET)
Chapter Four:	Family Systemic Counselling
Chapter Five:	Self Care

The Psychosocial Support (PSS) Manual

The material contained within this publication is primarily intended for a range of Psychosocial Support (PSS) staff working in non-specialised emergency settings and contains a range of MHPSS interventions more suited to the "focused, non-specialised support" layer and perhaps the "community and family supports" layer of the IASC Intervention pyramid.[1] (*see previous diagram)

PSS Manual	Contents
Introduction:	Mental Health and Psychosocial Support in Emergency Settings
Chapter One:	Psychological First Aid
Chapter Two:	Working with Women and Girls at risk of Gender Based Violence
Chapter Three:	Working with Men
Chapter Four:	Working with Children and Parents
Chapter Five:	Supporting Child Survivors of Sexual Abuse
Chapter Six:	Psychological Activation through Stand-Up Theatre
Chapter Seven:	Self Care

1 Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC.

The Mental Health Manual

This publication is the Mental Health (MH) Manual
A component of the MHPSS Training Pack

It is designed to provide some assessed, requested and customised training content in this complex area of need and challenging service delivery for MHPSS workers in Syria.

MH Manual Contents

An Introduction to MHPSS in Emergency Settings:
This chapter introduces and traces the origin of the MHPSS approach along with the long-standing history of attempts to promote a general psychosocial approach to human problems. It examines some of the common issues and comments on the recent review of the implementation of the IASC guidelines. Current practice with agreed definitions, models, problems and services is briefly discussed. Finally, it highlights the need for local adaptation of resources as being the main purpose behind the compilation of this MHPSS Training Pack for Syrian MHPSS personnel working in the region.

Chapter One: Mental Health:
General Concept and Mental Disorders: In the first part, Dr. Mazen Hedar deals with the concept of Mental Health. In part two, he outlines the full range of mental disorders found within the general and afflicted populations. The common finding of anxiety and depression in such affected populations and the vulnerability of people with already existing mental health conditions underlines the need for professionals to be aware of a range of conditions. MHPSS workers in emergency settings may find his fifth chapter on stress-related disorders of particular interest and relevance to the work they undertake routinely.

Chapter Two: Primary Counselling:
In addition to this chapter on primary counselling, Dr. Tayseer Hassoun has also provided a useful chapter on Psychological First Aid (PFA) which has been adapted from the WHO PFA manual and can be found in the second manual in this Training Pack (the Psycho-Social Support (PSS) Manual). His two inter-related chapters can perhaps be regarded as different but complementary approaches in the spirit of a combined MHPSS approach.

Chapter Three: Narrative Exposure Therapy (NET):
Given the inherent difficulties in trying to deliver effective evidence-based treatments for post-traumatic stress disorder in chaotic emergency settings and hostile environments, recent attempts have been explored to find suitable approaches in these challenging circumstances. One such approach which has shown a lot of promise is Narrative Exposure Therapy which is outlined in great detail by Dr. Andria Spyridou in this comprehensive chapter.

Chapter Four: Family Systemic Counselling:
This approach is outlined by Dr. Laurie Lopez Charlés in this chapter which has been refined and augmented following the use of the material in Lebanon-based training of a large group of MHPSS workers from Syria. It is hoped that this material may be of interest and use to a whole range of MHPSS workers, therapists, counsellors and health care providers who work in various ways and settings with affected families.

Chapter Five: Self Care:
Growing evidence suggests that there is a potential risk of workers suffering from general stress and strain or more specific vicarious traumatisation in the work they undertake. The occupational health risks of the humanitarian aid sector are becoming clearer and MHPSS workers require training and support to deal with a range of psychosocial hazards in the workplace. This comprehensive chapter attempts to address this issue and Ms. Ola Ataya offers a range of helpful self-care techniques and suggestions of ways in which MHPSS workers can take steps to minimise the adverse impact of their work on their own well-being and personal or professional functioning. The distinction between self care and staff care is highlighted and discussed. The main focus is on self care strategies for a range of individual MHPSS workers rather than organisations. Staff care is a more complex organisational issue.

INTRODUCTION TO MHPSS IN EMERGENCY SETTINGS

Introduction to Mental Health and Psychosocial Support in Emergency Settings:

1. A NEW FRAMEWORK: The origins of the MHPSS approach

The Inter-Agency Standing Committee (IASC) and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings have published influential and helpful material that has greatly influenced the mainstream thinking and behaviour of agencies and organisations that are providing support for those who suffer in worldwide emergency settings. [1], [2]

They introduced and defined the term Mental Health and Psychosocial Support (MHPSS) to "describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder." [1]

They also raised their concern about..

"the absence of a multi-sectoral, inter agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another." [1]

This view led to the creation of local MHPSS task forces or groups set up to purposefully function as much-needed "coordination mechanisms" in the local delivery of agreed and high quality MHPSS services to those most in need.

They argued that.. "background effective mental health and psychosocial support (MHPSS) programming requires intersectoral coordination among diverse actors, as all participants in the humanitarian response have responsibilities to promote mental health and psychosocial well-being." [1]

This positive assertion of a strong link between psychological and social factors and the need for multi-agency, multi-level cooperation and coordination has generated a way forward for this new and emerging field of psychosocial activity as part of the MHPSS framework. The helpful and well-known IASC four-tier pyramid model [3] summarises the combined approach which they proposed should be adopted by all organisations working in the humanitarian aid sector. This deliberate fusion of Mental Health and Psychosocial Support has paved the way for a recent proliferation of MHPSS activity which has brought with it:-

- expanded and innovative service design and delivery options for beneficiaries
- new joint-working and communication practices between partner aid organisations
- increased collaboration in local inter-agency task forces and co-ordination groups

2. HISTORY: The development of the psychosocial concept

The early origins of the notion of some kind of psychosocial model to define health in its broadest terms go back to the very constitution of WHO in 1946 which was founded on the principle that..

"health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This view continues to this day." [4]

In 1961, George Engel outlined his early idea of a bio/psycho/social/cultural model in a letter [5] which was subsequently published in 1977 in the form of his famous landmark bio-psycho-social model. [6]. This was a revolutionary major event in the field of mental health and probably a reaction to the dawning of the new age of biological psychiatry with the introduction of major psychiatric medications in the 1950s. It has, more recently, been argued that..
"George Engel's most enduring contribution was to broaden the scope of the clinician's gaze. His biopsychosocial model was a call to change our way of understanding the patient and to expand the domain of medical knowledge to address the needs of each patient. It is perhaps the transformation of the way illness, suffering, and healing are viewed that may be Engel's most durable contribution." [7]
Around the turn of the millennium (1995 to 2005) the literature contains many publications and key references to a range of interventions in emergency situations but one could strongly argue that the discussion, definition and promotion of the term MHPSS and the associated models developed by IASC in 2007 was a similar call to make an enormous shift in the way mental health and psychosocial well-being was viewed. This greatly influenced humanitarian aid organisational behaviour in terms of MHPSS service design and delivery. In fact, as Rehlberg [8] pointed out:-

"Prior to this document, there was no internationally agreed-upon standard or guidance for the provision of psychosocial interventions".

The deliberate fusion of mental health with psychosocial support (MHPSS) into one combined approach has enabled agencies and organisations working within the humanitarian aid sector to take a much broader and integrated view of what individuals in complex emergency settings require to begin to rebuild their lives and try to regain normal functioning. [3]

The psychosocial concept which is embedded in the MHPSS approach encourages services to view the range of the needs of the individual, family or community as a complete functioning interconnected system. This is welcome, helpful and in keeping with the best of longstanding mental health views, practices and innovations in mental health treatment and psychosocial support from the constitution of the World Health Organisation in 1946 until the present.

3. ISSUES: Language, outcomes and definition

There are, however, some areas of controversy within the MHPSS field of activity. The debates go back to 1990s [9] until the present. Given the short history of activity in this field and wide range of programmes and services available within a short space of time, it is hardly surprising that there are issues that may still need to be resolved. It is beyond the scope of this Training Pack to deal with the complexities of the political, philosophical and ethical arguments [8] [13] but for the sake of balance, it may be worth highlighting what some of the more practical and common issues might be. It is possible that there is still some confusion over the MHPSS concept and terminology and some inevitable inter-agency and inter-professional conflict and debate where boundaries exist and practices overlap.

3.1 The Issue of Language

Despite the progress and consensus, practical and linguistic challenges to organisations and policy makers in using a common and agreed language when describing MHPSS services and systems in discussions and documents may still exist. In the early days following the publication of the IASC guidelines, the language used in describing aspects of the MHPSS model was new, challenging and possibly a little confusing for agencies and practitioners. The 2007 guidelines acknowledged the close relationship and overlap between the terms "mental health" and "psychosocial" and commented that..

"Aid agencies outside the health sector tend to speak of supporting psychosocial well-being. Health sector agencies tend to speak of mental health, yet historically have also used the terms psychosocial rehabilitation and psychosocial treatment to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries." [1]

Today the mainstream literature contains many uses of the term MHPSS combined with a variety of other words resulting in many "compound terms." To illustrate this, a number of these compound terms have been grouped together in five main areas, in the table below. This is not a precise linguistic examination but is merely a simple attempt to try and show some examples of the range of current terms in use which may increase the risk of the possibility that agencies may not speak the same language when describing various aspects of the original MHPSS concept or range of interventions and supports. This process of evolving terminology and clarification of a common language is probably, thankfully, being addressed by the very existence of the various inter-agency co-ordination groups which are now in operation.

Examples of some of the common compound MHPSS terms in key documents

Compound Terms are often used as ...	..a way of thinking	.. a way of organising	.. a way of talking about service delivery	.. a way of talking about services	.. a way of describing the needs of beneficiaries
MHPSS is commonly combined with these terms in key documents examined	Approach Policies Strategy Concept	Programming Planning System Actors Co-ordination Focal Points Training	Interventions Services Resources Supports Responses Activities Programmes	Speciality Area Sector Field	Problems Assessments

To those who have worked for some time in the various sectors, most of these will not be difficult to understand but perhaps newcomers might feel that some of these terms have enough ambiguity to adversely affect the clarity of communication between agencies and individuals. The precise use of these terms can vary across writers and may impede the process of developing a common understanding and language. Various terms can be (and are) used interchangeably and sometimes they appear to mean very different things to different individuals or organisations in talks, presentations and publications. There appears to be more work to be done in firming up the precision of the language and terms used in the MHPSS field.

There have been some objections to regarding MHPSS as a "sector" or "specialism" as many have argued this goes against the intention behind the MHPSS approach concept and the notion of building sustainable solutions within existing systems as very well advocated in the "Building Back Better" strategy outlined by WHO in their landmark publication [10].

Encouragingly, in 2014, the IASC produced a review of how well their Guidelines on Mental Health and Psychosocial Support in Emergency Settings had been implemented. [3]
The noted that, from the feedback, there appeared to be widespread acceptance of the term MHPSS and that there was a greater understanding and common language used in describing the role that people or agencies can play in the MHPSS approach.

They also highlighted that this was reflected in the titles of key publications by large agencies and in the renaming of a journal in the field probably as a result of this more cohesive and integrated language, thinking and practice.

Despites the issues, some would argue that a consensus is emerging [21].

3.2 The issue of outcome research: a low level of evidence based reports

The current state of evidence base for MHPSS interventions and supports is perhaps best summarised by a recent Cochrane report.
For the last two decades, the Cochrane Collaboration has produced systematic reviews of primary research in human healthcare and health policy. These are internationally recognised as the highest standard in evidence-based health care resources. During the 24th Cochrane Conference in Seoul in 2016, some researchers reported their findings while examining the evidence for systematic reviews examining the implementation and delivery of MHPSS interventions in humanitarian settings. Their results showed that …

"of the fifteen systematic reviews included in the preliminary findings, four specifically focused on children and young people and one focused more broadly on adults and young people. Three reviews on adult refugees focused on psychological treatment interventions. Five reviewed effectiveness evidence on MHPSS programmes in armed conflicts and political violence settings, while one examined prevention and management strategies to address gender-based violence.
A further review examined evidence on the effectiveness of MHPSS for chemical, biological, radiological, and nuclear events." We found no systematic reviews examining the implementation and delivery of MHPSS interventions in humanitarian settings." [12]

To address this issue, and under their Humanitarian Evidence Programme, Oxfam have put forward a protocol to systematically review the impact of mental health and psychosocial support interventions for people who are affected by humanitarian emergencies. [14]. They comment on the complexities of such an enterprise and suggest that:-

"Given the ambitious nature and wide variety of MHPSS, their methods of intervention and potential outcomes, there is no single theory of change that can be applied for all possible types of MHPSS."

They have highlighted the difficult nature of the task and, having reviewed previous reviews , they suggest that there are inherent difficulties in carrying out high quality systematic MHPSS research and this may be due to the complex reality that MHPSS interventions and supports can impact on mental health and psychosocial well-being in many ways such as:-

"targeting singular presentations such as somatic or non-somatic panic attacks or flashbacks or they may focus more broadly on reducing depressive, PTSD or anxiety-related symptoms. Programmes may also seek to strengthen protective factors of those affected by humanitarian emergencies by focusing on increasing feelings of empowerment, resilience and other family, community, economic and social outcomes. Improving these broad range of outcomes by strengthening protective factors and addressing primary and secondary stressors may be achieved by supporting people to process their experiences, such as by re-framing them narratively or via cognitive processing; by facilitating greater social participation through contact with their families and/or the community; or by supporting people to access educational, employment, legal or other social welfare services, when available or appropriate." [14]

3.3 The Issue of definition: controversy over "psychosocial" term and approach

Although the term psychosocial is viewed as helpful, creative and appears widely accepted [3], UNHCR in 2013 [11] commented on the way in which the term "psychosocial" has been challenged over the years. They point out that leading experts in the psychosocial field report that the term has been used to denote three main things:-

1. as a synonym with mental health (often to avoid using potentially stigmatising language);

2. to "describe a wide and diverse range of programs involving recreational, cultural, informal and sometimes formal, educational activities"; and,

3. to describe approaches that aim towards "enhancing the capacity of a community or individual to engage with their circumstances, and more effectively identify and mobilise resources."..[16]

* {editorial emphasis added and layout altered for ease of reading}

Although the debate continues over the definition of the term, their review found that most practitioners believed that the IASC guidelines had given organisations and individuals a means of achieving a better understanding and consensus in many areas of policy, strategy, training and practice. Nevertheless, they conclude and acknowledge that ..

"MHPSS activities are a relatively new and emerging field within the broader field of humanitarian response. Therefore, agencies have found that defining, adopting and integrating the psychosocial approach within core activities has required significant investment in improving understanding and skills associated with psychosocial approaches. It is evident that promoting understanding and support for the psychosocial approach is a challenge for many organisations." [11]

4. CURRENT PRACTICE AND AREAS OF AGREEMENT: MHPSS Terminology, Models, Problems and Services

4.1 Terminology: Currently prevailing and widely accepted definitions

This MHPSS Training Pack is based upon a range of agreed definitions put forward and used by IASC and the main international organisations in their vast array of informative and influential publications and guides in the pursuit of a combined MHPSS approach to mental health and psychosocial well-being [1],[3],[10],[11],[15],[17],[19],[20],[22],[23]. Despite the possible issues with language and terminology highlighted in the previous section, some of the more widely accepted definitions, with a key source, are summarised in the table below:-

Table of definitions in widespread use and a key source in the MHPSS field of literature

Term	Definition	Source
Health	"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [4]	WHO 1946
Mental Health	"A state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community." [23]	WHO 2005
Psychosocial	"The inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other." [22]	IASC 2010
MHPSS	"Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder." [1]	IASC 2007
Approach	"Adopting an MHPSS approach means providing a humanitarian response in ways that are beneficial to the mental health and psychosocial wellbeing of refugees. This is relevant for all actors involved in the protection of and assistance to refugees." [11]	UNHCR 2013
Intervention	MHPSS interventions consist of activities with a primary goal to improve the mental health and psychosocial wellbeing of refugees. MHPSS interventions are usually implemented by in the sectors for health, community-based protection and education." [11]	UNHCR 2013

4.2 Models: Multi-Layered, Different, Complementary Approaches

In 2007, The Inter-Agency Standing Committee (IASC) asserted that..

"although the terms mental health and psychosocial support are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches." [1]

A strong positive finding of the IASC 2014 review was the widespread perceived utility of the IASC Intervention Pyramid as model to aid inter-agency communication, guide service planning and the delivery of services to beneficiaries. The pyramid has been widely adopted and adapted by many organisations and in many publications is often portrayed as a multi-layered model of complementary activities. Others have attempted to modify this, in meaningful ways, to capture the essence of the MHPSS approach. There is some variation and potential confusion over the labelling or numbering of these levels or layers. It is perhaps less confusing to refer to the layers by their descriptive labels rather than rank or numbers. To this end, an alternative simplified combination of the best portrayals is shown in the figure below and is adapted from two main sources [1] [19] omitting the use of numbers (1 to 4) or ordinal ranks. (First to fourth)

MHPSS Problems	Pyramid Layers	Services Required
Severe psychological disorders	Specialised Services	Professional treatment for individuals or families
Mild to moderate mental health disorders	Focused non-specialised support	Individual familyor group interventions
Mild psychological distress (natural reactions to crisis)	Community and family supports	Psychosocial support activities
General population affected by crisis	Basic services and security	Meeting basic needs and providing security

**Adapted and amalgamated from IASC Guidelines 2007 [1] and IFRC PSI Handbook 2010 [19]

The pyramid represents "tapering needs" in the population. There is a perceived higher demand for basic services and security for a very large percentage of the afflicted population at the "basic" services level and a lower perceived demand for specialised services at the "specialised" services level for a smaller percentage of the same population [1]

4.3 Problems: the nature and range of problems in emergency settings

The IASC Reference Group for Mental Health and Psychosocial Support [22] presented a very useful way of describing and categorising the large range of mental health and psychosocial problems that are commonly encountered in emergency settings as predominantly social or psychological in nature. They suggested that:-

* *"Significant problems of a **predominantly social nature** include:*

- Pre-existing (pre-emergency) social problems
  (e.g. belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems
  (e.g. family separation; safety; stigma; disruption of social networks; destruction of livelihoods, community structures, resources and trust; involvement in sex work); and
- Humanitarian aid-induced social problems
  (e.g. overcrowding and lack of privacy in camps; undermining of community structures or traditional support mechanisms; aid dependency).

*Similarly, problems of a **predominantly psychological nature** include:*

- Pre-existing problems
  (e.g. severe mental disorder; depression; alcohol abuse);
- Emergency-induced problems
  (e.g. grief; non-pathological distress; alcohol and other substance abuse; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and
- Humanitarian aid-related problems
  (e.g. anxiety due to a lack of information about food distribution). " ……. [22]

*{editorial emphasis added and layout altered for ease of reading}

Viewed against this simple but useful classification, the utility of the combined MHPSS multi-agency, multi-layered, multi mental health and psychosocial intervention and support approach is readily seen as an appropriate way forward in trying to respond to this highly complex matrix of interconnected human problems that are routinely dealt with, in emergency settings, by a wide variety of agencies, organisations and MHPSS workers

Surveying the list above, the potential need to respond to and manage anxiety and depressive symptoms (for example) in any one, combination or all of the above problem areas (regardless of their unique nature or presumed causes) can easily be seen. Co-ordinated input may be required by many people, agencies at various levels of intervention to impact effectively on the same presenting psychosocial problems as there may be many simultaneous causes of distress.

4.4 Services Required: The need for adaptation and contextualisation

It is fairly widely accepted thinking and practice that a diverse range of activities can and needs to be utilised to treat mental health disorders and to improve the psychosocial well-being of individuals and communities in various emergency settings in order to manage the large range of psychological and social impacts of conflict, disaster and displacement.

There are many excellent manuals in print that deal with a range of interventions and supports and some of them have been referenced in this chapter. There is no shortage of high quality material in the realm of the mental health and psychosocial support literature. There is, however, growing criticism and a challenge to the validity and utility of using American or European "pathological" thinking to address problems that often lie in other areas of the world. The political, philosophical and ethical considerations of this strategy and approach have also been raised. [8],[13]

Recently, it has been argued that:-

"Humanitarian crises often occur in non-Western, limited resources settings where Western strategies and approaches may not be feasible or applicable therefore MHPSS [services] maybe need to be adapted or developed to be context and culturally sensitive." [14]

What is of great interest and relevance to the development of this MHPSS Training Pack are the arguments in favour of adapting and contextualising a range of mental health and psychosocial support interventions to suit local needs, cultural sensitivities and be of maximum use to local providers.

This is the thinking and approach upon which this Training Pack is based. It has been devised by assessing the needs of MHPSS practitioners in the region. In addition, by giving some consideration to their requests for certain types of information and training, this MHPSS Training Pack has been specifically targeted to the assessed and declared needs of MHPSS practitioners working in the Syrian context within the region. The approach of assessment of needs, pilot training and review was used to try and maximise the usefulness of the material and its applicability to the local problems faced by MHPSS workers in specialised and non-specialised settings as they endeavour to treat and support the refugees and afflicted population in this longstanding and on-going humanitarian crisis and emergency setting.

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Chapter One

MENTAL HEALTH: GENERAL CONCEPT AND MENTAL DISORDERS

Chapter One
Mental Health: General Concept and Mental Disorders

Part One: The Concept of Mental Health

Definition of Mental Health:
The definition that we will adopt in this guide is the one put forward by the World Health Organisation:
"Mental health is defined as a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community."
(World Health Organisation 2002)
Mental Health does not mean the mere absence of mental illness.
On the other hand, many differentiate between the word (psychological) and (mental), including those who specialise in this field. But, if we bypass lexical details and focus on the scientific side, we find that the term (mental health) in English includes all that can be described as psychological and mental together, and includes all global classifications of Mental Disorders, from mild anxiety, phobias, sleep disorders, psychosis, to mental hindrance. Thus, I believe that it is not useful to continue with this lexical separation.
Differentiating between psychological and mental came to be through the historic development of this science, despite it serving in Syrian society an attempt to escape (and not combat) the stigma of certain disorders that were called psychological and promote the stigma of other disorders that used to be called mental.

Various Models to Explain Mental Illness
The Medical Model:
This views mental illness exactly as it does any other organic disease, which results from a defect in the structure and function of the brain. It is distinguished by the presence of a specific reason for the illness as well as manifestations, symptoms and predictable progress. It considers that the reality of the patient can be altered by the use of medical remedies.
This model, until now, has some shortcomings that caused argument and chaos in opinions to the extent that some categorically denied this status to mental illness, such as Thomas Szasz, among others.
The Psychological Model:
Which views most symptoms of mental illness as part of the psychological field, whether from a psychological dynamic within the individual, or the dynamic of interpersonal relations with others? From the psychological theory emerged the model of psycho-analysis, which views mental illness as a product of repression and deprivation during childhood, or an individual's fixation on a certain developmental phase.

The Social Model:
The stresses on the interaction of the individual with the social system.
And the theory of Social Construction that views disease as a human idea or condition applied by Man in accordance with human and personal standards, standards which can change. What is considered an illness at a certain social time frame may not be viewed as thus at another period.
The Psychobiological Model:
This model was devised by Alfred Mayer at the onset of the Twentieth Century. It views disease as an interactive process between biological potential and psychological factors of an individual.
The Biochemical Model:
A view adopted by the education school of thought, which considers that all behaviour can be explained on a material physiological basis, and the exception and isolation school of thought, which deems that anything that cannot be explained by physiologically and materially cannot be a disease.
Biopsychosocial Model:
This is the most comprehensive one. It links between illness and the individual, in his/her entire biological and psychological potential, as well as surrounding circumstances. The model views that the interaction between these three factors could be the instigator of disease. Disease causation or outcome is attributed to the intricate, variable interaction of biological, psychological and social factors. Moreover, the manifestations of mental disorders or their symptoms could materialise in any part of these three, and measures taken should be comprehensive of all three.

Classification of Mental Disorders:
Mental Health workers have endeavoured from the very beginning to classify disorders in order to distinguish between them. Among the first classifications of disorders was one that placed them in two categories: Neurotic and Psychotic. The, modern classification systems began to diversify to the point that almost each developed country had its own classification. For instance, there is the French classification of mental disorders (CFTM), the American one (DSM-5), and the global classification prepared and published by the World Health Organisation, which used to be reviewed every ten years. At the time being, the tenth version of it (ICD10), issued in 1992, is in use. The revision of the latest version has been long overdue, and the organisation is in the process of issuing the eleventh instalment, expected to be published this year (2016) and is to be called (ICD 11).
The fifth edition of the Diagnostic and Statistical Manual was issued in 2013, and it included some amendments and important changes to the fourth guide and the tenth global classification.
In this manual, we will use simpler and shorter descriptions for clinical manifestations and diagnostic criteria to describe mental disorders that are in tune with official classification systems, while avoiding many complications and details.
We will mainly use DSM-5 for two reasons:
First: Because it was issued in 2013, which is considered the latest classification currently present. While the latest global classification (ICD10) dates back to 1992, which is more than 24 years ago.
Second: Clinical experience has shown that it is much simpler and can define disorders in a more practical manner.

The Importance of Mental Health

Problems resulting from mental health are considered widespread and a cause of disability. A study conducted in 2004 showed the following results:
Among the top ten causes for adding years of disability experienced by people are four attributed to mental disorders

1. Depressive Unipolar Disorder: 10.9%
2. Hearing loss (commences after puberty): 4.6%
3. Immune Disorders: 4.6%
4. Alcohol abuse disorders: 3.7%
5. Cataract: 3.0%
6. Schizophrenia: 2.7%
7. Bone fragility (osteoporosis): 2.6%
8. Bipolar Affective Disorder: 2.4%
9. Iron deficiency anaemia: 2.2%
10. Hypoxia and birth trauma: 2.2%

These data are from the Global Burden of Disease study – 2004 data
In addition to that, prior studies have shown that by the year 2030, depression is expected to be among the top three reasons for disability and death worldwide.

Worldwide	1- AIDS
	2- Depression
	3- Ischemic heart disease
In High-income countries	1- Depression
	2- Ischemic heart disease
	3- Alzheimer's
In Middle-income countries	1- AIDS
	2- Depression
	3- Cerebrovascular diseases
In Low-income countries	1- AIDS
	2- Perinatal injuries
	3- Depression

In spite of all that, a large number of people who are afflicted with acute mental disorders do not receive any form of treatment. This percentage varies in developed countries between 35% -50%, while it ranges between 76% -85% in developing countries, if not more.

Mental Health in Time of Crisis:

Statistics produced by the World Health Organisation on mental disorders show that these double at a rate of 100% during crises, regardless of the intensity of the disorder:

	Prior to Crises	Post Crises
Severe Mental Disorders	2-3%	3-4%
Mild to Average Mental Disorders	10%	15-20%
Non-pathological tension	Unknown	High levels
		Decreases with time

Based on these estimates, the proportion of severe mental disorders among Syrians is now estimated at 1.2 million (4% of approximately 24 million). There are about 70* psychiatrists registered*, not working in Syria. If we can assume that each one of them is able to follow up on 15 cases per day working five days a week throughout the 52-week-year. If they follow up on each patient three times a year, the total number of cases that they can follow up on annually is (70x15x5x52) / 3 = 91000 cases. This represents 7.6%, of the affected population and means that there are more than 92% of severe cases with no kind of follow up.
* (The number of psychiatrists is the number registered by the Syrian Arab Association of Psychiatrists)

General Principles of Care:

There is a group of bases that must be followed by those working in the medical field in general and in the field of mental health in particular, and these principles are:

1. Good communication and trust building between the service provider and the one asking for it: This is based on the principles of communication, on top of which are active listening and emotional understanding and taking into account the differences in age, sex, culture and language. In addition to love, respect and non-judgement, understanding the extent to which a person understands his/her condition, and using easy to understand terms.

2. Good case evaluation:
   Evaluating everything related to the physical well-being of the beneficiary, in addition to medical and family history, as well as evaluating a variety of problems such as psychological, social, livelihood, relationship, pressing events, and discovering flexibility and resilience of a person, managing the case and referring it if need be.

3. Measures (treatment) and follow-up:
Discerning the importance of treatment and its objectives, placing a plan of treatment that respects a person's choices and the one caring for him/her, and making that plan by consulting with both the caregiver and the one cared for, while informing the person of all treatment options available and what to expect out of the treatment. Answering all questions and dispelling his/her fears in a realistic manner, monitoring the effectiveness of treatment and its impact on an on-going basis and adjusting it accordingly and encouraging him/her to self-monitor symptoms and document key aspects of the situation in a special folder.
Insuring the treatment of people in a holistic manner by addressing the mental health needs of people who suffer from physical disorders, as well as to meet the physical health needs of people who suffer from mental disorders.

4. Mobilising communal support:
The caregiver should take into account the social challenges that may face the person and be attentive to the likely impact of these challenges on his/her safety and psychological and social health, and to encourage participation in self-help and family support groups whenever possible. The caregiver should identify and mobilise potential sources of community support in the local area, including housing, education and employment and coordinate with schools for children and adolescents.

5. Attention to public safety:
The caregiver must educate the recipient on physical health (nutrition and weight - sports and physical activity - smoking - alcohol - risky behaviours such as unsafe sex).
Conduct regular tests of physical health
Educate about natural developmental changes (puberty - Menopause) and provide the necessary support
Discuss plans for pregnancy and contraception with women of childbearing age

6. Protect human rights:
Provide care in a manner that preserves the dignity of the patient and takes into account his/her culture. A manner that is devoid of discrimination against race, sex, language, religion, political views, and others.
Promote living independently in the community and not to encourage the admission of a person to institutional care.

Make sure that the person understands the proposed treatment and offers free consent. Make sure of the knowledge and involvement of children and adolescents in decisions concerning their treatment in a manner that corresponds with their developmental capacities.
Pay particular attention to confidentiality and privacy of the patient. Be certain of his/her consent on informing caregivers of his/her health condition, including matters relating to treatment and its side effects.
Reduce stigma and marginalisation and promote social integration.
Give special importance for national and international standards of human rights, primarily:

1. The Convention against Torture and other types of cruel treatment, punishment, and inhuman or degrading acts, effective as of June 26, 1987 and signed by the Syrian Arab Republic by Decree 39 of 2004 and made reservations on Article 20
http://www2.ohchr.org/english/law/cat.htm

2. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted on December 18, 1979 by the UN General Assembly 34/80, the Syrian Arab Republic joined in on the treaty by decree 333 on 26/09/2002 and had reservations on articles 9-15-16-29 or parts of them. http://www.un.org/womenwatch/daw/cedaw/cedaw.htm

3. Convention on the Rights of Persons with Disabilities and Optional Protocol adopted by the UN General Assembly on December 13, 2006 and signed by the Syrian Arab Republic on March 30, 2008 without signing on the optional protocol.
http://www.un.org/disabilities/documents/convention/convoptprot-e.pdf

4. Convention on the Rights of the Child (1989), endorsed by the Syrian Arab Republic under Law No. 8 of 1993 and made reservations on articles 14-20-21
http://www2.ohchr.org/english/law/crc.htm

Part Two: Mental Disorders

We will try in this chapter to review a number of mental disorders, which have been picked based on two main factors; first, their overall prevalence; and second, the special importance of these disorders, particularly under current crisis.

Chapter One: Depressive Disorders

The fifth Diagnostic and Statistical Manual of Mental Disorders (DSM-5) divides depressive disorders into:

- Disruptive Mood Dysregulation Disorder
- Major Depressive Disorder
- Persistent Depressive Disorder (Dysthymia)
- Premenstrual Dysphoric Disorder
- Substance/Medication-Induced Depressive Disorder
- Depressive Disorder Due to Another Medical Condition
- Other Specified Depressive Disorder
- Unspecified Depressive Disorder

The DSM-5 includes completely novel terms for depressive disorders, as an independent research that includes about eight disorders that share these common symptoms: Mood evoked sadness and emptiness, in addition to physical and cognitive symptoms that clearly affect functionality and differ in duration or times of occurrence, or emerging measures. In this manual, we will speak of a specific model, which is:

Major Depressive Disorder

It is the most common of depressive disorders, and spreads at an annual rate of 7% among the total number of population, and peaks among the age group of 18-29 year olds. The percentage of females to males who have it ranges between 1.5 to 3 times more. There is no proof that its spread differs among various nations, but what might change is some of its manifestations. Clinical experiments have shown a notable increase in physical manifestations of depression, such as sleep disorders, decline in energy, and a feeling of fatigue in the Arab region.

	Biological	Psychological	Social	
Causes and Pathogenicity mechanism	1 Hereditary. depression increases 2-4 folds with close relatives 2 Defect in neurotransmitters (Serotonin and noradrenaline) 3 Hormonal defect (Oestrogen) 4 Certain organic diseases 5 Drugs	Cognitive defect error in thinking Learned helplessness (Acquired)	Life's hardships: Most importantly Losing parents before age of 11 Losing partner Unemployment, losing job	Real reason remains unspecified accurately
Symptoms	1 Unintentional notable increase or loss of weight or loss or increase of appetite 2 Loss or increase in sleep almost on daily basis 3 Tiredness, fatigue and low energy	1 Sad mood 2 Decrease or loss of ability to enjoy things. 3 Psychomotor agitation or disability 4 Feelings of worthlessness or excessive or inappropriate guilt 5 Diminished ability to think or concentrate 6 Recurrent thoughts of death or a suicide attempt or a specific plan for committing suicide.	The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.	Diagnosis requires five (or more) of the following symptoms to be present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
Differential Diagnosis	Organic diseases such as anaemia, hypothyroidism-Parkinson disease-cerebrovascular incidents-tumours-epilepsy	Anxiety disorders-Bipolar disorder-psychosis-depressive disorders-alcohol and substance abuse-stress related disorders-dementia	Mourning	Some of these disorders may share symptoms with depression but priority goes to diagnosis of organic disorders
Measures	1 Regulate sleep by waking up at a set time 2 Regulate physical activity (walking) 3 Medicinal treatment 4 Alert Cranial Nerve X 5 Sleep deprivation 6 Phototherapy 7 Magnetic stimulation 8 electroconvulsive therapy	1 Self-education 2 Cognitive behavioural therapy 3 Cognitive treatment 4 Interpersonal psychotherapy 5 Family therapy 6 Group therapy 7 Directed analytical treatment (Some of these schools will be discussed in detail in this manual)	1 Dealing with current social pressure and problem-solving technique 2 Identifying supportive people in the family and community 3 Managing cases of abuse or harm 4vReactivating social networks 5 Restoring stability in a region characterised by security and safety has a special importance in the case of war refugees	Studies and research show that implementing more than one model of treatment concurrently yields better results than applying any one alone

Points relating to depression in the Arab world:

Arab women show symptoms of agitation and irritability more than those of a depressed mood.

Anthropomorphism, though not mentioned as one of the main symptoms in DSM-5 or ICD-10, is a common and important manifestation of depression in Arab patients.

Arab patients (particularly men) do not readily express their feelings of sorrow or low mood as other patients from western countries would.

Many Arab countries use the term distress to describe feelings of depression, and thought to describe brooding and preoccupations.

Model for the determinants of Major Depressive Disorder and their equivalent symbols in the ninth and tenth global classification

DSM-5	ICD9	ICD10
Major Depressive Disorder		(pp160-8)
Single episode		(_.)
Mild	296.21	(F32.0)
Moderate	296.22	F32.1)
Severe	296.23	(F32.2)
With psychotic features	296.24	(F32.3)
In partial remission	296.25	(F32.4)
In full remission	296.26	(F32.5)
Unspecified	296.20	(F32.9)
Recurrent episode		(_.)
Mild	296.31	(F33.0)
Moderate	296.32	(F33.1)
Severe	296.33	(F33.2)
With psychotic features	296.34	(F33.3)
In partial remission	296.35	(F33.41)
Unspecified	296.30	(F33.9)

Pharmaceutical treatment:

It is better for the patient to take part in the choice of treatment model preferred by him/her, after explaining all available options and giving the patient an idea about them. Certain misconceptions must be ratified concerning antidepressants, such as they do not cause addiction and do not have grave side effects on the brain. Antidepressants also need a period of 2-4 weeks for results to start showing. Moreover, the overall period of treatment ranges between 6-12 months. A drug is chosen from an array of antidepressants depending on the patient's symptoms and effects of each medicine. There are various groups of such drugs, the oldest of which are Monoamine oxidase inhibitors, which are rarely used now, Selective Serotonin Reuptake Inhibitors (SSRIs), and Serotonin/Norepinephrine Reuptake Inhibitors.

Following is a table of some of these drugs, their doses, and side effects:

Drug Name	Drug Group	Daily Dosage	Side Effects
Fluoxetine	SSRIs	20-60 mg	Insomnia-irritability-upset stomach-sexual functionality disorder
Sertraline	SSRIs	50-200 mg	Insomnia-irritability-upset stomach-sexual functionality disorder
Paroxetine	SSRIs	20-60 mg	Insomnia-irritability-upset stomach-sexual functionality disorder-dizziness
Fluvoxamine	SSRIs	100-300 mg	Insomnia-irritability-upset stomach-sexual functionality disorder-dizziness
Citalopram	SSRIs	20-60 mg	Insomnia-irritability-upset stomach-sexual functionality disorder
Escitalopram	SSRIs	10-20 mg	Insomnia-irritability-upset stomach-sexual functionality disorder
Amitriptyline	TCAs	75-300 mg	Constipation- Orthostatic hypotension- heart arrhythmia-weight increase-dry mouth-drowsiness
Imipramine	TCAs	75-300 mg	Constipation- Orthostatic hypotension- heart arrhythmia-weight increase-dry mouth-drowsiness
Venlafaxine	SNRIs	150-375 mg	Changes in sleep-upset stomach
Duloxetine	SNRIs	30-60 mg	Upset stomach-symptoms upon termination of treatment

It is imperative to follow the model of (4Ds) during pharmaceutical treatment:

D is for dosage. The correct dosage must be reached for each medicine before judging its effectiveness or the lack of it.

D is for duration of treatment which should not be less than six months of the correct dosage.

D is for drug. In the case where a patient does not respond to the drug in its correct dosage and duration, another drug could be chosen from another therapeutic group - either to replace it or be given in combination with it.

D is for diagnosis. It is possible to reconsider diagnosis in the case where a patient does not respond to two drugs from two different therapeutic groups (each one in the correct dosage and duration). In the case where a diagnosis is confirmed, then we could be facing resistant depressive disorder, which requires more specialised intervention. It should be noted that depression, in general, is a treatable disorder, with a success rate of 80%.

Finally, follow-up is an integral part of the treatment of depression. The intervals of the follow-ups should be determined based on the condition of the patient and type of therapy.

Chapter Two: Suicide and Self-harm

Suicide: Is the act of killing one's self intentionally. But, self-harm is a wide-scoped term that refers to any act of inflicting injury to the body, such as ingesting toxic material, or cutting one's self. There may or may not be a lethal intent or result to such acts.

Suicide must be investigated with any person who is above ten years of age and has any one of the following conditions:

1. Any mental disorder from the list of globally classified mental illnesses.
2. Chronic pain.
3. Intense emotional stress.

