American Friends Service Committee

Trauma Healing and Psychosocial Support: A Training Manual for Development Practitioners and Case Care Workers

Acknowledgements

The manual has been developed by the American Friends Service Committee in Zimbabwe (AFSC), which operates in Zimbabwe under a memorandum of understanding with the Ministry of Women Affairs, Community, Small and Medium Enterprises Development**.** This manual has been developed in partial fulfilment of AFSC Zimbabwe's grant agreement with Bread for the World (BftW), whose financial and technical support is hereby acknowledged.

The project will be implemented in Beitbridge District in Matabeleland South Province and in Mwenezi District in Masvingo Province in Zimbabwe, and Musina in Limpopo Province of South Africa, targeting four selected wards per district, through a partnership involving community-based organisations and service providers. Community based partners include Catholic Commission for Justice and Peace (CCJP), who will be implementing in Mwenezi and Beitbridge districts in Zimbabwe, and Messina Legal Advice Office (MLAO), who will be implementing in Musina district South Africa. Further acknowledgement is thus extended to them. Their cooperation and support towards the writing of this manual and the subsequent training conducted is greatly appreciated. AFSC also acknowledges civil society organisations from Beitbridge, Musina, and Mwenezi who participated in the initial training.

The American Friends Service Committee in Zimbabwe (AFSC) would like to acknowledge and appreciate consultants Winnet Manyadza and Shepherd Murahwi for both designing, writing, and producing this manual and conducting a training on trauma healing and psychosocial support for selected civil society representatives. Various resource materials were used in developing this manual, such as the CONNECT manuals in Systemic Counselling Training as well as other sources as cited in the reference sections.

AFSC also acknowledges the support from AFSC's Zimbabwe country office team, the AFSC Africa region, and our central office for their guidance and oversight.

Foreword

Globally, there are approximately 48 million internally displaced persons (IDPs) who have fled conflict and violence (UNHCR 2021). IDPs are people who have been forced to leave their place of habitual residence, but, unlike refugees, have not crossed an internationally recognized state border (UNCHR 1998). Such internal displacement occurs across various contexts, including conflicts, environmental disasters, and the negative impacts of climate change. This often leads to multiple human rights violations and increased vulnerability to all forms of abuse that include GBV, sexual exploitation, child abuse, and even human trafficking. Contextual analysis indicates that Zimbabwe accounts for 24% of all refugees and asylum seekers in South Africa. Zimbabwe is one of the significant irregular and regular migration corridors within

southern Africa due to its geographic proximity and its centrality within the region. This makes Zimbabwe a host of migrants from other African countries who are enroute/unable to cross to South Africa. Anecdotal evidence shows that South Africa has a population of about 60 million, about 3 million of whom are migrants. According to the national statistics agency, many of these are Zimbabweans driven south by two decades of political instability and socio-economic challenges that have affected their livelihoods. The map below best illustrates the movements by the migrants into South Africa through Zimbabwe.

It is in recognition of this background that the American Friends Services Committee's Zimbabwe program seeks to build the capacity of their implementing partners and CSOs operating in Zimbabwe and South Africa to implement a project called "Supporting Vulnerable People on the Move and their Communities in Zimbabwe and South Africa" in the districts of Beitbridge in Matabeleland South Province, Mwenezi of Masvingo Province in Zimbabwe, and Musina in Limpopo Province of South Africa. Capacity building is mainly focusing on psychosocial support in the context of trauma healing among IDPs, returnees as well as refugees.

Our overall objective is to strengthen the role of civil society and community-based organisations in disseminating knowledge and information on how to offer professional support to traumatised families and individuals through the provision of psychosocial support in selected districts of Zimbabwe and South Africa. The long-term desired outcome of this initiative is to produce case care workers who are able to assist themselves, as well as help survivors of trauma live in harmony with the rest of society.

Preface

This manual serves to introduce partners and civil society organisations (CSOs) working with the American Friends Service Committee to the concept of psychosocial support and trauma healing targeting internally displaced people, returnees, migrants, and their communities. The manual shall provide a step-by-step guide to the users on helping the targeted population deal with trauma and stressful situations. It is therefore important that this manual is read and made use of during trauma healing counselling sessions. Civil society organisations can use this manual as a reference tool for further training of colleagues or community volunteers. They can also make use of the additional references provided at the end of this manual. Hence the journey as a psychosocial support (PSS) counsellor has begun. AFSC encourages all users to be dedicated, professional, and ethical in the work ahead.

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UNIT 1

THE CONCEPT OF PSYCHOSOCIAL SUPPORT AND COUNSELLING

1.0. Introduction

Psychosocial well-being is a necessary condition for any human being to realize their full potential and to lead fulfilling, healthy, and productive lives. People who have psychosocial well-being are confident, have self-esteem, feel safe, and are able to solve problems, make decisions, build positive social relationships, work together, and resolve conflicts. All internally displaced people (IDPs), migrants, returnees, and their communities have different psychosocial support needs. These can vary depending on their age, their life experiences, their family background, gender, and even their individual personalities. PSS counsellors have a role to play in ensuring adequate support for the psychosocial well-being of their target group. This unit therefore shall provide an overview of what PSS is; the importance of PSS in the contexts of IDPs, migrants, returnees, and their communities; the core principles or elements of PSS; as well as the qualities of an effective PSS counsellor.

Objectives

At the end of this unit, participants or leaners should be able to:

- Describe the concept of psychosocial support.
- Explain the principles of psychosocial support in the context of migrants, returnees, IDPs, and their communities.

Outline the features of an effective psychosocial support counsellor.

Suggested training session delivery method:

The facilitator can introduce the topic by soliciting for participants' knowledge and experience in psychosocial support.

- Lecture method with intermittent question and answer approach to the concepts outlined below.

Plenary method where participants discuss their field experience in offering psychosocial support.

1.1. Defining psychosocial support (PSS).

The word “psychosocial” is a combination of the concepts of the individual “psyche” that is the inner world and “social,” which refers to the relationship with a person’s environment, that is the community in which the person lives and interacts. Psychosocial support is the process of facilitating and strengthening resilience within individuals, families, and communities to recover from and adapt to critical hardships and misfortunes with potentially damaging long-term impacts. It therefore promotes the restoration of the overall well-being of an individual. Psychosocial well-being is then the state in which an individual, family, or community has cognitive, emotional, and spiritual strengths combined with positive social relationships. Psychosocial support recognizes the importance of the social context in addressing the psychological impact of stressful events experienced in emergencies.

Reflection

Make a list of the nature of emergencies or crisis situations which IDPs, returnees, migrants, and their communities may face. Briefly discuss with a colleague how these can be addressed.

1.2. Objectives of PSS

The objectives of PSS when dealing with the migrants, returnees, IDPs, and their communities who go through the trauma and healing process include:

- To assist the affected people to attain stable life and integrated functioning: A PSS counsellor must have the capacity and skills to assist the affected people and facilitate their efforts to regain their full functioning by building on their strengths. This must have a rights-based perspective and be clearly gender and disability sensitive.
- To restore hope, dignity, mental and social well-being, and a sense of normality: Regardless of the contributing factors to the individual resulting in being a migrant, returnee, or IDP, PSS is there to help them go through their pain, address unfinished issues, deal with the trauma with the aim of restoring lost hope, restoring and maintaining dignity, as well as ensuring mental health.

1.3. Understanding the core principles of PSS

Stevan Hobfoll (2007) and a team of international experts distinguished five essential principles of psychosocial care to people confronted with disaster, tragedy, and loss. (*When offering PSS services to IDPs, migrants, returnees, and their communities, it will be useful for the counsellor to refer to the following five principles)*.

Figure 1 – Principles of PSS.

1.3.1. Safety

When in a traumatic and crisis situation, safety of an individual is compromised. In that situation, the body will react with increased stress levels. When the traumatic situation continues, or if reactions to a past crisis do not decrease, chronic high stress levels may prevent or slow down the healing process. Promoting a sense of safety then becomes important in order to reduce biological responses such as sleeplessness, or difficulties in concentrating and reduced mood levels. Therefore, it is essential that psychosocial interventions take place in “safe spaces.” These spaces need to be:

a. Objectively safe - a secure physical space that allows people to be protected from further danger.
b. Subjectively safe - creating a sense of safety, trust, and promoting positive relationships.

Reflection

Write down at least 10 characteristics of a safe environment when offering psychosocial support.

1.3.2. Hope

Hope is defined here as “a positive, action-oriented expectation that a future goal or outcome is possible.” When a person is hopeful, they experience positive and good feelings, instead of depressed and negative feelings about life and the present situation.

It is the PSS counsellor’s role to help IDPs, migrants, returnees, and their communities realise that they are not alone in their reactions. This reduces their sense of loneliness, even when they are facing significant problems. In a group counselling setting, the PSS counsellor needs to create a trusting atmosphere which helps participants to feel that they belong and are included, which results in a hopeful state of mind. This is instrumental, as it helps participants to believe in a future where they will once again feel good.

Exercise

What are the key factors to address when promoting hope?

1.3.3. Connectedness

Promoting connectedness of individuals, groups, and communities is the foundation for psychosocial support, as individuals are not islands, but rather belong to a social group and community. The role of a PSS counsellor is to identify and link the IDPs, migrants, returnees, and their communities to effective support systems that can positively assist in the trauma healing process. Help them establish good relationships with their peers, families, and community members.

Activity

List down the possible effective support systems that can assist the IDPs, migrants, returnees, and their communities in the trauma healing process.

