**Professional Package**

**For**

**Psychosocial Counsellors**

**Working in the BPHS in Afghanistan**

The Professional Package includes:

- ✅ **Introduction to Mental Health in BPHS**
- ✅ **Counselling skills and intervention techniques**
- ✅ **Psychopathology**
- ✅ **Basic knowledge of psychology**
- ✅ **Socio-cultural-interpersonal relationships and conditions in Afghanistan**

**Counselling skills and intervention techniques**

Mental Health Department of the MoPH

Kabul-group-08

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**Kabul-group-08**

**In fall 2008 under the leadership of Dr. Alia, the head of the Mental Health Department of the MoPH of the Islamic Republic of Afghanistan the following members of the Kabul-group-08 have met for three workgroups and have worked together on the contents of this training manual to support the integration of psychosocial care into the mental health component of the BPHS.**

**Members:**

Dr. Alia Ibrahimzai, (MoPH)
Dr. Sayed Azimi, (EC/MoPH))
Dr. Aminullah Amiri (HOSA)
Dr. Sayed Ataullah (AKU)
Dr. Hafizullan Faiz (HNTPO)
Ahmad Farhad Habib (WfL)
Dr. Iris Jodi (IAM)
Kirsi Jokela (IAM)
Inge Missmahl (EC/MoPH)
Dr. Safiullah Nadeeb (WHO)
Suzana Paklar (medica mondial)
Dr. Fareshta Queedes (HOSA)
Humaira Rasul (medica mondial)
Dr. Wahid Salim (HOSA)
Dr. Bashir Ahmad Sarwari (MoPH)
Dr.Peter Ventevogel (HNTPO)
Maryam Zormaty (WfL)

Responsible for this package: Inge Missmahl
With contributions from Sarah Ayoughi, Dr. Azimi, Dr. Aminullah Amiri, Ahmad Farhad Habib, Suzana Paklar, Humaira Rasuli, Dr. Fareschta Queedes, Dr.Peter Ventevogel

## Foreword

This training material for counselling skills and intervention techniques is for training of the professional psychosocial counsellor who will work in the CHC in a close teamwork together with the MD. It also includes the standard material for the basic counselling which is limited to the first 5 hours of counselling and which aims to have a quick impact on the clients feeling of being powerless, hopeless and helpless. Those first 5 hours of counselling also aim to have a better understanding of the situation of the client and will help to avoid mistakes of premature diagnosis of mental health disorders. We hope that through the teamwork of the MD and the psychosocial counsellor a diagnosis which might have severe consequences for the patient will be given with care and we also hope that the overall care for the patient with a mental health problem improves considerably through this integrated approach.

We want to emphasise here the success of the psychosocial counselling is apart from the technical knowledge and skill depending to a big part on the trustful and confidential relationship between counsellor and client. Therefore we did not put everything in a strict treatment manual but only outlined the structure of the counselling process as a red threat, which will give the counsellor a certain orientation. But each client and each situation is different and demands a certain flexibility based on the professional basis and ethics of the counsellor.

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# Psychosocial counselling

The aim of psychosocial counselling is to enable the client who comes and seeks help to regain a state of psychosocial wellbeing:

- To be able to have good relationships
- Being able to solve conflicts
- To use his/her own and surrounding resources
- To live a meaningful life

- Nowadays many people in Afghanistan feel helpless and powerless. They feel victimised and have the feeling of having no influence on their lives.
- In a victimized state, one accepts whatever he/she faces.
- Most of Afghans feel victimized due to social/cultural restrictions and events such as war, invasions, and migration and their consequences on every day life.

The following factors play an important role in the process of victimization:

- Social factors (tradition, value, politics, war, period of dictators)
- Learned behaviour
- Climate factors

- People feel victimized by the political situation due to living in different situations of occupation, civil war and periods of dictatorship without having had possibilities to do anything about it.
- A further relevant example could be the situation of a Afghan women: According to tradition and culture they are expected to be obedient and even to tolerate violence to a certain degree.