Important Information:

- Inquiring about suicide or self-harm neither encourages nor reminds a person of acts of self-harm or suicide, but rather elevates anxiety related to such thoughts and aids the person to feel understood. However, asking must be done at the appropriate time and in the appropriate form, following good communication.
- Suicide and self-harm must be evaluated during the preliminary evaluation, and then periodically during follow-up sessions when needed.
- Suicide and self-harm assessment and management must be done at the same time.
- Most cases of suicide are preceded by warning signs, whether verbal or behavioural. Of course, there are certain cases of suicide that happen without warning; nevertheless, it remains pivotal to recognise these warning signs and be vigilant about them.
- People who speak about suicide may be seeking help or support. A large number of people who think about suicide suffer from anxiety, depression, despair, and may feel that there is no other option.
- There were an estimated 804,000 cases of suicide worldwide in the year 2012. The suicide rate measured by age annually at the global level is 11.4 per 100,000 persons, 15.0 for males and 8.0 for females.
- Suicide is reason No. 15 for death around the world.

Assessment and Management:

Firstly: The following question must be answered: Has the person attempted self-harm or suicide (currently)?
This question could be answered in two ways:

1. Noting the presence of signs of injury such as (signs of poisoning or ingesting narcotic substances-bleeding-unconsciousness-extreme lethargy…)
2. Asking about forms of suicide and self-harm.

If the answer to this question is yes, then the following question must be answered: Does the person need urgent medical care? At this point, the injury or poisoning must be treated medically, and in case there is a need to hospitalise the patient, s/he must be closely monitored to prevent suicide. In any case, the person must be placed in a safe place and should not be left alone.
Secondly: If the person has not attempted either suicide or self-harm, the following question must be answered:
Is there eminent danger that this person might commit suicide?
The answer to this question is done through:

- Asking the patient or caregiver about:
  A. Thought or current plan to commit suicide or self-injury.
  B. Existence of prior thoughts to commit suicide or self-harm in the past month.
  C. Existence of a previous case of attempted suicide or self-harm in the past year.
  D. Ease of access to means of self-harm or suicide.
- Search for:
  A. Intense emotional strain
  B. Feelings of despair
  C. Intense irritability
  D. Violent behaviour
  E. Difficulty of communication
  F. Reclusive behaviour

If the answer were yes, then there is an eminent danger of self-harm or suicide. At that point the following precautions must be taken:

1. Removing means of self-harm
2. Not leaving the person alone at all
3. Placing the person in a safe and supportive place. Activate psychosocial support

Thirdly: Is the person suffering from any mental disorder or substance abuse?
Here we must eliminate any of:

1. Depression
2. Substance abuse disorder
3. Bipolar disorder 4- Psychosis
5. Epilepsy
6. Stress related disorders

If any of these exist, they must be managed in the manner adopted for each case.

Fourthly: Is the person suffering from chronic pain?

Here, the pain and any accompanying medical situation must be treated.

Fifthly: Does the person suffer from any inexplicable physical or emotional complaints that require intervention?

We ask about:

1. Decline in usual functionality (academic, familial, professional or social)
2. Repeatedly asking for medical help
3. Repeated attempts at self-medication

Chapter Three: Schizophrenia spectrum and other psychotic disorders

Psychosis is traditionally known as impaired functioning, and a distorted or non-existing sense of objective reality. It is currently known as an impairment in one of these five fields (1- delusions, 2-hallucinations, 3- disorganised speech, 4- disorganised or catatonic behaviour, and 5- negative symptoms).
The lifetime prevalence of said disorder is about 1% of the total population around the world and the annual prevalence for 2015 was 21 million inflicted, 12 million males and 9 million females. This disorder peaks at the age of 15-25 for males, and 25-35 for women. However, it could start as early as the age of 5.
The death rate among psychotic patients is 2-2.5 more than the rest of the population due to physical diseases, mostly cardiovascular or metabolic or infectious diseases.
Stigma, discrimination and the violation of human rights of patients with psychosis is common in most countries of the world.

Psychosis is a treatable disorder, and pharmaceutical and psychosocial treatments are effective.

	Biological	Psychological	Social	
Causes and Pathogenicity mechanism	1 Genetic: increases 10 times if one of the parents is schizophrenic and 20 times if both parents are, and 50 times in identical twins 2 Imbalance of neurotransmitters (increase in dopamine activity) 3 Medication or substances 4 Organic disorders (tumours -cerebrovascular incidents)	1 Fixation on early developmental stages that lead to a defect in the formation of the Ego (psychoanalysis) 2 Double bind (mixed messages)	1 Poor educational models in childhood 2 Over protection and over expression of emotions in parents 3 Harsh socio-economic background, especially the youth are more prone to schizophrenia 4 Immigrants suffer from increase in schizophrenic levels as compared to their counterparts who remain in the society they left and those who already live in the society they immigrated to	All are theories and there are many more, but none are confirmed until now. Genetics and neurotransmitters theory remains the most likely up till now

	Biological	Psychological	Social	
Symptoms and clinical manifestations	1 Hallucinations (sensory perception, in the absence of real external stimulant of any of the five senses, which is of the same vitality and strength as the real sense).	1 Delusions (clearly false but strongly held beliefs that are non-negotiable despite logical evidence, could be delusions of grandeur, physical or religious delusions 2 Disorganised thought, speech, or behaviour 3 Catatonia 4 Negative symptoms (lack of emotional expressions-indifference-demotivation)	Decline in academic, social and work performance	At least two symptoms must be present from the aforementioned five, and one of these must be in the top three and persist for a minimum period of one month in addition to a decline in functionality
Differential diagnosis	1 Brain concussion 2 tumours 3 cerebrovascular incidents 4 brain infections 5 Medicine and substances 6 epilepsy	1 Bipolar disorder 2 Depression with psychotic symptoms 3 misuse of alcohol or narcotic substances	1 Certain cultural, religious and social manifestations that commensurate with environment and culture (demons-magic)	Keeping in mind that the presence of these conditions may not be accompanied by psychosis
Management and treatment	1 Pharmacotherapy 2 Electroconvulsive therapy 3 Hospitalisation	1 Psychological education 2 Cognitive Behavioural Therapy 3 Dialectical Behaviour Therapy 4 Art Therapy 5 Cognitive Training	1 Social Skill Training 2 Family-Oriented Therapies 3 Vocational therapy 4 Group therapy 5 Interpersonal therapy	Institutionalised treatment must be avoided as much as possible, and if it occurs the hospitalisation period must be kept short, and it is preferable to integrate units of psychotherapy within public hospitals

Pharmaceutical treatment:

Treatment with a class of drugs known as antipsychotics is the most common therapy for people with a psychotic illness:

First: Typical antipsychotics (Dopaminergic receptor blockers) such as

haloperidol, fluphenazine, chlorpromazine, among others.

Second: Atypical antipsychotics (Dopaminergic and serotonin receptor blockers) such as olanzapine, risperidone, ziprasidone, among others.

Third: Third-generation antipsychotics (partial Dopaminergic receptor blockers) including: aripiprazole

There is a specific medication for resistant schizophrenia - clozapine.

Antipsychotics could be administered in the form of injections in case the patient does not comply with oral treatment. Most proven studies show that it is better to use medication on a continuous basis for schizophrenic patients (that is those whose psychotic symptoms persist for more than six months).

Chapter Four: Bipolar Disorder

Bipolar Disorder was placed in an independent chapter in the DSM-5 manual from other disorders such as Schizophrenic spectrum disorder and other psychotic and depressive disorders as a special study that bridges between them from the point of symptoms, genetic preparedness, and family history. This disorder is diagnosed by the presence of manic episodes and bipolar mood disorder. Bipolar disorder is a serious, chronic and recurrent mental illness, characterised by extreme shifts in mood, as well as fluctuations in energy and activity levels known as manic episodes or hypomanic episodes that fluctuate with episodes of severe depression.

It is enough for one manic or hypomanic episode to occur for a person to be diagnosed with bipolar disorder.

	Biological	Psychological	Social	
Causes and pathogenic mechanism	1 Genetic. Close relatives of bipolar disorder patients are 7 times more prone to be afflicted than other people 2 A number of neurotransmitters have been linked to this disorder (norepinephrine), serotonin, and dopamine 3 Medication, substances			Remains unconfirmed
Symptoms and clinical manifestations	1 Elevated levels of energy and activity 2 Decreased need for sleep (for example, feeling revitalised after only three hours of sleep)	Abnormally and p elevated or irritab That adheres to th following: 1 Inflated self-est grandiosity 2 Intensified spee 3 Rapid jumping a ideas or feels lik are racing. 4 Distractibility (a easily pulled aw irrelevant/unimp things).	1 increase in goal-directed activity (i.e. excessively plans and/or pursues a goal; either social, work/school or sexual) or psychomotor agitation 2 Excessive involvement in pleasurable activities that have a high risk consequence. 3 Extreme mood disorder to the extent of clearly disrupting functionality at work and in relationships	A period of at least one week during which the person is in an abnormally and persistently elevated or irritable mood. While an indiscriminately euphoric mood is the classical expectation, the person may instead be predominantly irritable. He or she may also alternate back and forth between the two. This period of mania must be marked by three of the mentioned symptoms to a significant degree.
Measures and treatment	1 Pharmaceutical treatment 2 Electroconvulsive therapy 3 Hospitalisation (a manic episode is an urgent medical condition)	Psychoeducation symptoms	Psychosocial support	

Pharmaceutical treatment:
A new drug group called mood stabilisers, includes (Lithium, valproic acid, divalproex sodium, carbamazepine and lamotrigine) is considered the first line of treatment of bipolar disorder

Additionally, certain antipsychotics have an active role in stabilising mood.

Bipolar Disorder treatment is long term and is divided into two parts:

First: treatment of the acute episode (whether manic or depressive. And in the case of a depressive episode, antidepressants should not be used until mood stabilisers were applied so as not to instigate a manic episode).

Second: preventative treatment to stop the recurrence of episodes.

Chapter Five: Stress related disorders

When faced with a traumatic event, various people react differently. Traumatic incidents vary, but can generally be defined as a sudden unusual event accompanied by feelings of fear, helplessness and threat.
Some people may develop one or two cases:

- Problems and disorders that often happen after experiencing stress, but they can also happen in the absence of such exposure. These problems include: depressive disorder, psychosis, behavioural disorders, alcohol and substance abuse, self-harm / suicide, or other serious emotional complaints or complaints that have no medical explanation.
- Problems and disorders that emerge upon exposure to stress according to DSM-5 include:
  G 00 Reactive Attachment Disorder
  G 01 Disinhibited Social Engagement Disorder
  G 03 Posttraumatic Stress Disorder in Preschool Children
  G 04 Acute Stress Disorder
  G 05 Posttraumatic Stress Disorder
  G 06 Adjustment Disorders
  G 07 Other Specified Trauma- or Stressor- Related Disorder
  G 08 Unspecified Trauma- or Stressor- Related Disorder

We will discuss two disorders, Acute Stress Disorder and Posttraumatic Stress Disorder.

Acute Stress Disorder

	Biological	Psychological	Social	
Causes and pathological mechanism	Exposure to trauma and life threatening situation that leads to a fight, flight or freeze response carried by the neurotransmitters noradrenalin for fight or flight and acetylcholine for freeze	Exposure to trauma that leads to fear, helplessness or threat	Exposure to a life-threatening trauma that endangers close people with the inability to reach help Social view of the trauma (disability, sexual assault, etc.)	
Symptoms and clinical manifestations	- Insomnia - Re-experiencing the symptoms that occurred during the trauma (accelerated heartbeats and breathing-muscular tensions-sweating-pains and tension in the digestive system-persistent urination or defecation-widened pupils, etc.) - bedwetting in children Symptoms related to increased sense of present threat - Physical complaints without medical explanation, such as hyperventilation and inability to move, or use sensory perception or speech	- Relieving the symptoms (fear-confusion-feelings of eminent threat-Negative thoughts and mood or feelings-Distressing changes in behaviour (such as aggression) and for teenagers dangerous behaviour	- Avoidance - Social isolation - Withdrawal - Difficulty carrying out daily activities or asks for help to get rid of these symptoms	These symptoms persist for less than a month after the traumatic experience
Measures and Treatment	1 Initial psychological first aid 2 Do not prescribe benzodiazepines or antidepressants for the treatment of acute stress disorder symptoms 3 Respiratory relaxation 4 Muscular relaxation 5 Physical activities (for example walking)	- Initial psychological first aid - Psychoeducation (often times people experience acute psychological stress after a trauma, but symptoms recede with time for most people - meditation and relaxation	Psychological first aid Help people determine means of positive adaptation and forms of social support	Psychological first aid will be explained in detail in another unit

Posttraumatic Stress Disorder
PTSD

	Biological	Psychological	Social	
Causes and pathological mechanism	Exposure to trauma and life threatening situation that leads to a fight, flight or freeze response carried by the neurotransmitters noradrenalin for fight or flight and acetylcholine for freeze	Exposure to trauma that leads to fear, helplessness or feeling threatened	Exposure to a life-threatening trauma that endangers close people without the ability to access help Social view of the nature of the trauma (disability, sexual assault...)	
Symptoms and clinical manifestations	Re-experiencing the traumatic event Constantly recalling the trauma (for example reliving the physical symptoms that occurred during the incident, such as accelerated heart beats, hyperventilation, sweating, shivering, tense muscles and stomach cramps) Recalling emotions experienced during the event (the smell of gunpowder or fire-scent of the attacker-feeling the touch of the attacker and the pain-seeing things and hearing voices) Symptoms of Avoidance Symptoms of intensified current threat The affected person might feel that the danger is still present. Two types of symptoms are linked to a feeling of increased current danger: Being easily startled or irritable, and having a severe fearful reaction towards any sudden or unexpected movement or noise (a person gets more scared than others and takes longer to calm down)	Re-experiencing the traumatic event - Avoidance Symptoms Include deliberate avoidance of thoughts and memories - a rape attack survivor might spend most of her time attempting to avoid thinking about the rape When a person attempts to avoid thinking about something, s/he ends up thinking about it even more. Exercise: Try not to think about a white elephant for a minute Symptoms of intensified current threat	Re-experiencing the traumatic event - Avoidance Symptoms Avoiding situations and activities that remind the person of the trauma. - a person might not want to talk about the incident with a doctor (healthcare professional) Symptoms of intensified current threat - Over vigilance: Being too careful of danger (for example choosing the safest place to sit) The symptoms cause difficulty in performing daily functions	The disorder is diagnosed when at least one of the symptoms from each of the three groups is present, accompanied by a decline in functionality after a month has passed since the traumatic event
Measures and treatment	1 Breathing relaxation 2 Muscle relaxation 3 Physical activity (such as walking) 4 Antidepressants In case those were not present, then cognitive behavioural therapy (CBT) Eye movement desensitisation and reprocessing therapy (EMDR) Not to be prescribed for children and adolescents 5 Do not prescribe benzodiazepines 6 Warn against the use of alcohol and narcotics as well as un-prescribed sedatives	1 Psychoeducation 2 CBT 3 Group Therapy 4.EMDR	1 Aid people in identifying positive coping techniques and forms of social support and work on strengthening them 2 Encourage resuming social activities and routine as much as possible 3 Inquire about current psychosocial stress factors and use techniques to solve problems 4 For children or adolescents who lost parents or caretakers: provide their need for protection and continuous supportive care, including social and emotional support	It is best to work on more than one field and eliminate the pharmaceutical option, as medication has limited effect on this disorder

Chapter Six: Anxiety Disorder

According to DSM-5, anxiety disorders are classified as follows:

E 00 Separation Anxiety Disorder
E 01 Panic Disorder
E 02 Agoraphobia
E 03 Specific Phobia
E 04 Social Anxiety Disorder (Social Phobia)
E 05 Generalised Anxiety Disorder
E 06-11 Substance-Induced Anxiety Disorder
E 12 Anxiety Disorder Associated with a Known General Medical Condition
E 13 Other Specified Anxiety Disorder
E 14 Unspecified Anxiety Disorder

We will discuss in detail two of these disorders, Generalised Anxiety Disorder and Panic Disorder.

Generalised Anxiety Disorder (GAD)

The annual prevalence of this disorder among adults in the United States of America is 2.9% and the rate of being subjected to this disorder during one's lifetime is about 1%. Women are more prone to it than men at a ratio of 2-1.

	Biological	Psychological	Social	
Cause and pathogenic mechanism	1.Agitation of the sympathetic nervous system 2. Neurotransmitters involved in anxiety are Norepinephrine, GABA and Serotonin 3.Heredity 4.Medication, substances	1 Conflict between unconscious sexual and aggressive instincts on the one hand and between the superego and reality on the other (analytical) 2 Conditional responses to external stimuli (behavioural) 3 Anxiety is a response to a state of emptiness and meaninglessness (existential)	- Socioeconomic pressure - Displacement - Threat of loss, such as loss of job or home, life's other accidents and hardships, such as debt, relationships, living as a refugee, all can cause anxiety. - Culture and traditions and not accepting emotional expression. - Complaint of "heart pain" is a common expression of anxiety and worry from threat or loss in the Arab culture. - Arab patients use the term "lower-back pain" to express problems in sex life.	
Symptoms and clinical manifestations	Anxiety and worry are accompanied by three (or more) of the following six symptoms (some of which persist for six months)-it is to be noted that only one symptom is enough for diagnosis in children- 1.Restlessness, anxiety, feeling on edge 2.Easily fatigued 3.Muscular tension 4.Sleep disruption (difficulty falling asleep or staying asleep, restless sleep)	1 Over worrying and preoccupation (prediction anxiety) often happens for a minimum period of six months around events and activities such as work and school. 2 A person finds it difficult to control preoccupation anxiety 3-Difficulty to concentrate, empty minded 4-Excitability	Anxiety, worry and physical symptoms cause important clinical distress or imbalance in social performance or occupational function among other important functions	Physical symptoms increase in Arab societies
Measures and treatment	1.Medicinal treatment 2.Regulating sleep 3.Physical activity (exercise, walking) 4.Breathing exercises for relaxation 5.Muscular relaxation	1.CBT 2.Counselling 3.Interpersonal therapy 4.Behavioural therapy 5.Psychoeducation	1 Clinical therapy 2 Group therapy 3 Problem solving 4 Social-skills training 5 Participation of social support institutions 6 Reactivation of social networks or creating new ones	Pharmaceutical treatment of anxiety disorder is recommended alongside CBT (or other psychological treatments)

Panic Disorder

	Biological	Psychological	Social	
Cause and Pathogenic mechanism	1 Genetic. Almost half of Panic disorder patients have at least one relative inflicted with it 2 Neurotransmitters involved are GABA and Norepinephrine 3 Drugs and other substances (Sodium-bicarbonate-sodium lactate yohimbine)	1 An unsuccessful defence mechanism to face anxiety stimulators (analytical) 2 Unconscious meaning of traumatic events (stress)	1 Life's stress (early separation from the mother-sexual harassment during childhood-physical or emotional separation from important people whether in early childhood or puberty 2 Recognising parents to be frightening, demanding, or controlling. 3 Fear of Punishment of the Grave after death and the fire of hell constitute an epicentre of panic episodes that many Arabs suffer from	
Symptoms and clinical manifestations	Repetitive and unexpected panic attacks. A panic attack is a period distinguished by intense fear or discomfort, where four or more of the following symptoms suddenly occur and it peaks in 10 minutes: 1 Palpitations or increased heart rate. 2 Sweating. 3 Twitching or trembling. 4 Shortness of breath or suffocation. 5 Feeling choked up. 6 Chest pain or discomfort. 7 Nausea or abdominal distress 8 Lightheadedness or dizziness 9 Disorientation (numbness and tingling) 10 Hot or cold flashes	1 Feeling unreal or detached from your surroundings 2 Fear of losing control, or going crazy 3 Fear of dying At least one of these attacks is followed by a month (or more) of one (or more) of these manifestations: a. Constant fear of further attacks b. Anxiety about the content and repercussions of the attack (e.g. losing control, heart attack, insanity) c. Obvious change in behaviour related to attacks	1 Quick change in decisions. 2 Social isolation 3 Distrust of others, particularly if the person has been hurt before 4 Overprotectiveness of children 5 Avoidance	Standards of diagnosis include what has been mentioned in the biological and psychological columns and not the social one
Measures and treatment	1.Pharmaceutical treatment 2.Sleep regulation 3.Physical activity (exercise, walking) 4.Breathing relaxation 5.Muscular relaxation	1 Psych-education 2 CBT 3 Interpersonal therapy 4 Behavioural therapy	Training on social skills - Helping the patient, following his/her consent, change the unhealthy method adopted to deal with anxiety, such as: - social withdrawal - alcohol and substance abuse - repetitive self-harm, such as ingesting an overdose of medication or cutting one's self - study the social case where the patient him/herself pinpoints the problems and anguish that precipitate his/her anxiety, and place a plan to solve these problems. The patient should do this, unless the patient does not have the resources to do so. In that case, adequate support should be provided in problem areas, such as housing and employment	

Chapter Seven: Obsessive Compulsive Disorder

	Biological	Psychological	Social	
Causes and pathogenic mechanism	Genetic: Relatives of OCD patients are 3 to 5 times more prone to suffer from the disorder Monozygotic twins have a stunning percentage of 80% to 87% of being inflicted by the same disorder. Neurotransmitter infections (serotonin)	Fixation on early developmental stages (anal fixation) (analytical)	Inter-personal relations: OCD symptoms have negative interactions with inter-personal relations. Families that have an OCD member could have a positive impact on the patient (for example, an OCD patient who suffers from paranoia might constantly demand reassurance for illogical fears, and these reassurances when constantly provided could aid the patient.	Causes of OCD remain unknown
Symptoms and clinical manifestations		1 Intrusive, repetitive and persistent thoughts, urges, or images that cause distress 2 Patient unsuccessfully try to suppress or ignore the disturbing thoughts, urges, or images 3 Patient knows that his/her mind simply generates these thoughts and that they do not pose a true threat 4 Excessive rituals or mental acts are performed to reduce the severe anxiety caused by obsessive thoughts	• The compulsive thoughts do not just excessively focus on real problems in a patient's life Compulsive behaviour is known as: 1 Excessive and repetitive ritualistic behaviour that a person feels s/he must perform, or something bad will happen. Examples include hand washing, counting, silent mental rituals, checking door locks, etc. 1 The ritualistic compulsions take up a least one hour or more per day and significantly impact a person's daily life, whether it is career, activities or social relations.	
Measures and Treatment	Pharmaceutical treatment is the first line of treatment. Selective serotonin reuptake inhibitors (SSRIs), which are antidepressants. Numerous research showed that noradrenaline inhibitors play an important role in OCD treatment.	-Psychoeducation -CBT -Behavioural therapy -Dynamic psychological therapy	- Family therapy - Encourage patients and families to form support groups - Ethical and religious issues in religious communities could form appropriate areas for help	The cornerstone for the treatment of OCD is medicinal, and some types of behavioural therapy (exposure and response prevention and cognitive behavioural therapy) in addition to education and family intervention

	Biological	Psychological	Social	
Cause and Pathogenic mechanism	1 Genetics, albeit genes responsible for substance and alcohol dependency have not yet been determined. Substance abuse increases when one close relative is an alcohol addict. 2 Monozygotic twins are 30-60% prone to develop dependency. It is thought that multi genes are responsible for alcoholism hereditary 3 Ingesting the substance causes chemical changes and/or compound changes that double the abuse: dopamine receptors in the pleasure areas of the brain are activated with the presence of dopamine (keeping in mind that physiological mechanisms differ between alcohol and other substances, just as they differ between one substance and the other)	There is a close link between personal disorders and substance abuse, the following points are considered important motives for such behaviour: - Gaining a unique pleasurable experience - Self-medication to reduce anxiety and depression. - Conditional and reinforcement factors play an important role in the abuse of drugs by interacting with other existing causational factors, such as the availability of the substance which reinforces the user's behaviour	1 Cultural orientations, such as achieving a mystical experience, or abiding by the behaviour of the group 2 Alcohol and substance abuse is diminished in societies that penalise such behaviour 3 Availability and price of the substance 4 Social deprivation and dysfunctional family increase possibility of substance abuse 5 Career: Certain careers are linked to alcohol problems. We notice that people who work in resorts, certain traders, doctors and journalists are among people prone to alcohol use. 6 Unemployment increase use of alcohol 7 Stressful life increase use of alcohol as means of overcoming sadness, shock and loss.	
Symptoms and clinical manifestations	1 Physiological symptoms (withdrawal symptoms) when substance is taken in lesser quantities or not available. These symptoms differ from one substance to the other. 2 Increase tolerance, which creates the need for a bigger dose.	1 Intense desire or overwhelming compulsive feeling to use alcohol or another substance. 2 Difficulty controlling the habit and intake quantity.	1 Increased negligence of important issues or alternative sources of pleasure, accompanied by an increase in duration and quantity of substance intake and getting over its subsequent side effects. 2 Continued used despite obvious proof of harmful consequences on the body, psyche and social life.	At least three symptoms should be present
Measures and treatment	1 Detoxing and treating withdrawal symptoms 2 Preventing relapse by use of medication such as disulfiram, naltrexone and acamprosate 3 Evaluating and treating any accompanying medical condition 4 Intervening to limit damage by providing information on the use of sterilised syringes and encouraging checking for blood-borne viral diseases, and treating overdose complications	1 Psychoeducation coupled by explaining the effects and dangers of addiction, both short and long term. 2 Holding shot discussions on motives behind abuse; advising patient to stop intake and asking him/her if s/he is willing to try to quit. 3 Evaluating any accompanying or instigating mental disorder (this takes place 2-3 weeks after abstention, as certain problems are resolved once the intake stops)		

Chapter Nine: Dementia

Dementia is progressive loss of cognitive functions, and it is not limited to loss of memory, contrary to common belief.

- Symptoms of dementia could be summed up by the five As
  - Amnesia: Deterioration of short-term memory
  - Apraxia: The loss or reduction of fine motor skills. Persons with apraxia will have difficulty with basic life skills, such as dressing themselves.
  - Agnosia: The loss or reduction of the brain's ability to interpret vision accurately, such as inability to identify faces.
  - Aphasia: The loss or reduction of the brain's ability to use and interpret language properly; difficulty to find words, which causes frustration for both the patient and the family.
  - Associated Symptoms: Accompanying symptoms: especially the above mentioned behavioural symptoms, which often bring the patient to non-healthcare facilities.
  - Alzheimer's is considered one of the most common causes of dementia, and forms 50% to 70% of all cases of dementia, as shown by a study conducted in developed countries, and others being carried out currently in developing countries. Almost 90% of dementia cases occur after the age of 65 and are caused either by Alzheimer's disease (60%-70%) or vascular dementia (20%). It was recently discovered that most cases suffer of the two.

Following, we will describe Alzheimer's disease.

	Biological	Psychological	Social
Causes and pathogenic mechanism	Genetics is a key contributing factor in risk of being afflicted by Alzheimer's disease, posing 70% danger. -Neurotransmitters (acetylcholine-glutamate) -Dysfunction of the Thyroid gland. -Vitamin B1 and B-12 deficiency -Encephalopathy -Tumours	Depression exhibits Alzheimer-like symptoms, called pseudodementia	
Symptoms and clinical manifestations	Presence of one or more of the following dysfunctions: 1.Aphasia 2.Apraxia 3.Agnosia	A. Multiple cognitive functions defects: 1.Memory impairment (inability to learn new information, inability to recall previously learned information 2. Impaired executive functions (planning, organising, following-up and deduction).	Cognitive impairments cause a malfunction in social and occupational functions, as well as a notable deterioration in previous levels of activity.
Measures and treatment	1.Pharmaceutical treatment: Donepezil, rivastigmine, or memantine 2.Nutrition 3.Daily physical activity 4.Personal hygiene 5.Regular urination to elevate urinary incontinence 6.Treating symptoms of psychosis with current medication	Traditional psychological remedies are impractical in treatment of Alzheimer. Supportive psychological therapy is more efficient and provides reassurance and guidance. Behavioural therapy and techniques in dealing with aggressive and non-adaptive behaviour. -	-It is advised to always have an identification bracelet or card on the person of the Alzheimer's patient. -Doors must be kept shut and secure so that a patient doesn't wander off unnoticed. -The patient must be accompanied whenever s/he goes out. -Group therapy. -Family therapy

Chapter Ten: Neurodevelopmental Disorders

Neurodevelopmental disorders are impairments of the growth and development of the brain or central nervous system. They appear early on and often during pre-school period and lead to a decline or disability on the personal, social, academic and professional levels.

Neurodevelopmental disorders are often mixed with other disorders. For example, autistic spectrum disorder is often coupled with a mental disability, and hyperactivity and attention deficit disorder is often accompanied by other disorders.

Classification distinguishes between 22 types of disorders. We will speak of three of these:

1- Mental development disability (mental disability)
2- Autistic spectrum disorder
3- Hyperactivity and attention deficit disorder

- A 00-01 Intellectual Developmental Disorders
- A 00 Intellectual Developmental Disorder
- A 01 Intellectual or Global Developmental Delay Not Elsewhere Classified
- A 02-08 Communication Disorders
- A 02 Language Impairment
- A 03 Late Language Emergence
- A 04 Specific Language Impairment
- A 05 Social Communication Disorder
- A 06 Speech Sound Disorder
- A 07 Childhood Onset Fluency Disorder
- A 08 Voice Disorder
- A 09 Autism Spectrum Disorder
- A 09 Autism Spectrum Disorder
- A 10-11 Attention Deficit/Hyperactivity Disorder
- A 10 Attention Deficit/Hyperactivity Disorder
- A 11 Other Specified Attention Deficit/ Hyperactivity Disorder
- 12-15 Learning Disorders
- A 12 Learning Disorder
- A 13 Dyslexia
- A 14 Dyscalculia
- A 15 Disorder of Written Expression
- A 16 Motor Disorders
- A 16 Developmental Coordination Disorder
- A 17 Stereotypic Movement Disorder
- A 18 Tourette's Disorder
- A 19 Chronic Motor or Vocal Tic Disorder
- A 20 Provisional Tic Disorder
- A 21 Substance-Induced (indicate substance) Tic Disorder
- A 21 Unspecified Tic Disorder
- A 22 Tic Disorder Due to a General Medical Condition

Intellectual Disability (Intellectual Developmental Disorder)

IDD is a disorder that begins early in the developmental period, and includes a decline in mental functions, adaptive skills, or tasks of daily living. It is diagnosed through these manifestations:

1- Deficits in memory, social, and problem-solving skills. Standardised tests such as an IQ test are used to determine a child's level of intellectual development.

2- One must also exhibit deficiencies in two or more specific areas of adaptive behaviour, such as communication skills, interpersonal skills, or daily living skills like getting dressed and using the bathroom.

3- The onset of intellectual development disorder is usually during developmental phase.

IDD replaced the term mental disability in the US classification. And it is classified into

1. Mild
2. Average
3. Severe
4. Profound

Its prevalence is 1% of the total population, and severe cases of IDD are up to six thousand. It is more common among males than females. Prenatal factors play a major role in causing it, such as genetic and metabolic causes and intrauterine hypoxia.

Measures:

1. Psychoeducation
2. Accepting and caring for the child
3. Social rehabilitation
4. Placing an individual plan based on the child's needs
5. Bolstering and guarding human rights
6. Offering support for caregivers

Autistic spectrum Disorder

The term Autistic spectrum disorder comes from the Greek word "autos," meaning "self." It was first used in 1943 by Leo Kanner. The term describes conditions in which a person is removed from social interaction -- hence, an isolated self. It is characterised by an inability to easily communicate and interact with others. Other symptoms linked to autism may include unusual behaviours in interest in objects or specialised information, reactions to sensations, physical coordination.

Causes behind Autism remain unknown, and it is thought that genetic factors have a role in it. Its prevalence is up to 1% of the population and it afflicts males more than females.

Diagnostic Criteria:

A. Persistent deficits in social communication and social interaction across multiple contexts, as manifested by the following, currently or by history (examples are illustrative, not exhaustive, see text):
   1. Deficits in social-emotional reciprocity, ranging, for example, from abnormal social approach and failure of normal back-and-forth conversation; to reduced sharing of interests, emotions, or affect; to failure to initiate or respond to social interactions.
   2. Deficits in nonverbal communicative behaviours used for social interaction, ranging, for example, from poorly integrated verbal and nonverbal communication; to abnormalities in eye contact and body language or deficits in understanding and use of gestures; to a total lack of facial expressions and nonverbal communication.
   3. Deficits in developing, maintaining, and understanding relationships, ranging, for example, from difficulties adjusting behaviour to suit various social contexts; to difficulties in sharing imaginative play or in making friends; to absence of interest in peers.

Specify current severity:
Severity is based on social communication impairments and restricted repetitive patterns of behaviour

B. Restricted, repetitive patterns of behaviour, interests, or activities, as manifested by at least two of the following, currently or by history (examples are illustrative, not exhaustive; see text):
   1. Stereotyped or repetitive motor movements, use of objects, or speech (e.g., simple motor stereotypies, lining up toys or flipping objects, echolalia, idiosyncratic phrases).
   2. Insistence on sameness, inflexible adherence to routines, or ritualised patterns or verbal non-verbal behaviour (e.g., extreme distress at small changes, difficulties with transitions, rigid thinking patterns, greeting rituals, need to take same route or eat food every day).
   3. Highly restricted, fixated interests that are abnormal in intensity or focus (e.g., strong attachment to or preoccupation with unusual objects, excessively circumscribed or preservative interest).
   4. Hyper- or hyporeactivity to sensory input or unusual interests in sensory aspects of the environment (e.g., apparent indifference to pain/temperature, adverse response to specific sounds or textures, excessive smelling or touching of objects, visual fascination with lights or movement).

Specify current severity:
Severity is based on social communication impairments and restricted, repetitive patterns of behaviour

C. Symptoms must be present in the early developmental period (but may not become fully manifest until social demands exceed limited capacities, or may be masked by learned strategies in later life).

D. Symptoms cause clinically significant impairment in social, occupational, or other important areas of current functioning.

E. These disorders are not better explained by intellectual disability (intellectual developmental disorder) or global developmental delay. Intellectual disability and autism spectrum disorder frequently co-occur; to make comorbid diagnoses of autism spectrum disorder and intellectual disability, social communication should be below that expected for general developmental level.

Note: Individuals with a well-established DSM-IV diagnosis of autistic disorder, Asperger's disorder, or pervasive developmental disorder not otherwise specified should be given the diagnosis of autism spectrum disorder. Individuals who have marked deficits in social communication, but whose symptoms do not otherwise meet criteria for autism spectrum disorder, should be evaluated for social (pragmatic) communication disorder.

Specify if:
With or without accompanying intellectual impairment
With or without accompanying language impairment
Associated with a known medical or genetic condition or environmental factor

Severity levels for autism spectrum disorder

Severity level	Social communication	Restricted, repetitive behaviours
Level 3 "Requiring very substantial support"	Severe deficits in verbal and nonverbal social communication skills cause severe impairments in functioning, very limited initiation of social interactions, and minimal response to social overtures from others. For example, a person with few words of intelligible speech who rarely initiates interaction and, when he or she does, makes unusual approaches to meet needs only and responds to only very direct social approaches	Inflexibility of behaviour, extreme difficulty coping with change, or other restricted/repetitive behaviours markedly interferes with functioning in all spheres. Great distress/difficulty changing focus or action.
Level 2 "Requiring substantial support"	Marked deficits in verbal and nonverbal social communication skills; social impairments apparent even with supports in place; limited initiation of social interactions; and reduced or abnormal responses to social overtures from others. For example, a person who speaks simple sentences, whose interaction is limited to narrow special interests, and how has markedly odd nonverbal communication.	Inflexibility of behaviour, difficulty coping with change, or other restricted/repetitive behaviours. Appear frequently enough to be obvious to the casual observer and interfere with functioning in a variety of contexts. Distress and/or difficulty changing focus or action.
Level 1 "Requiring support"	Without support in place, deficits in social communication cause noticeable impairments. Difficulty initiating social interactions, and clear examples of atypical or unsuccessful response to social overtures of others. May appear to have decreased interest in social interactions. For example, a person who is able to speak in full sentences and engages in communication but who's to- and-fro conversation with others fails, and whose attempts to make friends are odd and typically unsuccessful.	Inflexibility of behaviour causes significant interference with functioning in one or more contexts. Difficulty switching between activities. Problems of organisation and planning hamper independence.

Intervention:

1. Psychoeducation targeted at child and family in accordance with severity of the case. The family must be trained to:
   - Accept the child and identify what is causing the child's anxiety, as well as acknowledge that s/he faces difficulty when confronted with new situations. The family should organise the child's day between feeding, playing, sleeping and partaking in daily activities and simple chores, placing him/her in specialised schools, preferably integrated schools. The family should respect the rights of the child and provide a safe zone, monitor the movement and allow the child to play freely. It is advised that the family of an autistic child reaches out to other families with similar cases, share information and educate teachers.
2. Train the child in accordance with a plan based on his/her individual capabilities and needs modelled on certain schools, such as Lovaas and others.
3. Medicinal treatment could be used, such as antipsychotics like risperidone to control aggressive behaviour when needed

Attention deficit Hyperactivity Disorder (ADHD)

Attention deficit hyperactivity disorder (ADHD) is a mental disorder of the neurodevelopmental type. It is a persistent pattern of inattention and/or hyperactivity-impulsivity that interferes with functioning or development, it afflicts 5% of children globally, and is more common in males than females at a ratio of 2 to 1. Genetics play an important role in this disorder.
This disorder is diagnosed through -Either (1) or (2)
(1) Six or more of the attention deficit symptoms have persisted for at least six months to a degree that is inconsistent with developmental level and that negatively impacts directly on social and academic/occupational activities:

- Often fails to give close attention to details or makes careless mistakes in schoolwork, work, or during other activities (e.g. overlooks or misses details, work is inaccurate).
- Often has difficulty sustaining attention in tasks or play activities (e.g., has difficulty remaining focused during lectures, conversations, or lengthy reading).
- Often does not seem to listen when spoken to directly (e.g., mind seems elsewhere, even in the absence of any obvious distraction).
- Often does not follow through on instructions and fails to finish school work, chores, or duties in the workplace (e.g., starts tasks but quickly loses focus and is easily side-tracked).
- Often has difficulty organising tasks and activities (e.g., difficulty managing sequential tasks; difficulty keeping materials and belongings in order; messy, disorganised work; has poor time management; fails to meet deadlines).
- Often avoids or is reluctant to engage in tasks that require sustained mental effort (e.g. schoolwork or homework; for older adolescents and adults, preparing reports, completing forms, reviewing lengthy papers).
- Often loses things necessary for tasks or activities (e.g., school materials, pencils, books, tools, wallets, keys, paperwork, eyeglasses, and mobile telephones).
- Is often easily distracted by extraneous stimuli (e.g., for older adolescents and adults may include unrelated thoughts).
- Is often forgetful in daily activities (e.g., doing chores, running errands; for older adolescents and adults, returning calls, paying bills, keeping appointments).