1.3.4. Calming

During a crisis, it is normal and natural for people to react with strong emotions. While most people return to manageable levels of stress within days or weeks, others may experience panic attacks, sleeping problems, and other responses to extreme levels of stress, anxiety, and worry. The role of the PSS counsellor is to help the affected population to realise and acknowledge that certain stress reactions are common under extreme situations. This is a key intervention principle to promote calming. A wide range of strategies have been identified as useful to enhance calm. These include:

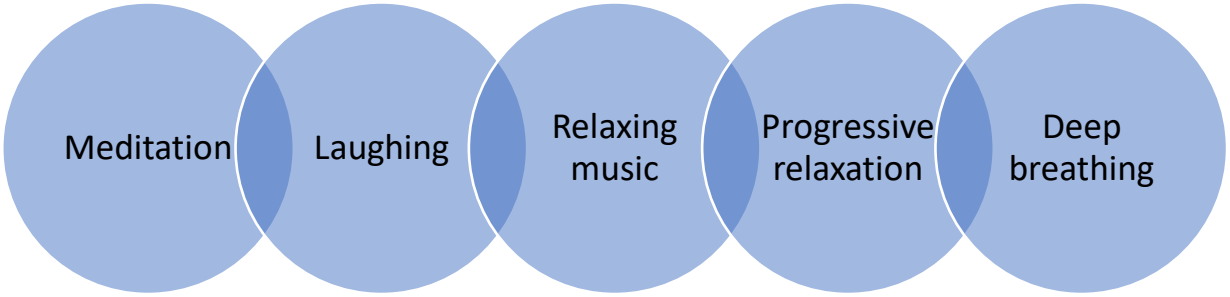


Figure 2 – Relaxation techniques.

1.3.5. Self-efficacy

Psychosocial interventions can help to improve self-efficacy, that is the belief in one's ability to act in a way that improves one's situation. The role of a PSS counsellor is to challenge the perceptions of IDPs, migrants, returnees, and their communities towards the traumatic situations they might be experiencing so that they discover new skills and abilities and increase their self-esteem. The PSS counsellor can make use of problem-solving activities to promote the development of skills to overcome difficulties. As the participants solve these problems, they experience and develop efficacy. After the exercise, allow for reflection and discussions to encourage participants to understand how to use this feeling of efficacy to promote trauma healing.

1.4. Qualities of a PSS counsellor.

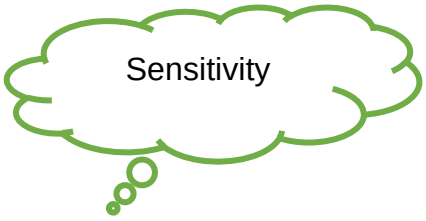
Counselling is a reciprocal interaction in which both the PSS counsellor and client create and shape the process. Being the trained helper, the PSS counsellor is largely responsible for ensuring that the process is beneficial and therapeutic for the participants. Hough (1994) indicated that the counsellor's personal qualities can enhance or detract from the helping process. These qualities are very essential in the trauma healing process.

Respect and maintain confidentiality of beneficiary traumatic experiences.

Explore and understand yourself: your needs, motivation for helping, feelings, personal strengths and weaknesses.

Do not be distracted by your own overwhelming problems.

Be free from fixed or preconceived ideas about your clients. It allows you to accommodate client feelings, attitudes, and behaviours that may be different from your own.



Be sensitive to the client's culture, beliefs, resources, coping styles and vulnerabilities.

Be reliable, responsible, and avoid any responses or behaviours that could threaten or injure the client.

Have the necessary correct information, knowledge, and skills required to offer PSS. If there are grey areas, refer for further management.

UNIT 2

UNDERSTANDING VULNERABILITY AND BUILDING RESILIENCE

2.0. Introduction

IDPs, migrants, returnees, and communities experience and respond to loss, pain, disruption and violence in significantly different ways, influencing their mental health and psychosocial well-being, hence increasing their vulnerability to mental health problems. People of different genders and ages may have different ways of experiencing and expressing distress. Their reactions to disruptive situations are often overcome with time. Most people cope with difficult experiences and may become more resilient if they receive psychosocial support in an enabling environment. Some people are more vulnerable to distress, especially those who have lost or been separated from family members or who are survivors of violence.

Objectives

By the end of this unit, participants should be able to:

- Define vulnerability in the context of peace, migration, and displacement.

List down factors that contribute to vulnerability.

Suggested training session delivery method:

- Group discuss and feedback.
- Lecture method, question and answer.

2.1. Defining vulnerability

Vulnerability in humanitarian emergencies is the result of class, gender, age, ethnic, racial, able-bodied, and religious inequalities and hierarchies that prevent the individual from satisfying basic needs, accessing resources, and exercising their rights (Bankoff 2001).

2.1.1. Categories of vulnerability

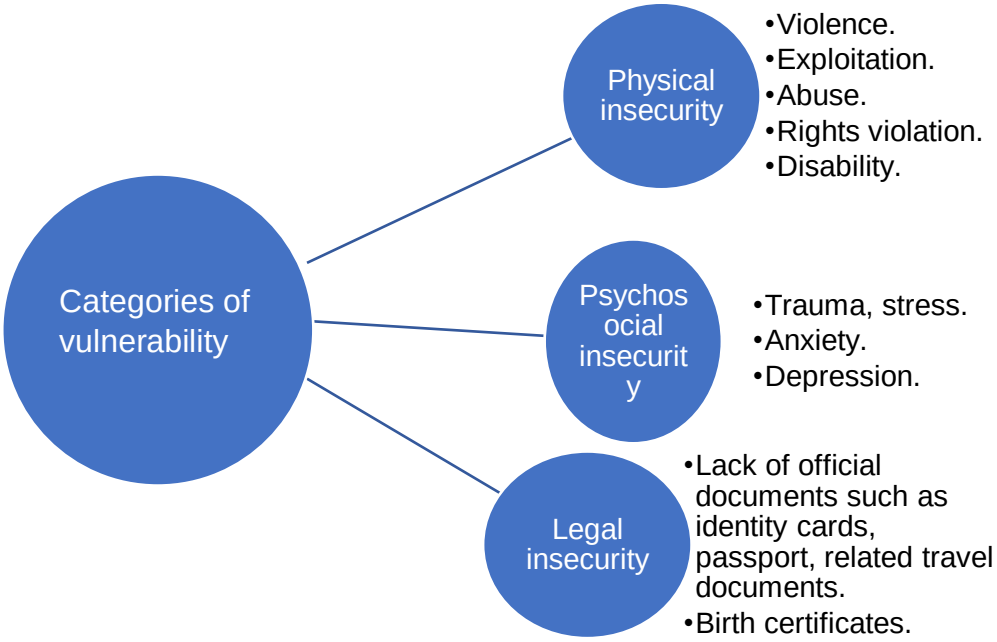


Figure 3 – Categories of vulnerability

Group discussion: Reflect and identify other situations and give examples under each of the types of vulnerability experienced by IDPS, returnees, migrants, and their communities.

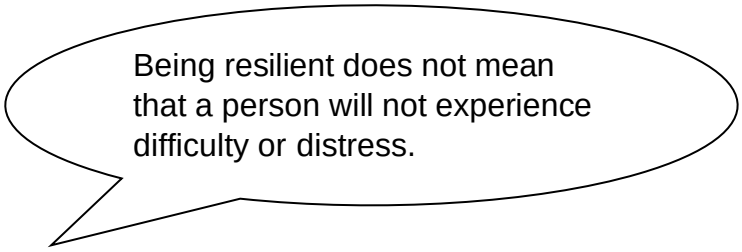
2.1.2. Gender, culture, disability vs. vulnerability

Disability: Persons with disabilities remain among the most hidden, neglected, and socially excluded of all displaced people. People with disabilities are often literally “invisible” in migrants, returnees, internally displaced persons (IDP), and community assistance programs. They are excluded from or unable to access mainstream assistance programs as a result of attitudinal, physical, and social barriers. As well, they are forgotten in the establishment of specialized and targeted services. Their potential to contribute and participate is rarely recognised, the general perception being that they are more often viewed as a problem than a resource. Moreover, traditional community coping mechanisms, including extended families, neighbours, and other caregivers, often break down during the move. The loss of caregivers can leave persons with disabilities extremely vulnerable and exposed to protection risks.

2.2. Developing resilience among IDPs, migrants, returnees, and their communities.

2.2.2. Defining resilience

Psychologists define resilience as the process of adapting well in the face of adversity, trauma, tragedy, threats, or significant sources of stress. As much as resilience involves “bouncing back” from these difficult experiences, it can also involve personal growth.



2.2.3. Strategies for building resilience

- Establish relationships: Help participants identify and establish supportive relationships with empathetic and understanding people. These people must be trustworthy and compassionate individuals who validate their feelings, which will support the skill of resilience.
- Join a group: Encourage participants to join active groups for social support. These groups can help in reclaiming lost hope and trauma healing.
- Self-esteem: Help participants develop a positive sense of self and confidence in their strengths. This helps in dealing with feelings of helplessness when confronted with adversity.
- Positive coping skills: Coping and problem-solving abilities help empower the participants who have to work through adversity and overcome hardship.
- Communication skills: Help participants develop effective communication skills. This will help them to seek support, mobilize resources, and take action.
- Emotional regulation: Self emotional care must be encouraged among the IDPs, migrants, returnees, and their communities. This is the capacity to manage potentially overwhelming emotions, which helps them maintain focus when overcoming a challenge.
- Realistic planning: The ability to make and carry out realistic plans helps individuals play to their strengths and focus on achievable goals.

Discussion

What can possibly hinder resilience building?