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The possibilities of psychosocial counselling

- **Psychosocial counselling** helps to reconnect people who feel victimised to their potential and such enable them again to participate actively in their lives.
- **Psychosocial counselling** also can help people who feel socially isolated for different reasons to be able to reconnect to family and friends.
- **Psychosocial counselling** explores the relationship of somatic, depressive and other symptoms with the problem and searches for possible causes and ways how to resolve such problems.

- **Psychosocial counselling** helps to explore the resources of the person and thus reconnects people with their strong points.
- **Psychosocial counselling** helps when people cannot see a way out of a difficult family situation or other interpersonal conflicts.

**The process of counselling**

In psychosocial counselling a professional helping relationship between the counsellor and the client will be established. This relationship is built on certain skills of the counsellor and follows certain principles. Both the client and the counsellor together try to find a good and supportive way to deal with the client's problems. The counsellor should avoid being a judgmental advisor as well as showing him/her-self in a superior position. The task is to help the client to find a way how to deal with his problems in a positive and good way.

- Counselling is a process, where the counsellor and the client create a trusting and helpful professional relationship.
- The counsellor and the client together want to understand the inner reality and the suffering of the client. They want to find out what the client can do to improve and change his/her situation so he/she feels better and can participate in an active life again.
- In the process of counselling the client can discover or learn to use his/her resources as well as developing his/her own potential.
- In the process of counselling the client can learn how to approach and solve conflicts and how to create good relationships.
- In the process of counselling the client can understand that he can have influence on his life again, shape it according to his/her own value system (developing a sense of coherence)
- In the process of counselling the client can try to accept what has happened to him, and thus might be able to integrate the difficult and traumatizing experiences into his/her biography.
- Psychosocial counselling tries to integrate the family or family members as a support
- In psychosocial counselling we explore the values of the client and discuss them with him. Then he can act on the basis and in accordance to his values. This point is extremely important especially in Afghanistan, because often people act out of hurt pride and against their values.

**The first steps**

The client must understand that there is no quick way to improve his/her situation and that there is no magic stick or wonder pill, which cures immediately.

- First steps are:

1) Raising awareness for the problems and explain to the client that many of these symptoms are normal reactions to an abnormal situation
2) Explaining to the client that medication does not help to solve psychosocial problems. If someone always gets a headache when confronted with a certain problem in his/her life then the medication can only treat the symptom, but not the cause of the suffering. (For instance a pill against a headache cannot eliminate the personal experience with the difficult situation)

**Why does psychosocial counselling work?**

The human relationship between the counsellor and the client is the most important factor in counselling. We all need to have a witness for what has happened to us in our life and what we have experienced. To see and experience empathy from the counsellor helps to connect to own feelings. It helps to reassure people that their feelings and the experiences are true and had a severe impact on their lives.

Many clients with psychosocial problems retreat and are slowly getting in a social isolation within their families. Often they do not want to burden the other members of the family with their experiences. Those experiences might be connected with feelings of shame. For instance, having lost control in a very difficult situation.

We all know the suffering of being separated and of feeling alone. In some magic moments the walls of separation break-down. When psychosocial counselling works the client again might be able to connect to his own self and to his social environment as well as his potential and possibilities. This are the moment we are searching for in psychosocial counselling.

**The aims of psychosocial counselling**

- Giving security
- Calming down
- Giving support
- Giving time to listen
- Asking carefully
- Naming the problems without fear
- Discovering the resources
- Activating the social network
- Finding together a new orientation

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People with psychological problems often have to re-experience what it means to live in a good relationship. It is difficult for them to get in touch with other people, often because they do not have a good connection or access to their own feelings.

A good relationship is defined by:

- Giving and taking
- Understanding
- Patience
- Behaving in the same way one wants to be treated
- Shared responsibilities
- Being able to trust
- Being able to open oneself up and express problems and feelings

All the above mentioned necessities for establishing a good and trustful relationship depend to a big extend on the skills of the counsellor.