(2) Six or more of the following hyperactive-impulsive symptoms sustained over a period not less than six months, to the point of inadaptability and inconsistency with developmental level:

- Often fidgets with or taps hands or squirms in seat.
- Often leaves seat in situations when remaining seated is expected (e.g., leaves his other place in the classroom, in the office or other workplace, or in other situations that require remaining in place).
- Often runs about or climbs in situations where it is inappropriate (e.g., in adolescents or adults, may be limited to feeling restless).
- Often unable to play or engage in leisure activities quietly;
- Is often "on the go" acting as if "driven by a motor" (e.g., is unable to be or uncomfortable being still for extended time, as in restaurants, meetings; may be experienced by others as being restless or difficult to keep up with).
- Often talks excessively.
- Often blurts out answers before questions have been completed (e.g., completes people's sentences; cannot wait for turn in conversation).
- Often has difficulty waiting turn (e.g., while waiting in line).
- Often interrupts or intrudes on others (e.g. butts into conversations, games, or activities. May start using other people's things without asking or receiving permission; for adolescents and adults, may intrude into or take over what others are doing).

A- Presence of certain hyperactive-impulsive symptoms or attention-deficit symptoms that cause impairment before the age of 12.
B- Presence of a certain degree of impairment in at least two settings (at home and at work).
C- There should be clear evidence of clinical dysfunction in social, academic and work performance.
D- The symptoms do not occur exclusively during the course of schizophrenia or another psychotic disorder and are not better explained by another mental disorder (e.g. mood disorder, anxiety disorder, dissociative disorder, personality disorder, substance intoxication or withdrawal)

Differential Diagnosis:

This disorder should be differentiated from oppositional defiance disorder in children, anxiety disorder, autism spectrum disorder, bipolar disorder, and disability, in addition to other specific learning disabilities.

Measures:

1- Psychoeducation
2- Training parents on behaviour modification skills
3- Psychosocial support for the family
4- Behavioural therapy for the child
5- Pharmaceutical therapy. Atomoxetine and phenidate are the currently used medications for children aged six and above.

Chapter Two

PRIMARY COUNSELLING

Chapter Two
PRIMARY COUNSELLING
What is Primary Counselling?

Primary counselling is a process founded on a relationship with empathy towards the other, acceptance, and trust. The counsellor focuses on the emotions, thoughts, and behaviours of the client, and then enabling the client to:

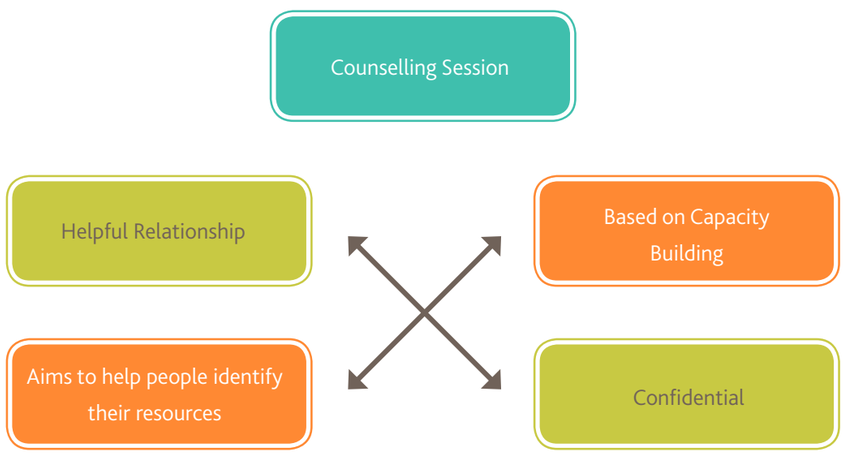
- Cope with their current lives
- Explore their options
- Take their own decisions
- Be responsible for their decisions

Counsellors are people who help others express themselves and understand their emotions. This process help people to: reduce their anxiety and worry, take decisions and act on these decisions; to grow and evolve. Counsellors do not give advice, they only help others face their problems and test their options.

The main tools of a counsellor are:

- Empathy
- Active listening
- Reverse emotions
- Asking good questions
- Assurance and acceptance

Counsellors create the environment where the clients are more familiar with their thoughts and emotions by listening to themselves talk.



What is the difference between counselling and other forms of support?

There are several examples of helpful relationships in society like doctor, lawyer, bank manager, and the question is how does counselling differ from other forms of help?

- Other types of relationships may include advice but counselling does not.
- Some may not have limits or boundaries. Counselling has clear boundaries.
- There might be a conflict of interest in other types of relationships
- They might be judgemental. Counselling does not offer advice.
- Some may provide sympathy rather than empathy
- They might not be objective.
- There are no mutual expectations during a counselling session, and the client is not expected to help the counsellor in return.
- The counsellors do not put conditions or expectations over their relationship with the client, while other non-counselling service providers may expect their client to act in a certain manner.

The Characteristics and Positions of an Effective Counsellor:

The counsellor can learn skills through practice. In order to be an effective counsellor, it is important to maintain certain characteristics that make the client feels comfortable and able to trust the counsellor for their self-development. The following are some of the practical characteristics and skills a counsellor should have to conduct a successful session:

- Understanding and respecting the client's rights
- Being patient and tolerant
- Having a vast knowledge about human behaviour and the issues of concern that relate to the client
- Gaining the client's trust by showing genuine concern and attention
- Understanding the client's cultural and emotional elements that affect him/her
- Adopting a non-judgemental approach
- Active listening
- Understanding body language and non-verbal communication
- Recognising and communicating his/her limitations and suggest referrals to other specialists

The Stages of Counselling

The process of counselling goes through the following different stages:

1. Initial contact and the first meeting
2. Evaluating and analysing the problem
3. Providing supportive and continuous counselling
4. Planning and initiating steps
5. Executing the plan
6. Conclusion and follow up

Initial Contact and the First Meeting

The counsellor should welcome the client with the traditional greetings that the client uses, giving him/her full attention, followed by the counsellor and the client introducing themselves to each other. Acceptance and voluntary participation during the initial contact gives the client a sense of comfort and hope. This does not require a lot of words but it can send the right message with a smile, direct eye contact and the proper body language shown by the counsellor.

Welcoming the clients with a similar greeting to that practiced in their own culture and traditions, gives them a sense of warmth and familiarity. Establishing the initial relationships helps in gaining the client's trust and assures confidentiality, which facilitates the understanding of the main issues that need to be addressed. This warmth allows the clients to express their fears and concerns more openly and freely.

This is the first step in exploring the client's needs. It paves the way to discover their inner world and their problems and gives more clarity on their expectations from the counselling sessions. It can also help the counsellor in identifying the means and methodology in which he/she should approach the client. Remember that the counsellor is responsible for the emotional safety of the clients. The counsellor should take into consideration the ethics of confidentiality to ensure the client's safety and respect. The counsellor does not verbalise what comes to his/her mind, but chooses their words carefully based on the context and the situation at hand.

Sometimes, many clients do not know a lot about counselling and may be anxious. Therefore, it might be a good idea to explain the goal of the sessions, the ground rules, the expectations and the expected outcome. Such explanations help the counsellor to overcome the barriers that may arise when establishing a counselling-relationship.
The presence of a safe and private environment, with well arrange seating that allows for direct eye contact with the client, are essential.

Evaluating and Analysing the Problem:

A skilled counsellor would conduct a thorough evaluation prior to setting a plan for therapy. The first step would entail exploring the detailed history of the client and focusing primarily on the problem. The best counsellors assess the problem's severity through active listening. The counsellor creates an environment where the client narrates their story, without the counsellor's intervention; thus, collecting the information needed to set the goals of the counselling sessions.

The aim of the sessions at this stage is to understand the clients. The counsellor should be in a state of alert and ask questions about the main fears of the clients. The counsellor should not only listen to the verbal communication but also to non-verbal ones. It is not only important what the client is saying, but how the client is saying it. The work-plan can be formed once the client is capable of expressing and understanding the facts surrounding his case.

Providing Supportive and Continuous Counselling

Supportive and continuous counselling should be offered after the client's needs are determined from their own perspective, while the counsellor responds empathically, to those needs. The counsellor should not disclose his opinion or dictate the solution, but rather he/she should identify the available options with the clients. During this stage, there might be a peak in reactions and contradictions. The counsellors should give certain assertions to help and support the clients to be on their side. During the process, the coping capabilities of the clients are identified, and the counsellor should explore how the clients responded to previous crises in the past. It is possible for the counsellor to look into developing a new set of coping skills depending on the situation. Brainstorming and working together will help facilitating the process of exploring the available options, thus developing the client's self-confidence. It is important to remember that the ownership of the options and actions should always be taken by the clients, and they are the ones who should think of these options, and feel the need to make the changes in certain aspects of their lives. The counsellor fills the gap by providing information for referrals to other therapeutic services, specialised care, or other kinds of supports.

Planning and Initiating the Steps

Counselling is a continuous process that is not simply limited to one or two meetings. Following the initial discoveries of available options and skills expressed by the clients, the counsellor should assist them in identifying their possible and realistic goals. The clients, at this stage, may not yet have the motivation to change their behaviour. Therefore, these options need to be evaluated parallel to their possible outcome or consequences before moving forward with their implementation. The counsellor should encourage a participatory discussion to the plan decided by the clients.

Executing the Plan:

Following the planning, the execution means should be studied and examined. There will be consequences over the client's life and maybe others too. Sometimes, executing the change may trigger pressuring reactions from others. The clients need a lot of support and reassurance from the counsellor to cope and adapt with the new needs and arising possible scenarios. There may not be one solution or one plan better than the other. Each person should choose one option from the many available. The counsellor should support the client in identifying the work plan and the means to achieve it. Some of the attempts may be successful or unsuccessful, and there may be a need to detail the plan and the sequence in which the actions should be taken. The counsellor should monitor the behavioural changes and the measure the means that the clients had taken during the follow up sessions. The clients need to be reassured through encouragement and support during the transitional phase to execute the plan.

Conclusion and Follow Up:

As mentioned above, the ownership of the decision to change behaviour should always belong to the clients; the counsellor is only a facilitator of that change. The counsellor should assist in evaluating the progress in behavioural change and coping resources. It is vital to strengthen the counselling follow up by ensuring the following:

- The clients work on executing the plan
- The clients maintain the gains in which they achieved so far
- The clients manage their daily performance and cope with it
- The clients have the needed attainable support system

Finishing the counselling should not be a sudden event, but by gradually by increasing the timeframe between the sessions. Reassurances should be given to the clients including the option that they can receive further support in counselling when needed. Referrals should be made, if needed, depending on the needs of the clients.

Process	Content
Initial Contact and the First Meeting	The process of counselling goes through different stage respectively as following "I'm a counsellor in this centre; we help people overcome all kinds of difficulties". "Any conversation we have will be confidential". (Ask about the personal information such as name, age, gender, residence, profession, etc…). "Can you tell me what drove you to come to us today?" "It seems you have some concerns you'd like to discuss with us?" • Reversing Emotions: The client may say "I'm afraid I'm pregnant for the second time in the same year and that won't be able to take care of the new-born". The counsellor can say "You seem concerned about taking care of your little baby in case you're pregnant"
Evaluating and Analysing the Problem	Ask open-ended questions like: "I would like to understand the problem that's concerning you" "I want to know what you know about contraceptives" "Tell me why do you feel at risk if you're pregnant" "What do you know about…" "Tell me more about yourself"
Providing Supportive and Continuous Counselling	"I wish to know how you deal with pressure. What did you do in the past and who was supporting you?" "I understand what you're feeling currently" "given the situation you're in at this moment, any person would feel the hardship, but a person should always find a way out of the problem they're experiencing" "it is okay to feel the need to cry because it helps you identify your real emotion, and I'm here to understand these feelings and the difficulties you're facing" "we may not be able to change the circumstances but we can look for other options to deal with the complications we're facing right now"
Planning and Initiating The Steps	"Since the ways you're using now to cope and handle the situation are not working, we should explore other new options" "I would suggest making a list of the things that are under our control and the ones that are outside of our control. Then we can work with the things that we can control" The counsellor could also mention phrases like "we can do that only if you have the will to change" "It is difficult to change the world around us, so what would you want to work on today?"
Executing The Plan	After identifying the methodology to execute the plan, the counsellor should encourage the client by saying "I'm confident in your capabilities to handle the situation" or using other references on how one should keep trying until they achieve success.

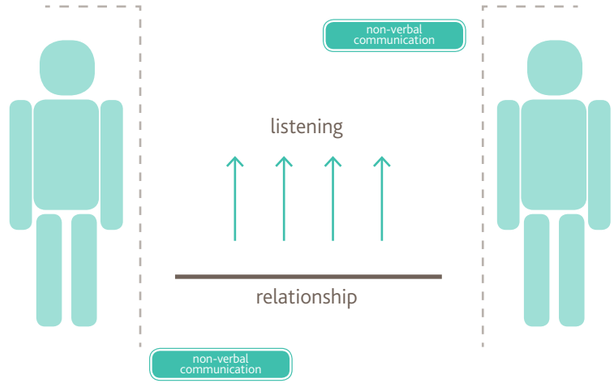
The Skills of Counselling

The aim from communication among people is to understand and be understood. Mostly, what is being said and what is heard are different. Therefore, it is important to be sure of what you heard and understood what the clients said. It is important to validate what is understood from the clients through asking for clarifications. It is vital to regularly check that you understand what the clients are saying. This is attained through communication.

Communication is transferring information, a message, from person to another who receives and understands the message.

The Elements of Communication:

- The Sender
- The Receiver: who might be more than one recipient, should listen.
- The Message: what is delivered, as in what is being said or written. The message should be concise and clear.
- The Medium: the pathway in which the message is sent; spoken, written, etc…
- The Feedback: the response of the receiver to the message.



Only a small portion of communication (about 30%) is verbal, while the other 70% constitutes non-verbal communication that relies on body language. Communication is a two-way action where listening is an important aspect and the relationship between people is influenced by this form of communication.

There are two main concepts to understand communication among people:

- Verbal Communication
- Non-Verbal Communication

What does Verbal Communication mean?

- What is said out-loud
- Including, but not limited to, a message
- Vocal (high or low pitch)
- Tone
- Language
- Sighs

What is Non-Verbal Communication?

- Information that can be sent, but not orally, thus cannot be heard
- Relies on senses other than hearing, like vision and touch
- Entails a larger capacity to communicate more than words that are sent back and forth
- It is often referred to as "body language", including:
  - Miming; crossed legs, folded arms
  - Facial expressions
  - Body's position; sitting straight or relaxed
  - Visual contact
  - Sitting
  - Distance; how close or far we are from a person in terms of distance
  - Touching

Our bodies play an important role in communication. Therefore, it is vital to know where our comfort zone is,- in terms of personal space, touching and getting close to others. It is also crucial for clients to realise that we care for their individual comfort. We should do our best to respect them. Touching is considered an important part of communication; but this is done after carefully taking into consideration the cultural and traditional practices of the clients since there are no unified international standards for this behaviour. (In some cultures, it is advisable not to touch the opposite sex. Even in same-sex cases, we should always take into account that the client may have suffered from sexual harassment or abuse, which makes her/him more susceptible or agitated by touch- as they may feel unsafe).

The Main Tools of the Counsellor

- Active listening
- Empathy
- Reversing emotions
- Asking good questions
- Reassurance and tolerance

Active Listening:

Listening is one of the most important tools of communication, it is crucial during counselling sessions where verbal and non-verbal communication are involved; as you can listen to a person without saying anything.

Non-Verbal Communication during Counselling:

The elements can be represented by a simple mnemonic - SOLER
S: Sit; sitting facing a person
O: Open; opening up and the body position is non-defensive
L: Lean; leaning a little towards the client
E: Eye; making eye-contact
R: Relaxed; looking relaxed

Verbal Communication during Counselling:

Minimal verbal responses: there are verbal responses that show you are paying attention, such as: "mmmmm", "aha", "yes". These small responses allow the clients to know that you are listening to them and encourages them to continue talking.

- Active and effective listening entails:
  Engaging in another person's world and be part of what they are experiencing. Not only through listening to their words but how these words are said, and in what tone, or what is the actual word used to describe the experience and their body language and facial expressions they use when they are talking.

- Listening to what had not been said, or listening to silence
  During counselling, active listening is important as it becomes part of the client's world and experience. The combination of active listening and empathy is one of the mandatory requirements in all cognitive behavioural therapy and has a therapeutic effect on the client on its own.

Active Listening:

Non-Defensive: explaining what is said with what you wanted to hear, or thought you heard
Non-Selective: not listening to the entire message but only hearing what you want to hear
Not distracted: seems that you are listening but your mind is very far away from what is being discussed
Non-sympathetic: listening to the story from the side-lines
Non-intentional: listening to the all the words but ignoring the emotions expressed by the person, whether verbal or non-verbal.

Active listening encourages the clients to clarify what they expressed and makes it easier for them to proceed with their speech. This allows for counsellors to have a better understanding of the client's perspective of their world. It also makes the clients feel understood and listened to. It is central to establishing a relationship between the counsellor and the client.

Have you ever experienced a situation where you were talking to someone about a problem? This person could have been a friend, family member who simply listened to you. They did not offer you any solution or told you what needs to be done but only listened to your thoughts and feelings. After that, you may have felt much better because you talked to them about the problem and they listened. Sometimes talking to someone can be therapeutic.

What obstructs active listening?

- Culture: when we have different cultures
- Language: when there are differences in language or dialect, communication may become difficult
- Personal values (what we consider important): each person has different values
- What went on in your life: this could change your perspective about what the client is going through
- Your own current emotional or personal issues
- Pre-ready responses: if you are e preparing your response then you cannot listen to the client
- Defensiveness or bias

Empathy

What Is Empathy?

Empathy could be one of the most important and effective tools for counsellors and also the most difficult for trainees due to the confusion between empathy and sympathy. It is vital for the trainee to focus on the empathy in their training and to demonstrate it himself until it is mastered after supervision and the training are complete.

- It is putting yourself in the other person's position
- Moving respectfully within the life of another person
- Temporarily living in another person's life, moving delicately without judgement
- Going into the consciousness of another person, and be susceptible to the changes, obstacles and experiences
- Empathy enhances the counsellor's understanding of the client's behaviours and their feelings
- Empathy allows you to view the experience from another person's point of view
- The characteristics of empathy are:
  - Open-mindedness: we should set aside our own values and personal beliefs in order to view the client's values and beliefs
  - Imagination: to imagine the background of the client's thoughts and feelings
  - Commitment: the will to understand the client
  - Knowing ourselves and accepting who we are: strengthens empathy towards others
  - Empathy means viewing things through the eyes of another, hearing with the ears of another and feeling with the heart of another.

- Differentiating between empathy and sympathy:
  - Sympathy: feeling what the other is experiencing. For example, feeling sad for a family that lost its child; we feel sadness and sorrow.
  - Empathy: placing ourselves in the position of the other to see the world through their eyes. This does not mean to feel exactly what they are feeling or to experience what they experienced.

What is important for a counsellor, Sympathy or Empathy, and why?

- Empathy is important because we cannot experience what other people had been through. We use our expertise and attention to the clients and what they experienced so we better understand their situation.
- Empathy is important for counsellors because when we feel sympathy we are limiting ourselves to an emotion or sensation. Empathy allows the counsellor to understand the thoughts and perspective of the clients and not just their feelings.

The Obstacles that Arise In the Absence of Empathy

Positions: It is a mental and emotional state. It is mental situation in relation to the rest of the world. It can be positive or negative. The negative behaviour and feelings towards the others can obstruct the development of empathy.

Values: It is what is important to a person. Values rely on principles or goals or social standards that a person or a group adopts and cherishes. Values are influenced by culture, family, religion, friends, etc…

Stigma: Categorising people as members of a group and not individuals.

Stereotyping: Labelling an individual with the characteristics of the group they belong to. It is an assumption that, as long as a person is part of that group, they must have the same positions and values.

Prejudice: When someone adopts a negative perception of an individual based on their group's characteristics, without taking into consideration the individuality of that person. Prejudice relies on stereotyping and comes from a negative perception of an individual based on a stereotype.

Reversing Skills:

Reversing skills work as a mirror that states the opposite of what the clients are saying. It is a means of communication and understanding the others point of view. It is valuable in building a relationship with the clients to clarify their emotions and problems. It also helps the counsellor to gain information about the client and how they perceive their situation. It helps the counsellor to validate their perception of what the clients said; whether they understood it correctly or not.

We will focus on four reversing skills that can be used during any stage of the counselling sessions, and are essential to build trust and to explore.

- Reversing emotions
- Rephrasing
- Validation
- Summarising

Reversing Emotions:
Reversing the emotions of the client and focusing on their feelings and not their content. For **example:**
Client: "I'm the only one who works in my family. My mom and sister and her two kids live with me and my 3 children. My sister arrived about a month ago and she was unable to find any job. I'm unable to bear the school tuitions for my kids, and I do not know what to do towards my sister's children".
Counsellor: "You seem exhausted and concerned"

Tips for reversing emotions:
- Listening and reversing verbal and non-verbal communication
- Reading the body language and reversing what you see if the client did not express their emotions verbally
- We need to remember the words used to express feelings in order to reverse them. As a counsellor, you should have a large repertoire of words to express emotions.

Rephrasing:
This is restating what you understood from the client for communication to occur. It is repetition of the content and the feelings within the messages by using slightly different words.

Tips for rephrasing:
- Use your own words to describe what you understood from the client
- Use slightly different words with similar meaning and do not repeat what the client said
- Rephrase all the content and emotions of the client
- Be clear and respectful as if you are saying " I heard you say…it seems you are saying…."

Example:
Client: "I'm very angry with my husband. I want to kill him, he drives me crazy!"
Counsellor: "You seem very upset and your frustration with your husband is at the maximum"

Validation:
This is stating to the client, or encouraging the choices, they have made. It could be assuring the choices, their knowledge, or behaviour. This is similar to what a teacher does with a student as a verbal reward, or a parent does with a child when they say "good job" or "you did your best".

This can start with a validation from the counsellor to a client's choice of coming for counselling, but opposite to that between a teacher and a student. The primarily skill of validation is encouraging the clients to assure and validate themselves instead of relying on the counsellor for it. For example, instead of saying "I'm very proud of you for coming back for your test results", the counsellor should say "You should be proud of yourself for coming back to get your results" or "For regularly doing the relaxation exercises".

Validation is an important tool to strengthen the clients through encouraging them to take the right and healthy choices and the positive behaviours that will follow.

Summarising:
This is the organisation and highlighting of the emotions and important views that the clients expressed.
For **example:** the counsellor (at the end of the session): "Today you talked a lot about your overwhelming feeling of responsibility that you feel towards keeping everyone in your family with you. We looked for ways that make you give up on things that you do not have control over and look for other ways to act when you do not have another choice. In the next session, we will review if there are any changes in the overwhelming emotions you have"

Uses of summarising:
- Can be helpful in organisation and clarifications of sessions
- Revising the session and reordering priorities and focusing on the next session
- Helpful for starting and ending the session
- Helpful for any transformation during the session

Asking Questions and Explanation
Asking Questions (clarification): This is an important part of counselling. The counsellor should be careful with the type of questions he/she will ask and how they will be asked.
Types of questions that could be asked:
Closed questions:
Closed questions are the questions that can be answered with one word. These are often called yes/no questions.
Example: How old are you? What is your name?
Closed questions place the counsellor in the position of the expert and enforce the role of the client as negative and non-participatory in the session. It also obstructs the discussion and the development of the relationship between the counsellor and the client.

On the other hand, closed questions can be helpful to retrieve specific information. They are good for clarification but not for exploration.

Open-Ended Questions:
Open-ended questions engage others to talk and they lead to a discussion or a conversation. Open-ended questions encourage the clients to present longer and more detailed answers as they cannot be answered with one word. The goal of these questions is to explore the ideas of the clients and their feelings and experiences but we should be careful when asking open-ended questions as to avoid ambiguity and vague answers.
Example: "What made you come here today? How are you coping with what's happening? Can you tell me more about how that felt for you? What happened after your husband came back home drunk?"

Clarification questions:
Are the Wh-questions (when, how, where, who, what…). These questions aim to find specific answers for clarification.
Example: What was your reaction when you heard the results? With whom did you discuss the results? When was the first time you visited the doctor?

Hypothetical Questions:

These are the questions that assume a certain situation. The goal from these questions is to assist the clients in thinking about possible scenarios and other options that allow them to imagine the possible outcomes of their behaviour. It also allows them to consider and imagine alternative behaviours.

Example:

If you told your friend about your situation, what do you think her reaction would be?
If one of your best friends discovered what happened, what do you think will happen?
If you asked your sister for help in the kitchen, what do you think her reply would be?

Marginal Questions:

This type of questions helps identify and rearrange the priorities of the client's schedule. This could be convenient; especially at the beginning of the session. This could help the client describe sensitive issues.

Example:

What is the worst thing that could happen?
If we were to deal with one thing today, what would be the most important to you?

Tips for asking questions:

- Ask clear and direct questions
- Ask questions concisely and briefly, and do not go out of context
- Share your reasoning behind asking these questions
- Ask nicely

Unhelpful questions should be avoided:

- Questions like "why" or "how did that happen" should be avoided because they may sound too judgemental.
- Too many closed questions will not allow the question to talk and explain in details, but they could be used for clarification or to retrieve specific information.
- Either/or questions; since the clients will answer what you would want to hear. For example: "In the future, would you want to stay late in the bar on the weekend or prefer to stay at home?"
- Multiple-questions: if you asked many questions at the same time, this could confuse the clients, and they may feel being interrogated. Ask one question at a time let the clients answer your question before asking another one.
- Misleading questions: These questions that make the client feel that there is one expected right answer. Therefore, the clients will answer in a way that they think is acceptable by the counsellor. This will not give them the space to explore other options. Misleading questions can be implied to the client through non-verbal communication.

Interpretation or making statements:

This skill includes using words or phrases to show that the counsellor understands what the client is trying to say.

Example:

Client: "I am very affected by my attempts to make enough money to support my family, keep my children in school and cook and clean the house. There's a lot to be done but there is not enough time."
Counsellor: "You may feel like the pillar that brings the family together".

Example:

Client: "It seems to me that I'm constantly tired. I feel that I have no energy. When I get to my house after work, my wife starts to annoy me and the kids are all over the place. All that I feel I want to do is to lie down on the bed and sleep".
Counsellor: "You just want to escape through sleep".

Tips for interpretation:

- Provide a nice statement or explanation. It does not have to be true.
- Include verbal and nonverbal interpretation.
- Validate the statement provided by an explanation and make sure that the client confirms what you say.

Interpretation differs from the reversing skill because your own ideas are included in the interpretation of the client's experiences and, as counsellor, you add your own interpretation or understanding to what the client says.

The First Interview and Its Goal

The first interview can be regarded as the cornerstone of the consultation. The main objectives are:

1. Comforting the clients while communicating with them.
2. Get an overview and understanding of the client's problems.
3. Reach an agreement with the client's about the purpose of counselling and a temporary plan to reach their goal.

Content: Usually discuss the following topics in this initial interview:

1. The problem as seen by the clients: the complaint, difficulties, what they want to change in their lives on their own or what they want to change with regards to others.
2. The background problem: In order to understand the client's problems completely, the counsellor should know the current context of the problem, for example:

- The role that people play in the client's problem.
- The way in which the regulations or laws contribute to the problem.
- All aspects of everyday life in the client's day.
- History of the problem: When and how it started? What the clients tried to do to solve it?
  Do the clients understand why the problem started? Why it has begun at this stage of their life? Talking about the past may be necessary to understand the current problem completely.

1. The counsellor can ask for things that are going well with the client.
2. With respect to solving the problem, the counsellor should know the resources available to the client. Examples of these sources can be family, friends or other persons or institutions in the community such as schools and organisations that provide services to the client.
3. At the end of the first interview, the counsellor should provide his perception of the client's problem and see if they have compatible views. If so, counsellors can discuss the goals of the counselling process with the client. If an agreement is reached, the counsellor will discuss the possible first steps on the way to deal with the problem.

Of course, it is not always possible to discuss all of these topics in detail; the discussion can occur in subsequent meetings.

The Mistakes of the Counsellors and the Challenges in Providing Counselling

The most important element in the consultation is to achieve the goals of maintaining the client's motivation to change their behaviour. The most pressing problem facing the counsellor would be the excessive dependence of the clients on them and the inability to follow-up and regularly monitor and maintain the counselling outcomes. Counselling sessions may remain inconclusive and incomplete for the following reasons:

- Diverse cultural practices
- Going over very sensitive issues unduly
- Inadequate training to deal with sex and sexuality
- Inadequate supervision

Some of the mistakes counsellors make are:

1. Rapid consultations. Counselling can begin by providing advice before discovering what the client's problems are causing the client to feel they had been misunderstood or rejected.
2. Not comprehending the client's feelings. Counsellors cannot take the client's perspective and feelings. For example, the counsellor may suggest to the client (who is deep in sorrow) to engage in activities to try to elevate their mood or reduce the size of a certain aspect of the problem.
3. Prejudice. The counsellor gives great importance to an action that the client will not see as a problem or important. This approach does not fit the way a counsellor should act.

Elements of Good Counselling:

There are many essential elements necessary to ensure an effective consultation:

Enough Time: Providing enough time for a client is important from the beginning. You cannot rush the counselling process; it takes time to build a therapeutic relationship.

Acceptance: The counsellor should not be judgemental but must try to accept the client, regardless of their social, economic, ethnic, religious, background or personal relationships.

Access: Clients need to feel that they can ask for help or contact the counsellor at any time. The counsellor must be available for the client at appropriate times and there should be a system in place to respond to the client's needs. For example, provide after hours or during lunch time services by adopting a rotation system.

Consistency and accuracy: The information should be provided in consistent and accurate manner.

Confidentiality: Trust is the most important aspect in the relationship between a counsellor and a client. Effective counselling includes confidentiality, understanding, empathy and action.

Empathy:

The ability to emotionally understand the client is one of the most important counselling skills. It involves understanding the client's thoughts and feelings and communicating this to them. It requires understanding and awareness of the emotional experiences of the client eg fear, anger, tenderness, confusion etc. In order to understand the client's feeling, the counsellor must be mindful of the signals sent through verbal and non-verbal means of communication.

A counsellor needs to ask himself / herself:

"What are the feelings expressed by the client?"
"What are the experiences and behaviours that underlie these feelings?"
"What is most important in what it says about my client?"

For example, if the client lists the incidents that caused her / him great emotional pain and the client starts to cry, a few words such as: "I can understand what you're going through," may help but avoid saying "it is okay if you cry, it hurts to have suffered such an experience". As discussed earlier, in the reversal techniques there are powerful methods to make the client feel she / he has been accepted and understood.

Recognition of intense feelings: Strong feelings are an inevitable of the session. To help deal with difficult feelings, counsellors should:

- Be aware of their own feelings
- Recognise the feelings and realities of the client
- Understand that it is not the function of the counsellor to remove hurtful feelings
- Respond to verbal and non-verbal messages
- Normalise the client's feelings and acknowledge them.

In order for clients to describe their problems and concerns through counselling, it is important that they feel accepted. The counsellor can facilitate this by being non-judgmental and receptive to clients regardless of their economic, social, ethnic or religious background or personal relationships. Counsellors must recognise the feelings such as anger, sadness, fear directly, noting these words and behaviour.

The use of a non-directive approach: exploring options instead of issuing directives reduces the chance of a power struggle between the counsellor and the client. When discussing behaviour change, counsellors should avoid guiding statements like, "You should use a seatbelt when you drive your car!" Instead, you can put the responsibility in the hands of the clients by asking the question, as follows: "What do you think you can do to protect yourself?"

Self-awareness among Counsellors

It is useful for counsellors to assess their needs and feelings and discuss them with colleagues and supervisors. The following questions will help counsellors to increase their self-awareness:

Do you feel uncomfortable with the client or a particular subject?

Often, counsellors do not feel comfortable with a certain type of client or with controversial topics such as drugs or sex. It is important for counsellors to recognise this and deal with it. If the counsellor feels that he could not overcome these difficulties, he should refer the client to another counsellor.

Am I aware of any avoidance strategies I have?

It is important for a counsellor to recognise their own weaknesses on some topics. A counsellor's own avoidance strategies may cause them to say: "This seems to bother me. It is better to explore what is happening so that I can be really useful for this client." Counsellors have to realise that, by adopting avoidance strategies, they will not be able to help the client properly because they may avoid important issues.

Can I be completely honest with the client?

Counsellors want to be loved and accepted like most people. Providing reassurance and supportive responses reduces the client's ability to develop responsibility and independence. Thus, it is important that counsellors are able to say things to their supervisors if they did not like something about a client.

Do I always need to be in control of the situation?

While consultants may also prefer some restructuring and guidance to achieve the goals and objectives, it is important to pay attention to how they feel when the client does not agree with them or when the clients wants to take a different approach. For example, sometimes a counsellor wants to change the approach but the client refuses. Instead of feeling anger or rejection the counsellor should try to accept the client's feelings and try to propose alternatives. Responsive listening should be used. In this kind of conflict within a session, counsellors should self-reflect and distinguish clearly between what they want and the needs of their client.

How can a counsellor develop self-awareness?

To develop self-awareness, the counsellor can use the following strategies:

- Self-disclosure: Sharing something about oneself with another person. Counsellors should be encouraged to form a peer group where it can become a platform for support to enhance their counselling skills.
- Reverse reflection: Unlike one's own feelings and reactions shared with any peer or elder it is another way to be aware of their knowledge, attitudes and perceptions. Workshops and meetings for research initiatives are forums that give the opportunity to look inward and to self-develop for a better performance.
- Accept feedback: This is the helpful for self-awareness. In some cases, there are feedback mechanisms by clients on their satisfaction with services and the development of systems to monitor feedback to facilitate services on the individual level or at the level of service delivery.

The Type of Problems that Counselling Can Provide a Solution For

In practice, most clients are facing a combination of problems. You can differentiate between six types:

1. Practical problems and problems resulting from difficult circumstances. The lives of victims of armed conflict are full of these types of problems, including conflict with people, friends and family members. Often the problems of this type require that the client make a decision or a difficult choice.
2. A dilemma when it is on the individual level; to choose between two evils.
3. Lack of skills, for example, the skills required to meet new friends after the separation from old and trusted friends. These problems are usually associated with "practical problems or difficult situations."
4. Symptoms and complaints related to trauma or severe stress. For example, physical complaints that cannot be helped by physical medicine. Some of the symptoms could be nightmares, anxiety, or tantrums that are sudden and unexpected. These problems usually appear after the client endured traumatic experiences and life-threatening situations.
5. Problems stemming from the overwhelming feelings of hopelessness and vulnerability.
6. Problems that are carried around with the person; the internal problems. An example of this is that the client blames himself for something and cannot get peace of mind or has a negative opinion, blaming himself, which makes him pessimistic. This type of problem is usually associated with feelings of overwhelming pressure.

At the end of the first interview, the counsellor will have some ideas about how to categorise and summarise the problem on the basis of the above and have a clearer vision about what is troubling the client. Determining the type of problem or a combination of problems is very important to the client since each problem may require different forms of counselling.

Provide Practical Advice for the Problem

Because of the usual arguments with her neighbours, Naya was referred to a counsellor through the team responsible for the refugee camp where she lived. She brought her younger brother, who seemed to be clearly concerned. It was not clear whether Naya had wanted to come on her own or not. I talked with them individually. I began by saying that her brother thinks she has a problem and asked her if she agrees or not. She agreed and said that she finds life in the camp very difficult. I asked her for details and she said she comes from a wealthy family and lived in a fancy house. She left her country after the armed men killed her older brother. She added that she is unaccustomed to stand in a row to get water. she also felt disturbed by the neighbours' voices and often quarrelled with them. I felt that they are the cause of her problem and that they should change their behaviour. When Naya said it, it exerted pressure and anger on her.

The counsellor responded by saying she had suffered a great loss and that he could understand how it was so painful. Then he asked her at what time of the day she feels disturbed. Naya replied that she had no problem between ten in the morning and four in the afternoon and that the problem is not so bad when she is preoccupied with something, but she often has a problem with them in the evening when she wants sleep but cannot because of the noise the neighbours cause.

The counsellor presented three possibilities to Naya to try and find a solution:

1. To move to a quieter place, which would have been impossible for her.
2. How many mouths do the neighbours have? The counsellor asked this with a half-smile on his face, to which Naya responded with a broad smile. It seems that she realised that she cannot change the neighbours. Naya changed her perception of the problem and realised that she has to find a way to accept them and improve the difficult situation.
3. The third possibility presented by the counsellor was to buy earplugs from the pharmacy. Naya found earplugs to be an interesting option. She was then told about some relaxation exercise, which could help her to ignore the noises around. She was also interested in this.

Help with thinking: During the session, the counsellor used his thinking and feelings to reach a better understanding of what is happening in the client's life. The counsellor had a fresh view of the client's problems, so he was able to ask questions not yet imagined by the client. The client was thinking of feeling the problems in a different way, and new questions may have helped determine the solution. These different methods can improve thinking and assist the clients to find different and better ways to deal with his problem.

Analysis of recent experience with someone else: If the difficult situation includes conflict or tensions with other people, the counsellor can ask the client to talk about a similar experience that occurred with that person. The counsellor can ask for all the details needed to form his own opinion about what is happening between the client and the other person. When there is a match between the two opinions, the counsellor will have a better understanding of the client's problem. The client will perceive this as support. When the opinion of the counsellor is different from that of the client, the challenge is to feed this back in a supportive and constructive way.

It can be helpful to ask the client what happened with him in the last few days. He can describe how he met other people and how these meetings went. Discussing these encounters can help improve the client's view of the way he behaves towards others. As a result, he may decide to change his behaviour in certain situations.

During the second meeting with Naya, the counsellor discussed a quarrel between her and her neighbours the night before. Naya described how her neighbours had a small party, and how disturbed she was by the sound of the music. Naya came out of her house and shouted at the neighbours to lower the volume. The counsellor asked her if she ever thought about how it would feel if she was having a good time with some relatives and neighbours and someone rushed into her house angrily. Naya fell silent for a while, and then said: "I would have lowered the volume if I was asked nicely."

When difficulties mount up on a client and there are tensions with his / her spouse or parent, a counsellor may ask family members for support. The goal is to let them share their views on the problem and to improve communication between the two partners or family members. When people become more concerned with the ability to listen to each other, the counsellor can help them reach an agreement on the nature of the problem and the first step towards solving it.

The challenge of the recipients of counselling: At times, it is clear that the client is acting in a manner not consistent with what he says. This may be suggested through body language and nonverbal communication and the contrast between what they do and what they say. In this case, the counsellor can gently point this out. This kind of confrontation is useful only when the type of trust between the counsellor and the client is established. The counsellor needs to confront the client in a neutral or impartial manner to avoid the client feeling attacked or judged in some way.

Give hints or help: During a consultation, the counsellor can sometimes give practical hints or propose a set of useful actions for the client. At times the counsellor may call the client over the phone or write a letter.

During the first interview with Naya, the counsellor suggested trying to use earplugs. It is also useful to make the clients more aware of the resources available in their surroundings.

Provide Advice on the Dilemma

Clarify a difficult decision or a choice between two evils: The difficulty with these situations is that there is no easy way out. The client has to choose between two options and neither may provide an ideal solution or both might have downsides. The counsellor can help the client to choose between "two evils" by listening to the pros and cons of the two solutions available.
A third option may emerge from this activity, and possibly with less disadvantages than the other two options.