2.2.4. Key issues to consider when building resilience among IDPs, migrants, returnees, and their communities

- **Gender sensitivity:** Vulnerabilities and risks for people on the move differ greatly between men and women due to socially constructed gender norms and roles. Considering gendered vulnerabilities and focusing on the real needs, capacities, and aspirations of women and girls is critical.
- **Attending to psychosocial needs:** Migration and displacement disrupt most facets of life, including culture, markets, education, and health. Affected communities need additional capacity to deal with these worsened situations.

2.3. Conclusion

It should be noted that IDPs, migrants, returnees, and their communities are at high risk of being exposed to various vulnerabilities which threaten their physical and emotional well-being. As the PSS counsellor works with the clients, there is need to help them build resilience so that they bounce back and move forward with life, maintaining a positive mind and attitude.

UNIT 3

BASIC SYSTEMIC AND PSYCHOLOGICAL FIRST AID COUNSELLING

3.0. Introduction

There are many theories that counsellors may use to do their work. This unit shall discuss the systemic counselling model as well as the psychological first aid counselling which the PSS counsellors shall utilise as they work with IDPs, migrants, returnees, and their communities. Furthermore, the counselling techniques to be used shall be explained.

Objectives

By the end of this unit, participants or learners should be able to:

- Explain in brief what first aid counselling is.
- Explain what systemic counselling is.
- List elements and concepts of psychological first aid counselling.
- List and or identify counselling techniques.
- Identify barriers to successful counselling.

Suggested training session delivery method:

- Question and answer.
- Lecturing.
- Demonstrations.
- Role plays.

3.1. Systemic counselling

Systemic counselling is an approach that helps in examining the various systems surrounding or within a client, for purposes of finding and releasing constraints which may exist in a client's system of inner personalities. It also helps in assessing the client's relationship with various systems surrounding the client and understanding how the outside environment affects the individual.

3.1.1. Concepts

A system can be defined as an entity whose parts relate to one another in a pattern. It can also be a unit made of different parts which are interrelated. Furthermore, it is an organised unitary whole composed of two or more interdependent parts. Components or subsystems are divided by identifiable boundaries.

When providing PSS to internally displaced people, the counsellor needs to remember the following concepts:

- Individuals are not islands but operate in the context of other systems. In as much as the IDPs, migrants, returnees, and their communities are affected by a number of factors, they are not isolated in finding lasting trauma healing solutions. They are surrounded by a supportive environment which facilitates healing.
- Change is contagious. Meaningful change comes in small steps. In order to facilitate trauma healing, the counsellors need to notice and compliment every small change they observe on the IDPs, migrants, returnees, and their communities, as this will lead to full and complete healing.
- The whole is greater than the sum of its parts, which means when working with the IDPs, migrants, returnees, and their communities, the counsellor needs to look at an individual holistically and their interaction with other systems around them and not as individuals.

3.2. Psychological first aid counselling

Psychological First Aid (PSFA) is an evidence-informed means of providing psychosocial support to individuals and families immediately after a disaster, terrorist or traumatic event, or any other emergency. Its goal is to promote safety, stabilize survivors of disasters, and connect individuals to help and resources. It consists of a set of helping actions which are undertaken in order to reduce initial post-trauma distress and to support short- and long-term adaptive functioning and coping, based on the principle of “do no harm.” (The Australian Psychological Society and the Australian Red Cross, 2010).

3.2.1. Elements

Five basic elements to psychological first aid have been drawn from research on risk and resilience building when helping IDPs, migrants, returnees, and their communities deal with trauma. The elements of psychological first aid are to promote:

- Safety.
- Calm.
- Connectedness.
- Self-efficacy and group efficacy.
- Hope.

3.2.2. Concepts

The World Health Organization (WHO) has developed a framework consisting of three action principles to assist in the delivery of psychological first aid.

Look	Listen	Link
• Check for safety. • Check for people with obvious urgent basic needs. • Check for people with serious distress reactions. • If you are not certain that the area is safe, then DO NOT GO; rather make use of virtual platforms to assist.	• Approach people who may need support. • Ask about people's needs and concerns. • Listen to people and help them to feel calm.	• Help people address basic needs and access services. • Help people cope with problems. • Give information. • Connect people with loved ones and social support.

Table 1 – PSFA concepts

3.3. Basic counselling techniques

The purpose of the techniques is to understand the client's situation, engage the client in conversation, as well as help the client find ways to deal with the traumatic experience.

Joining — This is establishing a relationship with the client. Joining is a process which starts when a counsellor meets a client, and it continues right through the session. The way the counsellor welcomes the client, the body language and tone of voice, all assist in establishing a relationship. Therefore, from the minute one meets the client one begins to form a relationship which will determine how the participants will open up.

Questioning — This is the primary tool counsellors use to obtain information or seek clarifications. There are two types of questions. **Closed questions** demand short or one-word answers. How old are you? What is your name? These are very useful for obtaining demographic data.

Open ended questions demand long explanatory answers. These are best to use in sessions, because they allow the client to talk more and also to come up with their own solutions. Can you tell me more about your relationship with your father? Could you explain that? How did that make you feel?

Listening — Every client has a story to tell, and the way one responds is effectively dependent on how one listens. Listening involves attending carefully to the client's verbal and non-verbal messages. It is very important for the counsellor to be in touch with their own thoughts and feelings and how these are interacting with those of the client.

Summarizing — This is a way of sifting out the less relevant material and also summing up the client's main concerns or issues discussed so far. Use this technique when stuck, to link and close sessions, and also to take a break.

Widening the system — When people are in a crisis, they usually forget the other people who can be there for them. So, widening the system is looking for support from any of the given systems surrounding a person. When looking for support we usually start with the immediate family, then, if necessary, move out to the extended family, then to all other systems.

Taking a one down — This is a way of acknowledging the client's expertise in a certain area, e.g., expert in his or her culture etc.

Use of exceptions — Usually when a person is traumatised or depressed, it is not present 24 hours a day. When exceptions have been identified, the counsellor amplifies them in order to eliminate the problem.

Externalising — In general when we speak, we attach a problem so firmly to a person that we make that person the problem. Externalising is removing a label from a person; that is, separating the person from the problem.

Reframing — Reframing involves taking a set of events described by the client and giving them back in a different frame i.e., getting the client to view the behaviour problem from a different perspective. The purpose of reframing is to change the meaning that an individual attaches to certain behaviours or interactions in such a way as to make the situation easier to change.

Scaling — Instead of asking participants to describe intensity of feelings or behaviours, scaling can be used to elicit more accurate information. For children, scaling is best done using the hands to show. For example: Last time you were this angry. Show me how angry you are today. With adults it is better to use a number scale of 0 to 10

where 0 is not angry at all and 10 is extremely angry.

Empty chair — The empty chair technique is used to symbolically bring in absent members of the family or other significant persons. The counsellor might say to the client: If your husband was sitting in this chair, what you would say to him? While the empty chair helps the counsellor to hear the voices of the absent people, it also helps in the enactment of solutions.

Group discussion

In groups of four, identify possible problems confronted by IDPs, migrants, returnees, and their communities and present a role play demonstrating the application of the basic counselling skills discussed above.

3.4. Conclusion

Utilising the concepts of systems theory, PSFA concept as well as the counselling techniques, the counsellor must be in a position to assist the IDPS, migrants, returnees and their communities, including those with disabilities, deal with the traumatic experiences in order to facilitate their healing.

UNIT 4

POST-TRAUMATIC STRESS DISORDER (PTSD)

4.0. Introduction

Post-traumatic stress disorder (PTSD) has been described as one of the most frequently reported mental conditions among returnees, migrants, and internally displaced populations. Individual and community resilience and coping mechanisms act as protective factors in dealing with post-traumatic stress disorder. This unit shall focus on describing the causes of PTSD among returnees, IDPs, and migrants; manifestations of PTSD; as well as management strategies.

Objectives

By the end of this unit, participants or learners should be able to:

- Explain in brief what Post-traumatic stress disorder (PTSD) is.
- Explain PTSD and the application of CBT in managing it.
- List down types of trauma.
- List down the causes of PTSD.
- Identify the effects of PTSD.
- Explain in brief how to manage trauma.
- Apply the basic concepts PTSD in therapeutic situations when helping individuals of families who are traumatised and presenting with PTSD.

Suggested training session delivery method:

Note: Introduce this topic by sharing experiences and participants' own understandings of trauma.

- Get participants to discuss causes of trauma in groups.
- Use the lecture method and question and answer to introduce the new concepts.

4.1. Explaining post-traumatic stress disorder (PTSD)

Post-trauma is the emotional aftershocks or stress reactions after a horrible traumatic event. The reactions may appear immediately after the traumatic event, or after a few hours, days, weeks, months, etc. (Slaikeu 2000).

The disturbing or moderate category can cause nightmares and flashbacks. Disabling or post-traumatic stress disorder (PTSD) is severe, with long lasting devastating effects that are overwhelming. Slaikeu (2000) asserts that characteristic symptoms of PTSD include persistent re-experiencing of the traumatic event and persistent avoidance of stimuli associated with the trauma. Both disturbing and disabling levels of trauma (PTSD) call for further specialized mental health assessment, treatment, and management.

4.2. Cycles of trauma

Victim cycle: Trauma is acted in.

- Shame, guilt, and hopelessness.
- Depression and anxiety, therefore internalized oppression.

Aggressor cycle: Trauma is acted out.

- Acts of aggression are justified in the name of self-defense.

4.3. Types of trauma

- **One-time trauma:** An event occurs once. Examples of single blow traumas include rape and natural disasters.
- **Prolonged or repeated trauma:** The traumatic experiences that result in most serious health problems are prolonged and repeated, sometimes over years of a person's life. Examples include a war situation or deliberately inflicted traumas such as assault, sexual abuse, and torture. These are by far harder to bear.