# Basic counselling

## I. Structure of the first 5 sessions

1) Explore and assess the symptoms and look to which category of syndromes they belong, how severe they are; have there been previous episodes, duration, treatments?
   - Screening; symptom-checklist
   - In order to find out what the client suffers from, we have to listen very carefully to what the client tells us
   - The client tries to explain his/her mental condition by describing symptoms on different levels, namely:
     a) **Physical – somatic symptoms**
     ⇒ These affect the body and physical functions, and include tiredness and sleep disturbance
     ⇒ It is important to remember that mental illnesses often produce physical symptoms
     b) **Feeling – emotional symptoms**
     ⇒ Being sad or scared
     c) **Thinking – cognitive symptoms**
     ⇒ Thinking that something terrible will happen, or that someone will harm you
     ⇒ Difficulty in thinking clearly and forgetfulness
     d) **Behaving – behavioural symptoms**
     ⇒ These symptoms are related to what a person is doing
     ⇒ Behaving in an aggressive way, attempting suicide
     e) **Imagining – perceptual symptoms**
     ⇒ These arise from one of the sensory organs and include hearing voices or seeing things that others cannot (“hallucinations”)
   - If necessary send the patient also to the MD and discuss the case with him.
2) Explore the relationship between the symptoms and the problem. Is there a psychosocial stressor behind the symptom or in a relevant context with the symptom? Identify the main stressor. Discuss the impact of the symptoms on the patients daily life, family involvement and support
   - If possible, relate the somatic symptoms to the problem
     ⇒ **When did the symptom occur first?**
     ⇒ **What was happening in your life at that time? Where there any changes?**
     ⇒ **Explore when the symptom appears and when not; can it be expected or does it happen unexpected?** (For example, the symptoms appear always after they have visited the in-laws).

⇒ **Try to explore and identify the problem which is in the background**

⇒ **How do you feel when it appears and how do you feel when the problem is not present?** (Perhaps the client feels then torn between the loyalty to the own family and the family of the husband/wife?)

- If there is any other psychosocial stressor in the background, please identify it and name it!

3) Give some psycho education regarding the connection between symptoms and problem

4) Together with the client explore the possible main complaint of the client and agree together with the client on the main complaint.

- Differentiate between, symptom, problem and main complaint.

⇒ The **symptom** may be a **somatic complaint** like a headache

⇒ The **problem** might be the bad relationship with the in-laws

⇒ The **main complaint** could be the bad relationship with the husband.

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Name the main complaint

5) Agree together with the client on a solution for the main complaint.

- The solution must be something realistic and the client must have a feeling that this is meaningful.
- There must be an observable change in the feeling of the client.
- Please be careful not to give your idea of the main complaint.

6) **Ask the client to say this sentence: "What can I do to make first steps towards the solution of my main complaint. "**

- This will help the client to feel less powerless and to start to get the feeling of being able to have influence on his/her life again.

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**Rule**

- Make sure you truly understand the problem and the main complaint and make sure you understand how the client perceives the problem.
- Empathise with the client, the client must experience and feel that he is understood and felt by the counsellor.
- Then focus more on solutions, don't focus too much on problems.

7) After you have agreed with the client on the solution to the main complaint explore together with the client how the solution for the main complaint could be reached

- <u>This can mean:</u>

a) To try a new behaviour
b) To avoid a damaging behaviour
c) To see the situation in a new light (**reframing**)

8) In the end of the session summarize what you have heard, what you have agreed on, what you have discussed.
   - By explaining the insights you have heard during this session please relate (again) the somatic symptoms to the problem and the main complaint, if possible. (When does the somatic symptom occur, when did it occur first?)

9) Agree with the client what he can do till the next meeting as a start to reach the solution of the main complaint. This means also to explore realistic possibilities for the client to influence the situation and or of gaining a different attitude towards the whole problem. It includes also self care.