Rania is a widow at the age of twenty-six. She was living with her parents who were pushing her to remarry and they suggested a person they saw fit. Rania did not feel ready for marriage and she wanted to pursue her education. The counsellor set a list of disadvantages of choosing one of the two options on the large sheet of paper writing down the words used by Rania. He did the same for the positive outcomes of each option and then Rania advised to postpone the decision for a brief period until she felt ready.
At times, the decision needs to be clarified further. The counsellor could suggest the method but the pros and cons are for the client to decide. After that, what is acceptable, painful, or completely rejected can be identified.

Ask for advice from the client in return: Often, clients who ask for advice have their own ideas on how to deal with a problem. However, they ask for advice because their faith in their abilities has weakened. The counsellor, in this case, asks them about their opinions. The client's thoughts will have helpful elements. Thus, the counsellor leads the client to think of a solution and the client will feel less dependent on the counsellor.

Give advice in a way that encourages the client to discuss it: If the counsellor believes he has good advice to provide, he can present it in a way that encourages discussion. That way, he can see if the client objects to it or not and see whether the context allows the client to pursue this advice.

The counsellor asked Naya if she had heard of a relaxation exercise that can help a person sleep. Naya had never heard of it, but she has shown some interest. The counsellor asked her whether she wanted to try this. She agreed and it appeared that she enjoyed the exercise. The counsellor also asked her if she could apply the exercise at home without being disturbed by anyone in the house. She thought she could. Therefore, the counsellor suggested that she try the exercise every day before going to sleep.

Counsellor mistakes: In addition to the mistakes mentioned and linked to the first interview, the sessions could also run into more difficulties and errors.

1. If the problem is a practical one, the counsellor could sympathise and offer practical solutions and give promises he could not fulfil.
2. If the problem is related to a difficult decision, the counsellor may find it difficult to identify all the options available, or is motivated to delve deeper into one option because of his own preferences.

Monitoring the Effect of Counselling:

Providing counselling to people around a practical problem or a difficult situation may produce the following changes:

1. The client may make a decision and deal with the consequences.
2. The client engages in activities that may help them deal with the problem.
3. The client becomes more capable of understanding that they cannot change the situation or solve their problem and are now able to enjoy other things in life.

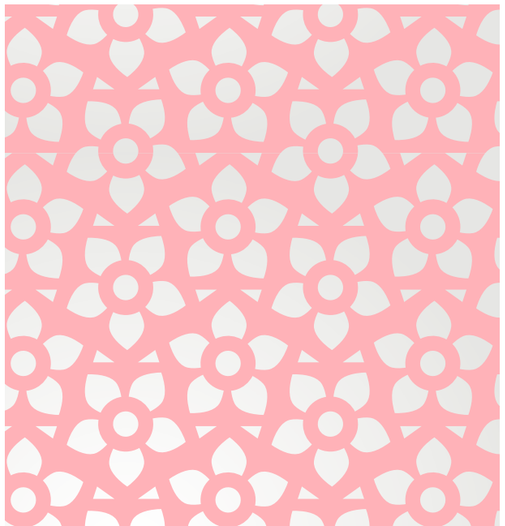
The counsellor can help the client to think about available decisions or different solutions that now seem possible, and only provides advice when it is clear that clients cannot think about the necessary steps to deal with the difficulties. The counsellor can offer these suggestions on a temporary basis, as they may not be a final solution. In this way, the clients can then think about other possible solutions.

Providing Counselling to Someone with an Internal Conflict/Problem

Internal conflicts: The internal conflict is described as an internal struggle between conflicting wishes, such as the desire to do something and the desire to do otherwise - at the same time. The internal conflict leads to irrational behaviour or thinking.

Youssef was the director of a local health centre. A shooting was heard at night: a fight broke out between the local government and the armed gunmen. In the morning, Youssef received news about the fighting: Both groups left the area. Youssef decided to go to the place where the fighting took place in order to take care of the wounded civilians. Five volunteers agreed to go with him. Upon arrival, he found that the information he received was wrong. The two armed groups were still in the area and they might have returned. Either way, he was stuck in the line of fire.

All the volunteers were killed, and Youssef was the only survivor. He hid in the woods for days. After the fighting ended, he returned to his village. Some people did not believe that he is still alive and they thought he was a ghost.



Several days later, Youssef left the country. When he returned after a few years, he met the families of the volunteers who were killed in the fighting. That bothered him, and he felt guilty despite the fact that the families did not hold any grudge towards him. He started buying gifts for the children of his deceased companions. At times he felt very depressed and that he did not deserve to live, so he also thought of committing suicide. He told his friends that he deserves to be in prison. They asked for a counselling session for him.

This indicates that Youssef has an internal conflict focused on guilt. From one side he had a clear intention to stay alive and from another he felt he should die following the death of five people that he was responsible for. Internal conflicts could be about:

- Feeling very ashamed and his unwillingness to talk about some of the incidents.
- The desire to be accepted by someone and be himself at the same time.
- The desire for intimacy compared to his fear of approaching people because they may die or betray him.
- Desire to show his abilities to other people in exchange for his fear of failure and then his feelings of humiliation.

Provide counselling to a client suffering from internal conflicts: The counselling provided to a client suffering from internal conflict means can be difficult for beginners. The counsellor should be mindful of internal conflicts and be trained to identify them. After identifying the internal conflict, a counsellor can help the client. He can also try to clarify the conflict. The counsellor can do so through a careful exploration of the client's wishes and feelings related to those desires. He can then refer to the contradictions between what the client says and his expressed feelings and his behaviour.

Counsellor mistakes: The counsellor may not recognise the internal conflict of the client. He might not take into account the possibility that the client has mixed feelings and sees the problem as just a difficult situation.

Farah married Tarek. Both were refugees in a neighbouring country. Their parents arranged the marriage. Tarek did not agree at first because he has a girlfriend in his country, but he eventually agreed.

The marriage was not successful at the beginning. Tarek was nice to Farah, and she liked him but he avoided intimate contact with her. He never took her out and never had sexual contact. Farah felt lonely and she wanted a child. She tried her best to make her husband happy. She discussed her feelings with him but he became violent. He told her that he cannot forget his previous girlfriend. Farah visited the counsellor in the refugee camp. When she told her story, the counsellor did not show any emotion.

Farah's story can be perceived as an attempt to explain her internal conflict. From one side she loves Tarek, and she is ready to do anything to adapt to his needs. From another side, she is angry and she wants him to love her without having to hide who she really is.

When counselling is offered to a client struggling with and internal conflict, it is important that the counsellor stays neutral and does not take a side with either of the conflicting feelings. In Farah's case, the beginning was wrong.

The counsellor did not make any effort to know Farah's feelings on the matter as a whole. Additionally, she asked her if she tried to be like Tarek's previous girlfriend. Farah answered that she would do anything to change to make her husband love her. The counsellor suggested that Farah asks Tarek about what his previous girlfriend looks like, so she could try to look like her, by wearing the same colours, for example.

The counsellor only supported one side - which is Farah's desire to adapt in any way to make Tarek happy. This could be explained based on the family background of the counsellor; Perhaps she grew up in a family where her mom completely adapted to her father's needs and she felt very close and devoted to her mother. Her colleagues mentioned that she took sides in an internal conflict. She realised this and decided to explore Farah's feelings towards her husband. It could be a combination of admiration and anger due to rejection.

Offering counselling to someone struggling with an internal conflict requires vast knowledge on human behaviour and feelings in addition to an understanding of certain ways to deal with internal conflict. This knowledge could be attained with practice and regular supervision sessions in detail with her non-judgemental colleagues.

Monitoring the effects of Counselling: The following changes in client's behaviour or appearance can suggest that the counselling was effective:

1. The clients begin to understand that there is a conflict within themselves, and accept the fact that they have contradictory feelings without trying to eradicate any of them
2. The clients seem less tense.
3. The clients begin to express their feelings more; including positive emotions
4. Improvement in the client's communication with people in their daily life.

Provide counselling to people suffering from intense feelings

Overwhelming feelings: These are common among people who have suffered a great loss or other traumatic events that changed their lives in an unexpected way; such as feelings of sadness or despair. Many people around them try to cheer them up and advise them to overcome these feelings or to look on the bright side of life. However, it is very difficult to follow this advice. Therefore, they can find it difficult to cope and the depression may overwhelm them.

A counsellor can help people suffering from these kinds of feelings by talking about them. He can try to explain to them that these are justified and understandable feelings and should not be ignored, but can be expressed in a way that usually brings comfort.

Expressing feelings: Most people are not used to talking about their feelings. Therefore, counsellors can imagine themselves in the client's position and then imagine what they might be feeling. As a result, the counsellors can help the clients by asking for words or sentences that best describe what they are feeling.
The clients may be able to express their feelings through drawings or writing a poem or letter.

Containment of feelings: A counsellor can help a client explore feelings and express them in a way to control and contain them. This means that he must be able to address the client's feelings and vulnerability without overwhelming them or getting his feelings mixed up with those of the client.

The counsellor, who may feel weak for any reason, will either protect himself by failing to recognise the true nature of the client's feelings or he will be overwhelmed by these feelings. In both cases, the counsellor will not be able to help the client to express his feelings without losing control.

Counsellor mistakes: The counsellor may not have the skill to contain the client's feelings and therefore ignore some of the feelings that are expressed. The counsellor may mix their feelings with the client's and it may seem like giving them a lecture on what to feel, or why the client should not feel a certain way.

Monitor the impact of advice: The following changes in a client's behaviour or appearance may suggest that the counselling has been effective:

1. The client appears less tense.
2. The client begins to express a variety of emotions in a broader way; including positive emotions.
3. Improved client relationships with people in their immediate environment.

Counselling about the lack of skills

Through counselling, it may become clear at times that the client lacks some practical and basic social skills. The counsellor can assist the client in the acquisition of this skill through role-play.

Nazih's parents were sending him 10,000 liras a month to pay for his food and his studies. He had never dealt with such an amount of money when he was living with his parents. He began spending the money during the first two weeks and then borrowing from his friends. The counsellor showed him how to manage money more responsibly.

A client can acquire social skills through role-playing.

Rashid wanted to stop drinking alcohol, but he was unable to say "no" when his friends gave him a drink. The counsellor displayed different ways through role-playing, where the counsellor played the role of Rashid, and Rashid and played the role of some friends who insist that he has a drink with them. They exchanged roles later.

Counsellor mistakes: The most serious error in this type of counselling is to dictate a certain approach that suits the personality and lifestyle of the counsellor not the client. The counsellor should introduce his approach or solution as a suggestion; many of the different possibilities can be tested and any one need not be considered an effective remedy on its own.

Monitoring the impact of the consultation: Counselling a client regarding a skill he lacks may be judged effective if:

1. The client acquired this skill, or
2. He began engaging in activities that develop this skill

Counselling for people with complaints, symptoms and problematic behaviour linked to experiencing a psychological trauma, or severe stress:

Symptoms of a trauma:

Symptoms	Characteristics
Physical	Eating disorders (more or less than usual) Sleep disorders (more or less than usual) Sexual impotency Low energy levels Unexplained chronic pain Fatigue, headache, exhaustion Digestive problems Physical discomfort Sterility Sexual dysfunction Imbalanced menstrual cycle High blood pressure and diabetes Weaker immunity system
Emotional	Depression, spontaneous crying, misery, losing hope Anxiety Panic attacks Sexual dysfunction Imbalance in menstrual cycle Obsessive disorders Overwhelming feelings Anger, feeling upset Emotional numbness Withdrawing from routine life and isolation
Memory	Forgetfulness, especially following a trauma Unable to concentrate Confusion Repetitive nightmares Problems in focusing and concentration Difficulty in taking decisions
Social	Isolation Marriage and family problems Unable to perform at work or education Problems in relationships with others Economic problems Addictive behaviour which affects life
Behavioural	Sleep disorders Crying and wailing Memory loss Anxiety and wakefulness Difficulty in understanding oneself Increasing conflicts with family members Anger/Violence Addiction Unsafe sexual behaviour

Other Symptoms that Relate to Trauma:

The following additional symptoms relate to severe trauma like natural disasters, war, rape, assault, violence, and car / airplane accident or child abuse. Some of the reactions and onset of symptoms may be delayed from the original time of the trauma.

Symptoms	Characteristics
Reliving the trauma	Intrusive thoughts Flashbacks Sudden eruption of emotions and images related to the event
Isolation or Emotional Numbness	Memory loss Avoiding situations that are similar to the original event Disconnection Depression Guilt Sad reactions Losing sense of time
Hyperactivity	Wakefulness, on high alert Overreaction including unexplained anger General anxiety Sleeplessness Obsession with death

The Principles of Counselling in Crises

One can use a selective approach to counselling in the event of crises caused by trauma. The counsellor should focus on the direct fears of the client and should not spend more time on history and evaluations. The evaluation should be focused on the problem and the approach should be to provide immediate assistance and relief for the disorders based on experience.

Counselling should be:

- Brief
- Oriented, requiring the counsellor to play an active and direct role.
- Dealing with the individual and his / her family and social network.
- Focus on the client's current problems.
- Geared towards reality, the client must be able to form a cognitively clear vision about the situation.
- Able to assist the client in developing more adaptive mechanisms to deal with problems and crises in the future.

Guidelines to counselling in crises:

- Remain calm and show confidence
- Practice effective listening
- Demonstrate acceptance and non-judgment
- Demonstrate understanding of emotional and reverse feelings
- Provide a relaxing atmosphere

- Allow the client to speak freely, with minimal obstruction
- Allow the client to ventilate feelings
- Explore the immediate crisis rather than the underlying causes
- Assess symptoms using assessment materials
- Assess the risk of suicide, and ask the client about suicidal thoughts
- Do not underestimate the crisis
- Agree on a plan of action; do not impose it on the client
- Identify priorities: agree on aspects that can be easily handled
- Do not go into the past and evoke immediate concerns
- Find local resources to help and look at the support systems available.

People with psychological trauma often experience physical discomfort. These complaints are associated with sensations such as heart palpitations, excessive sweating, headache, stomach pain, abdominal pain, nausea, tightness in the chest, the inability to sleep, loss of the ability to have an erection during intercourse and problems in the menstrual cycle. In addition, the counsellor can see physical signs such as: rapid breathing without the use of the diaphragm, muscle strain, anxiety and tremor. In addition to physical complaints, some people suffer strong feelings of anxiety, a lack of ability to think, problems with concentration and frequent forgetfulness and a strong sense of fear due to the nightmares. Some of them suffer from bouts of anxiety or fear during waking. This is accompanied by anxiety attacks, intrusive memory for painful events. These are called flashbacks.

People who experience trauma often show negative ideas. For example, pessimistic ideas about themselves and their surroundings, such as: "I've become weak," "I cannot be lucky at all," or
"I cannot trust anyone." Or expressions of despair, such as: "I find it difficult to make decisions, even trivial ones." or "I do not believe in anything anymore."

Selecting the targeted symptoms and suggestions on changes in behaviour: During counselling, the client will focus on the most troubling symptoms which have potential treatments e.g. sleep. The counsellor will instead wish to focus on the symptom, which he considers the core of the client's problem e.g. nightmares that make the client afraid to go to sleep. This can only be achieved if the client considers this an important presentation.

This is a useful approach for a person who suffers from the effects of post-traumatic experience. If this approach creates new problems, the counsellor can try out alternative approaches.
The counsellor can discuss the circumstances in which these symptoms occur or worsen. He can then discuss the possibility of the client to change his behaviour when this symptom occurs.

Behaviour change: It is possible at times to discuss a change in behaviour which may prevent symptoms from appearing. For example: For some clients, watching the news on television about the armed conflict in their country may be the cause of their nightmares about the traumatic experience. In this case, the counsellor can propose that the client do exercises to relax after the news. He could also suggest they avoid watching the news late at night. This may help prevent sleep problems and nightmares.

The change in behaviour also aims to regain control after the symptom occurs. For example: counsellors can discuss the normal behaviour of the patient after he wakes up from a nightmare to try and propose other alternatives. If the client says he often has nightmares when in bed and feels scared, the counsellor can say something (for example): "I have a suggestion. Maybe you can try this: first get up out of bed, wash your face with cold water, take a look out the window to make sure that everything safe, write in the diary briefly about the nightmare to discuss with me later. Put the notepad aside, work out, then relax on your bed. Do you want to experiment with this?"

Changing the behaviour in different ways: This strategy is intended to prevent fear and anger becoming overwhelming. For example, the client can start taking notes about his feelings every two hours for three days. In this way, the counsellor can recognise the first sign of his troubles such as anger or anxiety which may become overwhelming. They can then create a programme of activities. These activities can protect the person from engaging in aggressive or self-destructive behaviours.

If overwhelming emotions cause aggressive behaviour, the person may feel remorse and may need help in order to control their anger. This can be achieved through:

1. Provide an explanation of the origin of the event. This includes discussion with the possibility that there is a good reason to feel angry because of the many painful things that happened to him. This explanation also emphasises the fact that the aggression does not usually arise instantly but builds up and this can be felt in bodily changes.
2. Make the client aware of the feelings that flooded his body when the anger arises. There are physical exercises that may help to increase anger awareness.
3. Explain the methods that can prevent the client from escalating anger (for example, taking deep breaths or staying away from people who induce bad feelings).
4. Explain the ways in which the client can express his anger without losing control.

Jassim, a child, was frequently fighting. Therefore, his teacher wanted to send him away from school, labelling Jassim as the problem. He was not sure if he wanted to change his behaviour or not, because of the need to defend himself. The counsellor said it was clear that Jassim could be a stronger man if he knew how to control his anger when he wishes to do so. He used the analogy of martial arts heroes who fight always according to the rules without displaying anger. Jassim was interested in this idea, and then began giving the counsellor an explanation of what is stated in the previous paragraph.

Discuss the client's feelings or his sense of hopelessness: You can also discuss the client's pessimistic ideas or his sense of hopelessness with a session. The counsellor can also advise the client, asking if these thoughts may be related a traumatic experience. However, this will only be possible for the client after he is able to control the physical symptoms.

Talk about the painful experiences of the past:
Discussion about the symptoms and complaints and behaviour associated with traumatic experiences often leads to discussing the trauma itself. Most people believe that you should not discuss these experiences because they make it difficult for the client. However, some clients feel the need to discuss their painful experiences. This can be compared to talking about the painful experiences of the past, like vomiting after eating spoiled food. It is not a pleasant experience for the person concerned but it gives a lot of immediate relief.

Talk about the content of the dreams:
Many people have difficulty recalling their nightmares. A counsellor can suggest that they put a pen and paper next to their bed in order to write the content of their dreams as soon as they wake up. In the case of traumatised people, dreams can take different forms. Sometimes dreams are more like living through the traumatic experience again. It is therefore useful to talk about the content of dreams while discussing painful past experiences.

In other cases, dreams are less "realistic" and more difficult to understand. However, these dreams can be discussed as follows:

1. The counsellor can first ask the client to tell him about what happened in the dream and write down the client's narration.
2. Then he summarises the dream in a timeline using the same vocabulary used by the client.
3. The client is then asked about his thoughts and feelings during every part of the dream, and about the details of the storyline. The reactions are recorded.
4. The counsellor remarks on the first part and the client's thoughts and feelings related to this segment. This is done for every segment of the storyline. Dreams can often be understood as a reflection of the primary client's attitude towards life or as a reflection of the internal conflict which he was struggling with. The counsellor can offer some interpretations to the client.

Firas dreamt that his father had died. Everyone was at his parent's house awaiting his arrival. However, Firas did not arrive. His brothers and neighbours wanted to bury his father, but his mother stopped them and held onto the body of her husband. She was crying "we have to wait for Firas". Firas woke up screaming and sweating and his heart was beating fast. In fact, Firas has not seen his parents for years and was very worried about their situation. He had been feeling guilty because he could not help them. Visiting them at the time was impossible, since they lived near the area of armed conflict. A few months later, the attacks wounded Firas's father and killed one of his sisters. After that, Firas's parents followed in his footsteps, and they moved out of their area. They are now living in a refugee camp two hours away from Firas. Firas is very busy in his work as a volunteer and his parents often complain because they rarely see him, and he feels guilty about it.

Counsellor mistakes: Counselling based on symptoms. It is easy to give advice very quickly before studying the problem adequately and making sure that the client wants a particular form of help. Some clients just want someone to listen to them and feel that someone understands the full impact of their problems. In this is the case, they may not need further counselling.

Monitor the impact of counselling:
We can discuss progress on addressing the nightmares and anxiety attacks and other symptoms that encourages the client to engage. If the client can see some progress it may lessen the feelings of helplessness and despair. If the progress is not convincing enough for the client, the counsellor will help by noting the progress to try and contain the feelings of despair when the client becomes overwhelmed and desperate.

In the case of nightmares related to the traumatic experiences, one can talk about an improvement in the following circumstances:

1. Nightmares becoming less frequent: For example, once a month instead of once every night.
2. Nightmares becoming less severe: The client still sees disturbing dreams but it is not as bad as it was. The client may still feel scared when he wakes up but he does not sweat, his heart is not racing, and he does not find it difficult to return to sleep.
3. Dream contents change over time.
   - It is a direct transformation of the tragic experiences into a symbolic depiction.
   - The client's feeling in a dream is less severe. eg. At the beginning of therapy, a refugee's dreams were about persecution and imprisonment, and he wakes up when he feels unable to escape and they are killed. A few days later, he may dream that he managed to escape along with others.

The above client often dreamt that he was being chased by gangs and that he was surrounded. At times, he saw himself on the edge of a ravine and jumping was the only way to survive. He was alone. Three weeks later, he dreamt that he was with a friend and they were both chased. He escaped with his life, while his friend was killed. A few days later, he dreamt that he managed to escape with others and also became the leader.

A client spent the last four years in jail after being arrested for security reasons. Shortly thereafter, the prison was bombed by an armed group.
After twenty sessions of treatment that targeted the nightmares and the traumatic memories of the client, he talked about a dream in which he returned to his native country where he was arrested and sent back to prison. It was a frightening dream until he dreamt that the prison was painted in bright colours and there were no bars on the windows. He opened the window and jumped out and ran away. Then he woke up, feeling somewhat happy.

With regards to anxiety attacks and flashbacks we can talk about progress:

1. The flashbacks are less severe than what the client is expecting.
2. The flashbacks fade away quickly. In other words, the client realises immediately that if flashbacks occur, he quickly returns to reality and controls his behaviour.
3. When the traumatic memories become less intimidating and painful and happy memories merge together.

After six sessions of counselling focused on nightmares and memories, some memories of the prison experiences remained but they only lasted a minute or two. Sometimes, he ended up remembering happy memories about one person from the past.

Ethical Consideration of Counselling

Limits of the relationship / setting limits:
Boundaries in the counselling relationship are crucial. These limits are set in counselling to protect the client-counsellor relationship. For example, you should not have a counsellor and client relationship beyond counselling. These other relationships, e.g. sexual, dating, business, or simply being close to the person or their family are not permissible.
The counsellor controls the boundaries. If the client tries to push this relationship or wants to take this relationship to another level, they should be stopped. For example, if the client attempts to seduce the counsellor, the latter should not get drawn in or get involved in a sexual relationship with the client.
The client should be comfortable with the boundary-situation according to what is agreed upon to ensure that client feels safe within the counselling relationship.

Avoid multiple relationships:
A counselling relationship is effective if there are no other relationships between the counsellor and the client.

Confidentiality and privacy:
This is a way to provide security and privacy for the client. What has been discussed during the counselling is confidential and will not be shared with others. Even the fact that someone met a counsellor within a counselling session must be kept confidential.
However, there are two exceptions:
Supervision: A counsellor will meet with his supervisor in order to discuss cases. During supervision, it is best to avoid client identification (anonymity or personal qualities) when discussing the situation.
Harm: If the client is at risk of harm to himself or someone else, the counsellor can violate confidentiality. For example, if a client has suicidal tendencies and will not develop a safety plan, then the counsellor should contact an appropriate person and alert them.

Supervision of Counselling

Supervision is a complex activity with many functions. It is a means of providing emotional support for the supervisee and to give them additional training. It is also a form of monitoring and evaluation of the professional performance of the counsellors and enhances the quality of their work.

A supervisor provides supervision either in small groups, individually or in a team of individuals working within the same organisation. Each of these forms has advantages and disadvantages.

In the group, participants can engage in a variety of supervision methods (eg role-playing, games etc. Exploring family interaction often requires a combination of methods and counsellors can learn from their peers who bring case examples to the group or from the account of their colleagues. Individual supervision is more personal and intense and it requires a considerable investment of time and money which is not always possible.

Supervision as support:
During the supervision, the supervisor begins to establish a relationship with the counsellors. This relationship is a professional relationship and similar to the relationship between the counsellor and the client, it is also a trusting relationship.

The supervisor will create a climate in which the supervisee will feel safe enough to discuss his or her concerns. In this safe relationship, supervisors can ensure a better understanding of the counsellor's work, so that people learn, make mistakes, or are supported through periods of feeling helplessness and vulnerability.

Supervision sessions:
are so designed to help the supervisee recognise their strengths, weaknesses and personal problems which may interfere with effective counselling. It is an opportunity to find new ways to deal with personal problems for both the client and the counsellor, which may impede or block the counselling process.

Supervising as a form of education:
Education may be provided in terms of vocational role or improving counselling skills. it can also help the supervisee understand the problems and the behaviour of their clients with respect to their history or current status, using psychological theories to explain the possible relationship between the facts that may seem, at first glance, unrelated.

Supervision can develop expertise through learning by action:
This learning process also includes the practical experience of writing reports for counselling sessions. Recorded data enhances critical thinking and practical experience through dialogue with the supervisor.

It is helpful for the counsellor to reflect on their experience through internal dialogue. The counsellor asks themselves not only what they observed during the counselling sessions, but also their own thoughts and feelings.
Through this process of thinking, the counsellor uses theoretical concepts to analyse the client's problems and summarise what has happened in the relationship between the counsellor and the client This aids planning for future interventions through counselling.
Supervision includes reflecting on the feelings of the counsellor, his thoughts and behaviour. This contributes to the promotion of self-understanding and knowledge.

A supervisor assesses the daily work of a counsellor:
by supervising and monitoring trends in work demands, pressure, and gaps in skill or knowledge, as well as job-satisfaction among the counsellors. Although supervision is a private meeting, the supervisor may decide to inform the administration of the organisation about the general trends observed. In this way, it contributes to the development of the organisation as a whole. This could lead to measures such as increasing staff training, modifying the distribution of cases across the counsellors, and other measures that can support the work of the latter.

Supervision is a form of monitoring and evaluation of professional performance or quality control. Counsellors may have blind spots related to their problems or personal prejudices. The function of supervision is to ensure that the work of a counsellor is appropriate and consistent with ethical standards.

The basic preconditions for supervision are supervision contract, motivation, mental horizon, safety, and supportive attitude.

Supervision contract:
When providing supervision of counsellors, three parties are usually involved: the supervisor, the manager and the organisation for which they work.

Typically, the organisation is employing this supervisor. These parties should prepare a written agreement setting the goals and rules of basic supervision relating to monitoring procedures (including confidentiality) and the duration and frequency of sessions.

Motivation:
The counsellor can only benefit from supervision if he has the motivation to actively participate in the learning process. It should not be controlled by fear of discussing possible errors within supervision. If the process of supervision evolves well, the motivation will grow with the counsellor.

Mental Horizon:
Supervising will not be effective unless the counsellor is aware that his job is not just the application of technical skills. His behaviour in the counselling process is not only governed by rational processes. The counsellor should be aware of specific feelings (which are sometimes influenced by his past) and his personality.

For the development of these skills and tools, they should discuss personal thoughts and feelings during the counselling process. It stimulates the awareness of the supervisor and the sensitivity of the counsellor. It increases the awareness in the counsellor for internal dialogue.

Safety:
During supervision sessions, a counsellor needs to feel protected against personal attacks and feel that criticism is constructive. The supervisor has a responsibility to create a safe environment.

Supportive attitude:
The supervisor also needs to be open to criticism and self-criticism.
This supportive attitude also includes supervisor recognition that the concerns of the supervisee could raise questions which cannot be answered immediately. The supervisor needs to show tolerance towards uncertainty and confusion and become a "partner in the lack of knowledge." This creates deep open participation and hopefully leads to more creativity.

Levels of discussion during supervision
The discussion that takes place during the supervision sessions with counsellors is at five different levels.
Level I: Fuzzy: The counsellor has difficulty expressing the problems faced. He asks for clear instructions. The supervisor focuses his supervision to stimulate the counsellor to think in an orderly manner.
Level II: The counsellor can provide a coherent story. He reproduces the basic concepts discussed during the counselling training but cannot use these concepts to illustrate the problems faced by the client. In other words, he has difficulty in conducting an assessment of the client's problem.
This is often due to lack of experience in abstract thinking or the inability to give a theoretical formulation of the problem. The supervisor is to concentrate on linking practical intervention experience with theoretical concepts, trying to build bridges between theory and practice.
Level III: The counsellor uses theoretical concepts used to discuss the client's problem systematically. At this level, counsellors do not tend to think about the client's problems with regard to the internal or personal history of the client and thus may ignore important tools for understanding the client's feelings and problems.
Level IV: The counsellor presents his views on the internal processes and the history of the client. However, he does not tend to discuss what is going on in his mind during the counselling session. The supervisor may remind him gently to think carefully about the internal dialogue, trying to increase the counsellor's tolerance of his own feelings and to increase the emotional awareness.
Level V: The counsellor can discuss his own thoughts and feelings freely and uses this as a tool to gain a better understanding of the problems of the client. He actively supports the supervisor in determining his personal limitations and handling of the case.

Supervision process: Phases and Stages
The level of debate the supervisor can have with the counsellor can vary, to a large extent, depending on the client being discussed. During the supervision of the group, it may not be possible to have all the participants at the same level. This may change with the passage of time given the nature of cooperation and process of change during supervision. The following stages can be distinguished: stage-oriented work, stage-oriented person, and existential stage.

The first phase is characterised as a stage-oriented work:
Here, the supervisor is trying to improve the basic skills of reporting back for the counsellor as well as the interpretation of verbal and non-verbal behaviour of the client. Here, the supervisor is trying to get a clear picture of the situation presented by the counsellor.
The supervisor is trying to establish what happened during his meetings with the client. That is why he is asking questions. Most of the questions are designed to increase awareness of the difference between what the counsellor observed during the interaction with the client and his explanations for these observations. Through asking questions on the interpretations of the client's problem he can then suggest alternative interpretations. After reconsideration of the assessment and the development of the perceptions of the situation, he may ask the counsellor to discuss interventions planned for the next session with a client. They can sometimes experiment with such interventions through role-playing.

The second phase is characterised by a stage-oriented person.
Here, during the presentation of the case, the focus is on feelings of the feelings of the counsellor; special attention is given to his internal dialogue.
At this stage, the counsellor will be able to recognise that he has a problem in providing counselling for a particular client and that part of the problem may be due to his own attributes. In this case, it can help the supervisor and counsellor to demonstrate the problematic part of the counselling experience; for example, through role-playing games.

It may also help to discuss the detailed observations of the behaviour of both the client and counsellor, as well as the emotional reactions of the supervisee to clarify the situation. The supervisor may discuss the emotional reactions of supervisee with respect to his background, thoughts or feelings during counselling sessions.

In some cases, it can be identified as the third phase, a phase of existentialism:
During this phase the counsellor's attitudes about existential issues (e.g. death, loneliness, and the meaning of life) are open for discussion.

Supervision Outcomes

The supervision process may lead the counsellor to a number of learning outcomes. The counsellor may gain more understanding towards the client, especially toward those who have been considered uncooperative. It can increase the counsellor's ability to assess client problems and become more creative in formulating hypotheses about the causes of some of the client's difficulties or the links between the various problems. It can allow the counsellor to recognise resistance of the client or the same resistance if faced with his own personal problems and to be more adept at dealing with such resistance.

He may become more tolerant of situations that seem hopeless or stuck and develop more confidence in the client's ability to find a way out of difficult situations - even those that seem hopeless.

Supervision does not necessarily lead to better performance immediately. It is a process that may seem, at an early stage, confusing for counsellors. Even though the implementation of supervision is conducted in a responsible manner, the counsellor may question their own ability to provide counselling or doubt their aptitude for this vocational role in the first place.

This can happen when dealing with the supervision of personal experiences or unresolved issues in the past. Supervision then becomes an opportunity to expand the coping skills and deal with issues. In the meantime, the supervisor needs to ensure the quality of support provided to the client. He can do so through a temporary increase of the frequency of the supervisory meetings, while the counsellor continues to see the client. Alternatively, he can refer the client to another counsellor, while providing personal counselling and support for the supervisee.

Case Study

Maryam, a 35-year-old woman came for counselling after six months of separation from her husband, Mahmoud. Their marriage has lasted nine years, and they have two children, Youssef (6 years old) and Kinan (12 months old). The children are currently in the care of Maryam. Maryam was referred for counselling by a general practitioner who she had visited complaining of a number of minor physical ailments and early signs of depression.

Basic Information

Mahmoud met Maryam at the university. After graduating they worked in separate companies for a number of years before their marriage. Both continued to work until the birth of their first child Youssef, when Mary took a vacation for a year before returning to work part-time. Mahmoud continued to work full time and received a number of promotions over the years. Mary continued to work part-time until the birth of their second child Kinan, then stopped working for a year to care for the children at home. She was about to return to work when Mahmoud disappeared. Mary did not feel good enough to return to work, and was now in danger of losing her work with the company.

Session Details

Upon the arrival of Maryam, the counsellor spent some time in the forming of the relationship in an attempt to make her feel welcome and comfortable.
Maintaining good eye contact and an open position, he asked her what the problem was and waited for a period of time for Mary to start talking. After a long silence, during which Maryam was looking at the ground, she finally spoke while crying. "I lost my husband six months ago, and I am not able to move forward in my life."

The counsellor observed Mary's emotional reaction, and decided to allow her to express her feelings surrounding her loss of the marital relationship.

Counsellor: "You look exhausted as a result of the loss of your marriage Maryam, he responded, reflecting the feelings of Maryam.
Maryam replied, "Yes, I am, but it was six months ago, and now you will tell me I must get on with my life because this is what my family and friends say to me, but I still miss Mahmoud terribly, and the children are crying for him every night at bedtime."
Counsellor: "So if I am not mistaken, you and your children still feel sad while your friends and family believe that you should have gotten over it by now?"
Maryam: "Yes, maybe. What do you think?".
Advisor: "Let me ask you a question, Maryam, do you think that six months is a sufficient period of mourning for the loss of an intimate relationship that lasted for a long time?"
Maryam: "I do not think so."
Counsellor: "And you are the only one who knows how it feels to have lost your relationship with Mahmoud."

Maryam nodded her head and continued narrating the story of her life in the past six months, pausing occasionally to wipe her eyes, still crying. Maryam described the physical and emotional turmoil while they were struggling to care for their children on limited income. She also expressed her fears and uncertainty about her future and the future of her children.
The counsellor continues to focus on Maryam emotions and uses encouragement and reverse emotions to validate her feelings.

Session Summary
In this session, Maryam was given the freedom to express the emotional pain in an atmosphere of understanding, empathy and positive unconditional regard. That is what makes clients capable of recognising that the expectations that have been set are unrealistic and she was able to start looking at other ways to manage her new life.
It was based on providing a counselling approach in the first session in an entirely appropriate way for the client, such as Maryam, who was able to express and explore feelings associated with the loss of her marriage and uncertainty about the future.

The basic concepts in this session are:

- Creating a climate to promote growth so that the client feels the attention and respect.
- Adopting a harmonious and understanding approach by the counsellor that confirms and enhances self-esteem, empowerment and encourages clients to find the answers that are consistent with their values and beliefs.

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Chapter Three

NARRATIVE EXPOSURE THERAPY (NET)

Chapter Three
Narrative Exposure Therapy (NET)
1. Theoretical Background

1.1 Contextual Specificities: Syrian Refugees and displaced people

Since the fighting in Syria erupted in March 2011, many thousands have been killed and injured. The on-going war has brought imbalance in the already troubled Middle East; this situation affects also Europe that is requested to become a generous host for hundred thousands of Asylum seekers forced to leave their land. The exodus of Syrian refugees accelerated dramatically in the past years, with massive influx of refugees spilled across its borders [26]. Countries bordering Syria are approaching a dangerous saturation point, particularly Lebanon, which hosts the largest per capita refugee population in the world. Host Governments, UN and International Non-Governmental Agencies (INGOs) are struggling to cope in the midst of the increasing needs of affected people. Lebanon is currently the country with the highest number of Syrian refugees after experiencing a steady increase of registered refugees by the UNHCR from July 2012 and (25.411) to July 2015 with 1.172,753 registered refugees [83]. Syrian refugees are resettled in four areas: in the South of Lebanon near the border with Occupied Palestine, in North Lebanon, in Bekaa where the higher numbers of refugees are registered (i.e. 410,269) and in Beirut that follows with 343,902. In Beirut the child refugee population reaches 38.5% (ages 0-11) and the adolescent population 10.6% (ages 11-17). Adult women add up for 24.6%% of the population while men for 23.6%. Children and women are definitely the ones who suffer the most in this war. Additionally to the "usual" war atrocities the conflict has been distinguished by a dreadful targeting of women and little girls. In the grey literature and UN reports inform about the domestic and sexual violence, child-marriages of girls, sold to men by their parents for a few thousands, are raped and then abandoned [31]. Despite the humanitarian crisis created by the millions of refugees only a limited number of studies have looked into the presence of PTSD and other psychopathology. Among Syrian refugees in Turkey the frequency of PTSD was 33.5% while the probability of having PTSD was 71% for individuals of female gender; with previous psychiatric disorder, a family history of psychiatric disorder; and having experienced two or more traumas [3]. Depression and PTSD was also reported among Syrian refugees in Jordan in a sample of 155 adults, but no prevalence rates are reported in the general refugee population [4]. In a study developed in the refugee camp Bahçeşehir in Turkey with Syrian refugee children 74%, had experienced the loss of a family member or an important person [60]. Presumably these losses also affect the well-being of the children's parents and may contribute to diminishing their capacity for care and support to the children. Refugee youth routinely encounter difficult challenges related to past trauma, loss, and resettlement stressors. In order to cover their basic material, medical and psychosocial needs, millions of US dollars from donations are spent through local and international organisations. The UNHCR in the report concerning Syrian children's future stated: "*beyond the emergency services provided by humanitarian organisations, there is a serious gap in the availability of state-run mental health services in both Jordan and Lebanon. There are no specialised child psychiatrists working with refugee children in Jordan, and only some 30 psychiatrists country-wide in Lebanon*" ("The Future of Syria | Refugee Children in Crisis," 2014.).

Frequently the interventions used to relief refugees' psychological suffering are not evidence based, and follow-ups are not applied to assess the long-term outcomes of the interventions. The Inter-agency Coordination of Mental Health and Psychosocial Support for refugees and people displaced in Syria was initially developed by the German Agency for International Cooperation (GIZ) in collaboration with a working group from 13 different organisations, including UN agencies, international non-governmental organisations (INGOs) and national organisations, and co-funded by the EU aimed to deliver a structured approach to mental health and psychosocial support (MHPSS) programming. During this period the group prepared and approved: a national MHPSS framework with minimum standards, a guidance document for mainstreaming MHPSS across sectors, a framework for MHPSS assessments during the emergency, and regularly updated 4Ws (who is where, when and doing what) mapping (Eloul et al., 2013). The onset of the Syrian Crisis has led to the restructuring of the Inter-Agency Coordination Group when in December 2012, the two staff members from the co-chairing agencies left Syria (for more information on the restructuring of the new MHPSS Technical Reference Group (TRG) please see EU page: "Syrian Crisis: Humanitarian Aid and Civil Protection,").