Levels of trauma include

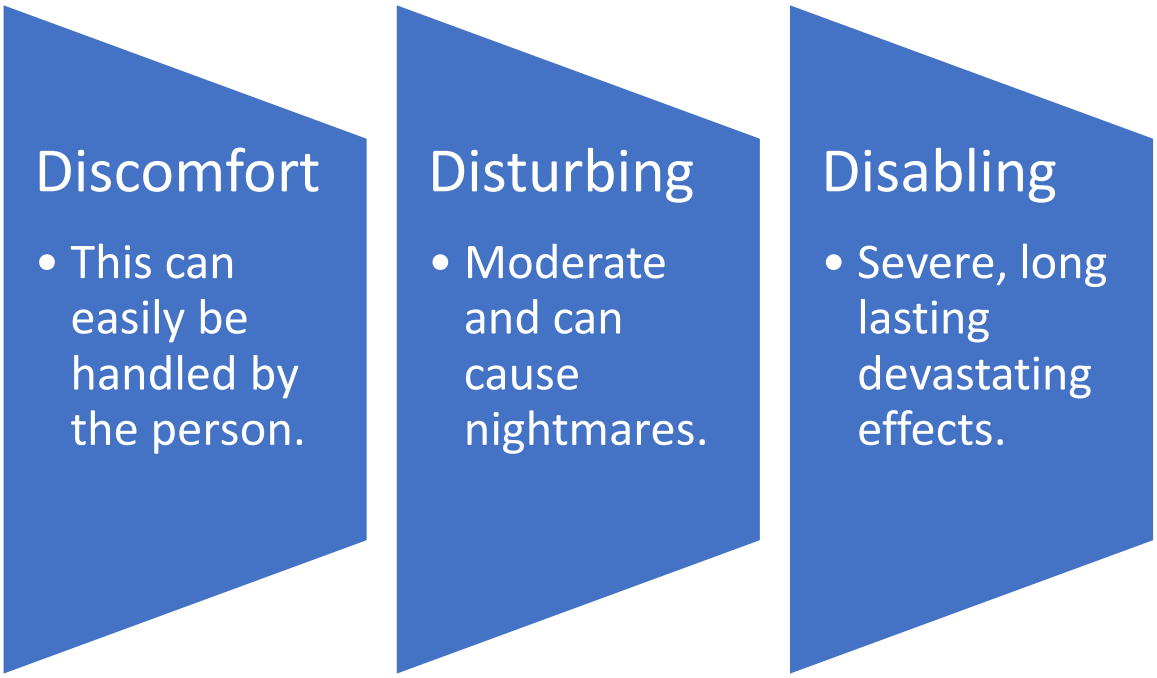


Figure 4 – Levels of trauma

4.4. Causes of trauma among IDPs, returnees, and migrants.

Witnessing violence and murder.	Long illness, broken relationships, etc.
Rape, war situation.	Bereavement, sudden displacement, and destruction of property.
Child abuse, physical assault.	Natural disaster, fire, or flood.
Torture, disability.	Threats.

4.5. Effects of trauma

Short term	Long term
Anxiety. Guilt and shame. Irritability. Outbursts of anger. Flashbacks. Loss of interest in activities previously enjoyed. Discrimination.	Sleep disturbance at night. Loss of memory. Lack of trust. Low self-esteem, feelings of hopelessness. Suicidal depression. Serious psychosomatic disorder (complaints of illness without medical basis). -Hallucinations, fits, phobias.

4.6. Physical reaction to trauma

- Aches and pains e.g. headaches, chest pains, stomach aches.
- Heart pounding, nausea, trouble breathing, and chest pain.
- Having trouble falling or staying asleep.
- Poor appetite or eating too much.
- Being in a state of hyper arousal (constantly on the lookout for danger).
- Feeling shaky or sweaty.
- Having little or no interest in sex.
- Becoming sick often, thirst, headaches.
- Panic reactions, fainting, and restlessness.
- Muscle tenseness and tremors, visual difficulties, vomiting.
- Profuse sweating, chills, shock symptoms.

4.7. Emotional reaction to trauma

- Upsetting images/thoughts about trauma.
- Nightmares (bad dreams) and/or night terrors (fearfulness once night falls).
- Feelings of aggression, fear.
- Flashbacks, grief.
- Emotional shock and mood swings.
- Inappropriate emotional response, overwhelmed.
- Poor concentration.

- Trouble thinking clearly.
- Unreal detached feelings/numbness.
- Asking oneself how a merciful God could allow this to happen.
- Feeling of shame, guilt, intense anger.
- Irritability, agitation.
- Depression, suicidal thought.

4.8. Behavioural reactions

- Actively avoiding trauma-related thoughts and memories.
- Trying to be in control of everything.
- Avoiding conversations and staying away from places, activities, or people who might remind of trauma.
- Losing interest in things that you normally found joy in.
- Substance abuse.
- Engaging in high-risk behavior, e.g. promiscuity.
- Social isolation.

4.9. Cognitive reactions to trauma

- Blaming someone, confusion.
- Poor attention, poor decisions.
- Heightened or lowered alertness.
- Poor concentration, memory problems.
- Hyper vigilance.
- Difficulty identifying familiar objects or people.
- Increased awareness of surroundings, poor problem solving.
- Poor abstract thinking.
- Loss of time, place, or person orientation.
- Disturbed thinking.
- Nightmares.
- Intrusive images.

4.10. Management of cycles of trauma

- Psychological / cognitive restructuring.
- Helping client develop coping mechanisms.
- Giving problems another world view or meaning.
- Management or mainstreaming of safety.
- Unpacking new roles, viewing self as survivor and not victim or aggressor.
- Unpacking emotional baggage.
- Reframing to help client have another meaning of situation.
- Normalizing the situation.
- Breaking the cycles through the healing process (see diagrams).
- Choosing an appropriate counselling model.
- Identifying level of trauma.
- Checking physical and psychological condition, normalising and supporting reactions, e.g. shock.
- Allowing display of feelings (catharsis) and handling feelings of loss and their intensity. Help overcome feelings of isolation and stigmatisation by reconstructing meaningful social connections**.**

Group discussion

Group activity: In groups of four, identify and discuss other trauma management strategies in the context of peace, migration, and displacement.

UNIT 5

MULTIPLE WOUNDS PHENOMENON

5.0. Introduction.

The concept of the multiple wounds phenomenon is considered important when working with IDPs, migrants, returnees, and their communities. This is as they would have experienced a number of different traumatic events which might have contributed to their migration or displacement. This unit explains what the multiple wounds is, its effects, and the PSS counsellor's role when providing PSS to the participants.

Objectives

By the end of this unit, participants or learners should be able to:

- Explain in brief and simple terms the concept of multiple wounds phenomenon as it relates to traumatic experiences among IDPs, returnees, migrants, and their communities.

Suggested training session delivery method:

- Lecture.
- Demonstrations.
- Role plays.
- Group discussions.

5.1. Defining multiple wounds

- Working with the multiple wound phenomena means accepting that the wounds are collective as well as personal.
- Trauma and pain afflict not only individuals but a whole group.
- When they become widespread and ongoing, they affect entire communities and even the country as a whole.
- It was discovered that while the traumatized express their fears and concerns about the traumatic event, they have a greater need to talk about other losses that they had never voiced before.

5.2. Effects of multiple wounds

When a person has a number of unresolved personal traumas:

- They become aggressive and isolate themselves.
- They lose the capacity to communicate with others.
- Their flexibility and tolerance levels are enormously reduced.
- Their ability to function adequately becomes affected.
- Expression of traumatic emotions differs for men and women based on gender socialization.
- Men are often allowed to express anger, and even violence, but not fear, guilt, or sadness, and they are often not allowed to cry. On the other hand, women are often socialised to express guilt, but not rage, and are more often allowed to complain and cry.

5.3. The role of the PSS counsellor.

- Identify the unprocessed trauma in a client and assist them in dealing with it.
- Assess the different manifestations of the multiple wounds phenomenon, which are social, behavioral, as well as personal.
- Explore the cultural and gender components of how the client deals with trauma or expresses pain.
- Have a clear picture of the traumas and pain the client went through and find best ways possible to empower them to deal with it.
- Refer for further management by other specialized mental health service providers.

5.4. Conclusion

As the PSS counsellor offers trauma healing counselling, there is need to consider other hindrances and unprocessed traumas so as to adequately ensure complete healing.

UNIT 6

COGNITIVE BEHAVIOURAL THERAPY

6.0. Introduction

This chapter briefly introduces the concept of cognitive behavior therapy as a psychological approach that has proven to be very effective for a wide range of psychosocial problems. Participants and therapists work together, once a therapeutic alliance has been formed, to identify and understand problems in terms of the relationship between thoughts, feelings, and behavior.

Objectives

By the end of this unit, participants or learners should be able to:

- Describe the concept and practice of cognitive behaviour therapy.
- Explain post-traumatic stress disorder and the application of CBT in managing it.
- Explain what trauma-focused cognitive behavioural therapy (TF-CBT) is.
- Apply the basic concepts CBT in therapeutic situations when helping individuals of families who are traumatised and presenting with PTSD.

Suggested training session delivery method:

- The facilitator can introduce the topic by soliciting for participants knowledge and experience in the use of CBT.
- Lecture method with intermittent question and answer approach to the concepts outlined below.
- Group discussions.
- Use of flash cards to introduce concepts and definitions.
- Role plays used intermittently to reinforce therapeutic concepts.