Syria has received and hosted refugee populations for many decades with Palestinians, Iraqi, and Kurdish being the most prevailing populations. In fact, UNRWA has supported the refugees, providing services in nine official refugee camps and three unofficial since 1948, when the first Palestinians fled the north of Palestine and the Golan Heights after the occupation of these territories by Israel. The impact of the Iraqi war on Syria was the increase of refugees reaching the country during 2006 and the years that followed; during this dramatic influx of refugees the emerging need for experienced mental health providers and community care was made evident. This situation elevated the need to develop a mental health system in Syria where there was no structured approach to mental health and psychosocial support (MHPSS) programming. Up to that day only 80 psychiatrists nationwide were operating in the country with no real legislation backing them up [24]. The current situation and the on-going conflict for the 6th consecutive year has create an increasingly number of Syrians to flee the country and among them many professionals draining the capacity in the field of MHPSS system in Syria which is actually an aggravating factor for the relief of victims of violence and displaced people in the country. Another important factor to take into consideration when conceptualising mental health in Syria is that of the particular shift from being the third largest host country for refugees to becoming the country with many millions of civilians abandoning their land in search for a better future for themselves and their families. With a population of fewer than 22 million [89], according to government estimates in 2010, the Syrian Arab Republic hosted 750,000 Iraqi refugees, nearly half a million Palestinians and several thousand refugees from Somalia, Sudan and Afghanistan [63]. It would be of course unsafe to make accurate predictions, but taking into consideration that many will remain in the country, and some of those who left will at some point return, we could expect dramatic societal changes and phenomena.

1.2 The long-lasting impact and the aftermath of war

Another important factor to take into consideration when conceptualising mental health in Syria is that of the particular shift from being the third largest host country for refugees to becoming the country with many millions of civilians abandoning their land in search for a better future for themselves and their families. It would be of course unsafe to make accurate predictions, but taking into consideration that many will remain in the country, and some of those who left will at some point return, we could expect dramatic societal changes and phenomena.

When caregivers are chronically stressed in a violent environment, it has long-term effects on the offspring who develop higher rates of psychological and behavioural disorders [8, 77, 78, 68, 51] and are more likely to have a child with epigenetic alterations in their HPA-axis [64]. In other words, women living under stressful circumstances reprogram the major stress defense system, the HPA-Axis of their children [29]. Moreover, the altered stress response leads to altered parenting, predicting the risk for psychopathology [80]. There is a positive correlation between increased stress of the parent and child maltreatment as well as inconsistent discipline, hostility against the child and physical punishment [67, 70, 85 ,45] There is a relationship between parental trauma and children's PTSD symptoms; while untreated PTSD in children would lead to a negative effect on child intelligence and self-esteem; children of traumatised parents may display behavioural and cognitive impairments manifested mainly as PTSD-related symptoms [21]. Maternal rather than paternal PTSD is associated with PTSD in adult offspring of Holocaust survivors, indicating that classic genetic mechanisms are not the sole model of transmission. Traumata experienced by the entire community (i.e. collective trauma) are sustained in the collective memory for a longer period of time and is possible to be passed from one generation to another creating what is known as the intergenerational trauma [30,22,10]. The family also suffers disruption of ties, decadence of parenting practices, and in many cases, an increase of domestic violence [17]. The UNHCR estimated that at the end of 2012 there were 10.5 million refugees worldwide, of which approximately half were under the age of 18. Only a small proportion of all refugees reach high-income countries amounting to less than half a million in 2011 [83].

1.3 Post traumatic stress disorder

Have you ever wonder how you could cope if your worse fears were to become true? Even at times that you were confronted with a devastating situation; do you remember how your body reacted, what were your thoughts and how you managed to endure the event? These details are hard to forget normally because such events may alternate our world perception, the way we think and act in everyday life and our interpersonal relationships. For some people that have endured several traumatic events these thoughts and sensations are "trapped" in the memory in a disorganised manner and aggravate the functionality of people. The amount of people worldwide suffering from experiencing stressful and traumatic events is much larger that we could ever imagine.

Our world is experiencing wars that target primarily humans while mass recruitment and armament of men is increasing around the globe; there is an eruption in the number of individuals turning to extremism, driven by an appeal for violence; and thus there is a dramatic increase in the number of people having to survive under inhumane conditions [40]. Aggression and deprivation have destructive impacts on mental health, resulting in a psychiatric emergency of pandemic proportions. We argue that the psychological impact of this is not only devastating for the individual, but also is a factor in perpetuating both, conflicts and mental ill-health.

More than 20 percent of the world's population is living in extreme poverty with limited access to nutrition, education and other basic services, under circumstances of social discrimination and exclusion, and lacking the income and resources to ensure a sustainable livelihood and participate in collective decision-making [90]. This imposes a heavy burden on human lives. As human beings, most of us grow up to be resilient and adaptive to new situations and challenges. Nevertheless, resilience is very unlikely to be observed for people that have already suffered a big number of traumatic events since their childhood.

1.3.1 Diagnostic Criteria (DSM-5): Posttraumatic Stress Disorder

Post-traumatic Stress Disorder (PTSD refers to a trauma- and stressor-related disorder that usually occurs after an individual experiences or witnesses severe trauma that constitutes a threat to the physical integrity or life of the individual or of another person. PTSD affects not only the mental health but also creates adverse general health conditions that may result chronic if not adequately treated. Both adults and children may develop PTSD but it is expected that symptoms may vary, and the impact on different life areas will be different as well. Thoughts and perception is affected and individuals may be more concerned with the content of intrusions, delusions, suicidal ideation, phobias, and reliving the experience. Suicide and homicide risk may increase due to the altered mental status [5].

The current definition of Posttraumatic Stress Disorder (PTSD) in the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders – the DSM-5 [5] specifies the syndrome as a psychiatric disorder caused by an external traumatic stressor (Criterion A) and consists of four symptom clusters: intrusions (Criterion B), avoidance (Criterion C), negative alterations in cognition and mood (Criterion D) and alterations in arousal and reactivity (Criterion E). In addition, the diagnosis includes the duration (Criterion F) of the symptoms, the functional significance (Criterion G) they cause in daily life, as well as the absence of exclusion conditions such as drug abuse or other medical conditions (Criterion H). In contrast to other DSM diagnoses, the occurrence of an external traumatic stressor is required to develop PTSD.

Note: The following criteria apply to adults, adolescents and children over 6 years	
A	Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways: 1. Directly experiencing the traumatic event(s). 2. Witnessing, in person, the event(s) as it occurred to others. 3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental. 4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse). Note: Criterion A4 does not apply to exposure through electronic media, television,
B	Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred: 1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). Note: In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed. 2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s). Note: In children, there may be frightening dreams without recognisable content. 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.) Note: In children, trauma-specific re-enactment may occur in play. 4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event(s). 5. Marked physiological reactions to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).
C	Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following: 1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). 2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
D	Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs). 2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined"). 3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others. 4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame). 5. Markedly diminished interest or participation in significant activities. 6. Feelings of detachment or estrangement from others. 7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
E	Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following: 1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects. 2. Reckless or self-destructive behaviour. 3. Hypervigilance. 4. Exaggerated startle response. 5. Problems with concentration. 6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
F	Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
G	The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H	The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

1.3.2 The Defence Cascade

The peri-traumatic response (also known as defence cascade see Figure 1; [72] follows a course of physiological reactions that start with an immediate sympathetic response (freeze) and may peak at a sympathetic fright reaction, or a parasympathetic shutdown (faint).

The different suggestions for a defence cascade model consist of the following components: ''freezing'' in case of a large distance between subject and threat; ''flight'' when the distance is reduced; ''fight'' when the distance is eliminated; and ''immobility'' in case of prolonged elimination of distance [58]. Recently, a model has integrated ''faint'' as another response possibility [2, 44]. First, the freezing (orienting response – OR) facilitates a ''stop-look-listen'' perception of the threat. Evidence has shown the predictive value of reported peritraumatic dissociation for the development of mental health problems including PTSD [9], especially peritraumatic tonic immobility is a risk factor [28]. Our model wants to fill the missing link and suggests six defence responses, notably Freeze, Flight, Fight, Fright, Flag, and eventually Faint, whereby during the two Fs Flight and Fight bodily responses are mainly regulated via the sympathetic branch (''uproar reactions'') and the following three Fs, the second half of the cascade, are dominated by parasympathetic arousal, determining the spectrum of dissociative responding (''shut-down'' reactions: Fright, Flag, and Faint). If PTSD symptoms develop in the aftermath of the traumatic stressor, they frequently mirror the dominant peri-traumatic response [72].

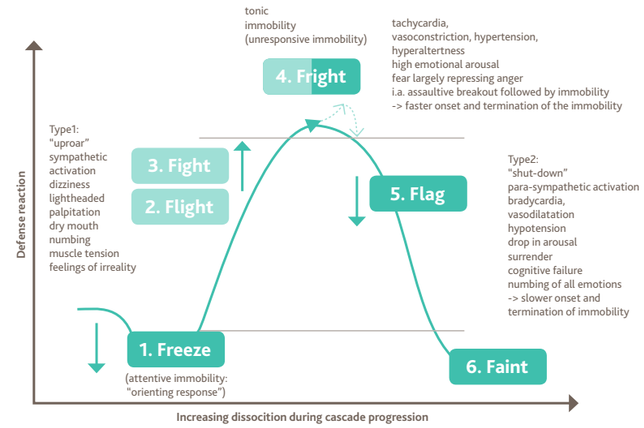

Figure 1: The five stages of the peri-traumatic response [72]: 1. Freeze: Recognising the threat, the organism enters the first phase of attentive immobility; 2. Fight or Flight: Depending on previous experiences, opportunities to escape, as well as the relative strength of the opponent, the subject decides under an extreme activation of the sympathetic path whether either fight or flight is appropriate. 4. Fright: The failure of fight or flight will initiate the fright reaction, a tonic and unresponsive immobility. 5. Flag: Confronting on-going aggression in which the subject has no chance to defeat the offender (e.g., torture or rape). The activation of the para-sympathetic path and its associated systems become dominant. 6. Faint: The final reaction is fainting. Information (sensory, physical, emotional, cognitive, place, time, happening) is not processed by the brain nor is stored in the memory.

1.4 The Defence Cascade Model

During a traumatic event, mainly sensory and perceptual information (for example: the sound of heavy breathing, the smell of sweat) is stored in memory. The mind and body become extremely aroused (rapid heartbeat, sweating, trembling) and are braced for actions such as hiding, fighting, or escape. The sensory elements, together with the related cognitive emotional and physiological responses then form associations in memory related to the traumatic experiences. We refer to the storage of this information as hot memory [47] it has also been termed situational accessible memory, or sensory perceptual representation [14, 74, 17]. For a new type of experience, this hot memory is connected to the contextual information, the cold memory (which has been referred to also as verbally accessible memory or contextual representation): the individual will remember the event within its context, i.e., where and when it has happened. Repeatedly experiencing similar types of events fosters a generalisation of their memory representation. Therefore, evolution has prearranged the organisation of memory such that sensory and emotional experiences are stored in brain circuits separate from those relevant for contextual information. Following principles of associative learning, any important experience is stored in an interconnected neural network (see Figure 2), which, for repeated adversities, may establish a fear network, the collection of cues encountered during the traumatic event (see Figure 3). This fear network encompasses sensory, cognitive, physiological representations and includes the emotional response related to the experience (hot memory). In PTSD, the hot memories have lost their association to the contextual cold memory system (see Figure 3).

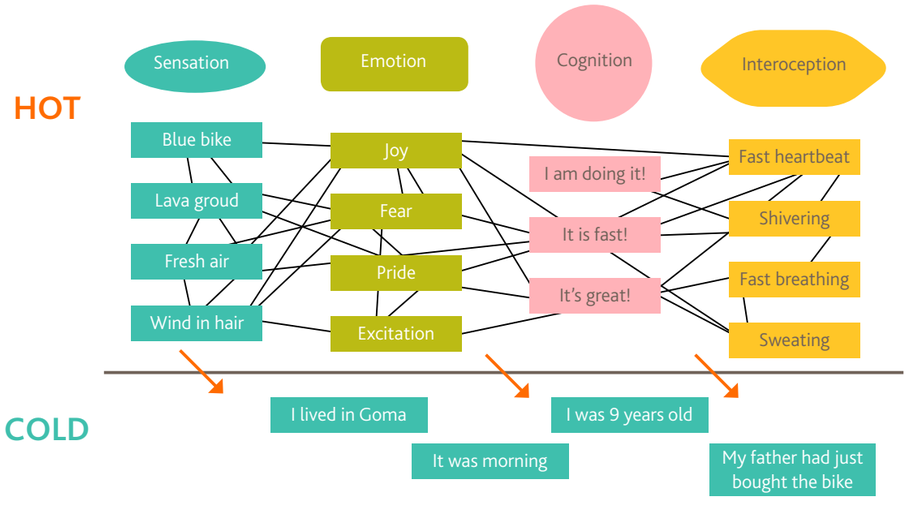

Figure 2: Perceptual neural network of a non-traumatic event. Hot – sensory, emotional, cognitive, and physiological – information linked with cold – contextual – information from the memory of an event. Environmental stimuli (e.g., a smell or noise) and internal cues (e.g., a thought) can still activate the trauma structure. The ignition of just a few elements in the network may be sufficient for activating the whole network (Figure 4). The survivor will experience this as intrusive recollection or even a "flashback", i.e., the perception that one is back in the traumatic situation with its sound of bullets, smell of sweat, feeling of fear and/or disgust, defensive response propositions, and thoughts.

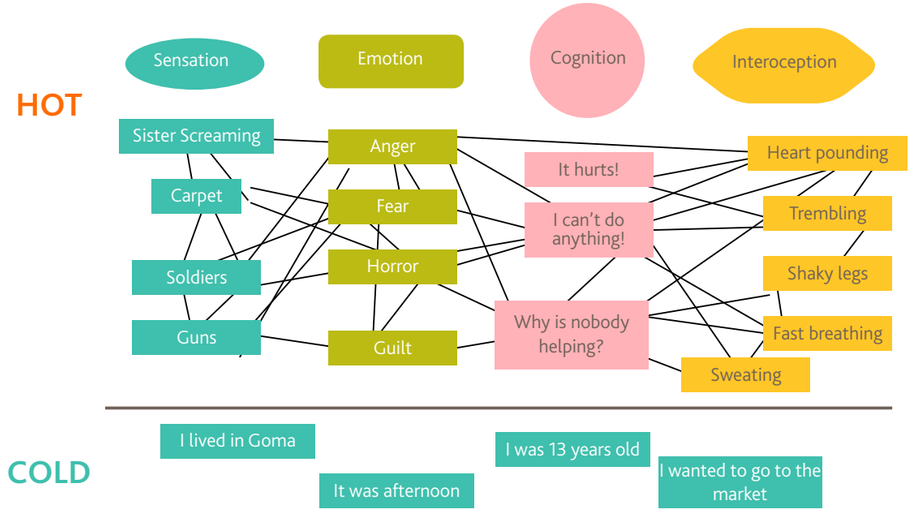

Figure 3: Perceptual neural network of a traumatic event. In PTSD, the hot memories have lost their association to the contextual cold memory system.

Since the activation of the fear network serves as a frightening and painful recollection, many PTSD patients learn to avoid cues that act as reminders of the traumatic event. They attempt not to think or talk about any part represented in the fear network and to stay away from persons and places that remind them of the frightening event. In contrast to their prominent hot trauma memories, survivors who suffer from PTSD have difficulties with autobiographical cold context; that is, they are unable to orient the fear associated with the events appropriately in time and space or to clearly structure these traumatic events in chronological order [Figure 3; 74]. Such challenges, in conjunction with the avoidance of activating the trauma structure, make it difficult for PTSD patients to narrate their traumatic experiences [53]. It is likely that these mechanisms of traumatic memories are not restricted to PTSD. Individuals suffering from other anxiety disorders, depression or eating disorders frequently also report repeated vivid intrusive recollections abounding in highly distressful content but lacking cold memory contextual elements [13].

Note that the network connects to response dispositions (= emotions), which can be either an alarm response involving fight and flight or a dissociative response (up to the extent of fainting, i.e., playing dead; [72]. Thus, dissociative amnesia or "shutdown" can occur, replacing intrusions and hyperarousal with dissociation and passive avoidance. Both response types are evolutionarily prepared and a patient may show either one, depending on the cues that activate the related memory. Narrative Exposure Therapy is thought to reverse these detrimental conditions by strengthening connections to the context.

We conclude that repeated exposure to traumatic events results in the distortion of not merely the content of events but also the overarching organisation and structure of both memory storage and retrieval; the more seriously threatening or damaging the survived experiences, the greater the degree of disorganisation.

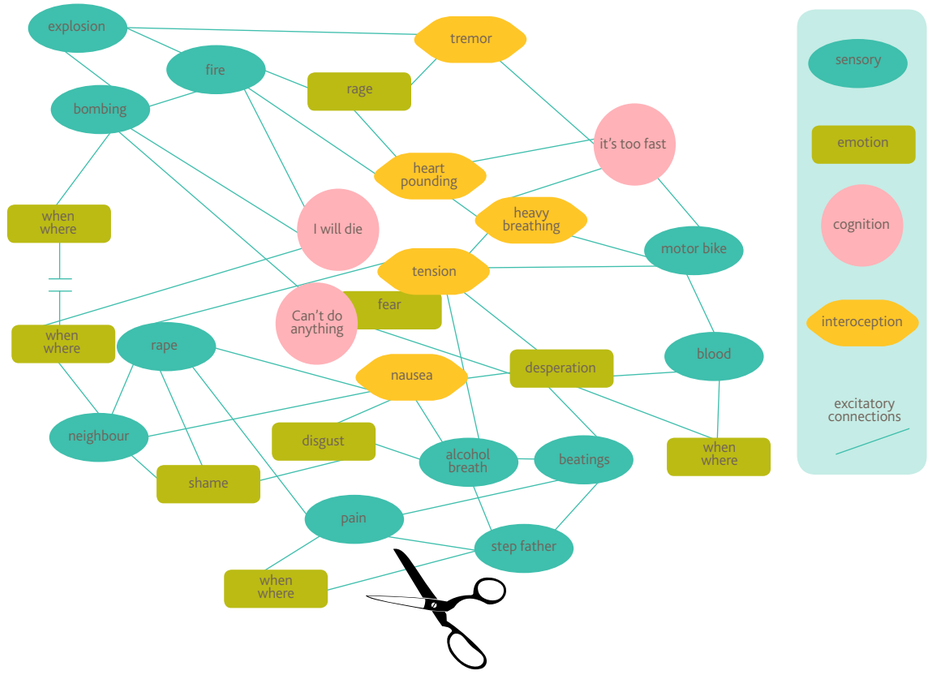

Figure 4: Fear network – the perceptual neural network of multiple traumatic events. A fear network is composed of mutually excitatory connections. It results from multiple fearful experiences: the representation of a single event may well connect to the particular context, the "when" and "where" it happened. If, however, an additional stressful experience cues an already existing network of traumatic hot memories, the connection to the cold memory is lost while sensory, cognitive, emotional, and physiological representations interconnect with increasingly mutual excitatory power.
Cold, contextual memories, i.e., codes of the "where" and "when," however, are not consistently co-activated as the brain's architecture does not support the simultaneous activation of two different places (coded by "place cells" in the hippocampus). Thus the fear/trauma network becomes disconnected (symbolised by the scissors) from time and place, and the fear generalises, giving rise to feelings of impending threat. Narrative Exposure Therapy is thought to reverse this process by reconnecting hot and cold memories while segregating the memory traces of the different events
(Figure modified from [72]).

1.5 The building block effect of traumatic load

With cumulative adversities and stressors, the trauma network becomes enlarged, ultimately leading to forms of trauma-related suffering: survivors are unable to contextualise cues and thus the past becomes the present. The writer and Holocaust survivor Primo Levi describes such experiences in his work The Truce:

"[..] I am sitting [...] in a peaceful relaxed environment, apparently without tension or affliction; yet I feel a deep and subtle anguish, the definite sensation of an impending threat. And in fact – slowly and brutally – everything collapses, and disintegrates around me, the scenery, the walls, the people, while the anguish becomes more intense and more precise. I am alone in the centre of a grey and turbid nothing, and I know what this thing means, and I also know that I have always known it: I am in the Lager (death camp), and nothing is true outside the Lager. All the rest was a brief pause, a deception of the senses, a dream."

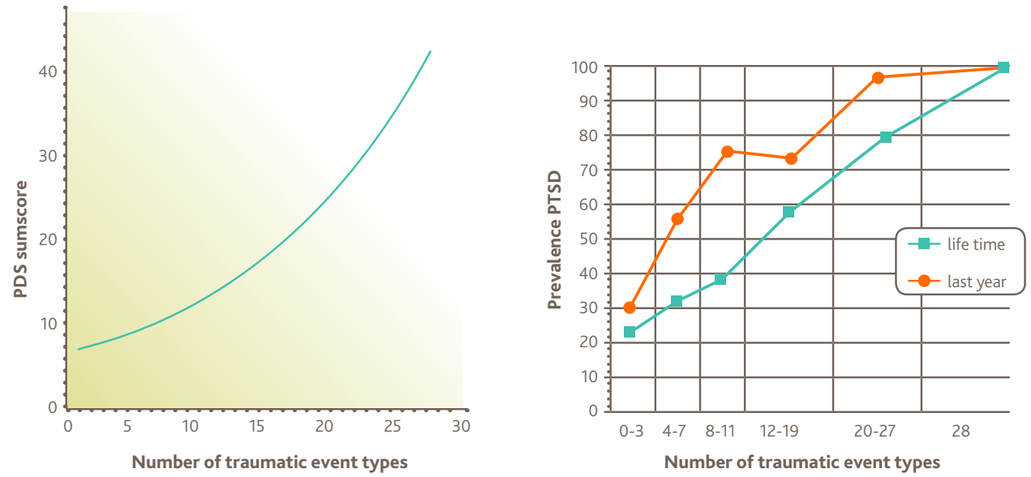

Figure 5: Building block effect: the more traumatic events have been experienced the higher the risk to develop PTSD and the more severe are PTSD symptoms.

All symptoms of PTSD and trauma-related disorders have repeatedly been shown to correlate in their severity with the cumulative exposure to traumatic stress (Figure 5; 48, 56, 42]. More recently it has become obvious that childhood adversity is the other major dimension in predicting trauma-related mental disorder [15, 16, 54, 52].

2. The Narrative Exposure Therapy

Given the structure of traumatic memory representations, the goal of an etiologically oriented therapy must be to reconnect hot and cold memory, focusing on the most arousing experiences. Therefore, in NET and its variations, the client, with the assistance of the therapist, constructs a chronological narrative of her/his life story with a focus on the traumatic experiences. Within a predefined number, usually about four to twelve, of 90 minutes sessions, the fragmented reports of the traumatic experiences will be transformed into a coherent narrative. Empathic understanding, active listening, congruence and unconditional positive regard are key components of the therapist's behaviour and attitude. For traumatic stress experiences the therapist explores sensory information, resulting cognitions, affective and physiological responding in detail and probes for respective observations. The patient is encouraged to relive these experiences while narrating, without losing the connection to the here and now. Using permanent reminders that the feelings and physiological responses result from activation of (hot) memories, the therapist links these mnemonic representations to episodic facts, i.e., time and place (cold memory). The imagined exposure to the traumatic past is not terminated until the related affection, especially the fear presented by the patient, demonstrably decreases. In this way, the therapist is supportive yet directive in eliciting the narrative in order to recover the implicit information of the trauma in its entirety. For survivors of domestic, SGBV-related or organised violence, the testimony can be recorded and used for documentary purposes – a community intervention we refer to as NET facts (for more details refer to section 4).

After an assessment of the individual's mental health status, a psychoeducational introduction is presented to the survivor, focusing on the explanation of his or her disturbance and symptoms, and, if appropriate a statement about the universality of human rights, followed by an outline of the treatment rationale tuned to the cognitive capacity of the survivor (age, formal education etc.). Narrative Exposure Therapy then starts with a biographical overview of the life span. Figure 6 schematically indicates the goal of the therapist: to determine arousal peaks across the lifespan. Lifetime periods and important biographic events of the survivor are symbolised in a ritual called the lifeline. The lifeline exercise consists of placing positive and negative life events, symbolised by flowers and stones, along a 'line' (e.g., a rope) in chronological order. With the guidance of the therapist, the patient places the symbols next to the line while classifying them only briefly – just a label will do. The purpose of the lifeline is the reconstruction of subjectively significant life events in their chronological order. An initial, cursory overview of the times and locations in which events occurred within the overarching context of the individual's life, it serves as introduction to the logic of the therapeutic process. The therapist asks questions concerning the when and where an event took place, i.e., focuses on cold memory and moves on before hot memory contents become strongly activated. The therapist attends to the body language of the patient. When the patient shows any signs of emotional arousal or begins to recall pictures or other sensations, the therapist reminds the patient that a detailed processing and narration of the event will be constructed later, beginning in the next session. The lifeline exercise should be concluded within one session. Otherwise an avoidance conspiracy between client and therapist may delay the essential healing agent, i.e., the imagined exposure of the traumatic experience.

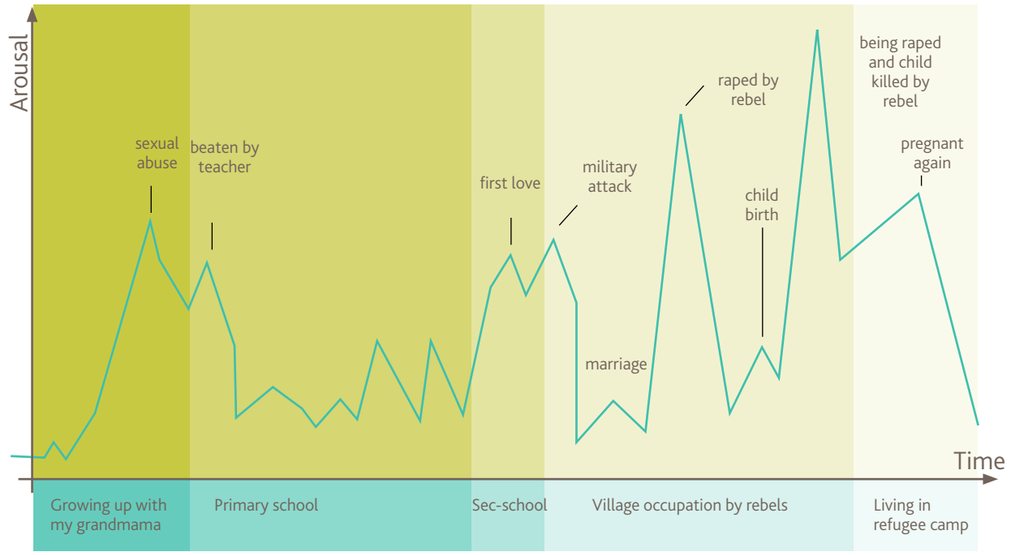

Figure 6: Emotional arousal varies greatly across the lifespan. The lifeline exercise marks the arousal peaks above a threshold with a symbol: negative valence with a stone, positive valence with a flower, and assigns them to a place (e.g., Goma) and a time (e.g., 5 years); ideally a specific event, (like "childbirth") or at least a general event ("when my uncle visited us"). A life period ("when I went to school"; "when I was working in Rutshuru") can always be assigned (for more details see [74 and 76].

In the next session, the narration starts with essential background information and then the earliest arousing events in life and continues sequentially over time. A pre-trauma period may be used as the time during which a foundation for the therapeutic core process is laid and a good rapport between or exciting moments in the patient's early life offer themselves as a training ground for emotional processing and communication between patient and therapist.

During the narrative procedure, the survivor continues recounting his/her life-story in chronological order. Wherever a 'stone' (traumatic incident) occurs, the event is relived in a moment by moment reprocessing of the sensory, cognitive, emotional and bodily details of the traumatic scenes, ensuring the interweaving of hot and cold memory elements, meaning-making and integration. During the telling of the events, the therapist structures the topics and helps to clarify ambiguous descriptions.
The therapist assumes an empathic and accepting role. Inconsistencies in the patient's report are gently pointed out and often resolved by raising in-depth awareness about recurring bodily sensations or thoughts. The patient is encouraged to describe the traumatic events with sensory details and to reveal the perceptions, cognitions and emotions that had been experienced at that time. During or after the session, the therapist either writes down a version of the patient's narration or drafts brief notes next to the lifeline that has been sketched or photographed. In the subsequent sessions, the autobiography is briefly repeated, now emphasising the cold memories of the event. The patient may add details that may have been missed and that he or she feels are important. Then subsequent emotionally arousing peaks (the next stones and flowers) are processed, i.e., additional traumatic experiences are added to the narration. The procedure is repeated in subsequent sessions until a final version of the patient's life span and complete biographical highlights are created. There are several

options for the closing session. The lifeline may be completed and used as review of the patient's life. In cases where the narration has been fully recorded in written form, the document may be read aloud to the patient. The patient, the translator, if present, and the therapist sign the lifeline and/or written narration. A copy of the signed document is handed to the patient. With the agreement or upon request of the patient, another copy may be passed on to lawyers or (in anonymised form) to human rights organisations as documentation of these events. In addition, rituals can be used to ease the mourning and grief. Lastly, the patient may be counselled how to go on with life and is potentially offered further, but now future-oriented sessions (such as adjusting to a new role for a refugee or coping with relationships for a battered woman).

2.2 NET step by step

The following procedure follows the treatment manual [74]

Session 1: Diagnosis and psychoeducation.

Prior to the diagnostic assessment for trauma-related disorders, we recommend the use of an extensive checklist of family violence and other traumatic stressors encompassing the entire life span. In case of victims of Sex and Gender Based Violence (SGBV) specific checklists exist to identify the type, severity and frequency of exposure to such events. Such checklists provide the therapist with an indication of the traumatic history of the patient and suggest which events might and should appear on the lifeline. For survivors of trauma it is vital that they learn to conceptualise and understand their condition. Moreover, they need an explanation about the motivation of the therapist and her/his ability to listen to the worst stories ("I am here to assist people who have experienced extremely stressful conditions such as war, rape, forced migration, torture, massacre or natural disaster and to document the human rights violations that have taken place. [...] We hope to use what we learn from you to improve the way survivors of extreme stress are supported and respected in the future"). If the person suffers from symptoms of trauma-related disorder, it is advisable to proceed with psychoeducation immediately following the diagnosis. It is important to explain to the patient that alarm and/or dissociative responses are part of the defence repertoire of all humans and that trauma symptoms result when extreme and harmful events have been repeatedly experienced. Explain that memories of the trauma are intrusive memories, which may be triggered by single sensory cues, or internal states, in the mind and body. Provide information that these intrusions are perceived as a current threat, keeping the survivor in a state of vigilance as long as the trauma remains unresolved. The intrusive pictures, sounds, smells, together with the feelings they elicit, require conscious processing before they can be assigned to the past. This will occur during the course of therapy. The therapeutic procedure is outlined to the patient as an offer. At times, some patients believe that they are an "ill-fated creation of God" or "cursed" and are unworthy of treatment. The reasoning that documentation of human rights violations alone justifies the joint effort involved in therapy is often helpful in these cases. Others found joy in the violence they committed and were proud of the team spirit in gangs or armed groups. There are several reasons that a survivor might feel ashamed or guilty or believe that the therapist will not like what they hear about certain details of the individual's life. As the therapist, it is important to assure the individual that they have the professional skill to support testifying and that their main job is to provide a beneficial experience, regardless of the details, controversial or otherwise.

In sum, the psychoeducation includes the following elements:

Normalisation The therapist makes the patient understand that it is normal to have such reactions after a trauma.

Example of Normalisation

"Anyone would be distressed after what you have experienced. This shock experiences after such events is known as a posttraumatic reaction. The human brain is designed to promote survival. Therefore, our mind and body are made in such a way that they will perceive and store threatening information to a great degree. Because this happened to you, your body is in a state of looking for and predicting danger before it occurs again. It is far preferable for us vulnerable humans to be too cautious, too hypervigilant. However, this is a survival strategy that is painful and extremely exhausting, as you know. It is no longer needed now, as the event you survived happened in the past."

Legitimisation The therapist explains to the patient that the symptoms experienced today are the result of responses from the traumatic situation.

Example of Legitimisation

"The problems you are experiencing now like [symptoms of the patient] are not adaptive responses for your present life. In a life-threatening situation, people become highly aroused (no sleeping), danger-focused (not concentrating on other things), and numb (not feeling any pain in your body). During the event, your body and mind were in such an alarm mode (e.g., sweating, heart pounding, rapid respiration). This is a common state for your body to be in following a traumatic event."

Session 2: The lifeline exercise

The lifeline in NET displays the emotional highlights of the individual's life in a ritualised and symbolic way. Hereby the survivor places the major events along a rope or string that symbolises the continuous flow of biographical time. Flowers designate happy major events and the good times in life e.g., for positive, empowering occurrences, moments of achievement, for important relationships, experiences of bliss and acceptance. In this way, flowers can serve as resources. Stones symbolise fearful ordeals, especially traumatising experiences such as life-threatening events or anything that triggers an alarm response or evokes a dissociative response, like abuse, rape, assault, injury or harm, captivity, natural disasters, accidents, etc. Survivors usually also place stones for difficult moments in life, such as times of hardship (divorce, dismissal, sickness).
While further symbols may complicate the exercise – flowers, stones carry a clear message and give structure. Nevertheless, additional symbols may meet the needs for special cases: For very sad experiences that cause continuous grief, like the death of a loved one, a candle can be placed and lit. For criminal offenders or perpetrators committing violent acts may not necessarily be of negative valence and thus a stone may not be an appropriate symbol, neither would a flower be adequate for victory after a massacre. A more neutral symbol may thus be introduced for these cases: we use a small stick to symbolise participation in any form of aggression or violence, including combat [35, 18, 17, 41]. It is good to offer a variety of differently sized, coloured and shaped stones and flowers, so as to give choices for the representation of events. When the rope/string is put on the floor, the therapist encourages the individual to start placing the symbols along the line. The therapist guides the patient to name and mark important events and turns in life, following a

chronological order. For each arousing event, the questions "when?", "where?", and "what?" should be answered with only a few words, without going into the details (e.g., "In secondary school, 2006, living in my hometown (Goma), raped by my neighbour" or "A few months ago, living here in this town (Bukavu), a car hit me", "during the birth of my first child named 'Jonnie' in 2005, at the hospital in Rutshuru, I was forced to undergo a Caesarean section", etc.). The therapist affixes a name to each symbol and notes the where and when. Clear brief naming of the symbol and appropriating it a title is important to build confidence in approaching the hot memories. However, it is crucial to not go any deeper at this point, as the lifeline exercise is not the designated time to begin confronting the content of the event. During this stage of the lifeline procedure, the therapist guides the individual in staying on the cold memory side (questions focus on facts, names, dates etc. rather than on emotions, sensations, physiology etc.). The lifeline exercise is only an overview of important life events – a 'roadmap'. In this regard, it is helpful to settle and cool down after each symbol placement, especially stones, before placing the next event. The focus remains on the when – naming the life-time period – and where, not on the what. Otherwise feelings 'pile up' towards the end of the lifeline and emotions get mixed up and confused.

In this way the lifeline tool in Narrative Exposure Therapy is a useful first step towards discussing the traumatic material. [76]. The lifeline was first introduced in trauma therapy with children: KIDNET [59] and continues to be utilised as such [16, 66, 25, 35, 18, 41]. Later, the classic lifeline method was adopted in NET for different groups of adult survivors of multiple and complex trauma [17, 71, 16, 33, 34, 61, 79], sometimes as a paper-and-pencil version, in which the patient marks the biographical highlights along the timeline on a piece of paper [23, 87]. There is clear evidence for the effectiveness of NET with the lifeline being included in the treatment plan. However, treatment success has also been confirmed for NET without the lifeline module [56, 73, 74, 37] and also, alternatively, with the lifeline module at the end of the therapy [87]. Conversely, clinical efficacy of the lifeline as a stand-alone procedure in the treatment of traumatised individuals has not been demonstrated and would not be predicted on the basis of the theoretical assumptions.

Example of a life line using flowers, stones and candles as symbols

Session 3: The narration of stones

The narration begins during the third session, starting at the very beginning of life. The chronology of the narration should address the most arousing events of the patient. The family background should not be neglected: how the patient grew up, what the relationship to his parents was, and what other attachment figures and bonds played a role during the early stages of development ("When are you born and where? Who was bringing you up? Which people were your family? What did they tell you about your first years of life, before your own sessions, discussion of the pre-trauma period should remain limited, so as not to avoid narrating the more difficult material later on. Usually time is allocated to work through a first traumatic experience during the same double-session (90-120 minutes) that the narration is initiated. Full expression of the fearful and defensive responding is desirable now during the imagined exposure, allowing for the individual to subsequently experience the reduction in arousal that occurs while narrating the period that followed the most threatening hot spot. The contextual information must first be clearly recollected, then the event is reported in detail, and, finally, it is put into the past from its present perspective:

WHEN? Time and setting

Establish when the incident took place. Lifetime period? Season of the year? Time of day?
It is frequent that people who suffer from complex PTSD are confused concerning when the events took place or in which order. If a person doesn't remember the exact date or the year the event took place he/she can describe the period of the year (eg. winter, summer, during a public/religious holiday).

WHERE? Location and activity

Establish as precisely as possible where the incident took place. Where was the person at that time? The setting can be described based on what the person remembers, like the surroundings, distance from the place of residence, as in some cases people have confusion as well about the exact place. Begin asking for sensory details of the scenery, the house, the road etc.

WHAT?

Begin the narration, when the arousal begins to rise.
Only then, the therapist shifts to slow motion. It may take some courage for both the client and the therapist to deliberately slow down and recall in detail what happened. The therapist supports the processing of the material by allowing the emotional responses to run their course. Hot memory (the associated elements of the fear/trauma structure) is activated involving the following sequence: sensation ("What did you see, hear, smell, body position, ..."), cognition ("What did you think?"), emotion ("What did you feel?"; note that a therapist will not be able to understand the feelings of a client, as long as the respective thoughts are not known), physiological responses (heartbeat, sweating, cold hands etc.) and meaning content. The therapist helps to put the hot memory into words and connect them to autobiographical flow, i.e., fit them into the narrative. Basically, the therapist keeps pushing on until the experience, especially the emotions, have been put into words and the client starts to feel relief. Stopping any time before that point is detrimental. The therapist has reached the goal, when a good movie could be made from the client's descriptions. For the therapist, it is a good idea to let this little film play in one's mind, although only as if moving together, shoulder by shoulder with the survivor through the scene.

NOW!!