6.1. What is CBT?

CBT Stands for cognitive behavioural therapy. It is used for a whole range of mental health problems and, increasingly, to develop the mental health and resilience of people who have particular problems. It was originated in the United States by Aaron T. Beck in the late 1970s and has developed since then. Its goal is to change patterns of thinking or behavior that are behind people's difficulties, and so change the way they feel. Cognitive is the mental process that people use to remember, reason, understand, problem solve, and judge things. Behaviour describes your actions or reactions to something. CBT aims to help you change how you respond to situations or emotions (White 2001). The approach usually focuses on difficulties in the here and now. It therefore relies on the therapist and client developing a shared view of the individual's problem. This then leads to identification of personalized, usually time-limited, therapy goals and strategies which are continually monitored and evaluated.

6.2. Goals of CBT

- To change particular behaviors efficiently and specifically.
- To help participants understand how their thought patterns may be contributing to feelings of depression or anxiety.
- To assist participants to learn new behaviors.
- To replace irrational thinking with more rational thoughts.
- To assist the individual client in attributing improvement in their problems to their own efforts, in collaboration with the CBT counselor.
- To improve communication and reduce problem behaviors.

6.3. The process of a CBT session

A CBT counselling session will cover the following:

- Ask about the client's traumatic experiences and what prompted the person to seek counselling.
- Ask what they expect to get out of the counselling process.
- Check things that are currently contributing to experiencing post-trauma disorders, either directly or indirectly.
- Formulate a plan for helping the client. Do this together with the client.
- As the sessions progresses, assess and measures progress towards the desired change.

At each of those stages the therapist will be thinking in terms of five areas as follows:

Things to consider	Comment
Emotions.	Sad or happy, worried or relaxed, irritable or laid back, feeling ashamed, feeling guilty, and any other feelings.
What you do.	That is, how you spend your time, and anything you do that may affect your problem, for better or for worse.
The thinking processes.	Occasionally, it is not so much events themselves that bother individuals, but the view they take of them.
Physical factors.	For example, sleeping patterns, eating habits, exercising, and any possible illnesses that may be affecting the participants.
The environment.	This can mean physical surroundings but also the people around the client; that is the friends, family, work colleagues, neighbours, etc.

Table 2 – Things to consider during a CBT session

6.4. CBT techniques

The following are some of the techniques that can be used by a PSS counsellor when helping IDPs, migrants, returnees, and their communities deal with trauma.

Behavioural experiments:	Identifying thought patterns that influence behaviour. Participants intentionally “try out” specific ways of thinking and observe the outcome behaviours. This helps participants gain a deeper awareness of their patterns of thinking.
Relaxation and mindfulness:	Progressive muscle relaxation (PMR) involves the systematic tensing and releasing of each muscle group. Mindfulness meditation involves clearing the mind and focusing on the sensations and thoughts in the moment, observing them, and allowing them to pass. Deep breathing is taught and practiced at a rate of approximately four seconds each for inhaling and exhaling.
The SOLVED technique:	S – *Select* a problem that the client wants to solve.

	O – *Open* your mind to all solutions. Brainstorm all the options with your client. L – *List* the potential pros and cons of each potential solution. V – *Verify* the best solution. Decide which choices are practical or desirable. E – *Enact* the plan. D – *Decide* if the plan worked.
Journaling:	Used to identify, describe, and evaluate moods, thoughts, scenarios, and responses. Therapist and client "unpack" and explore the journal, leading to new insights.

6.5. Cognitive behaviour therapy (CBT) for post-traumatic stress disorder (PTSD)

6.5.1. Goals for trauma CBT

Trauma CBT aims to help survivors of trauma address and resolve the distress resulting from these events and ultimately decrease negative behavior patterns and emotional responses.

6.5.2. Why CBT for trauma or crisis?

The CBT approach focuses on individual automatic thoughts. It focuses on individual belief systems, assumptions about self-world, meaning, experience, and the future. CBT is therefore interpersonal and deals with one's individual style of relating to traumatic situations.

6.5.3. Barriers to trauma or crisis management

- Inability to facilitate change in one's self.
- Personal ideas about needs to avoid change to self, group, or family ideas.
- Maintaining status quo.
- Lack of motivation.
- Rigidity.
- Vague or unrealistic goals.
- Vulnerability factors like acute illness, hunger, loneliness, major life loss, poor problem-solving ability, substance abuse, major life upheavals, or circumstances including migration and displacement.

6.5.4. Therapeutic skills of the counsellor

- Engage participants and form a collaborative working relationship with them.
- Conduct a comprehensive assessment involving interview, observation, data collection, and the use of relevant clinical measures.
- Formulate a plan for therapeutic change.
- Use educational strategies and relationship skills to inform the client and encourage their active participation in decision-making.
- Monitor the effects of treatment, reinforcing and shaping client participation and modifying the treatment procedures as dictated by progress.
- Skillfully utilize the client's environment, family, and significant others (where relevant) to facilitate effective change and feedback.
- Evaluate the client's progress.
- Prepare them for increased independence from therapeutic help and termination of the counselling sessions.
- Utilize skills, knowledge, and ethical values to work effectively with participants from diverse backgrounds, understanding and respecting the impact of difference and diversity upon their lives.
- Practice high level skills in self-care and self-awareness that enable transfer of knowledge and skills to new settings and problems.
- Think critically, with ability to be reflective and evaluative.

The best way to engage a client is to demonstrate to them at an early stage that change is possible and that CBT is able to assist them to achieve this goal. A minimum of eight CBT trauma healing counselling sessions would ensure that the client heals, though there is need to take into consideration the different personal variables in the trauma healing process.

Individual assignment

Discuss the role of CBT in managing trauma among IDPs, migrants, returnees, and their communities.

Group task

1. ***In small groups of four, agree on the following for role plays: a counsellor, a client, and two observers. Take turns to take up the roles.***
2. ***What would you identify as the main challenges that a counsellor faces during therapy?***

6.6. Conclusion

In conclusion, CBT is a widely used and successful approach, which hinges on you and your therapist discussing things openly together and trying out the ideas you collectively produce. It usually results in improvements that the therapist will be keen to measure. Therapists are usually enthusiastic to ensure that you have a rewarding experience of therapy that stands you in good stead in the long term.

UNIT 7

UNDERSTANDING LOSS AND GRIEF

7.0. Introduction

When people face disruptive life events they go through the process of bereavement and grief, same as IDPs, returnees, migrants, and their communities. This is mainly due to the emotional and physical detachment from their loved ones. This unit introduces the concept of loss and grief as bereavement issues in the context of IDPs, migrants, and returnees.

Objectives

The unit shall help participants:

- Explain in brief the process of grief.
- Identify and list down the PSS skills needed in assisting IDPs, returnees, migrants, and their communities in handling grief.

Suggested training session delivery method:

- Lecture.
- Question and answer.
- Group discussions plenary

7.1. Definition of terms

Bereavement is a physical loss/deprivation of a person or object to which one is attached. (Island Hospice Manual, Zimbabwe)

Grief is the normal, universal mental processes that are set in motion by bereavement. It is a self-healing way of recovering from loss.It acts as a healing process and can be associated with physical symptoms. At times it is an intense, painful process which participants should be helped to work on through negotiations (e.g.) forced mourning.

7.2. Prolonged grief disorder (PGD)

IDPs, migrants, returnees, and their communities are at great risk of experiencing prolonged grief disorder due to the various vulnerabilities they are exposed to. PGD is the most common form of complicated grief in adults. It is different from normal grief in that the immediate grief reactions persist over time with more or less unrelieved strength, causing a considerable loss of everyday functioning. One may also observe little change or flexibility with regard to the way in which this grief is handled.

7.3. Grief manifestation/signs

Complicated grief may be observed when people:

- Have trouble carrying out normal routines.
- Isolate from others and withdraw from social activities.
- Experience depression, deep sadness, guilt, or self-blame.
- Feel life is not worth living.
- Wish to die.
- Experience numbness or detachment.
- Feel bitterness about the loss.
- Feel that life holds no meaning or purpose.
- Lack trust in others.
- Are unable to enjoy life.
- Feel tightness in the chest, hollowness in the stomach, breathlessness, weakness in the muscles, dry mouth.
- Feel confused, preoccupied; have hallucinations and are absentminded.
- Become an insomniac; have appetite disturbances.

7.4. PSS skill with bereaved participants

- Allow shock and denial. It is protective in early stages. Listen and use reflection on the past.
- Give sorrowful words, e.g. "it must be difficult to…
- Give space to talk about the loss experience.
- Encourage crying. It cleanses the heart and mind. Tears are healing.
- Help clarify and promote effective communication.

- Encourage undoing “the bond” and initiating investment in new relationships.
- Use the empty chair technique to help with unfinished business.
- Be patient with the client.
- Be available physically and emotionally to provide support.
- Encourage the client to be patient with themselves, taking time to go through grief period.
- Accept the client and their pain without judgment.

7.5. Conclusion

The greatest need for the bereaved is to have someone to share the pain, memory, sadness, and to help them to grieve at their own pace, not suppress loss. In as much as being displaced or becoming a refugee disrupts the normal way of life, the memories and relationships that existed will remain in the mind of the client. It is for the PSS counsellor to help the IDPs, migrants, returnees, and their communities deal with these emotions in order to facilitate healing.

UNIT 8

SELF-AWARENESS and SELF-CARE TIPS

8.0. Introduction

Self-awareness is an important aspect to consider when providing PSS services to communities and vulnerable groups including IDPs, returnees, migrants, and their communities. When we engage in self-evaluation, we can give some thought to whether we are thinking, feeling and acting as we “should” or following our standards and values. This is referred to as comparing against our standards of correctness. This unit allows participants to reflect on the, self, identify areas that may influence their effectiveness, and explore ways to become more effective counsellors.

Objectives

At the end of this unit, participants or learners should be able to:

- Identify their strengths and areas of continuous personal improvements.
- Explore their triggers and discuss ways of managing them to improve their effectiveness.

Suggested training session delivery method:

- Group discussion.
- Plenary.

8.1. Defining self-awareness

- Self-awareness and understanding help counselors to see things more objectively and avoid missing important information.
- Self-awareness is noticing and taking into account a wide range of aspects of the self.

This can be achieved through:

- Introspection (looking inward) or self- exploration.
- Receiving feedback about ourselves from others, about how other people define us.

8.2. Why self-awareness

Counseling is a very sensitive field because:

- It deals with people's emotions, feelings, and thoughts.
- Issues brought by participants may be similar to the counselor's experiences or someone close.
- Issues and factors that influence the counselor are same as those that influence client.
- Counselors are just as human as participants.

8.3. Aspects of the self

- The physical self.
- The private or hidden self (the part that lives in us, that only we know).
- The social or open self (the aspect of self shared by others).
- The spiritual self (belief system).
- The "blind self"(unknown to you, known by others).
- The self as defined by others.

8.4. Trigger issues

Triggers are external events that may produce very uncomfortable emotional symptoms such as anxiety, panic, discouragement, despair, or negative self-talk. Reacting to triggers is normal, but if we do not recognize them and respond to them appropriately, they may actually cause a downward spiral, making us feel worse and worse. This section is meant to help you become more aware of your triggers and to develop plans to avoid or deal with triggering events, thus increasing your ability to cope.

8.5. Possible reactions when triggered

- Focusing on own problem at client's expense.
- Breaking down, sympathizing, getting confused or lost.

- Getting emotionally involved.
- Loss of concentration; avoiding certain participants.
- Becoming angr, shouting, interrogating, aligning.
- Blaming, judging, accusing, prescribing solutions.
- Using negative facial expressions; becoming stuck.
- Imposing own belief system; clock watching.
- Minimizing client's problems.

When triggered during a counselling session:

- Acknowledge to self that you have been triggered.
- Take a break and recollect yourself.
- Can refer client so as to get best service.
- Debrief with a professional colleague to empty out.
- Know that resurfacing of unresolved issues does not mean that one is a ***bad counselor.,*** It is an opportunity to deal with unresolved issues*,* making one an ***effective counselor.***

8.6. How to become an effective counsellor

- Be aware of your trigger issues and unfinished business, and work through them.
- Seek professional counseling, to develop good psychological health or emotional stability. Help yourself first before helping others.
- Know your personal coping skills, limitations.
- Don't block your problems and feelings.
- Caring for self is as important as caring for others.

9.0. Self-care tips

9.1.1. Why self-care

- To maintain and promote own emotional, physical, mental, and spiritual well-being to best meet professional responsibilities.

- It prevents compassion fatigue, burnout, and vicarious traumatisation.

9.2. Compassion fatigue (CF)

- CF is defined as the stress resulting from helping or wanting to help a traumatized or suffering person.
- CF is a natural consequence of caring between two people, one of whom is affected by the first's traumatic experience.
- Compassion fatigue is also called compassion stress.

9.3. Why are counsellors vulnerable to CF?

- Counsellors may develop CF in the process of empathizing with the client, as they help them deal with the trauma.
- Counsellors' own traumatic experience might be similar to that of the client.
- Counsellors may have unresolved trauma or crisis.
- Counsellors may be dealing with children's trauma.

9.4. Self-care activities and restoring balance

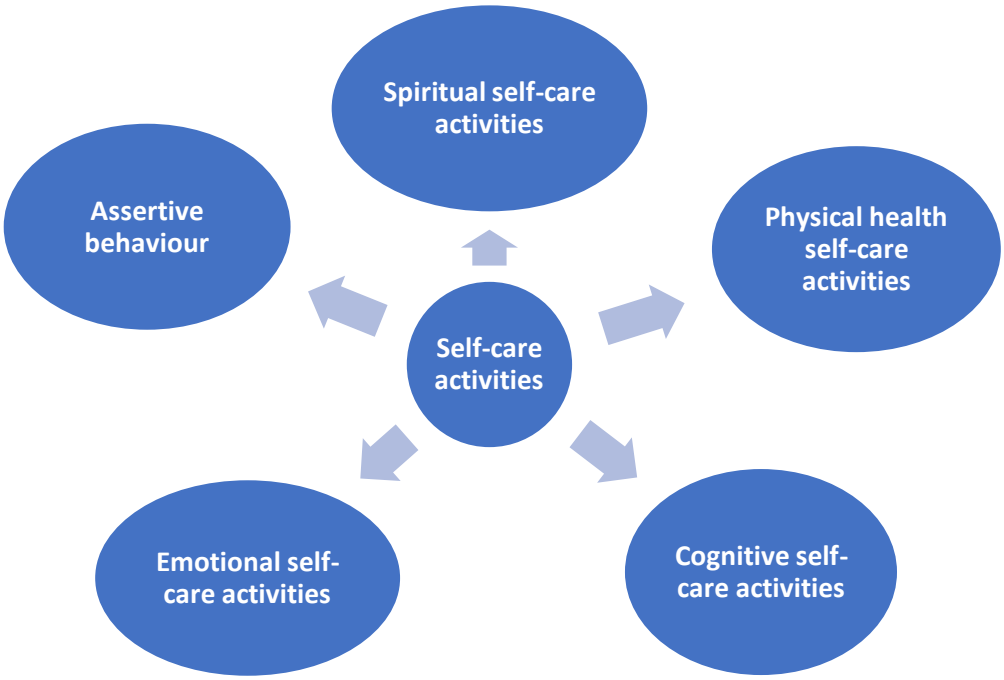


Figure – Self-care activities

UNIT 9

PSYCHOSOCIAL SUPPORT ETHICAL PRINCIPLES

9.0. Introduction

Counselling is not a neutral activity. Rather it is a profession based on values which are orienting beliefs about what is good and how that good should be achieved. On the basis of the values, counsellors and participants take directions in the counselling process and make decisions. Counsellors are guided in their thoughts and actions by moral values, professional and personal ethics, as well as legal precedents and procedures. Counsellors who are not aware of their values, ethics, and legal responsibilities as well as those of participants can cause harm to their participants despite their good intentions. It is, therefore, vital for counsellors to have knowledge of professional counselling guidelines, which are discussed in this unit.

Objectives

At the end of this unit, participants or learners should be able to:

- Identify and apply ethical principles in their practise.
- Explain in brief the process of resolving ethical dilemmas.

Suggested training session delivery method:

- Plenary.
- Group discussions and reporting back.

9.1. Defining ethics

Ethics are defined as:

- ❖ Regulations guiding the practice in a given profession.
- ❖ Behavior expectations and practice guidelines.
- ❖ Morals/rules required in a particular profession.
- ❖ Code of conduct.

9.2. Ethical principles

The code of ethics protects the participants from any abuses resulting from the mishandling of a situation or any dilemma. Familiarity with and adhering to ethical codes will not prevent the counselor from encountering circumstances that are confounding and/or confusing.

Competence	Continuing education to ensure competent service to the public.
Integrity	Trustworthy manner; honest about services, profession, and qualifications.
Respect for peoples' rights and dignity	Respect participants' rights to privacy, confidentiality, and *autonomy;* also their values, attitudes, norms, and opinions, even if they differ from yours.
Concern for other's welfare	Promote and protect the welfare of participants, and also know where to refer participants. Terminate a counseling relationship if client is not benefitting.
Social responsibility	Must be guided not by monetary gains, but by concern for client's needs. Minimize misuse of your position.
Confidentiality	Must be maintained, not sharing information that can easily lead to client identification. State limits to *confidentialit*y, such as no harm to someone.
Informed consent	Inform client of counseling conditions which include: purpose, goals, rules of proceedings, benefits, timeframe, referrals, confidentiality, and its limits.
Dual relationship	Clash of interest, when counselor has other relationship with client.
Sexual harassment	Should not engage in sexual harassment, i.e. comments or physical contacts of a sexual nature.
Sexual contact with participants	Not allowed with participants until five years have elapsed after terminating a counseling relationship.

9.3. Resolving ethical issues

- A dilemma is generally defined as a circumstance or situation that is perplexing because a decision is required between equally unacceptable or unfavorable choices (Leong, 2008).
- An ethical dilemma is defined as a situation which is caused by the chaos between two values in a decision or in circumstances when two or more options are encountered and there is a difficulty in deciding which is better, as a result

of which the existing necessities cannot be met by present alternatives (Lindsay & Clarkson, 1999).

9.4. Identifying ethical dilemmas

For most counselors, an ethical dilemma is apparent when they encounter a confounding situation in which they feel hindered in their decision making because:

- There appears to be a conflict between ethical and legal standards (Leong, 2008)
- There appears to be a conflict between or inconsistency among the ethical standards.
- The situation is so complex that the ethical codes offer little guidance (Leong, 2008).
- There appears to be a conflict between the moral principles that underlie most ethical codes.

9.4.1. Ethical dilemmas encountered

- Management of confidentiality.
- Self-disclosure.
    - This refers to a counselor's sharing of personal information to participants during or outside the counselling session.
    - With self-disclosure, boundaries can be blurred and the professional relationship compromised as the client comes to view the counsellor more as a friend.
- Multiple or conflicting relationships and dual relationships.
    - According to Ford et al, (2008) a multiple relationship occurs when a counsellor is in a professional role with a person in addition to another role with that same individual.
- Use of technology.
    - The internet can blur the boundary lines between counselors' personal and professional lives. For instance, in the case of providing online counselling.
- Issues relating to boundaries.