Let the patient contrast the past and present feelings together with the current bodily sensations: Patient: "At the time of the disaster, I felt horrified, now as I look back, I am getting sad." Therapist: "I can see you are sighing", "Your eyes are tearing up now." "Can you feel the fear in your body now? Where do you feel it?" This will allow the individual to develop better sensorial awareness. There is no need for hesitation when attempting to label the patient's affective responses: a patient will inform the therapist immediately if the feelings have been labelled incorrectly. Once the fear has been put into words, the client realises that there is no current danger and that the source of arousal is the memory of a threat rather than an instant threat itself. Consequently, the arousal will decrease.

Important: After the arousal has noticeably reduced, be sure to bring the narrative to a close for this session.

Even if time in the session is running out, it is of utmost importance to establish a clear ending to the traumatic event that has been worked on. The way to bring this closure is by transitioning to the time that occurred immediately following the event. To do this, the therapist wants to have the client verbalise in at least a few sentences what happened in the time period following the incident. In case it seems difficult to let go of the emotions of the imagined exposure, a question helpful for moving forward can be to ask how the survivor subsequently managed to live through the aftermath of this event (the hours, days, weeks, and months afterwards). This strategy assists in transitioning from stress and discomfort of the hot memory toward session closure by aligning with the directionality of the NET lifeline to which the individual is already accustomed. It is important to clarify the time period following the traumatic event in order to enable the patient to integrate the incident into the greater life-story. During "exposure," arousal and negative emotions are escalating. During "closure," arousal is decreasing, the therapist supports this calming down process. Always be clear about the direction in which you are headed.

BOND!!

The therapist attends to the healing of social pain. The warm, empathic and non-judgmental attitude of the therapist while processing the events allows for the healing of attachment wounds. This undertaking invites the establishment of corrective relationship experiences by revisiting old social pain situations in the presence and with the support of a therapeutic relationship. Hence, the arc of tension within a session begins with storytelling prior to the trauma, proceeds to the details constituting the trauma itself and then extends to the period occurring shortly after the traumatic event concludes. This allows for the trauma and combat to be contextually situated and for the patient to orient the time and space, as well as the emotional and meaning context, of the event. Finalising the exposure session and before drawing the session to a close, the therapist will ascertain through observation and questioning as to whether the patient's arousal level has subsided and that the individual once again has their bearings in the present reality.

Session 4 and subsequent sessions: completing the narration

In the subsequent sessions, the narrative elaborated in the previous session will be summarised, and the narration of subsequent life and traumatic events is continued. The number of sessions (usually 10-12) required depends on the setting and the severity of PTSD (in complex cases, e.g., in patients with borderline personality disorder, a greater number of sessions may be required). However, a limit to the number of exposure sessions should be set early on so to circumvent avoidance or a delaying of the narration of the worst events.

2.3 Cognitive restructuring and the days after

At the end of a session, patients often begin to reflect on the meaning content. A more formal cognitive restructuring process may be supported by explicitly pointing out e.g.:

- New insights about the meaning of the event for the patient's life. Patients may realise how the everyday emotions and unhealthy behavioural patterns (such as general anxiety, mistrust, rage, outbursts of anger) have their origins in the traumatic event.
- The detailed narration leads to a more thorough understanding of a person's behaviour during the event. This might help to modify feelings of guilt and shame.
- The recognition of interrelated life-patterns and incidents, allowing integration.

Much of the beneficial process of increased awareness of what has happened takes place between sessions. When the therapist and patient meet again, the therapist should be open to positively receiving any thoughts and considerations the patient might have had since they last met.

2.4 Final session of the NET-module

During the final session the events constituting the individual's life are reviewed as a contextualised and integrated narration. The patient might look at the narrative with a sense of distance (it is a sad but true story) or s/he might look at the document as a tool for peace building or educational purposes (awareness raising). Laying out the complete lifeline at the end of the NET treatment this time including all the formerly inaccessible memories – enables the person to oversee the biographical work done and to perceive the 'Gestalt' of the course of life. After the completion of the NET, patients are less preoccupied with their past and now focused on how to find their way back to life and how to construct a liveable, productive future.

2.5 Follow-up period

Ideal times for evaluation are at 4-6 months and 1 year post-treatment. Over time one can anticipate symptom remission to a degree at which PTSD is no longer diagnosable. NET initiates a healing process that requires months, if not longer, to fully unfold.

2.6 Overview of the therapeutic elements of NET

Several elements of NET have been identified as contributing to its efficacy that the clinician may wish to keep in mind [74]. They are summarised below.

1. Active chronological reconstruction of the autobiographical/episodic memory.
2. Extended exposure to the hot spots and full activation of the fear memory in order to modify the emotional network (i.e., learning to separate the traumatic memory from the conditioned emotional response and understanding triggers as cues, which are just temporarily associated) through detailed narration and imagination of the traumatic event.
3. Meaningful linkage and integration of physiological, sensory, cognitive and emotional responses to one's time, space, and life context (i.e., comprehension of the original context of acquisition and the re-emergence of the conditioned responses in later life).
4. Cognitive re-evaluation of behaviour and patterns (i.e., cognitive distortions, automatic thoughts, beliefs, responses), as well as re-interpretation of the meaning-content through re-processing of negative, fearful and traumatic events – completion and closure.
5. Revisiting of positive life-experiences for (mental) support and to adjust basic assumptions using them as well as resources.
6. Regaining of one's dignity through satisfaction of the need for acknowledgment through the explicit human rights orientation of "testifying."

2.7 NET as an evidence-based treatment

Results from more than a dozen treatment trials in adults and children have demonstrated the power of using NET in reducing the suffering of interpersonal or organised violence, as well as other disasters, for survivors. These stressors frequently produce detrimental effects in combination with childhood abuse and neglect, issues directly addressed in NET. By the very nature of NET, it is constructed to counter the impact of multiple and complex traumatic stress experiences that have occurred across an entire lifetime. NET provides a proven treatment option to complex trauma survivors [61] and survivors of repeated torture as evidenced by large effect sizes [34]. The most pronounced improvements are observed at follow up, suggesting a sustained change in psychopathological symptoms, physical health, functioning and quality of life. NET has effectively been applied in situations that remain volatile and insecure, such as in continuous trauma settings. It effectively reduces PTSD symptoms in the individual whilst bearing witness to the atrocities endured. A number of reviews identified NET as an evidence-based treatment, especially for survivors of violence [65, 19, 46, 57]. A number of studies showing the effectiveness of NET have been independently conducted [87, 37, 32, 36] and thus, the NET procedure has been taken up in a variety of countries (e.g., [88, 39]). Manuals have appeared in print in Dutch, English, French, Italian, Korean, and Japanese.

An interesting strength for the evidence of NET is the validation of its effectiveness by means of markers from neurophysiology and molecular biology. Successful psychotherapeutic interventions reorganise memory and with it, modify the architecture of the brain. Imaging of corresponding changes may indeed be possible, even on a macroscopic level: in a controlled trial, NET was compared to treatment as usual of traumatised asylum seekers [75]. The success was not only demonstrated in symptom scores but also in parameters of magnetic brain activity. During the 6-month follow-up, oscillatory neural activity in the NET group, but not in the control group, became more similar to that of healthy controls. Moreover, using magnetic source imaging of the brain, it was observed [1] that NET causes an increase of activity associated with cortical top-down regulation of attention towards aversive pictures. The increase of attention allocation to potential threat cues obviously allowed treated patients to re-appraise the actual danger of the current situation, thereby, reducing PTSD symptoms. PTSD is a well-documented risk factor for various somatic diseases, including chronic pain, cancer, cardiovascular, respiratory, gastrointestinal, and autoimmune diseases [11, 43]. The poor physical health found in individuals with PTSD seems moderated by altered immune functions and inflammatory processes [62]. One study [53] indicated that NET reduced the frequencies of cough, diarrhoea, and fever. Another, [50] showed that symptom improvements were mirrored in an increase in the originally reduced proportion of regulatory T cells in the NET group at the one-year follow-up. These cells are critical for maintaining balance in the immune system, regulating the immune response, and preventing autoimmune diseases. Moreover, NET is able to reverse in individuals with PTSD the increased levels of damaged DNA back to a normal level [49]. These findings may have implications for physical health, in particular for carcinogenesis. The reversibility of pathophysiological processes in individuals with PTSD via psychotherapy indicates that there is a therapeutic window not only to revert the psychological burden of the disease PTSD but also to reduce the long-term, and potentially lethal, somatic effects of this mental disorder. However, it should also be noted that other immune parameters (like the proportion of naïve T lymphocytes) have not changed and thus might render these patients more susceptible to infectious diseases across extended periods even after the completion of successful treatment.

Two decisive strengths of NET include its very low dropout rate and its high potential for dissemination, including to counsellors in low-income countries and war and crisis regions [16, 53, 25, 38]. With NET, in the case of central Norway, refugees as well as asylum seekers can be successfully treated for PTSD and depression in the general psychiatric health care system.

3 Challenges

3.1 Diffuse recall of time

Some survivors of childhood abuse, continuous trauma or personality disorders are utterly unable to retrieve reliable memories of their past. This often results from severe dissociative responding when attempting to retrieve autobiographical memories [72] Laying the lifeline at the opening of the NET procedure therefore takes place without requiring completeness. It is worth the effort to attempt to structure the autobiography at the beginning of treatment, even when voluntary retrieving of hot memories is a serious challenge. The laying of the lifeline should be concluded within one session of up to 120 min, regardless of level of completion. Narration must begin in the following session for the following reasons: Delaying the exposure may strengthen the avoidance and reject a patient who finally is prepared to talk about the worst drama. Alternatively, it is possible to start with the narration immediately and have the lifeline exercise only at the very end of the treatment [87].

3.2 Dissociation and flashback

Like any other imagined exposure procedure, dissociation and flashback may be a topic to be aware of. While in both conditions the patient relives the traumatic event with a complete cut of awareness for the present, the therapist intervenes with different methods; in flashbacks the key is to calm down the client and in case of dissociation the client has to be kept active. With it, the therapist encourages the client to counteract the automatic reaction at the hot spot of the traumatic event. Importantly, the therapist constantly reassures the patient of the safety in the therapeutic setting.

3.3 Shame and guilt

Furthermore social (self-conscious) emotions such as shame, experiences of social pain or feelings of guilt may cause a challenge for the narrative work. Particularly shame, with its confusion of mind, downward cast eyes and lowered head, but most of all its silence and speechlessness may create a formidable challenge to any story telling. Pathological shame-proneness is ultimately the fear of being rejected and socially excluded because deep inside it feels impossible to meet the (moral) requirements of the community. A client thus hides everything deep inside as showing it will cause others to dislike and reject the individual. NET is then like a behavioural experiment: as a client reveals portions of the true inner self she/he will expect rejection. The therapist responds with the opposite, showing true and honest compassion – i.e. sets an inclusive social signal. At times, socially traumatised (e.g., raped) individuals may be so sensitive that they will suspect that the therapist may not be honest. Thus, shame caused by social threat cannot be treated by either exposure or compassion alone, but only by the combination of both. Attempts to cure shame with self-compassion will not work; individuals need to feel included by others not by themselves. Obviously, relief from shame requires knowledge of cultural values by the therapist

3.4 Avoidance

Most importantly, avoidance is not only a "challenge", but also a symptom of PTSD. Therefore, the therapist needs to be sensitive for possible avoidance behaviour during the therapy, e.g., the client may come up with daily life problems, s/he may need to go the toilet, talk about other things, etc. The therapist may then directly, but empathically express her/his assumption. The explanation of why it is so difficult, but also so important to talk about it and the assurance of going through it together will help the client to overcome burden of silence.

3.5 Intoxication

If a patient is acutely intoxicated, abuses drugs, suffers from a severe, current eating disorder or demonstrates an acute psychotic crisis, the facilitation of narrative exposure is neither possible nor advisable. Trials that start NET during detox are underway and case studies seem promising.

Drug misuse and most commonly excessive alcohol intake frequently co-occurs with trauma and aggression symptoms, though the client may not arrive intoxicated in the therapy sessions. The therapist should openly ask the client about his alcohol and drug intake and explain its functionality, but especially also the negative consequences on the long turn. The client should be advised to cut down drug intake to permit the proliferation of treatment gains; being intoxicated the brain cannot properly reprocess the traumatic event, which is the necessary therapeutic process in NET.

3.6 Malnutrition

Ideally, a patient may have regularly eaten prior to a treatment session and water is offered during the session. A therapist may routinely ask about nutrition before the initiations of each session.

3.7 Victims of amputation

Many of the victims of violence have suffered severe physical damage like amputations or injuries that have led to physical impairment. Victims of violence with such injuries may be suffering from chronic pain, which might be intensified during the narration of the events that have led to the injury. In some cases the patient might have the need to show to the therapist the scar in order to "convince" of the severity of the event experienced. The therapist must demonstrate the same empathy and compassion to the suffering of the patient and acknowledging that what he/she has suffered is indeed very sad. The attention should not be shifted on the current impairment but continue with the narration of the events encouraging the patient to proceed despite the bodily unpleasant sensations related to the physical injury.

4. NET facts

In communities that are affected from organised violence or where domestic violence or SGBV are widespread, similar types of traumatic events are experienced by a relatively large part of community members. Trauma-related aggressive outbursts, stigmatisation and isolation of the survivors have been prominent consequences. Therefore, the narrations produced during the NET sessions bear a great wisdom of what many individuals experienced. Feeding them back to community members who are not necessarily affected in a directly traumatising way increases awareness for the situation of the community and empathy to the survivors. It is hoped that these community members develop a way to encounter the facts of their collective past and find their way to step into a peaceful future.

5. The KIDNET: Treating Children with PTSD

Violence against children, such as family violence, sexual abuse, child labour, and neglect are common phenomena worldwide. Apart from these, many children are affected by violence caused during massive human-made violence such as, civil conflicts and war. Current wars are characterised by high levels of deliberate and systematic violence against the civilian population [40], including victimisation of women and children. More than 30 countries are affected by current wars, and the populations of many now peaceful countries suffer from the aftermaths of a recent armed conflict. Longitudinal studies show that trauma symptoms in children are more than simply a behavioural problem that dissipates over time as the child matures. In a large proportion of severely war-traumatised children, PTSD can persist for more than 10 years even when the children are living in a safe environment [69]. As a consequence, intervention strategies for severely traumatised children in war-affected populations are necessary to prevent a downward spiral in development. Intervention research in this area is still in its infancy, however, and common practice rarely is informed by scientific knowledge.

The Narrative Exposure Therapy, initially developed for adults, but has been adapted for use with children older than 8 years [67]. In narrative exposure procedures, children are asked to describe what happened to them in great detail, paying attention to what they experienced in terms of what they saw, heard, smelled, felt, the movements they recall and how they felt and thought at the time. Initially, the session is distressing, but as it is long enough to allow habituation, distress levels diminish towards the end and more and more details are recalled. After only four sessions of exposure, scores on intrusion and avoidance may drop significantly [59]

Box 1. Interventions of KidNET in an eight-session format

Prerequisite
Structured psychologic assessment including diagnosis of PTSD, comprehensive list of traumatic events, context condition (family background, current threats and violence), and
exclusion criteria (substance addiction, psychosis)

First session
Psychoeducation with child and caretaker
Informed consent by caretaker and child
Lifeline

Second session
Revisit lifeline
Start narration at birth

Third through seventh sessions
Revisit lifeline
Reread and correct the narration of the previous session
Continue narration with focus on traumatic events

Eighth session
Revisit lifeline and add symbols for hopes in the future
Reread whole narration and include hopes for the future
Sign and hand over the narration

After treatment
Follow-up examination about 3 months after treatment

BOX 1 Proposed structure of an eight session KIDNET proposed in Neuner et al., 2008

As described, “any trauma-focused treatment including an exposure element requires high motivation in the child and a good and trustful relationship between the child and the therapist [53]. Consequently, treatment never should be started without detailed psychoeducation of the child. Parental consent should be obtained, if possible, and parents should be included in the psychoeducational part of treatment. The education includes information about trauma symptoms, a simplified model of the memory theory, the implications for treatment, and a detailed explanation of the treatment procedure.
The child and the caretaker should be prepared for the activation of memories from the past that might be painful and that they might want to avoid; they should know that the therapist will counteract this tendency. Depending on the child’s age, different metaphors can be used to explain the memory theory. (One example is the metaphor of a cabinet that is so full and messy that items fall out of it. Constantly holding the doors and occasionally putting the items back might be one solution, but it would be better to open doors once and to sort the items systematically.) In KIDNET, parents or caretakers are present only during the psychoeducational part of treatment. The rest of the treatment is conducted with the child alone (or with an interpreter if necessary), to allow the child to make his or her own report free of the influences of the parents or caretakers”.

6. A case of Narrative Exposure Therapy

Below we present one case study of a child soldier that has been treated with NET as it was reported; we have changed the names of the people and places to protect personal information. In bold characters are the moments of physiological and psychological arousal of the narration.

…One day I and my brothers Bahati and Amani went to the village. I was very happy to be home with my parents again. They gave us many good things to eat. After some days my father told my mother to bring my brother Bahati from Kichanga, home also. My mother went and came with Bahati. When they got off the vehicle that brought them from Kichanga, they met the rebels and the rebels took Bahati and allowed my mother to go home…

…It was 10.00 am when I and five other friends went to the valley were the sugar cane was. I had a panga. We found the rebels had broken many sugar canes. We were not bothered, I started cutting sugar cane. My friends were chewing and collecting others. We did not know that some rebels were hiding there. In fact, they were now surrounding us. I raised my head and saw a rebel moving towards us. He shouted: "don't run! If you do, I will kill you." The panga in my hand fell down. **My legs were shaking. My heart was racing very fast. I just went blank. I stood there, still.** My friends also just stood there. Then the other rebels started coming towards us from all directions. It was about 11.30 am that time. They told us to start walking. We just walked without any objections. **I kept thinking we have survived being killed at the sugar cane field, but now they are going to kill us. By this time my head was hot.** I just gave up everything. I did what the rebels told us to do without understanding. After walking for about two hours, we found a big group of rebels and people abducted. These were people who were abducted at night from Goma Camp. I recognised some of them. That day I saw one rebel was putting on one of my shirts, which was taken by the rebels the previous night. When I recognised my shirt **my heart was filled with anger.** The rebel who was putting on my shirt recognised that I was putting on a shirt exactly like the one he was wearing. He came to me. As he was walking towards me **I thought maybe I had done something wrong and they were going to kill me. I had great fear. My heart was beating fast, I was also angry at him.** When he reached me he asked: "where did you get this shirt from?" I told him that they were bought from Kichanga. I found myself telling him that they were two and the other one was stolen last night. He told me not to worry. He said now that you are here you will get more things. From that time he kept me near him. I was all this time having thoughts of death. I thought, may be this group was waiting for us to join another group and they kill us together. What made matters worse was that we found them beating a man who was about 40 years old. The man lay face down and they were beating him using the back part of an axe. The man could not even cry. **I thought for sure the next group to be beaten will be my group. My head was full of thoughts, my body was shaking. I had no feelings.** I could not feel hungry although it was already 2.00 pm. They then took my 5 friends and me aside. This was too much. I knew that was the end of us. **My mouth became dry. I was empty. I was sweating and so scared. Fear filled my heart…**

…At 6.00 am the rebels warmed their food, ate it and told us to start moving again. It was now Friday, I was very hungry. The rebel who was putting on my shirt gave me his bag again. We walked for long. The rebels told us to walk fast and that we shall get food where we were going. We walked until 3.00 pm and were told to rest.

As we sat down resting the big man told us: "here is a man who wanted to escape." He said the man should be killed. He was brought, and the big man ordered that some of the new captives should go and kill him. That this will show all the prisoners that escaping is bad. Three girls and one boy were chosen to go and kill him. The girls and the boy were told to tie him and beat him with clubs. He was beaten until death. It was not far from us. When I saw this, my soul ran out of my body. I was fearful. Then all the captives were told to come and step on the man who had just been killed. Girls and women were to step on him four times and men and boys three times. We all lined up. I was lifeless. I just stood there. I could not even hear the people standing around me talk.

We moved towards the dead man in the queue and people stepped on him. The rebel whose bag I had been carrying called me. It was a horrific site. The body had blood all over. His head was smashed and white stuff mixed with blood was scattered all over. It is a very bad scene to remember. I was lucky; I did not step on the dead body. We were addressed again by the "big man" who said anyone who tries to escape should know what will happen to him by what has just happened to the man over there. **Fear filled my heart; my mind was full of thoughts of death. The picture of the dead man remained inside me…**

7. Sexual and gender-based violence (SGBV)

7.1 The psychological, societal and generational impact of SGBV

Sexual and gender-based violence (SGBV) has been omnipresent throughout human history. It takes place both in times of war and peace, and targets mainly – but not exclusively – girls and women. It can cause enduring – often lifelong – physical and psychological suffering. In many cases, survivors carry the burden in silence for many years. Only when the torment becomes unbearable do some of them start to talk about their experience and finally seek help. SGBV and its detrimental sequelae often destroy the lives of individuals and profoundly affect their families. In contexts of armed conflict, where rape is particularly widespread, SGBV even has the potential to undermine social structures and cripple economic activity [82]. With increasing numbers of SGBV survivors, societies are faced with enormous social and economic losses. Dysfunctional members lose their capacity to contribute to the community systems and need more assistance. Continuing risks of attacks add additional costs, as women avoid important economic activities (such as going to marketplaces for trading or to fields for agricultural activities) out of fear of assaults. Finally, many survivors of SGBV suffering from psychological disorders are less able to function as caretakers and can thereby pass on trauma-related suffering to their children, i.e. the next generation. In the current scholarly discussion, this phenomenon is referred to as a transgenerational effect [86, 67, 21]. There is consensus amongst most scholars and human rights activists that rape during armed conflict is neither a side effect of, nor an adjunct to, large-scale violence, but is an inherent part of it.

The UN Security Council Resolutions 13258 and 1820 (on Women, Peace and Security: Sexual Violence in Armed Conflict) have established that armed conflict exposes women to increased levels of rape and is a major threat to women's physical integrity and their human rights (UN Doc S/RES/1820; June 19, 2008; UN Doc S/RES/1325; October 31, 2000). Amongst others, the UN has condemned the widespread rape of girls and women during the conflicts in Afghanistan, Burundi, Chad, Ivory Coast, Sudan, and the Democratic Republic of the Congo. It has implicated state and non-state armed groups as perpetrators of rape and sexual abuse. The UN also takes into account rape as a "weapon of warfare" and describes it as a "tactic of war to humiliate, dominate, instil fear in, disperse and/or forcibly relocate civilian members of a community or ethnic group". To encounter armed conflict and build sustainable peace, it is necessary to address SGBV and its long-term consequences in individuals and communities.

In Syria, assessments of the impact of the crisis indicate high levels of sexual and gender-based violence, with rape, assault, intimate partner violence and survival sex have are increasing. Reports are also alarming concerning SGBV in the refugee camps, where women and girls suffer domestic violence, sexual abuse and harassment [31]. In the report "Dimensions of Gender Based Violence against Syrian Refugees in Lebanon", by Ghida Anani [6] in a rapid assessment in 2012 by the International Rescue Committee in collaboration with ABAAD-Resource Center for Gender Equality concerning the vulnerabilities of Syrian women and girls to increased exposure to GBV both prior to crossing the borders and in their new host communities, and concluded the following:

- Rape and sexual violence were identified by focus groups and key informants alike as the most extensive form of violence faced by women and girls while in Syria.
- Intimate partner violence (IPV), early marriage and survival sex were identified by adult women and adolescent girls as other forms of violence experienced since arriving in Lebanon. Adult female participants in several focus groups reported that IPV has increased since their arrival in Lebanon, while adolescent girls stated that early marriages have increased, most frequently framed as efforts by families to 'protect' girls from being raped or to ensure that they are 'under the protection of a man'. Survival sex, typically linked to the desperate need of women and girls to earn money to cover the cost of living since arriving in Lebanon, was also identified as a type of violence frequently experienced by Syrian females.
- Many newly arrived women and girls are living in unplanned and overcrowded refugee settlements, with minimal privacy and compromised safety, particularly among those refugee populations inhabiting abandoned public buildings.
- Survivors are reluctant to report SGBV or seek support due to the shame, fear and 'dishonour' to their families. Women risk further physical and sexual violence, including death, often from their own families, when reporting GBV, a pattern that exists in many contexts
- Minimal coordination and lack of adherence to international standards of humanitarian assistance have hindered the ability of women and girls to access services. Discrimination and mistreatment are key barriers to accessing services.
- Women and girls have restricted access to information about the availability of services and support, particularly those that are relevant to survivors of GBV. Key informants strongly agreed that there are few services currently in place specifically designed to meet the needs of survivors of GBV or that are accessible to Syrian refugees (Anani, 2013).

7.2 SGBV as traumatic event and continuous stressor

During rape, sexual abuse and most forms of SGBV, the victim feels that her or his life is immediately threatened. This constitutes a traumatic event (see Section 1) and triggers an automatic response within the victim's mind and body. Extreme feelings of fear go along with a distorted perception of the traumatic event. For the most severe forms of SGBV-related events, there is a dissociative physiological and mental shutdown. For these reasons most of these events are extremely traumatising and carry a high risk of Posttraumatic Stress Disorder (PTSD) and other trauma-related syndromes.

These include severe forms of depression, substance misuse and suicidal ideation. Nevertheless, not all survivors of SGBV develop a full psychopathological syndrome; in fact, only a minority does. However, as traumatic events accumulate, the risk of developing trauma-spectrum disorders increases – a phenomenon called building block effect (see Section 1.3). In the context of armed conflict, individuals typically experience multiple traumatic events, and therefore present with a particularly high risk of developing chronic psychological disorders. At the same time, they often carry the burden of their experiences and their consequences in silence for long periods of time before finally seeking help for their physical and mental suffering.

One of the treatments that has been shown to be feasible and effective in settings of on-going armed conflict with little or no pre-existing medical and psychotherapeutic infrastructure is Narrative Exposure Therapy (NET). It has also been proven that this approach is suitable for survivors of sexual violence and can be disseminated in low-resource settings by training lay counsellors and trainer [38, 41]. Moreover, anonymous testimonies can be derived from survivor's narrations and fed back to the communities. With this strategy, we believe that communities can develop a greater awareness of the consequences of SGBV, and will enable themselves to take the necessary steps in countering SGBV. Providing relief to the suffering of SGBV survivors with easy-to-disseminate evidence-based psychotherapeutic interventions like NET, and collectively acknowledging and addressing the facts and devastating consequences of SGBV, will help communities to mitigate the negative effects of SGBV, and pave the way for a less violent future.

8. Conclusion

The healing attributed to NET extends well beyond the alleviating of core PTSD symptoms. Empathic listening creates a unique and secure venue in which survivors can provide testimony and bear witness to human rights violations, contribute to collective memories via their individual narrative, and reap and confirm the benefits of autobiographical storytelling. These additional assets cumulate and pave the way to not only an honourable tribute to a survivor's experience but also the restoration of their dignity. On a personal level, successful NET treatment can lead to quite practical changes and developments in an individual's life. While scientifically sound documentation of these changes remains a challenge, the informal evidence abounds: Former trauma inpatients go on to successfully complete job training. Go shopping in a crowded mall without panicking or fainting. Begin wearing skirts and earrings after decades of avoiding attention by hiding under bulky clothes. Meet friends at a public café after years of isolation. Establish a romantic relationship. Or even simply apply lotion to their body without feelings of disgust. Survivors may be able to experience moments of sudden joy again. They would take a leisurely stroll out in nature. Or as one survivor put it in her own words: "... It already helps to tell myself that the scary and unpleasant feelings probably have nothing to do with the current moment and perception. Already to explore the dates and time, when things happened gives me support and – finally – a feeling of identity! Even bad experiences, as long as you can locate them can give you the feeling of "this is my story, this is how I survived." Without that, every day is a gauntlet – and when a day gets worse, you have NOTHING to hold against it. If you have a past, this defuses immensely and it is a huge relief. Also to describe things reduces the bad feelings often truly enormous. And I keep on working through my own story..."

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Chapter Four

FAMILY SYSTEMIC COUNSELLING

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FAMILY SYSTEMIC COUNSELLING
I. BRIEF INTRODUCTION TO THE APPROACH

Mental health and psychosocial support (MHPSS) needs in communities are radically different from place to place. This is especially so in a humanitarian setting, when it is the family who is the buffer against the stress of atrocities (Walsh 2007). Addressing barriers to psychosocial well-being in the low-resource setting of a humanitarian context requires creativity, humility, and, in structural terms, multi-sectorial partnerships (Tol et al. 2011). It requires local people and the local, tacit knowledge they hold about their community, as well as their definitions of health and suffering. These definitions of health and suffering are meaningful in a family systems viewpoint; they become the resource by which families can transform problems into solutions. The basic assumptions of family therapy, with its emphasis on systemic understanding (Bateson, 1972) and utilisation of family strengths and resources, is an approach that can be moulded to the context, unlike other therapy models, which are often more prescriptive. This approach holds a deep respect for and attention to utilisation (Haley, 1973) of a client's worldviews. "Worldview" is a term that can refer to how a client understands and explains their experience of the world around them. In therapy, it can be extremely useful because it may refer to their "theory of change," or what it is they believe works best for them and their family.

Family therapy methods can be extremely useful in humanitarian settings; as a set of clinical ideas, they have an inherent focus on strengths and resources of people. In situations where families are affected by war and violence, family therapy includes use of community-focused interventions (Landau and Saul 2004; Walsh 2007), and thus, can be adapted easily to the context (Charlés & Samarasinghe, 2016). In humanitarian settings, there are often challenges to a country's (and a community's and a family's) infrastructure, resulting in needs that are more concerning and immediate, for example, security, accessing potable water, use of functioning institutions (such as in the education, health, and financial sectors), and networks and community resources (Charlés, 2016). Community social supports and basic needs become more salient.

At the time of this writing, families remaining in Syria have a particular profile. It is the norm, not the exception, for families to be repeatedly displaced. Families may be living in new and changing extended family configurations that may include in-laws or distant relatives. Additionally, each family has members—often more than one—who have been disappeared, and/or killed in armed conflict, and/or kidnapped at some point, and/or tortured, and/or displaced outside the country, perhaps at great risk. As it is so common to have family members with "unknown" whereabouts, many family cases presenting for psychosocial support or mental health services have had the experience of "ambiguous loss" (Boss, 2003). Not knowing what has happened to a family member, usually a key one or a close relative, is a routine part of family life in Syria today. Ambiguous loss is the new normal in Syria. Its impacts can otherwise exacerbate what may have been routine developmental changes in a family. The following type of situation is not unusual:

Hala, 14, was referred to a psychologist by her primary care physician, for constant arguing with her grandmother and her father. Hala's mother was disappeared three years ago, and shortly after that the family moved in with her father's parents. Hala is always arguing with her grandmother, who she says she hates, and secretly tells the psychologist she wishes that her grandmother would die. One month ago, Hala made a suicide attempt. It happened shortly after her grandmother told her she could not wear what she wanted to school. Hala states she misses her mother, who was abducted one day after work by unknown armed men.

In this chapter, the focus is on the essentials of systemic family methods that are judged to be the most useful for MHPSS in the context of the humanitarian emergency in Syria. The focus of our attention is on those providing MHPSS services to families affected by the current humanitarian context in the country. After a brief discussion of the theoretical assumptions of this model, the use of genograms is described to organise family information, and outline how to use strengths-based approaches (questions and interventions) relevant to the context in Syria.

2. THEORETICAL BACKGROUND OF A FAMILY SYSTEMS APPROACH

Family systems methods are clinical approaches derived from systems theory, and applied to "the system" of a family; that is, they are methods derived from ways to think about how to work with systems. A family is a system, but it is only one of many that a person may live in throughout their life. However, it may be perhaps the most constant system, and it can have great impact on our psychosocial health and our resources for well-being. The focus in family systems approaches is intervening in the ways a "family"—whether related by blood or non-blood kin—interact with each other in a constant and dynamic changing environment.

The field of systemic family practices is based on some core assumptions about the nature of change. Core ideas include that the behaviour of individuals always influence one another, and that what affects one member of a family often affects other members as well. Further, it is also an assumption that family systems operate by rules of behaviour that are sometimes known, but often hidden and concealed, and even out of the awareness of the family system itself. These assumptions lead to very specific type of practices/implementation of techniques and methods used with families from a systems approach. First, however, it is critical to understand as much as possible about the current "system" of the client, which is most relevant to the presenting problem.

Before Hala's mother disappeared, the family had a good life. Hala and her brothers did well in school, her parents got along, and there were no arguments with her grandmother. Hala's grandmother today is very angry all the time, according to Hala. She has become extremely conscientious about Hala and her brother's use of water in the home, and their use of various household items, which are very scarce in the current environment. Hala has taken to keeping food under her bed, to try to avoid the constant counting and inventory taking her grandmother does every day.

The defining feature of all systemic approaches is viewing the family as a system, an entity in itself, with the whole greater than the sum of its parts (Watzlawick, et. al 1967). This means that systemic clinicians view the interactional patterns of the family as a type of organism. As an organism, the family is a system with properties, i.e. with certain patterns of interaction among its members.

"A systems perspective …. see(s) each member of a family in relation to other family members, as each affects and is affected by the other person's" (Watzlawick, et. al., 1967).

Although any mental health intervention can certainly work with a family, not all family approaches are systems approaches. In other words, a systems approach is fundamentally different from traditional, individual oriented approach to psychotherapy. The assumptions that guide it are of a different order. They are based on a set of ideas about the nature of change, which shape every model and every intervention with families. They also are inclusive of the professional in the systemic equations; we, too, become part of the family system, albeit only temporarily. This assumption about the nature of change makes systems approaches unique in the types of interventions that the therapist uses, and how she conceptualises every move she makes. Systems approaches focus on the relation between persons (Bateson, 1972). The concepts below are relevant for the systemic practitioner because they affect how interventions and our engagement with the family are monitored.

- Homeostasis—The idea that systems (families) have a tendency to resist change.
- Feedback—That how a family system processes information helps it maintain a steady course (stability).
- Interrelatedness: That there is a pattern of relationship between people and their problems.
- Process and Content: That there is a key difference between "How" families talk & "What" families say, which must be constantly noted.
- Circular Causality: That behaviour is not always part of a cause/effect relationship; it is an on-going feedback loop.

Like other mental health professionals, family therapists or counsellors also keep a close eye on the family systems

- **verbal communication:** The explicit, the words or labels that are used to transmit information.
- **non-verbal communication,** which refers to things such as voice tone, gestures, facial expression, body posture, inflections.
- **context** which is closely associated with non-verbal communication. Where a person is, with whom, and when, all define how they relate with others in different settings. In other words, the changes a family experiences as they are displaced, or as they live through adverse events, affect their relationships with each in very unique and vivid ways. For example, what was not a problem before the war, such as inventorying how much food is left before one must go shopping again, can easily be exacerbated in the context of war, when food is scarce and one has limited access to it.

How a counsellor works with a family from a systemic approach becomes even more relevant in the systemic understanding of how daily life is experienced in a context of armed conflict. In the case of Syria, and other humanitarian emergencies and war-affected communities, it is critical to understand the micro-needs of people who present with psychosocial issues in the context of war. Further, these understandings of patterns seen in the war-affected population (Papadopoulos, 2005) must be integrated into the context of intervention. The basic ecological sensibility of systemic work is our primary guide to making sense of the behaviours seen in the setting. Both the larger system (for example, loss of food security in parts of Syria) and the family system (the grandmother's household) are war-affected, and the chronic intensity of the conflict very clearly influences what happens in and outside the context of therapy (hoarding food becomes a problem when food is scarce and family members feel chronic stress or fear of further insecurity). While making sense of family behaviour from a systemic viewpoint is critical to an effective intervention, this understanding will never occur if the family does not feel confident and safely comfortable with the therapist. Thus, perhaps no session is more critical than the first session, when one has the potential to maximise capacity to be useful to a family, while gaining their trust and inspiring hope in the chance that their situation can be improved.

3. ENGAGING FAMILIES IN A FIRST MEETING

Jay Haley, one of the founders of what is now the field of family therapy, said that for family therapy to end well, it has to begin well (Haley, 1987). Thus, family therapists spend a great deal of effort on their interventions in the first contact with a family. The most important of these methods, one that is on-going as long as one is working with a family, is "joining," or developing rapport with each member of a family. Joining is critical in the context of war-affected countries, where trust is at a minimum, resources are low, and the needs of families are complex.

Hala enjoys singing. She sings in her room and is hopeful someday to get a new phone so she can hear more of her favourite singers on the internet. She doesn't know that her grandmother also used to be a bit of a singer when she was young. Hala's father, Bassel, tells the psychologist that Hala and his mother have this thing in common, although neither of them are aware of it. Bassel states his daughter has a lovely voice.

In family therapy work, it is a long-standing hallmark to focus on the presenting concerns of the client, in preference to asking about past history or childhood experience. In situations like Hala's family has in Syria, where communities are encountering many problems inherent to a humanitarian situation, alongside significant historical origins and contextual subtleties, family therapy methods are very useful as they can be adapted to be even more present-focused. It is not that the past does not matter. However, in a family systems approach, a counsellor is most concerned with helping the family improve their immediate presenting concern. To do that, they must know clearly what the presenting concern is. Can it be named? What is its name? If there is more than one concern, what are they, in priority? Which is most important? If the family members have different concerns (of course they do; they are different people, and they likely would not be meeting with the counsellor if they did not have different concerns), it can be useful to try to elicit information on what they want to achieve together, as a family? If things were going the way they wanted or hoped, what would be happening in the family? What would be different? In family systems approach it is the first session that one must get this information. It should not wait. The time to maximise the impact of the session starts the moment the first member of the family system meets the counsellor. They must find out, using a present-centred focus, what is the precipitating event that brings the client to the attention of a psychosocial team? What do they want most to improve?

To get a picture of what a client family wants, it is critical to understand what the picture is right now. It can be helpful to try to find out the history of and the nature of their current household makeup. Among other circumstances, multiple displacements are common in countries in the midst of on-going conflict (Phama, Vincka & Weinstein, 2010). Forced displacement, even if to another family member's home, can be extremely distressful in the best of circumstances. In the context of on-going armed conflict, however, they can also be traumatic. However, it is not necessary to know all the details of the traumatic event in order to be helpful (Papadapolous, 2005). Instead, it can be equally useful to notice the resources people already have, compliment clients on what they are doing well. This respectful and genuine curiosity is conveyed by the statements and questions used in the session, with all members of the family, equally.

Some steps that are useful in engaging families are found below. Although the steps are named individually –joining, normalising, maintaining flexibility in the interview, pacing and leading, and asking about resources and strengths—one by one, these steps are integrated with each other. They are not necessarily completed in chronological order. One is joining at the same time one is asking about resources and strengths. One is always concerned about normalising family's concerns and maintaining flexibility with all family members present during a session. One is constantly looking for opportunities to learn the family's resources and strengths, and offering questions that elicit this information.