- ❖ Boundaries are a crucial aspect of any effective client-counsellor relationship, and they set the structure for the relationship, providing a consistent framework for the counselling process.
- ❖ For instance, in some cultures, with a grieving client, putting your hand on the client's shoulder or giving a hug shows support, but carrying out that same gesture with a client who has a history of sexual abuse would be very wrong.

❖ Transferring own values.

- ❖ This occurs when a counsellor encounters a situation which is not acceptable according to their own values, and in turn they try to interfere with the problem via their own personal values (Elliot, 2011).

❖ Lack of competency.

- ❖ This happens when a client brings an issue which is not in the counsellors' expertise.

9.5. Resolving ethical dilemmas: a decision-making model

Step 1: Develop ethical sensitivity, integrating personal and professional values.

- It is important to develop an ethical identity through education, insight into one's own personal values and beliefs, and experience.
- Be aware how these issues will impact on decision-making processes.

Step 2: Clarify facts, stakeholders, and the sociocultural context of the case.

- Take time to complete fact-finding. Not taking the time to identify the facts can lead to a mistaken line of reasoning or unsatisfactory outcome.
- Determine who the stakeholders are in addition to the client.
- Take into consideration the culture of the client to determine the ethical options for the situation.

Step 3: Define the central issues and available options.

- What are the ethical issues present? What are the available options?

Step 4: Refer to professional standards, guidelines, and relevant laws/regulations.

- Refer to the code of professional standards and guidelines.

Step 5: Search out ethics scholarship.

- Identify relevant resources and ethics literature to help inform the decision.
- Reading can help remove the emotional aspect involved in difficult decision making.

Step 6: Apply ethical principles to the situation.

- Professional literature narrows and clarifies the options available.
- Understanding ethical principles can help see patterns among unconnected situations.

Step 7: Consult with supervisor and competent colleagues.

- Be sure to describe the facts of the situation, your understanding of relevant ethical standards, your understanding of the ethics literature, and current options.

Step 8: Deliberate and decide.

- After collecting all the information needed, personally deliberate to decide which alternative is the most ethical option and develop a plan to implement your alternative.

Step 9: Inform supervisor. Implement and document decision-making process and actions.

- When you are ready to carry out an ethical decision, you need to inform your supervisor.
- Supervisors have a legal and ethical right to hear the choice and the reasons behind it.
- The client's right to privacy must still be honoured to the fullest extent possible.

Step 10: Reflect on experience.

- Reflect and provide insight.
- Reflection increases ethical sensitivity so the next ethical issue to arise will be addressed quickly and effectively.

When resolving an ethical dilemma, take note of the following:

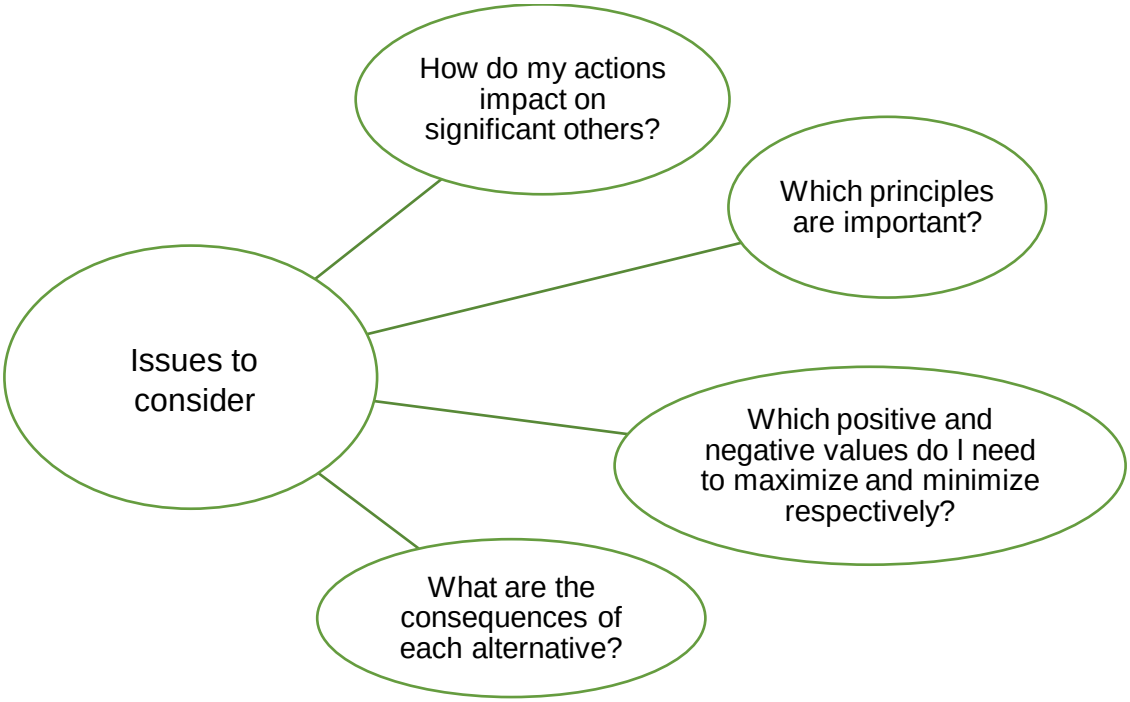


Figure 5 – Things to consider when resolving ethical dilemmas

UNIT 10

MANAGING THERAPEUTIC GROUPS

10.0. Introduction

Counselling can be provided in groups or to individuals. In trauma healing, group counselling is more effective as it allows participants to share and learn from each other their different coping mechanisms. An in-depth analysis of group sessions shall be done in this unit.

Objectives

At the end of this unit participants/trainees will be able to:

- Appreciate the fundamentals of group counselling sessions.
- Screen participants who will participate in group counselling.

Suggested training session delivery method:

- Lecture.
- Question and answer.
- Group discussions.

10.1. Objectives of group therapy

- Involves individuals who are having difficulties they wish to resolve that are of a personal, educational, social, or vocational nature (Corey & Corey, 1992).
- Deals with specific problems that members are aware of prior to joining.

10.2. Fundamentals of group therapy

- Screen potential members before accepting them. Consider their presenting traumatic problems, such as those who would have been exposed to sexual violence in their own group, children and adolescents in their own group, etc.

- The ideal group size is eight to 12 members.
- This allows participants an opportunity to express themselves without forming into subgroups.

10.3. Rules in group counselling

- Counselling groups run best when the rules governing them are few and clear.
- Rules should follow the ethical standards. Members should agree to:
    - Keep each other's confidentiality.
    - Not attack each other verbally or physically.
    - Actively participate in the group process.
    - Speak one at a time.

Time and place for group counselling:

- Members need a specific, consistent time and place to meet.
- For most groups, a group session is two hours long.
- The meeting room should be quiet and inviting and away from other activities.
- Arrange chairs in circle where everyone feels a sense of equality with one another.

10.4. Group counselling skills

- Active listening, where the counsellor is sensitive to the language, tone, and nonverbal gestures surrounding members' messages.
- Linking, where members are helped to recognize their similarities.
- Blocking, where the counsellor keeps unfocused members from disrupting the group.
- Summarizing, where members are helped to become aware of what has occurred and how the group and its members have changed.
- Empathy, personal warmth, courage, flexibility.

10.5. Benefits of group counselling

- Group therapy helps participants realize they are not alone.

- Group therapy facilitates giving and receiving support.
- Group therapy helps you find your “voice.”
- Group therapy helps you relate to others (and yourself) in healthier ways.
- Group therapy provides a safety net.

UNIT 11

MAINSTREAMING CROSS-CUTTING ISSUES IN TRAUMA MANAGEMENT AND PSYCHOSOCIAL INTERVENTIONS

11.0. Introduction

This unit introduces the participants or trainees to the concept and practice of mainstreaming cross-cutting issues in development and humanitarian work. These include psychosocial interventions within communities and CSO and welfare institutions. Innovative and technological interventions can help prevent and mitigate trauma and other psychosocial challenges faced by poor, vulnerable, and socially excluded groups. In this unit participants will be introduced to the more pertinent issues, which include gender, disability, and human immunodeficiency virus (HIV).

Objectives

At the end of this unit, participants will be able to:

- Identify ways of ensuring effective mainstreaming of gender, disability, and HIV in trauma healing.

11.1. Defining mainstreaming

Mainstreaming is the process of identifying and making the necessary changes to a development or humanitarian response programme, or to workplace practices and policies, in order to ensure that these remain relevant and effective and that they do no harm in an environment also affected by various relative factors that include poverty, gender-based violence (GBV), HIV and AIDS (Catholic Agency For Overseas Development (CAFOD, 2007).

There are two levels of mainstreaming, namely internal and external (*ibid*):

Internal mainstreaming	**External mainstreaming**
This involves adapting workplace policies and practices to ensure that the work of the organisation: • Remains effective if the capacity of the workforce has changed because of e.g. GBV, abuse and/or HIV and AIDS.	This involves designing or modifying all programme responses to ensure that these: • Remain effective and relevant when the changed capacity and needs of communities affected by GBV, abuse, and exploitation and HIV are taken into account.

• Does not increase the vulnerability of staff members or participants to GBV, abuse, and/or HIV or the impact of AIDS.	• Do not increase people's vulnerability to abuse, GBV, HIV infection, or the impact of trauma and AIDS.

Table 3 – Levels of mainstreaming

Mainstreaming is not about:

- Making everyone do gender, disability, or HIV-focused work or become gender, HIV and AIDS, or counselling experts.
- Diverting people away from their core business.
- Inserting a disability, gender, or HIV component into every programme response or workplace policy.
- Making changes to programme or employment issues that apply only to people identified as living with or affected by HIV, GBV, trauma, disability.
- Claiming to consider gender, disability, and HIV but ignoring them in reality and continuing with business as usual.

11.2. Rationale for mainstreaming

The overall purpose of mainstreaming is about acknowledging the reality and existence of various psychosocial problems that come with cross border movements, migration, and displacements and how they have affected and will affect the foreseeable future and people's ability to respond to the challenges of poverty, injustice, humanitarian crisis, and food insecurity. Hence failure to mainstream these cross-cutting issues will:

- Make broader development, agriculture, peacebuilding and humanitarian relief work increasingly irrelevant and ineffective in communities affected or threatened by socio-economic and political instability exacerbated by poverty.
- Affect the longer-term sustainability of program interventions.
- Unwittingly exacerbate the effects of trauma on individuals and communities and increase people's vulnerability to various psychosocial problems.
- Examples of strategic mainstreaming:
    - Accelerating HIV, gender, disability, and human rights mainstreaming and strengthening of community participation.
    - Strengthening the involvement and participation of youths, women, people living with HIV, people with disabilities.

Remember, we are mainstreaming because the returnees, migrants, IDPs, and their communities experience some of the following:

- Poverty and economic instability.
- Reduced labour capacity.
- Decreased mobility and increased care needs.
- Vulnerability to GBV, including sexual violence and exploitation.
- Increased susceptibility to HIV infection, COVID-19.

- Vulnerable to stigmatisation.

11.3. Closer look at gender mainstreaming

11.3.1. Defining gender

Gender refers to the socially-constructed roles, responsibilities, and power relations between women, men, girls and boys which are based on their sex. Gender-based roles and responsibilities are changeable over time and can vary due to key factors such as ethnicity, economic class, religion, and age.

Gender is defined as, “the relations between men and women, both perceptual and material. Gender is not determined biologically, as a result of sexual characteristics of either women or men, but is constructed socially. It is a central organizing principle of societies, and often governs the processes of production and reproduction, consumption and distribution” (FAO, 1997).

11.3.2. Gender equality

- Implies that all human beings, women and men, girls and boys, should enjoy equal rights opportunities and treatment in all spheres of life.
- They should be free to make choices about their behaviour and aspirations and define the practical and strategic gender needs and interests without being limited by rigid gender roles, stereotypes, and prejudices.

11.3.3. Gender equity

- Measures for gender equity seek to ensure more fairness in treatment and opportunities for women and men according to their interests and respective practical and strategic gender needs. Such measures are strategies used to achieve the goal of gender equality**.**

Given the above, gender mainstreaming means making the necessary adjustments to the working and community environment so that both men and women enjoy equality in the manner in which their issues and concerns are adequately addressed without prejudicing the other sex. Gender mainstreaming is also regarded as the process of assessing the effects and implications of programme practices, projects, and policies on women and men, as well as formulating and implementing strategies that are spatially and temporally specific.

11.3.4. Guidelines for gender mainstreaming

An intervention’s gender content should reflect the following elements:

- The diversity of the population: There is need to recognize the differences that exist in the target population's economic activities, as well as age, sex, level of education, and the differences in men's and women's access to productive resources.
- Family strategies: Family members view and understanding of their well-being. It means identifying the positions of men and women separately and engaging in an in-depth analysis of their differentiated needs that are also influenced by variable factors that include culture, religion, and context, including the general socio-economic and political situation they are subjected to.

11.4. Strategic conditions for gender mainstreaming implementation

- Selection of project staff: Whilst exercising equality at all times, there is need to select staff on the basis of their understanding of gender dynamics in communities as well as their attitudes for any technical and management positions.
- Intervention in communities should be needs, community, and gender sensitive.
- Address direct questions as to how men and women are affected differently and their reactions to traumatic experiences.
- Provide systematic training in gender issues among project staff.
- Ensure gender disaggregated data.

Individual exercise

1. You are in a therapeutic session. How do you ensure the effective use of a gender lens?

2. You have been recently assigned a task of working with a group of returnees and migrants in Beitbridge and Musina respectively. Describe how you would put in place social protection measures for the welfare of these returnees and migrants. using gender lenses.

Group discussion

What interesting observations can you identify from this understanding of disability compared to the definition of gender?

11.5.1. Understanding disability

When one looks at disability, there are issues of human rights, the ways in which people may be excluded socially, and lack of access to resources or exposure to poverty. Disability can be considered multi-dimensional in outcome, and it may arise as a result of the social and physical environment on the actual or implied condition.

The Disabled World (2014) classifies disability in accordance with the way people view persons with disability; namely, the social and the medical models of disability. An understanding of the two models necessitates effective disability mainstreaming in any given context. Disability cannot simply be categorized as a medical and physical condition affecting people. It may be the social and environmental issues that dominate. Disability can be considered in the context within which people view the disability.

11.5.2. The medical model of disability

The medical model looks at disability as a problem of the person, directly caused by disease, trauma, or any other health condition which therefore requires sustained medical care provided in the form of individual treatment by professionals. In the medical model, management of the disability is aimed at a "cure," or the individual's adjustment and behavioural change that would lead to an "almost-cure" or effective cure. In the medical model, medical care is viewed as the main issue*. (ibid)*

11.5.3. The social model of disability

The social model looks at disability as a socially created problem and a matter of the full integration of individuals into society. In this model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence, the management of the problem requires social action and is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities. From this perspective, equal access for someone with an impairment or disability is a human rights issue of major concern.

11.5.4. Practical situations relating to disability

The following are examples which reflect disability exclusion during an intervention.

- Production of hand-outs or any IEC materials in a small font without considering those with visual challenges.
- Not providing hand-outs or notes prior to a training or session to accommodate members who are likely to have a slower processing and writing speed.
- Organising a meeting at a venue which is not accessible to the disabled members.
- Conducting a session with members with hearing impairments without a sign language interpreter.

Group work/plenary

1. ***Discuss ways in which you can ensure that as a psychosocial support counsellor, you embrace disability mainstreaming in your respective areas of work.***
2. ***What challenges do you normally face in communities and how do you overcome them?***

UNIT 12

MONITORING AND EVALUATION

This topic aims at assisting participants develop a monitoring, evaluation, accountability, and learning (MEAL) framework for monitoring purposes. Specific indicators shall be agreed on.

Objectives

To be able to:

- Identify the programme or project planning cycle and its stages.
- Make use of the logical framework tool for planning programmes and or projects.

Suggested training session delivery method:

- Group work: Larger group discussion.
- Lecture: Question and answer.

Introduction

Unit 3.1 is founded on the understanding of the concepts and definitions of planning, portfolios, programmes, and projects. Having gone through the basic information on trauma management and psychosocial support and mainstreaming of key and cross-cutting development issues, it is a logical step for the trainee and practitioner to go through some basics in planning, monitoring, and evaluation. This is a way of providing the means of applying the knowledge and skills acquired in the earlier chapters.

Group task and plenary

With the support of the MEAL officer, participants should develop a logical framework with specific indicators for monitoring each of the key elements of the logical framework which include: inputs, outputs, outcomes, and impact.

APPENDIX 1

CASE MANAGEMENT

Referrals

Reasons for referrals:

- The difficulty the client is experiencing is outside of the therapist's knowledge base.
    - If the counsellor suspects there may be a medical reason for the client's emotional state, refer the client to their doctor.
    - If the client needs some other services outside counselling, refer accordingly.
- The counsellor feels triggered.
    - The client's situation may be too closely parallel to the counsellor's own difficulties.
    - The counsellor refers and deals with the problems they are facing.
- Dual relationships.
    - If the counsellor has any other relationships with the client outside the counselling relationship, make a referral.

Group exercise

In groups of five, identify other relevant service providers (at ward, district, or province level) whomay assist in the management ofpost-trauma. Include their contact details.

Client case notes or write up.

The following are the key issues to consider when writing case notes for the client:

- Use simple and clear words.
- Leave out words that are not needed.
- Write clearly.
- Document what transpires in each and every session conducted.

Case notes templates

1. **Activity work plan.** This shall .be utilised to plan for both individual and group therapy sessions.

Activity	Target group	Timing/by When	By whom	Means of verification	Resources/support needed

Group work and plenary

In groups, develop plans that you think would best suit your situation, using the guideline below if you so wish.

Groups report back their findings.

2. Group therapy session data intake form

This tool is always to be accompanied by the full group therapy session register, with a minimum of five participants and maximum of 10. Ensure that participants give written consent. Each participant to sign confidentiality form.

Name of counsellor	
District	
Ward	
Date	
Session number	
Number of group members	

#	Name and surname of participant	Gender	Age
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

Session notes

Presenting problem / trauma issues presented	
Issues discussed	
Session summary	
Way forward	

3. Individual counselling session data intake form

This tool is always to be accompanied by the full group therapy session register, with a minimum of five participants and maximum of 10. Ensure that participants give written consent. Each participant to sign confidentiality form.

Name of counsellor	
District	
Ward	
Date	
Session number	
Name of client	

Session notes

Presenting problem / trauma issues presented	
Issues discussed	
Session summary	

Way forward	

Appendix 2 – Post traumatic stress disorder screening tool

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4

9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger,guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being "super alert" or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Scoring

Low 0 to 35 The client is experience low levels of PTSD; hence they may need a few trauma healing sessions to assist them in dealing with the PTSD symptoms.

Moderate 36 to 69 The client has moderate levels of PTSD; hence the need to book for more trauma healing sessions. You can refer them to join trauma healing group therapy sessions.

High 70 to 100 The client is highly affected by the traumatic event. More sessions within short spaces of time are recommended. Where necessary, refer to other mental health specialist for further management.

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