Further, the steps must be practiced in a variety of ways, depending on the presentation of the family. Pacing and leading gets the counsellor going from step to step; however, it cannot be achieved without joining. Without manoeuvrability, very little can be achieved in an interview. In other words, each of these processes, in combination, is a circular, not linear. Systemic approaches, as noted earlier, include in the circular causality the person doing the viewing--that is, us, as the provider, along with the family. In essence, the provider temporarily becomes part of the family system when working. One must not be too "inside" however (Salvador Minuchin called this being "inducted" by the family"); instead, one must keep one foot in the family and one foot outside the family--at all times--balanced in such a way that the family trusts the counsellor , and that they, too, are trusting of their questions and their approach—but remain sufficiently "outside" it. Thus, reflexivity and critical thinking--often helped by supervision, peer supervision and support--is necessary for any meaningful outcome in family therapy methods.

4. PRACTICAL IMPLEMENTATION OF THE STEPS

4.1 RAPPORT: JOINING THE FAMILY SYSTEM

"Joining or developing the therapeutic rapport, with families is a hallmark of systemic family therapy methods. The term derives from the work of family therapy pioneer Salvador Minuchin, but is relevant to many therapeutic approaches. In fact, most health care professionals have their own method for establishing a strong relation with their clients. What makes joining unique in family systems work is that it involves engagement with more than one person, simultaneously, who often have directly incompatible views of their situation and entirely different methods of expressing that view.

There are some basic steps to take to achieve joining. Of course, it is critical to for the counsellor to use their professional skill, and natural ability to develop and maintain a relationship with everyone who is there. Joining is critical, because it is the entry point for the counsellor of the family's worldview. It influences everything that comes after. Thus, it is critical to find authentic ways to express awareness of difficulties, to use silence well (use pauses effectively), to interrupt productively, and, most significantly, to acknowledge everyone present and give them a chance to speak and to hear each other speak.

Although there are many things to be curious about when one first meets a family, it is important to be selective with these questions. One way to do this is to distinguish therapeutic curiosity from personal curiosity (Flemons, 1997). In other words, one should ask questions about their questions. Is this information relevant for treatment? How so? What is the clinical reason to ask this line of questioning? Clarifying the type of questions asked is important because family situations in a humanitarian setting are often urgent, it is always useful to maximise the time one has with a family, and the first session with the family member may also be the last. Additionally, it is important to remember that family members are often already used to being blamed, judged, or asked questions in a judgmental way--often by other family members, but sometimes also, by professionals. They may expect this from their counsellor, and perhaps be somewhat surprised at their interest in being curious about their dilemma, without judgment. If they are in a hurry to tell them things, the counsellor can use this complexity of their issues to join with them: "I think I would never have enough time to learn all I need to learn about how you've dealt with this situation. If you had to prioritise today what is most important for me to learn, what would it be?"

The next thing is to find out from each person present what is the current issue that is most concerning? What is the reason (presenting problem) that brings a client to go and see a counsellor (or they going to them)? Is it that Hala is doing poorly in school? That she has expressed hate for her grandmother? To whom are the concerns most relevant? To whom is it least relevant? What does each member of the family think most needs to change in the family? How might each of them answer this question?

Hala's father also seems to be suffering. When he accompanies Hala to the second session, he reports privately difficulty sleeping; he is preoccupied with the difficulties of life. He can no longer provide for his family. His communication with his mother is increasingly difficult. He respects that his parents allow his family to live with them, but he feels his children are not doing well, and he doesn't know what to do.

Questions about the primary concerns and matters the family wants to see change is very important to hear from each person. In fact, it is critical. And it must be done gently, but with expert professional curiosity, and sensitivity. It may not be hard to ask these questions of individuals, but when one is sitting with a family who is arguing, angry, grieving, despondent, or aggressive toward each other, these simple questions quickly become highly complex, even provocative. They must be asked delicately and in a strong, meaningful way. The responses matter. Despite differences they may have between them, or despite the counsellor's own assumptions about what is going on, the words of the family members become critical to understanding their meaning and worldview. If Hala's biggest concern is how to get along with her grandmother, that wish for increased family harmony can also be something the father would benefit from. Perhaps grandmother would not agree, nor submit to the attention, but then at least the counsellor has father and daughter united in the goal of trying to work together to improve a difficult situation. The worldview of the family--how they see their problems and its inherent solutions--is necessary to include as much as possible in any potential intervention. It is effective, and more importantly, more sustainable, to include aspects of the family's worldview in the counselling or clinical intervention.

4.2 INTERVIEWING A FAMILY: MICROSKILLS

Microskills in family therapy refer to the essential skills needed to build more complex interventions. Sometimes, these microskills are enough on their own to promote meaningful change. On the other hand, the most creative intervention is likely to fail if essential microskills are ignored. This chapter focuses on four particular skills: Normalising, Manoeuvrability, Pacing and Leading (Watzlawick, Weakland and Fisch, 1987), and Asking about strengths and resources (de Shazer & Berg, 1992). Some examples of questions, statements, or possible points to raise when using each of the four microskills are listed below.

Normalising: is to reassure clients that their reactions to their problems are not uncommon. This is done by validating the things that have happened to the family.

"I think it must be incredibly challenging in ways I cannot appreciate; can you tell me more?" Also, for example, "It makes complete sense to me that you are so worried about Hala," or "Many families who have been through what you've been through experience similar worries," or "It's incredible how well you've managed up to this point, given what you've gone through in this time." Normalisation is generally defined as the use of indirect or direct statements that refer to client problems not necessarily viewed "as pathological manifestations but as ordinary difficulties of life" (O'Hanlon & Weiner-Davis, 1989).

In order to perform "normalisation" effectively, one must be unafraid to learn things that may seem uncomfortable or disagreeable. As health care providers in Syria already know too well, in a humanitarian emergency, many of the circumstances and issues families have faced are vividly painful, graphic, and upsetting. For providers working with these families, there can be mixed reactions to doing this work. It can help the counsellor to think about clients (and themselves, if they are also from the context) as ordinary people caught up in extraordinary circumstances. In a sense, the family is in crisis, because the larger system is also in crisis. Further, the providers may also be living in the same larger context--thus, they do not escape "the crisis context." They may not have the same experience the family has had--but it is probably recognisable to the providers, and not unfamiliar. Supervision and self-care, which is discussed briefly at the end of the manual, are critical to maintaining one's effectiveness in family therapy work.

Manoeuvrability implies "the ability to take purposeful action despite fluctuating obstacles and or restrictions" (Fisch, Weakland and Segal, 1982). One often does not realise how critical manoeuvrability is until it is absent. Any time a therapist feels he or she cannot say nor do something that is important to the session; it is an indication of lost manoeuvrability. Consider someone who has their hands tied behind their back. If that person their hands bound, they cannot use them; they cannot reach; they cannot direct, engage, or share. One maintains manoeuvrability by considering how each person's contribution can be used to the purpose of the session, even if it seems like it is a problem or not relevant.

Manoeuvrability, in a sense, also refers to flexibility as an interviewer. One can ask about anything that is clinically relevant, and based in a professional rather than personal curiosity (see Flemons, 1997). Some questions to think about for Hala's situation might be those questions that the therapist might be afraid to get the answer to, but which may be very relevant to the case and also, critical for the client to respond to. For Hala, the counsellor might ask at this point, "What is the worst thing that has happened so far with the situation with your grandmother?" This question allows me to get a baseline of "how bad things are," which also conversely gives information about "how good things could be," i.e. solutions. When they tell the counsellor how bad it could get, they could quickly ask how it is they have managed to prevent so many worse things from happening. What has kept things, as hard and challenging as they are, going along, even now? Also, manoeuvrability also illustrates that the counsellor is willing to ask something that maybe no one else has asked, but surely, that the client has an answer to. This type of skill becomes very relevant in crisis situations, when there are extreme stressors and a great deal of adversity. Manoeuvrability allows me to ask about "the worst of the worst"—or about the things no one is willing to ask out loud—but only if it is clinically relevant and based on professional curiosity—so that the counsellor can better plan treatment.

Pacing and leading are terms that can be used to think about how to lead the session and direct the attention and behaviour of the counsellor. Pacing refers to listening to and staying with the family and on what is occurring. Leading focuses on encouraging the family to move to another topic, or perhaps explore it from another perspective. Systemic family therapy requires expert use of both pacing and leading, in a dynamic and meaningful way, that is in time with the way the family interaction unfolds in the session. For example, pacing might be saying something like,

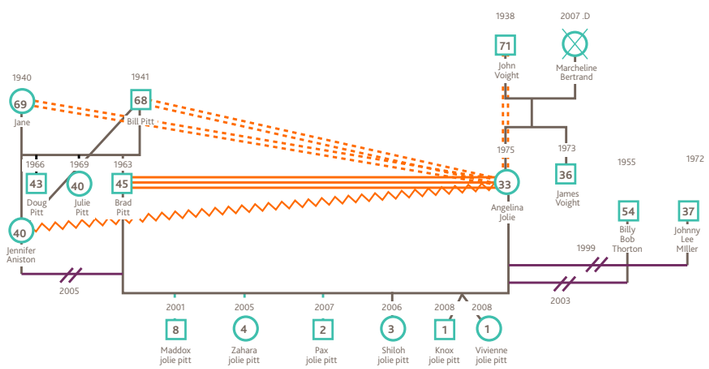
"Hala, you have been keeping food under your bed," as a type of question posed as a statement. Although Hala may have just told the counsellor that, the repeating it as a type of question posed as a statement is also a way to pacing her ideas alongside her as she expresses them to me. "Hala, you've told me about your food….what else do you think it's important for me to know about you?" This is very important if the counsellor wants to introduce something new, because it shows they are listening to her. It is much easier to introduce something new (i.e. 'change'), once something the same (i.e. 'stability) has been addressed. Pacing, from the client, may be acknowledged by a verbal yes, a nod of the head or eyes, or another expression of agreement. As pacing is accomplished, the counsellor can make another type of statement more easily, such as "When do you think you will no longer need to keep food under your bed? Do you foresee a time when that is no longer something you will be doing?"

Pacing and leading are critical, essential skills in systems therapy. They refer directly to systems theory in their address of change and stability. They are also easy skills to learn, and with practice, can lead to many types of interactions with a client that might otherwise be too difficult. For example, although the goal as a counsellor might be that the family no longer is hoarding food from each other, they are much more likely to get to that goal if the counsellor acknowledges the utility they (Hala) currently identify about the behaviour, and then ask them, directly, if it is something they hope to see change one day.

4.3 ORGANISING FAMILY INFORMATION: GENOGRAMS

Genograms are illustrations of a family's make up, its demographics, which also display family information in a graphic, visual way (McGoldrick & Shellenberger, 1999). Genograms are like a family tree, but include patterns of family relationship in the representation. Genograms, because they allow the illustration of family patterns, can provide a rich source of hypotheses about how a clinical problem may be connected to the family's evolution and context over time.

Although genograms can be very complex at first glance, they are not hard to construct. Below is a basic genogram illustrating three generations of a family, and in particular, where the red lines are, relationships between some of the men and women in the family system, across generations and in the same generations.[1] In general, the more lines there are, the more intense the relationship. Solid, dotted, and zig-zag lines are all used to illustrated different types of relatedness. Double or tripled lines tend it indicate a deeper intensity of the relation the type of line signifies.



1 Acknowledgements to Paula Moebus Leech, who constructed this demonstration genogram

A basic genogram, such as the one above, can help clinicians and anyone working with a family get a very quick picture of how the family is organised. While a full discussion of how to construct a genogram is out of the scope of this chapter, a basic genogram can be completed very easily, using established guidelines for how to construct it. In general, in a genogram:

- People are represented by circles and squares; men are squares and women are circles.
- The person at the "centre" of the genogram (the client, for example) is represented by a double circle (if a female) or double square, if a male.
- Lines represent relationship, and vary in colour and shape depending on the type of relationship.
- Usually depicts current year but can hone in on any moment in the past—such as symptom onset or critical event in family, e.g. start of the conflict or time of displacement, death, loss etc….
- Can be done by anyone in the family; it is a "snapshot" of a family map at a certain moment in time.
- Consists of a family's "vital statistics," the important data about them, i.e. births, deaths, education levels, jobs or livelihood, migration, illness…
- Brings in at least three generations. Usually, the elder of the generations is at the top, and the younger is at the bottom.

The utility of a genogram is especially helpful for those working with families in the context of complex emergencies. As noted already, the experiences of these families are full of similarly complex data. A genogram in this setting is a very efficient way to grasp a large amount of information about a family—esp. family history, patterns, and significant events. It can map a family's evolution through time periods, which can be very relevant in the constantly dynamic set of displacements in a humanitarian setting. Genograms can help serve to broaden historical perspective of a family as well—to look at themselves from another point of view—one of longevity, perhaps, or a future-oriented view.

Genograms can illustrate the intensity of conflict relationships between members, intergenerational conflict, areas of accord or connection—including love, conflict, and discord—as well as others in the family system orbit that are not necessarily blood kin. With practice, one need only look at a genogram to get a sense of the family complexity, and also, understand very quickly what is happening in this family right now. In addition to being visually rich, genograms are useful in filling out the discursive practice of psychotherapy. If they are done in a session with a family, they often elicit family narratives and cultural stories, and facilitate discovery of family's strengths and resources (McGoldrick & Shellenberger, 1999).

Hala's father, Bassel, has not told anyone that he has started to see a psychiatrist at the clinic where his daughter is in therapy. HE is not willing to tell anyone in the family he is on medication for depression. However, Bassel's concern is not the secret of his treatment for depression. Rather, he is suffering very much from his lack of work, a lack of money, and living with his mother, who he states "is a very difficult person." He has always worked hard in his family; like his father, grandfather, and great grandfather before him, he is a talented craftsman. However, since the war, he has not been able to maintain his livelihood, and this deeply upsets him.

4.4 VALUING RESOURCES AND STRENGTHS IN A COMPLEX EMERGENCY

Helping families in the way they want to be helped is one of the most important aspects of family therapy work. Family systems methods tend to be resource-focused, rather than deficit-based. It is common for the counsellor to adopt an eagle-eye view on: What is working in the family? What is happening when the problem is not occurring? How has the family managed to overcome so many hardships? The family can be asked this directly: "Tell me the last time you noticed when this was not a problem? Who was around? What was different?" However, a theoretical reason for following the family's lead is because of the counsellor's assumptions of the way in which systems work. Family systems, like all systems, are very powerful. They are laden with rules that are hidden as well as overt; they have been honed over many years and many experiences. (One need only think of one's own family to appreciate the complexity of how a family system is honed over time).

Families have quite sophisticated ideas about their problems (Singer, 2005). Embedded in these ideas the counsellor can find solutions. It is important to build on what the client's ideas are because clients more likely to use ideas that are consistent with their own beliefs. But to appreciate the family's belief system, one must ask questions that elicit those beliefs—from everyone involved, not just one or two people, not just the person who talks the most, nor only the person who is the one with the complaint. One must be able to elicit information from all involved. The microskills are a way to set the stage for listening to the family's understanding of their situation, the terms and phrases they use to describe it and to learn what they think can improve their lives.

It is useful to train one's self to learn to see strengths: How has this family made meaning of their experience? What adaptations have they made? Notice and compliment families on what they are doing well in spite of their problems. Listen to what they say about what they want different in their lives. What are the times the problems do not happen? What else is happening at that time? How does the family understand the difference between the times the problem is happening and the times that it is not?

Although humanitarian situations bring multitudes of problems to a family's life, it is important not to let problems be the only thing that is discussed (de Shazer, 1988). A counsellor may ask about times the problem is better, or non-existent. They may ask about how things will be when the problem is less of a concern. Even activating a client's imagination, through a sensitively asked question, about what they want to see different in their future can be a critical intervention.

"What do you want most to see different in your and your family's life?";"What do you think you will tell yourself, sometime in the future, about how you and your family survived this time?"; "If you were to write a letter to your future self, 20 years from now, what words of encouragement would you share? What advice would you give yourself? What wisdom?"

Although there are infinite ways to activate a client's imagination about their concerns, perhaps none is more well-known in the field of systems therapy than the Miracle Question. The miracle question invites clients to describe, in their own imaginative terms, how their lives would look if a miracle occurred and their problem disappeared (De Shazer et al., 2007). The miracle question was originally worded by De Shazer (1988) as follows:

"Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different? How will your husband know without you saying a word to him about it?" (p. 5).

The question is a relational one, asking not only about what one person sees as different if a miracle occurred, but also, how others in their life would see things differently as a result of the miracle. This interactional and relational stance used in the miracle question, as well as its cultural adaptability ("miracle" can be identified in many different ways), make this question very useful to keep in an interviewer's repertoire of skills.

4.5 FAMILY LIFE IN A SHELTER IN SYRIA: A SIMULATION TRAINING EXERCISE

Forced migration and the constant displacement of families in a country in the midst of six years of armed conflict can take on many forms. "Shelter" is sometimes concrete, sometimes metaphor. In Syria, at the time of this writing, families living in shelters across the country is no longer an exception to the norm; it has become a norm. Yet this extremely common situation is not reflected in training attended by the author and co-trainers or in the literature reviewed for this document. Family systems training is ripe with role-play scenarios; however, scenarios must be as realistic as possible and in some training groups this is a challenge. What follows is a description of a novel exercise and way of bringing data from the Syrian situation for families in shelters as part of a recent Beirut-based Systemic Family Counselling trial training programme. This was a part of a much larger training event under the Bel Salameh European Union initiative.

The following group activity that was developed and trialled was built on role-plays. This was a more elaborate exercise in that it included an activity where a scenario was created from the collective experiences of the participants. In order to maximise the utility of the system concepts in this group of MHPSS professionals within a family systems training, this "role-play" can easily become a multiple scenario "play", or "performance". The logic behind this was to allow the trainees to experience, learn about, and discuss the "things that cannot be said" and "things that cannot be seen" in a shelter setting in contemporary war-affected Syria. It is argued that an experiential activity like this can increase or maximise later discussion of the type of content happening during war time or humanitarian crises, which may be more difficult to access in a didactic way in a training module.

In Syria, shelters differ across governorates in a number of different ways, with regard to who is the organising/funding partner, the types of spaces families use in a shelter, or many other reasons. While there can be many differences across family shelters across the country during this time in the war, there are a few commonalities worth noting:

1. Living in a shelter means an extreme lack of privacy for behaviours that are normally private or perhaps, hidden.
2. Quantity of family size changes dramatically, with a lack of walls that would normally divide a house into rooms, or a neighbourhood into houses.
3. Families living together in family units in the shelter are not necessarily "blood-kin". Even if they are, they may not have ever lived together before nor necessarily had much contact with each other, before the war. Thus, it can be become a new family system.

4. Everyone living in the shelter, including the people in charge of its operation on the ground, are also affected by the conditions in the war. No one is immune. Thus, the shelter can become a microcosm of the larger system in the war. This is important to keep in mind.

The training, in which this exercise originated was conducted in Beirut, in December 2016, comprised 44 participants from Syria. The participants were a range of mental health professionals and MHPSS workers all working and living in Syria. The participants had a great deal of clinical and/or caseworker experience with families, but less formal training in family systems methods. The 3 co-trainers had both the MHPSS professional background with families, as well as over 2 years of training and technical support in systemic family therapy methods specific to the Syrian context. In this exercise, the following steps were found to be useful in using shelter conditions in training for systemic family counselling. They can and should be adapted according to the context and the trainer's judgement.

Instructions to Trainers

Ask participants to divide up in groups, perhaps by region, governorate, or organisation. In a recent trial of the situation/training, with 40 participants and specific differences in family contexts across districts, the group members were broken up by region. However, size of the group is immaterial and can be adapted.

Time Needed: 1.5 Hours Minimum.

10 minutes: Introduction to Exercise

20 minutes: Preparation of Shelter Performance/Play/Scenario by Group

30 minutes: Shelter Exercise/Performance (simultaneous scenes happening at the same time)

45 minutes: Discussion

Note: This exercise is recommended in a large, enclosed space.

Instructions to Participants:

A. Beginning. In your group, choose one person as observer. All others should choose a role of a person/family in a shelter. Make sure everyone has a role to play in the scenario. Together, choose the scenario of a family system that is likely occurring inside this shelter, or is similar to what you have learned from your clients takes place in the shelter. Take a full 20 minutes to discuss this so your performance is as rich and detailed as it can be. Then, if possible, go up to your hotel room or wherever you have access to some of your belongings. Choose and items from your things that you can use as props for the scenario of the family in the shelter.

B. Observer Role. The observer should act as a person who is unseen, unnoticed, and strictly in the role of observer in the scenario. The observer should not be privy to the scenario planning, and should leave the preparation discussion. As observer of the family-in-the-shelter system, take detailed notes on what you see, and what you hear. Try to keep interpretations in a separate column in your notes and focus on using your sensory input: what you see, hear, smell, touch. Focus especially on the dialogue, conversation, behaviours, in other words, verbal and nonverbal behaviour. If you have time, put together what nonverbals occur with verbal behaviours, and vice-versa. Observe inside the system, walk around, explore. Do this the entire time of the performance.

C. All performances should occur at the same time, simultaneously, in different parts of the room. The point of the exercise is for the participants to fully experience the context of their own shelter scenario. Trainers and any co-trainers should and can walk around to observe across the scenarios. They can speak to or comment on overall themes at the end of the performances and the end of the exercise.

D. An experienced trainer should coordinate the discussion by participants after the activity. Each observer should be brought to the front of the room to share his/her observations and experiences as a systemic observer. After all have spoken, the trainers should offer their own observations.

E. Roles performed within the scenario, i.e. "the things that cannot be discussed but are seen" should be utilised in other parts of the training.

Mollica (2008) stresses the importance of observing the traumatic incident effects on families as well as the full range of human experience that accompanies adaptation to forced displacement or other traumatic events. The advantage for trainers is that this exercise allows participants to observe and consider a full range of human experience, both positive and negative, that contributes to family functioning in a shelter in the midst of a humanitarian crisis. It may be a useful exercise to explore solution behaviour, secrets, and thus, more precise treatment planning and family assessment.

4.6 ASSESSMENT AND REFERRAL

Assessment is a picture of the family at a particular moment in time. It is a continuous process, formal & informal. It is highly dependent on the accompanying model/theory assumptions. In working with families, there is a focus on promoting and building on change that can optimise the psychosocial benefits a family can provide to itself. In this work, the counsellor will analyse the family structure, the presenting complaint, the family's functioning, and their goals and needs, as they describe them, in their own words. At the same time they are conducting an analysis, through methods of joining, normalising, maintaining our flexibility as an interviewer, and pacing and leading their questions, they are also observing the family system's rules of communication, its laws and alliances, in order to encourage everyone to rebuild the structure again in proportion to everyone's interests and desires.

Froma Walsh (2007) has discussed some important assessment data to learn about a family that is in the midst of experiencing extreme adversity. These things inform a clinical assessment of the family. They include the family's beliefs, practices, rituals, ceremonies, significant achievements or milestones; family, social, and community roles; pre-trauma functioning, highest functioning level in home country (who were they before emergency?) It can also be very useful to learn: How was daily life lived prior to the emergency? What is the status of their home, the meaning of home, and their ties to the land, and to other people? What are important aspects to learn about their educational background or observations? What are their resources? What are their beliefs and practices relevant to health, healing, suffering, sickness, loss, grief, and mourning? (Walsh, 2007)

Additionally, there are a number of simple but elegant practices one can develop in working with families that can be extremely effective in promoting change that enhances psychosocial health. The psychiatrist Richard Mollica (2006) named the following as critical to providing support to those living in extreme adversity:

- Being a Witness (Listening)
- Establishing Trust
- Assisting with basic needs
- Linking to Local services
- Advocating for Clients
- Educating the Community

The above steps are simple, but very effective, especially when approached from a family systems perspective. Focusing on the whole, treating family members in an equitable manner, and learning how symptoms and problems in families have an interactional component, changes the nature of how one works with a family system.

The hallmark of assessment is assessing family structure and interaction patterns. The structure of a family is easily visualised with the help of a genogram, even a brief one. Quickly, with a genogram one can view various dimensions related to the pressures on the family, and/or the family history, and/or the family structure, and/or the family processes over time, or those relevant to the family situation right now. It helps to assess smaller units of the family (subsystems) in order to get a picture of the whole; when assessing the family subsystems, the counsellor will often choose to assess the most relevant subsystem, depending on the current family context, pressures, and history.

The assessment of a family is highly dependent on the context of the setting/the counsellor role. The family is more likely to trust other providers, and work with other healthcare professionals, if the counsellor has have set the stage with trust, validation, normalising their situation, and listening to all concerned. In fact, sometimes the counsellor will find that the first contact with the family is the last one; it can be very effective to maximise that time, and often, the essential skills that are named here are sufficient to send the family on their way, for now, until, like any other health care matter, another issue arises in which they require support and ask for help.

In assessing a family's needs and functioning, it is useful to look at their capacity to accept information from outside the system. If the family system has flexibility and openness, rules can change easily; secrets have less power; outsiders can influence the system in positive and helpful ways. In other cases, if the family system tends to be less flexible, it may be unable to accept new information from outside the system, and rules can be difficult to change openly. Further, it is not uncommon that developmental changes in certain members of the family--when children become adolescents, or when girls or boys enter puberty and early adulthood--inspire a challenge to a family's overall development, including the rules for how they communicate with each other.

In all cases, it is important to keep in mind that family systems are not bad or abnormal; they only require a different set of methods to work with, and ready sensitivity to understanding the meaning of the family's tendency to be less or more flexible in certain areas. Here is another area to focus on the verbal and nonverbal behaviour of family members. Often, if a family member is trying to break out of rigid rules in the family system, the counsellor may see a vivid depiction of this in the client's behaviour e.g.

This family recently had an emergency situation. They came to the clinic without an appointment and told the doctor that 8 year old Majd, Hala's youngest brother, threatened to kill himself, and then used a knife to threaten his older sister. He told his grandmother he wanted to throw himself from upstairs, from the roof. His grandmother had recently told the family she doesn't like them, she doesn't want them, she wants them to go away, especially Hala and Bassel. When Hala first heard this from her grandmother, she began to stutter, a pattern she repeats in sessions whenever her grandmother is mentioned.

Often (but not always), a symptom in one family member indicates an effort to change the family system to achieve better terms, broader alliances, and to be more effective. Systems are always changing; there is never a time when a system is not changing. The larger context in Syria is similarly dynamic. In fact, a complex humanitarian emergency maintains an active pressure of conflicts for families, more than what is expected or natural in a family. In fact, these larger factors will exacerbate what may be typical, normal family conflicts or disagreements.

Sometimes simply reminding families that they are living in the midst of a crisis outside their own family, with deleterious effects on many systems, can be enough of an encouragement for them to go on, and to feel less alone. This is in fact an example of "normalisation." Ironically, families that manage to overcome and live through suffering that is inherent to a humanitarian situation also are, perhaps unbeknownst to them, in the midst of developing a kind of wisdom and special skill set, that is getting them through something heretofore unbelievable or non-existent in their family. Acknowledging this can be very effective way to normalise an abnormal situation.

5. SINGLE SESSION WALK-IN APPROACH AND COMMON FACTORS

A unique and yet elegantly simple approach that is highly useful in a humanitarian setting or other type of low-resource setting is what is referred to as a "Single Session Approach." In this approach, families are provided with one session of counselling in anticipation that can be sufficient to help clients get on the right track for the changes they want in their lives (Slive & Bobele, 2012). The process in based on several basic principles: 1) Clarifying client's expectation, 2) Checking in during session to ensure meeting a client's expectations, 3) Delivering feedback to the client, 4) Ensuring to make the most out the session, and 5) Keeping in mind that this might be the only opportunity you have to provide services to the client (Young, et.al, 2012). It is the latter point in particular that makes SS therapy so useful in a humanitarian setting.

By implementing these principles the counsellor/mental health actors provides an inviting environment for families to engage in reflection and initiate research about resources available in their lives for change and improvement (Young, et.al, 2012).
This approach can also be used for "walk-in sessions"—where no appointment is required for a meeting to occur. For example O'Hanlon & Weiner- Davis (1989) proposed that single session walk-in (SSWI) counselling relies of the following assumptions—ironically, they are all quite systemic and particularly relevant in humanitarian settings:

- Rapid change (behaviours and thoughts) is possible and also very common in the human experience
- In overtly and covertly ways, the professional communicates the client expectations about how rapid and how much change can be anticipated
- There is not a direct link between the duration of the complaint and the duration of the treatment or severity of the complaint and duration of treatment
- There is no need for extensive knowledge on the history of the complaint.
- The client is not interested in or available for long-term psychotherapy.
- The early stages of treatment provide the greatest opportunity for change, as most change occurs in the first session.

The above conditions are already in constant motion in a humanitarian settings where the context is urgent, the situation severe, and the timing and chronology of everyday life rapid and unpredictable. Thus, SSWI can be a very useful approach to take with families in Syria.

Slive and Bobele (2011) stated that in order to be effective the counselling process does not have to be longer; quantity does not necessarily mean better in terms of treatment. Other reasons include:

- The client's preferred number of sessions is one. It is beneficial to the therapeutic alliance to work with this timeframe as reference.
- By empowering the client making them aware of the significant difference just one session can make, professionals are indirectly communicating our confidence in them and the changes they can make. Long-term view of therapy can indirectly communicate the family that the problems are severe.
- Cost efficiency is highly important in a humanitarian setting; there is often diminished human resource capacity in mental health professions.

Additionally, this counselling service delivery approach holds as main goal to stimulate new ways of thinking about the problem, allowing the client to have a new perspective. The goal for each single session (even if there is more than one) is to increase hope, activate emotional relief and help the client define a favourable outcome to help them move forward (Slive & Bobele, 2011).

Slive, McElheran, and Lawson (2008) described the relevance of the common factors when working in a walk-in setting. Common factors is the concept some scholars defined as the elements involved in the treatment setting that are present in counselling regardless of specific techniques or therapeutic models (Lambert, 2005). Some of these elements include: the counsellor-client therapeutic relationship or alliance, the placebo effect, hope and expectancy, and client's factors such as persistence, openness, faith, optimism, a supportive social or family network, or membership in a community (Lambert, 2005; Duncan & Sparks, 2010).

Single session approaches emphasise the importance of using: Client/system resources, attending to client motivation, focusing on client wants, linking hope with expectations for improvement from the therapeutic process, and seeking continuous feedback from the client regarding fit between the procedures used by the counsellor (the model) and the client's own ideas about what will work (p. 11)
As noted earlier, joining is critical in family systems work. Besides helping build the trust, rapport and comfort level of the client with her therapist, during this time the counsellor can identify the client's resources (support system, strengths, hope, expectancy, exceptions to the problem). The instillation of hope is a key factor in counselling. If the client does not have hope that things can get better or they can solve their problems makes it difficult to move forward with single session. It is helpful to ask: On a scale 1 to 10 (ten being very hopeful), how hopeful are you today that you can make the changes in your life that would move you in the right direction to achieve your goal/goals? Commendations and positive feedback through session is also an effective way to instil hope and make the client aware of their available resources and strengths.

SSWI therapy works much the same way as microskills in family systems approaches. After joining and building a rapport with the family, the counsellor moves quickly to identifying well-formed goal or goals. For example, the counsellor will often start by asking the client what she or he expects to be different in their life as result of coming to counselling. Solution focused questions used to elicit goal identification are:

1. What is it you are hoping for from coming to counselling?
2. What types of things would you be doing if the problem that brought you to counselling was not present or did not exist anymore?
3. What would be the most helpful to talk about today?
4. If a miracle happens (de Shazer, 1988) and the problem you came in with does not exist anymore, what would be different? (always using the context of the client's everyday life).
5. What would you or others around you notice different in you or your behaviours?

SFBT relies on exceptions to the problem or concern that the client brings to the therapeutic room, that is, the counsellor facilitates the identification of the past successes of the client and takes full advantage of the client's resources. Counsellors need to acknowledge that each client has resources and these can help resolve their problems. Collaboratively, after identifying the client's strengths and resources, it is important to identify behavioural steps that will help move toward the desired goal. Some useful questions: what would you need to do when you leave here today to keep moving in the right direction? When, where, how and who can help you to do this? Which of these steps can you get done today or tomorrow? Making these behavioural steps as specific as possible facilitates the client's perspective and visualisation of her/himself actually executing these steps.

It is important to check in and get feedback from the client through sessions; in SSWI approach, this is critical to do in the first session itself. Asking questions such as: What has been helpful so far, how has this session been helpful so far? And then promoting the identification of specific behaviours that will help make the changes with questions such as: if this has been helpful, what do you think you will be able to do different after this session to help you move toward your goal?
In a single session approach, therapy should always end with a concrete homework that the client should complete in a short time period. The homework should be related to the problem that brought her/him to counselling and should move the client forward toward the established well-formed goal. For example, once the crisis of Majd is managed, the counsellor can focus the family on specific homework assignments, depending on the goal they have for their sessions.

"Hala, I would like you to take notes of the times you notice your family getting along better," or, "Bassel, can you take note of one thing each day that someone in the family is doing to support your family's overall well-being, despite all the obstacles"; or, "Hala and Bassel, please find one thing to do together during the week that you both enjoy, just for yourselves as father and daughter, but do not tell the other one what it is you have decided to do."

The homework should address the questions (before or after the session when the homework is assigned): What will you do or what did you do? When did you do it? Where did you do it?" If the client does not return, contact the client and check in on their progress. Ask, What has gotten better since you came to counselling? What steps have you been able to take?

6. FINAL REFLECTIONS

The goal of this chapter was to provide an introduction to systemic family counselling, specifically for use in a humanitarian setting of Syria. The Intention was to outline key methods that counsellor may find helpful in enhancing the technical capacity of host country nationals to perform family therapy methods, which increases both access and availability of psychosocial services. An important part of this work is the on-going supervised experience of family work. Family therapy supervision is unique from other types of clinical supervision. What makes it more precisely unique from other kinds of clinical supervision is its particular content focus—on work that focuses "primarily with individuals, couples, families, and groups from a systemic perspective, one that requires expertise in system theory and thinking that is distinct from individually oriented therapies.

Task shifting, which involves "delegating tasks to existing or new cadres with either less training or narrowly tailored training" (Kakuma et al., 2011, p. 16), is a recommended action in countries with human resource challenges in mental health professions. This method is critical to the delivery of family therapy clinical work in low resource settings. Task-sharing, especially on complex cases (such as families or couples methods, which may be very new for psychosocial workers) is critical. The skill mix set that task-sharing supports, if enhanced through supervision, can have long-lasting effects on trainees, their supervisees, and the clients they see.

Another response that works incredibly well, as a sustainability measure as well as a supervisory one, is to involve and include interdisciplinary teams in every step of service delivery. Diverse teams (in terms of their professional training) mean broader sets of skills can be brought to bear when a family is seeking assistance. Thirdly, in terms of family therapy, content knowledge must be crystallised in way that serves practice in the setting. In humanitarian settings, the pace of MHPSS service delivery is urgent. Families are in highly stressed situations, in dangerous situations, and face many challenges to their personal and material resources. Yet families continue to survive, and yes, even thrive, in the context of life in Syria. One must be willing to hear both/and of the suffering and the joy in a family's life. Hala can be asked about her feelings toward her grandmother; but one should also not forget to ask about her singing, and her beautiful singing voice.

Contextual factors in a place shape the therapy content (e.g. hoarding of food or lack of space in a home with many family members), yet the counsellor must still attend to the client's theory of change. They must ask about and incorporate their belief systems into our interventions, and highlight their strengths every place they can. Doing this competently requires more than theoretical skill; it requires critical attention to the form of interviewing the entire family as one unit (whether they are in the room with the counsellor or not, they still see them as one unit).

It is a hallmark of the field to apply in practice the key idea that each family has its own worldview, which must be taken into account if one is to promote meaningful change. Arguably, this does not change in humanitarian settings; rather, what changes most is the external setting –lack of resources commonly found in non-humanitarian settings such as electricity, potable drinking water, functional institutions, rule of law. These indicators deftly influence the type of problems families face, and the challenges communities have to thrive. It is our hoped that this chapter, is a useful resource and collection of ideas that and relevant professional may find useful and relevant in their family work.

7. APPENDIX

General Recommendations:
Try to ensure that you

- Talk to everyone present in front you, in an equitable manner.
- Interrupt in purposeful but respectful ways.
- Ask everyone a version of your question so that no one is ignored and you get more in-depth and systemic information.
- Pay close attention to verbal and nonverbal behaviour of the clients with you, the clients with each other, and how this changes according to the discussion content.
- Focus on clarifying each client's priorities for coming to talk to you. What is priority?
- Ask the family what their goal is for coming to see you. What will tell them coming to see you was a good idea?
- Have explained your role in the organisation where you are seeing the client, and limits or exceptions to your confidentiality.

Try to avoid

- Asking questions that help you clarify what the family's reason for coming to see you.
- Letting just one person monopolise the session.
- Talking too much. Listen.
- Being afraid to talk, ask questions, or interrupt.
- Ignoring or not commenting on things that you are seeing in front of you in the session, which might give you more information about what you are seeing.
- Letting the session go without understanding the full range of the family's experience.
- Leaving the session without giving the family some sort of compliment on what they are doing well, in spite of their problems

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Chapter Five

SELF CARE

Editorial Foreword

This is an important topic as growing evidence, from key experts and organisations, suggests that there is a potential risk of workers suffering from general stress and strain or more specific vicarious traumatisation in the roles that MHPSS workers undertake in emergency situations.

Self Care versus Staff Care

It may be helpful to make a distinction between staff care and self-care as these terms are sometimes used interchangeably in the MHPSS field. The main consumers of this chapter will probably be MHPSS staff and much attention has been given in the next chapter to what they can do as individuals to take good care of themselves.

The prevailing occupational health view is that "**staff care**" is the responsibility of the organisation to "take care of their staff" and make sure that their employees work in safe and optimal conditions in order to fulfil their contractual obligations and suffer no severe mental or physical harm or ill-health as a result. There are a number of legal case precedents and legislative examples of this "health and safety" view and approach to preventing psychosocial hazards in the workplace in America, Europe, Australasia and beyond.
Ideally, "**self-care**" should feature as an integral component of an "organisational **staff care** package" where the individual can take responsibility and action for a number of steps that will optimise their resiliency and minimise their susceptibility to occupational stress and ill-health - while the organisation simultaneously takes steps to monitor, protect and support them in their work. However, even in the absence of a comprehensive organisationally-driven **staff care** policy, individuals can still take a number of positive steps to protect and manage themselves effectively. In this respect, self care packages can be a stand-alone exercise under the control of the individual MHPSS worker.

It is therefore judged that the complexities of staff care (from an organisational perspective) is beyond the remit of this Training Pack as the two related manuals are primarily designed to enhance the skills of individual MHPSS workers rather than serve as an agenda for organisational change for any one organisation. Even in the absence of a coherent and overt Staff Care Policy and Programme, there is nothing to prevent an individual or organisation using the following material to base their future actions, within their organisation, if they so wish.

In summary, this chapter on **self care** is not a replacement for a comprehensive organisational response to **staff care** but is best regarded as a repertoire of skills for the MHPSS worker to enhance their own coping and self-help skills and perhaps utilise any available support from any source inside or outside their organisation. On a positive note, there are certain actions that individuals could take, in terms of approaching or having a dialogue with their organisation, where there are persistent difficulties. In keeping with the intended purpose and target audience of this **MHPSS Training Pack**, the next author deals comprehensively with **self care** and discusses the distinction **between self care and staff care** where appropriate.

Self-Care

Introduction

This chapter aims to provide information on self-care and staff well-being necessary for humanitarian workers in emergency settings. It builds on the findings of an assessment study, carried out by ABAAD and supported by the EU, on the self-care needs and resources of MHPSS workers in Syria [1]. It also builds on identified needs of humanitarian workers working with crisis-affected populations, the common existing challenges and gaps in self-care and staff-care interventions and best practices in the field.
The chapter discusses the rationale behind self-care and staff-care, describes some common sources of stress for humanitarian workers, presents information that help humanitarian workers identify signs of stress and burnout, and provide some practical tips and recommendations on stress management and self-care at the individual, relational and organisational levels.
The chapter describes some obstacles in the way of self-care and staff-care while highlighting the need for more holistic organisational wellness policies, programs and self-care systems for humanitarian workers.

We hope that this chapter will prompt humanitarian workers to promote effective self-care strategies and also prompt humanitarian and development organisations to ask searching questions about their staff care provision to protect and promote the psychosocial well-being of their staff.

Self-care for humanitarian workers in emergency settings: Background, Rationale and Purpose

The context of humanitarian work is intrinsically stressful. It involves responding to emergencies and being routinely exposed to a wide variety of sources of stress. Humanitarian workers increasingly work in complex environments where problems related to prolonged civil conflicts, extreme poverty, and personal tragedies are common and inescapable. These workers often find themselves involved in stressful, distressing and sometimes traumatic sights, sounds and situations. They work in some of the toughest circumstances and often experience overwhelming workloads, long working hours, massive needs that need to be addressed, direct exposure to misery, ever-growing numbers of people affected by humanitarian crises, deteriorating safety and security conditions, unpredictability, lack of personal space and limited available resources. Regardless of their background, specialty and specific roles, humanitarian workers in the field are repeatedly exposed to stories of suffering and experiences of personal tragedy, and they may themselves witness horrific scenes, have distressing experiences, or be chronically exposed to serious risks

These stressors place humanitarian workers, national or international, at risk of experiencing cumulative psychosocial effects. Without proper self-care, these stressors, on the short-term, can leave humanitarian workers feeling overwhelmed, insecure, sometimes de-motivated and chronically fatigued. On the long-term, these stressors cause cumulative stress that can have more serious effects of burnout, chronic anxiety and depression, apathy and sometimes post-traumatic stress syndrome.

The strong desire of humanitarian workers to provide assistance, care and support to people in need often masks their own needs. Despite their professional capacities, they usually overlook and/or are unaware of stress as a phenomenon that can influence their capacities, performance and motivation. Accumulated stress affects not only their motivation, personal morale and individual performance, but also the quality of care they provide. These stressors place humanitarian workers at risk of causing more harm to the organisation and project, and also to the people they are trying to serve. When humanitarian workers experience severe stress, burnout or compassion fatigue, their beneficiaries suffer as well. Workers suffering from the effects of stress are likely to be less efficient and less effective in carrying out their assigned tasks. Experiences from different emergency settings show that if humanitarian workers neglect their emotional well-being and do not practice regular self-care, their ability to care for others will be diminished or even depleted.

Why is it is important to make a personal commitment to oneself to focus on self-care? The answer is simple and compelling, as presented by Saakvitne and Pearlman [2]:

- Because I hurt.
- Because I matter.
- Because my clients (people I work with) matter.
- Because the work I do matters.
- Because the profession matters.
- Because I must.

Humanitarian work carries along with it great opportunities for learning and development on the personal and professional levels; however, it is, at the same time, characterised by being stressful. Since staff in humanitarian and development organisations work in emotionally demanding environments and experience multiple stressors, they need appropriate support in reaching their potential and promoting their resiliency.

The growing number of crises around the world is stretching the humanitarian system, where needs are currently exceeding the existing resources. Reports and studies have abundantly documented the negative emotional consequences of exposure to these stressors on various groups of humanitarian workers. In the last twenty years, the number of attacks on aid workers around the world has risen and continues to grow sharply. Nearly 80% of aid worker victims are nationals of the country being served [3]

In addition to these physical security risks, there are growing psychological risks for aid workers. Research has indicated that the longer aid workers are in the field, the more psychosocial support may be needed. Illuminating research was conducted by the Centres for Disease Control and Prevention in 2000, in which longitudinal impacts on humanitarian aid workers were studied over a period of time. What the CDC found was, at around the fifth assignment, there was a dramatic increase in levels of clinical anxiety, depression, cumulative stress, burnout and potential post-traumatic stress disorder. Surprisingly, the longer people work (as aid workers) does not necessarily mean that there is more resilience. In fact, it could be that the longer people work in this field, the more they are cumulatively negatively exposed and affected [4]. Burnout and turnover of staff indeed are becoming realities for aid organisations.

On the occasion of the World Humanitarian Day [5] August 19, 2014), Jan Eliasson, Deputy Secretary-General referred to dangers faced by humanitarian workers on the frontlines of disaster and war that represent a "world-wide deficit of humanity", stressing that the situation was getting worse, and that humanitarian and aid workers are increasingly coming under direct attack.

Why manage staff stress?

Managing stress in staff of humanitarian organisations is crucial for many reasons. Stress of humanitarian workers is not just the problem of the individual staff member. Beyond its detrimental effects on the personal level, the stress experienced by individuals has a negative effect on the functioning of their team and agency. Staff that are "stressed out" have higher accident rates and higher rates of illness. They are absent more often and use more health services. They also show less commitment to their employing agency and have higher rates of turnover. The result is a loss of skilled, experienced staff in the field and increased recruitment and training costs. Moreover, under conditions of chronic stress, staff may be poor decision-makers and may behave in ways that place themselves or others at risk or disrupt the effective functioning of the team. Their own safety and security and that of beneficiaries may be put at risk, and their team may experience internal conflict, regular fights and scape-goating. "Stressed out" staff members are usually less motivated, less efficient and less effective in carrying out their assigned tasks.

Although stress among humanitarian workers is unavoidable, some stress can be prevented or reduced and the effects of stress on individual staff members, on their team, and on their agency can be lessened. This requires actions undertaken by individual staff members, by managers and supervisors, by teams, or by the agency as a whole [6].

Theoretical perspectives on self-care & staff-care

The concept of self-care is multidimensional, with many defining elements. Self-care is not a new idea. Since the beginning of humankind, people have taken action to ensure personal safety and have developed strategies to address illness and other health challenges [7, 8]. Primitive societies developed healing rituals that sometimes involved the consumption of special foods to promote the health of particular individuals or entire communities [9]. Implementing self-care strategies to address day-to-day concerns about health is normal and usual. Individuals select self-care behaviours in order to maintain an acceptable level of health or well-being, to prevent illness or injury and to promote health. These self-care behaviours contribute to one's ability to perform a variety of tasks, ranging from ensuring survival to attaining self-actualisation.

Today, there is absence of a consistent and generally agreed-upon definition for the term "self-care". A review of the concept of self-care from the perspectives of experts in six disciplines which are: medicine, psychology, nursing, public health, economics and anthropology-did not find complete consensus but found agreement on four characteristics specific to self-care [10]. Self-care was seen as: situation and culture specific; involves the capacity to act and make choices; is influenced by knowledge, skills, values, motivation, locus of control and efficacy; and focuses on aspects of health care under individual control [11].

Historical, social and economic factors and perspectives have shaped the current concept of self-care and the more recent term ''self-management'' drawing on a range of epistemological and philosophical backgrounds. Medicine, psychology, nursing, public health, economics and anthropology have all contributed to knowledge on self-care. This creates rich diversity on one hand and fragmented information derived from differing and often opposing theoretical perspectives and frameworks on the other [12].

Different definitions include or even emphasise different aspects of self-care. What is needed for practical implementation of self-care is a description of elements under different domains or areas. The International Self-care Foundation (ISF) proposes that a framework for self-care can conveniently be visualised or organised around seven "pillars" or "domains" which are [13]:

1. Health literacy – includes: the capacity of individuals to obtain, process and understand basic health information and services needed to make appropriate health decisions
2. Self-awareness of physical and mental condition – includes: knowing your body mass index (BMI), cholesterol level, blood pressure; engaging in health screening.
3. Physical activity – practicing moderate intensity physical activity such as walking, cycling, or participating in sports at a desirable frequency.
4. Healthy eating – includes: having a nutritious, balanced diet with appropriate levels of calorie intake.
5. Risk avoidance or mitigation – includes: quitting tobacco, limiting alcohol use, getting vaccinated, practicing safe sex, using sunscreens.
6. Good hygiene – includes: washing hands regularly, brushing teeth, washing food.
7. Rational and responsible use of products, services, diagnostics and medicines – includes: being aware of dangers, using responsibly when necessary.

From the literature, it appears self-care could be understood as people being responsible for their own health and well-being through staying fit and healthy, physically, mentally and where desired, spiritually. This includes taking action to prevent illness and accidents, the appropriate use of medicines and treatment of minor ailments (Department of Health, 2005 in Gantz, 1990; Orem, 1991; Astin and Closs, 2007; National Health Committee, 2007).Self-care can be defined as the ability of individuals, families and communities to promote health, prevent disease and maintain health and to cope with illness and disability without the support of a health care provider [14]. Beyond just focusing on health and well-being, self-care incorporates self-management. Self-management means people drawing on their strengths and abilities to manage or minimise the way a condition may limit their life, as well as what they can do to feel happy and fulfilled. Self-care is what people do for themselves to establish and maintain health, and to prevent and deal with illness. It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure etc), environmental factors (living conditions, social habits, etc.) socio-economic factors (income level, cultural beliefs, etc.) and self-medication.

The issue of self-care and staff-care for humanitarian workers is gaining more attention recently. The Antares Foundation Framework, the Interagency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Sphere Core Standards and People in Aid Code of Good Practice have all increased the attention on staff-care. Together with increased attention - if not cohesiveness - of staff welfare initiatives, many organisations are modifying their historical approach. This includes a recent petition circulating to get it on the agenda at the upcoming World Humanitarian Summit.

The effects of working in the humanitarian and development sector have been well documented, but there is little research into how organisations mitigate the negative consequences and enhance staff care practice [15].

The humanitarian and development sector has made considerable progress with respect to staff care in the last 10-15 years; however, no organisations have conducted research - that is shared and made publicly available- on staff care. Staff care practices vary among organisations and no monitoring and evaluation of such practices is made. By providing scientific evidence on the effects of staff care, organisations can determine the effects of the intervention on the staff (positive or negative), as well as the return on investment. The need for stronger staff wellness/staff-care strategies is expected to increase in the deteriorating security context of the humanitarian aid environment.

There are also no consistent definitions relating to staff-care practices in the humanitarian and development sector, and the scope of staff-care provision within agencies is also inconsistent. Staff care, in general, refers to self-care and institutional responses to stress among humanitarian workers intended to mitigate distress, support staff in managing stress and enhancing their resilience in response to stressors encountered during the course of providing humanitarian assistance. The purpose of staff care is to create a healthy and productive workforce; to create well-being among staff and improve the quality of their work. well-being is influenced by internal and external factors, and refers to emotional, cognitive, spiritual, and physical health. Each organisation and each individual has different staff-care needs.

Under Bel Salameh, ABAAD's European Union-funded project in Syria, ABAAD organised a Training of Trainers on "Self-Care and Staff well-being in Humanitarian Settings". The training was based on the findings of the Self-Care Needs and Resources of MHPSS Workers in Syria Rapid Participatory Assessment, conducted by ABAAD and supported by the EU. It aimed at addressing the different need and challenges related to humanitarian workers self-care. This training covered several topics (see training agenda in Annex-), including but not limited to:

- Rationale behind self-care in emergency settings (why do we need self-care?)
- Distinction between self-care and staff-care, and theoretical perspectives
- Psychosocial effects of humanitarian work
- Identifying signs of severe stress and/or burnout (including tools for self-evaluation)
- Developing appropriate self-care plans
- Practicing different relaxation, mindfulness, breathing techniques and stress management activities
- Skills of conducting self-care and staff-care trainings

Building a common ground of concepts & terminologies: Definitions

During the ToT workshop on Self-care in humanitarian settings, a session was conducted and aimed at building a common ground of concepts & terminology; thus, building a framework of definitions. Since there is no clear, unified and agreed upon definition of self-care, participants worked in small groups and a general discussion followed that allowed a synthesis of an agreed upon definition of self-care & staff-care. Participants also worked on defining related terms including resilience, coping, stress, adversity-activated development and other terms that shall be used throughout the training.

Results of group work in the ToT workshop in Beirut-
Agreed upon definitions of self-care & staff-care

Self-care: Interventions or activities targeting one's physical, psychological, social, spiritual, and professional wellbeing, aiming at promoting resilience and wellbeing, alleviating and managing stress. Self-care could be understood as people being responsible for their own health and well-being through staying fit and healthy, physically, mentally and where desired, spiritually.

Staff-care: institutional responses to stress among humanitarian workers intended to mitigate distress, support staff in managing stress and enhancing their resilience in response to stressors encountered during the course of providing humanitarian assistance. The purpose of staff care is to create a healthy and productive workforce; to create well-being among staff and improve the quality of their work.

Common Sources of Stress for Humanitarian workers in emergency settings

Stress is the body's way of getting energy to operate outside an individual's normal comfort zone. Stress is caused by stressors, these can be internal, such as thoughts or feelings or external, such as poor health, conflict, noise etc. If it is not possible to relax between demands, or there is not enough time to unwind between the problems, the stress builds up. It is not the actual difficulty of the task that causes chronic stress; it may be the sheer quantity or continuity of work [16].

Recognising the Signs of Stress

Suffering from stress in humanitarian work is only normal and not a sign of weakness or inadequacy. Stress management starts with being aware that stress may cause problems and being able to recognise how these are manifested. Stress reveals itself in five main aspects appearing in physical, emotional, cognitive, behavioural, and spiritual/philosophical reactions. Because each individual has characteristic ways of reacting to it, responses to the same situation vary. Responses may also be both gender-specific and culturally-defined. Other factors affecting the number, duration and intensity of stress reactions may include personality traits, personal history, training and sufficient knowledge, previous disaster or humanitarian emergency experience and current life situation. Additionally, stress reactions depend on the type of stress encountered.

Three main categories of stress affect humanitarian workers [17]:

- **Day-to-day Stress** as one manages the competing demands of personal maintenance, transport, and work.
- **Cumulative Stress** is the most common, familiar and corrosive kind of stress encountered at humanitarian work sites. If unmanaged, it erodes the effectiveness of both workers and work groups over time.
- **Critical Event Stress** is a combination of acute responses to violence, trauma and threats to life. These require immediate attention from colleagues and the organisation. Critical events cluster in emergency response situations, but may occur anywhere and at any time.

Stress factors faced by humanitarian workers can be also categorised as:

Situational factors	Job-related factors
• Insecurity and lack of safety • Surrounding poverty and violence • Demanding relations with populations, local authorities • Health risks, poor facilities, lack of resources	• Ambiguity in roles and responsibilities • Dislocation: social, cultural, spiritual • Excessive workload or inactivity • Tense relationships within the team • Working with difficult and severely stressed cases • Difficulty of setting boundaries and limits
Organisational, management factors	**Personal risk factors**
• Management issues (bureaucracy, decision making process) • Programme roles and objectives (unrealistic, ambiguous)	• Limited contact with home, pressure from home • Poor social supportive network • Lack of or insufficient experience in humanitarian work • Unrealistic expectations and motivations • Poor self-care behaviour

Many dedicated health and mental health professionals who work in under-resourced settings with clients or patients with enormous needs overextend themselves and have a hard time setting appropriate limits. These situational factors are common professional hazards that can contribute to the development of burnout.

Some possible psychosocial effects of humanitarian work include:

Conflict of emotions

Humanitarian workers may experience different conflicts of emotions, such as feeling powerless facing the immensity of humanitarian needs, feeling guilty for benefiting from better living conditions or for not being able to respond to people's needs, feeling powerful and playing the role of a "rescuer", feeling of frustration when plans are disrupted by security problem, and also feeling of anger towards the differences in priorities with the local government, or due to the organisation bureaucracy.

Re-Entry Syndrome

Re-entry syndrome is a psychological response experienced by many people returning home from field work in a different culture. After an initial couple of days of euphoria, many returned aid workers experience feelings of loss, bereavement and isolation. They feel that no one really understand what they have been through and what is more, people are not that interested.

Compassion fatigue, vicarious trauma and burnout

Professional quality of life is comprised of two aspects of the helping process: compassion satisfaction (the positive aspect- the satisfaction drawn from the act of helping and the positive outcomes of helping others) and compassion fatigue (the negative aspect-burnout and vicarious traumatic stress). Humanitarian workers whose work involves working with individuals, families or communities that have experienced significant trauma and suffering need to be aware of these issues. Understanding the psychosocial impacts and stress reactions that might result from helping people who survived extremely difficult experiences is crucial.

In working with severe cases of trauma survivors, humanitarian workers providing mental health care and psychosocial support might experience vicarious trauma and counter-transference reactions that might go unnoticed. Counter-transference, known by psychotherapists, arises in the therapist/helper as a result of interacting with their client and identifying with their client's feelings and experiences, as well as when the therapist's own repressed emotions are aroused. When professionals work with survivors of severe human-perpetrated trauma, the counter-transference reactions may be particularly intense. The therapist's counter-transference is characterised by emotional reactions that develop due to the interaction between multiple factors, including the therapist's own unresolved inner conflicts, the stories the client shares with them (including of trauma), and the client's behaviour and personal characteristics [18].

The recovery from trauma is promoted when the survivor experiences the therapy environment as a safe and secure place to integrate and work through the trauma and its effects. One of the key tasks (and challenges) of the therapist in this endeavour is to sustain empathy for the client throughout the process. Empathy involves the capacity to understand, be aware of, and vicariously experience the world and perspective of another and feel their distress. The clinician's capacity to maintain their empathic stance and stay in tune with the client can become strained as the survivor shares more and more pain and details of their traumatic experience [19].

Burnout, which refers to work-related feelings of hopelessness, emotional exhaustion, and being overwhelmed, may result from work environments that involve excessive workloads and little support. Compassion fatigue, which refers to evidence of secondary traumatisation, is a term people also use to refer to changes in feelings toward beneficiaries, loss of interest, compassion, or work satisfaction—and increasing self-doubts about one's abilities or choice of profession [20]. Compassion fatigue is caused by empathy. It is the natural consequence of stress resulting from caring for and helping suffering people or people who experienced severely traumatic events. It involves a preoccupation with an individual or his or her trauma, and it does not require being present at the stressful event. It is extremely important to encourage humanitarian workers to recognise and accept symptoms and to commit to addressing personal issues.

Recognising Signs of Cumulative Stress

Cumulative Stress is pervasive and subtle. It occurs when a person suffers prolonged unrelieved exposure to a combination of personal, work, and situation related factors that are causing frustration. The best defence against the harmful effects of any kind of stress is information about some of the more common signs and symptoms. Although stress is experienced in a highly individualised manner, the following list provides examples of what people suffering from cumulative stress may experience.

Physical Reactions

- extended fatigue
- physical complaints, headaches
- appetite changes
- loss of energy, chronic fatigue
- frequent and prolonged colds
- sleep problems (insomnia, nightmares, excessive sleeping, interrupted sleep, early awakening)
- psychosomatic reactions including ulcers, gastrointestinal disorders, headaches, muscle aches
- weight loss or gain
- flare-up of pre-existing medical disorder
- injuries from high-risk behaviour

Emotional Reactions

- anxiety
- feeling alienated from others
- desire to be alone
- negativism/cynicism
- suspiciousness/paranoia
- depression/chronic sadness
- feeling pressured/overwhelmed
- diminished pleasure
- loss of sense of humour
- helplessness
- feeling trapped
- irritability/anger
- frustration
- over-reactions/under-reactions

Cognitive Reactions

- tired of thinking
- obsessive thinking
- difficulty concentrating
- increased distractibility/inattention
- problems with decisions/priorities
- diminished tolerance for ambiguity
- constricted thought
- rigid, inflexible thinking

Behavioural Reactions

- irritability
- anger displacement, blaming others
- reluctance to start or finish projects
- social withdrawal
- absenteeism from work
- unwillingness to take leave
- substance abuse, self- medication
- high alcohol consumption
- disregard for security, risky behaviour
- increased consumption (caffeine, tobacco, alcohol, drugs)
- difficulty expressing oneself

Spiritual/Philosophical Reactions

- doubt of value system/religious beliefs
- questioning the major life areas (profession, employment, lifestyle)
- feeling threatened and victimised
- disillusionment
- self-preoccupation

Reactions at the level of work

- de-motivation
- high job turnover
- frequent conflicts
- lowered work output
- increased sick leave
- scapegoating (blaming one individual for every problem)
- lack of initiative

Other Signs of stress

Stress among caregivers in the field of humanitarian work manifests itself in a wide range of signs and symptoms, psychological, behavioural and physical. Typically, they include:

- loss of interest in and commitment to work;
- loss of punctuality and neglect of duties;
- feelings of inadequacy, helplessness and guilt;
- loss of confidence and self-esteem;
- a tendency to withdraw – both from clients and from colleagues;
- loss of sensitivity in dealing with clients;
- loss of quality in performance of work;
- irritability;
- difficulty getting on with people;
- tearfulness;
- loss of concentration;
- sleeplessness;
- excessive fatigue;
- depression; and
- Psychosomatic complaints including bowel disturbance.

Many of these feelings are not of themselves unhealthy, but they become so if they are neglected or suppressed and allowed to accumulate. These should be considered warning signs that should encourage the humanitarian worker to give more time to him/her, seek possible ways of self-help, expression and support.

Resilience in Humanitarian work

Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress— such as family and relationship problems, serious health problems or workplace and financial stressors. It means “bouncing back” from difficult experiences (American Psychological Association APA).

A combination of factors contribute to resilience and enhance the person’s coping abilities. During the Training of Trainers on “Self-Care and Staff well-being in Humanitarian Settings”, a session was focused on resilience. After defining resilience and its different elements, participants worked in small group on identifying factors & elements of resilience on the individual as well as institutional levels.

The results of the group work were as follows:

Individual level	Institutional level
At the level of personal traits: Self confidence Good skills Good self-care skills & strategies Social support network Peer support Motivation to work Availability of a supportive environment Sense of stability and inner balance Belief in the value of humanitarian work Coping skills At the level of knowledge: - understanding one's experiences and awareness on what is going on; making use of experiences and learning from them At the level of attitudes: - positive & objective expectations - acceptance of changes - acceptance of others who are different - adopting positive attitudes At the level of skills: - effective communication skills - Ability to apply self-care strategies - Ability and readiness to ask for help when in need - Formative years + Cognitive – Emotional – Spiritual – Behavioural – Relational/social factors	Team spirit Recognition of staff efforts Provision of supportive activities Clear job description & clear roles and Responsibilities Clarity in institutional structure Effective two way communication between Management & staff Regular staff meetings and complaint box System of promotion that is neutral and fair Limiting of bureaucratic issues Respecting rights of employees/ staff (health, vacations, emergency situations) Salaries appropriate with living conditions and amount of work Providing opportunities for training, Capacity building and professional development Provision of regular and on-going technical support

Findings of the Rapid Assessment of Self-care Needs and Resources of MHPSS Workers in Syria

A study on the self-care needs and resources of MHPSS workers in Syria was implemented by ABAAD and supported by the EU as part of "Bel Salameh" project. The study was launched in October 2015 and ended in January 2016. The study aimed at identifying needs and forms of self-care among humanitarian workers who work in the field of mental health and psychosocial support with individuals and families affected by the Syria crisis. The assessment was conducted to provide ABAAD, other organisations and public health and humanitarian actors with information necessary for planning and designing protocols and policies for proper staff-care and staff well-being. The assessment aimed at:

- Exploring the strategies of self-care among humanitarian workers who work in the field of psychosocial support and protection with individuals and families affected by the Syria crisis.
- Identifying the self-care needs and the existing gaps and obstacles as well as the existing and available resources that can be built upon.

The assessment study revealed substantial and diverse self-care needs and challenges faced by humanitarian workers working in the psychosocial and mental health fields in Syria, which impair their psychosocial well-being on one hand and their ability to respond effectively to the growing mental health and psychosocial needs on the other.

Study respondents, who are national humanitarian actors working in mental health and psychosocial support, have been substantially affected by the protracted crisis and the on-going violence in Syria. Besides the stress resulting from their work with crisis-affected population, the majority of study respondents have themselves experienced traumatic events and/or loss of someone dear or people they know. Some have experienced displacement and significant changes in their living conditions.

Results indicated that stress is common among humanitarian workers and negatively influences their psychosocial well-being. Many respondents described their reduced ability to relax and pointed out to frequent disturbances in their eating habits.

Self-care at the physical level

Self-care at the physical level revealed some unhealthy behaviours among the study participants. Many reported that they skip meals, rarely engage in physical activity, rarely miss work when they are sick and sometimes neglect themselves. Alcohol consumption, as revealed by the study, is not common among national humanitarian actors in Syria.

Self-care at the spiritual level

Results on self-care at the spiritual level revealed positive indicators. The majority of respondents reported always feeling that their work has value and meaning, hoping that things will get better even when they go wrong (indicator of optimism and positive thinking), practicing meditation or praying, and making sure they get time to rest.

Self-care at the psychosocial and emotional levels

On the psychosocial and emotional levels, respondents reported some positive indicators. Being frequently aware of their feelings and sensing when they are not feeling well, giving themselves time to review and reflect on what they experience, talking to someone when they are stressed, feeling adequate and appreciating themselves, encouraging themselves and engaging in a positive and supportive inner dialogue, being kind and empathetic with themselves, having a supportive social network, being empathetic with others, having positive and realistic expectations and motives are all indicators of positive emotional and psychosocial well-being and self-care. Many study respondents explained that they believe that it is their duty to intervene and help others during these difficult times. They also explained that their work makes them feel they are actively helping their country during the crisis and contributing to its recovery.

On the other hand, respondents reported some negative indicators on psychosocial well-being that require prompt interventions. These indicators include feeling overwhelmed with stories of people they work with, sometimes feeling emotionally numb, frequently feeling stressed because of the workload, feeling exhausted and frustrated because of work in the humanitarian field, feeling easily irritable and unable to relax.

Studies on the self-care needs and psychosocial well-being of humanitarian workers

Concerning research on the needs of humanitarian workers in Syria, to date, there are no assessment studies exploring risks to mental health and psychosocial well-being among humanitarian workers currently working in Syria or assessing their psychosocial and self-care needs and resources. The psychosocial and self-care needs of those workers are usually overlooked.

Resources on self-care

In Syria, there is lack of resources on self-care, and scarcity of self-care and staff-care trainings and stress-management activities. Study respondents referred to a strong need for learning opportunities on recognising signs and sources of stress, understanding the consequences of cumulative stress and its impacts on well-being, recognising indicators of severe stress and burnout, and learning ways of dealing with stress (stress management). The only available resource that includes information on stress management and self-care is the WHO Psychological First Aid Guide for Field workers and Facilitator manual. Some humanitarian workers who participated in this study are not aware of this resource and the majority pointed out to a pressing need for Arabic, contextualised resources on self-care and stress management to help them personally and assist them in facilitating self-care sessions for other staff.

As per the study results, the most stressful cases that the study respondents deal with are cases of people suffering from financial difficulties and cases of people suffering from severe mental or psychological conditions (including those struggling with loss and grief).

Self-care at the organisational and professional levels

With respect to self-care at the organisational and professional levels, results indicated good self-care skills related to work, such as the ability of humanitarian workers to set appropriate boundaries with the cases and their ability to set realistic goals, timelines and work plans. However, the study revealed significant stressors related to work. Weak coordination among stakeholders, insufficiency in technical support and supervision, insufficiency of available and appropriate resources and information, the poor referral system along with the humanitarian workers' stress at the personal and professional levels were among the main stress factors identified by study respondents.

At the level of agencies, the main self-care needs identified were related to the lack of proper and adequate interventions to mitigate stress among staff. Results of the study respondents indicated significantly poor staff-care initiatives, activities and protocols at the organisations they work at. There is a significant need for appropriate and regular staff-care and psychological support interventions.

Among the obstacles MHPSS practitioners identify as standing in the way of self-care are lack of energy, too many responsibilities, time constraints and the fear of appearing weak or vulnerable. However, most of the study respondents reported that they need to promote their self-care practices and that they deserve to engage in self-care activities.

Study Recommendations

The main recommendations drawn from the study can be summarised as follows:
The diverse identified needs necessitate coordinated and well-planned interventions and a strategy on staff-care to ensure that humanitarian workers can access psychosocial support services when needed.

– Psychological first aid should be immediately available to workers who have experienced or witnessed extremely distressing events.
– There is a need for activating a MHPSS taskforce to establish a long term MH strategy and coordinated activities that aim at responding to the various needs, including self-care needs of humanitarian workers.
– Specific percentages of programme budgets must be dedicated to staff-care activities that aim at providing regular support to humanitarian workers.
– Additional efforts should be made to improve coordination between organisations and service providers, establish a clear referral system and ensure proper case management and follow up. Moreover, efforts need to be made to secure on-going, sufficient and culturally sensitive technical support and supervision of MHPSS practitioners.

To prevent and reduce the risk of burnout and compassion fatigue in staff members, organisations should focus on:

- Creating an open environment where staff members have a venue for mutual support. Encouraging staff members to meet with supervisors to talk about how they are affected by their work
- Encouraging peer support within the organisation or with other humanitarian workers
- Offering training that educates humanitarian workers about burnout and compassion fatigue and how to recognise the symptoms
- Sharing the caseload among team members, particularly the most difficult cases
- Making time for social interaction among teams
- Organising appropriately planned social events and retreats away from the workplace
- Encouraging healthy self-care habits such as good nutrition, sleep, taking work breaks
- Offering training that focuses on self-care and a balanced lifestyle as a way to promote resilience

Practical self-care tips

Stress will not resolve spontaneously. People need to act and take steps to break the cycle of stress. It is important for a humanitarian worker to identify what causes stress and put in place some steps to reduce and manage stress. There is no single approach to stress management that works for everyone and in all situations.

There are many benefits to be gained from developing a self-care plan. However, unless one devotes time and attention to developing a plan to take care of oneself, it rarely or only sporadically happens. In addition, one is less likely to spontaneously implement an optimally effective plan without some planning. Equally important is reviewing this plan periodically to reflect on whether it is working (in part or in whole) and/or whether changes should or need to be made.
Some self-care tips that might help you deal with the stress you face:

- Think about your motivations and expectations, be realistic, coherent and honest about your goals and drivers
- Increase awareness of specific stressors, more positive or harmful coping mechanisms
- Identify emotions in yourselves, in your colleagues and in those you will be helping; learn how to build up appropriate response to your own emotions
- Articulate your thoughts and write them down or discuss
- Think about what has helped you cope in the past and what you can do to deal with the stressors.
- Be sensitive to your emotions, learn coping skills to protect emotionally, distancing techniques (positive images, relaxation, exercise)
- Monitor your sleeping, eating habits, promote physical exercise and hygiene, and avoid temptation to use alcohol or drugs as coping behaviours. Try to take time to eat, rest and relax, even for short periods.
- Minimise your intake of alcohol, caffeine or nicotine and avoid non-prescription drugs.
- Try to keep reasonable working hours so you do not become too exhausted.
- Consider, for example, dividing the workload among helpers, working in shifts during the acute phase of the crisis and taking regular rest periods.
- People may have many problems after a crisis event. You may feel inadequate or frustrated when you cannot help people with all of their problems. Remember that you are not responsible for solving all of people's problems. Do what you can to help people help themselves.
- Check in with fellow helpers to see how they are doing, and have them check in with you. Find ways to support each other.
- Talk with friends, loved ones or other people you trust for support.
- Regularly read novels that have nothing to do with your work

- Establish an informal peer group within the organisation, a type of peer support group, to hold regular meetings where workers can freely express, discuss and share issues of common interest as well as challenges faced during their work. Such groups can benefit psychosocial health workers by collectively thinking about possible and available opportunities;
- Promote coordination with other workers in the field, by organising and/or taking part in regular events to share available resources and lessons learnt;
- Take part in different training workshops and ask for on-going supervision in field work, where one can feel supported whenever faced by difficulties.

Ideas for a self-care plan

Below are some ideas to get you started in developing your own self-care plan. It may be helpful to start with a couple of ideas and build on that.

Physical self-care

Physical self-care is an area that people often overlook. It includes:

Food

Food is a component of self-care that humanitarian workers often overlook. They are often so busy that they do not have time to eat regularly or that they substitute fast food for regular meals. It is not always reasonable to expect people to get 3 meals and a snack a day but everyone should make sure they get adequate nutrition. Remember that skipping meals, forgetting to drink fluids, and overdosing on sugar, fatty snacks and alcohol can create nutritional stress.

Exercise

Exercise is one of the most overlooked types of self-care. It is recommended to carry out at least 30 minutes of exercise 5 times a week. Exercise, even if it is just a quick walk at lunchtime, can help combat feelings of sadness or depression and prevent chronic health problems.

Sleep

Although everyone has different needs, a reasonable guideline is that most people need between 7-10 hours of sleep per night. One example of a self-care goal: I will go to bed by 11:00 p.m. during the week so that I can get enough sleep.

Medical care

Getting medical attention when you need it is an important form of physical self-care. Some survivors put off getting medical care until problems that might have been relatively easy to take care of have become more complicated.

Emotional self-care

- Take every day at a time
- Allow yourself time to talk, grieve, be angry, or cry according to your needs. Allow time for exercise, rest, and recreation.
- Focus on the things that you need to accomplish today.
- Try not to get disturbed over what you cannot influence.
- Face reality, this will help you come to terms with the event(s).
- Talk, express your experiences and how you feel about them.
- Encourage yourself to practice supportive inner dialogue or self-talk (words of encouragement, remind yourself of your strengths…)
- Give yourself time to review & reflect on what you experience
- Ask others for help (friends, family members, others) when you are feeling stressed
- Learn to be assertive and say no if you are unable to accomplish what is asked from you
- Seek out privacy, you need that to relax, sleep, and to sit quietly with your own thoughts and feelings.
- Combine exercise with relaxation and rest; it will sooth some the physical reactions.
- Try to keep a journal if you have difficulties to sleep; for yourself – not to share with others.
- Try to listen to your feelings and sense when you are not feeling well.
- Practice self-compassion, and use it whenever you are experiencing a tough day
- Do not bottle up thoughts and feelings.
- Do not fight back recurring thoughts, dreams, and flashbacks to try and keep them away. They decrease over time. Share them with someone and they will lose power.
- Do not avoid talking about what has happened or is happening.

Self-care at the organisational and professional levels

- Work on setting appropriate boundaries at work with the cases you work with (ex: no phone calls after work hours…)
- Set realistic goals, work plans & timelines
- Meet with your colleagues and talk about issues, share problems and solutions
- Talk to your colleagues at appropriate times about your feelings and reactions to professional issues

Indicators of the need for referral to specialised care

Promoting enhanced resilience among humanitarian workers, through proper self-care and staff-care, could help mitigate the adverse effects of stress and trauma, with a consequent positive impact on both their professional and personal lives. Some humanitarian workers, however, might experience severe and acute stress that requires specialised care.

Signs of severe stress – warning signs of unmanageable stress
Humanitarian workers should be aware of warning signs of unmanageable severe stress and burnout either in themselves or in their colleagues. These signs include:

- Mental/ psychological confusion, inability to make judgments and decisions, inability to concentrate and to prioritise tasks
- Inability to clearly express verbally or in writing
- Feeling unappreciated by the organisation
- Anxiety, nervousness, tension, irritability, depression, excessive rage reactions
- Agitation, excessive sweating, hyperventilation,
- Neglecting one's own safety and physical needs
- Sleep difficulties
- Appetite disturbances
- Excessive tiredness and extreme fatigue
- Progressive decline in efficiency
- Loss of spirit
- Self-blame
- Decreased self-esteem
- Heroic but reckless behaviour
- Changes in behaviour, including impulsivity and/or aggression
- Grandiose beliefs about themselves
- Sleeping difficulties (e.g. sleep apnea, excessive sleeping)
- Body aches and pains
- Excessive use of alcohol, tobacco or drugs

Acute stress requires professional help when it persistently interferes with important areas of one's life. It is important for humanitarian workers to ask themselves the following questions, and they should consider talking to a mental health professional if they answer positively on more than one of the following questions:

- Am I having difficulty carrying out or completing my normal activities and responsibilities?
- Am I unable to do my work, or has my work suffered, because of the way I have been feeling or acting?
- Am I having difficulty interacting with friends, colleagues and other people?
- Has my behaviour or temper damaged my relationships with friends or family members?
- Have I been avoiding people or important events frequently because I have been feeling anxious?
- Has my drinking or drug use interfered with my relationships, my performance or my other responsibilities?
- Do I need to drink or smoke to feel better?
- Am I having suicidal (or self-harm related) thoughts?

Consider a referral for a more thorough evaluation with a mental health professional if:

- Traumatic stress reactions are severe or prolonged (more than a month).
- Traumatic stress reactions interfere with recovery or with returning to normal activities.

Critical events

Critical Events are unexpected and violent occurrences that present a threat to personal safety and challenge one's sense of security and predictability in life. Examples include:

- Witnessing the death or serious injury of another human being
- Involvement in actual or potentially life threatening situation
- Injury or death of a co-worker
- Dealing with serious injuries, death or severe human-rights violation
- Exposure to mass casualties
- Involvement with any event described as an atrocity

Humanitarian workers who experience critical events may experience the following:

- Feeling vulnerable, frightened, sad, angry and afraid of losing control
- A periodic feeling of unreality, events seeming dream-like
- Increased alertness, heightened response to loud noises, reminders of the event scene, or any other surprise
- Discomfort at being alone
- Discomfort being in a group
- Difficulty concentrating on what to do next
- Difficulty making decisions and thinking creatively
- Difficulty relating to those who were not part of the event
- Difficulty resting and sleeping, fear of nightmares
- Increase or decrease in appetite

Some humanitarian workers who have experienced a severely critical or potentially traumatic event might suffer from symptoms of Post-traumatic-stress disorder (PTSD), including re-experiencing and avoidance symptoms. The following necessitate referral to a mental health professional for specialised mental health care:

- Symptoms of acute stress with onset after the event
- Difficulties in day-to-day functioning
- Re-experiencing symptoms - which are repeated and unwanted recollections of the event as though it is occurring in the here and now (e.g. through frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror).
- Avoidance symptoms - which involve deliberate avoidance of thoughts, memories, activities or situations that remind the person of the event.
- Symptoms related to a sense of heightened current threat -which involve hyper-vigilance (excessively watchful for potential threats) or exaggerated startle responses (e.g. easily startled or jumpy with fear).
- Prolonged grief symptoms (e.g. persistent and severe yearning for the deceased, preoccupation with the deceased or circumstances of the death; bitterness about the loss, difficulty accepting the loss; difficulty progressing with activities or developing friendships; feeling that life is meaningless) with associated emotional pain.

Psychological first aid should be immediately available to workers who have experienced or witnessed extremely distressing, life-threatening or traumatic events. Professional mental health care and medical care should be made available for staff members who require it. Organisations should facilitate referral of staff members to specialised services within or outside the organisation.

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