10) Motivate the client to work together with you for 5 sessions, and agree on the goals, which you found in these 5 sessions.

11) After the 5 sessions evaluate together with the patient the progress, improvement or no improvement.

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- If further counselling is necessary, the client should be referred to the psychosocial counsellor in the CHC centre
- If there is a significant improvement, the counselling is finished here and the client can take advantage of support groups or other psychosocial activities in the community

12) Register the client and write a short report

13) **Ending**
   - Explore with the client the changes and improvements in his life since the beginning of the counselling
   - Look again at the relationship between symptoms and problems and explore the changes
   - Look at the main complaint and value the efforts and contributions the client has made to reduce the main complaint
   - Explore together with the client what he has learned and how he will incorporate these new abilities and behaviour in the future.
   - Assure the client that he can come back, should the symptom and problem come back and should he not be able to cope with it.
   - Ensure the autonomy and ability of the client to be in charge of his life again.

- Discuss again the resources the client has and how he/she can use them in every day life
- Assess how the client feels about ending the therapy
- Find a good ending by showing respect to the client
- Short documentation

## II. How to go on after the first 5 session

The aim at this stage is to come closer to the solution of the main complaint and to improve the overall condition of the client

1) Consider the results of the first 5 sessions! Therefore re-examine together with the client the steps: 2), 4) and 5) of the first phase.
2) If necessary send the patient also to the MD and discuss the case with him.
3) Check the symptoms! Have they changed? Have they improved? Are there new symptoms?
4) Explore and agree with the client on realistic therapy goals and ensure the commitment of the client to work together with you for another 5-8 sessions.
5) Make a treatment plan and choose a psychosocial intervention-technique depending on the indication.
6) Implement the intervention-techniques: A continuous evaluation goes on. Please assess the development in each counselling-session and write it down.
7) Explore the resources of the client and explore and explore with the client how he can integrate them in his life
8) After 5-8 sessions evaluate the progress.

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There are different options to go on:

- If the improvement is significant the client can be referred back to the community and can take advantage of support groups or other psychosocial activities in the community.
- If the improvement is visible and the compliance of the client good then there is the option to reassess, agree on new goals and continue counselling for another 5 hours.
- If there is no improvement, the client must see the MD again and have a second check up with follow up medication and ongoing support through the psychosocial counsellor, or will be referred to the DH or RH

9) Ending this phase of the psychosocial counselling
10) Short documentation of the progress and/or referral

III. Useful intervention techniques for avoiding or changing damaging behaviour and attitudes

**1) Interventions to explore the problems, attitudes and possibilities for a change in behaviour**

- Develop **fantasies** together with the client how other people would react in such a situation.
- Address **different parts** of the person (compare the chapter about ego-states) that have different ideas about the situation
  - ⇒ Explore what the different parts would say
  - ⇒ Explore which part is he most encouraging for the client.
- Try a **role play** with the client and an **empty chair**
  - ⇒ Someone he knows sits opposite to him and then encourages the client to lead a kind of imagined dialogue with this friend/mother/son/uncle....
- **Wonderquestion**
  - ⇒ **If the problem would disappear over night, what would you do first in the morning?**
  - ⇒ **What would your husband/wife/child do?**
  - ⇒ **How would they react?**
  - ⇒ **Who would be surprised most? And how would your life look like in 1 year, in 5 years from now?**

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After a new or less damaging behaviour is identified and seen as a good possibility by the client, the difficulty is to which extend the behaviour can be integrated into the real life.

**2) Interventions to encourage new behaviour**

Some helpful ideas for the counsellor can be:

- Encourage the new behaviour by emphasising and imagining the consequences of the new and old behaviour
- Explore the process of the new behaviour
  - ⇒ **"How will you do it? You will come home now, what exactly will be different after this session then before?"**
  - ⇒ Through the imagination of such situations the client will do something like a probing acting, as an exercise. This will help to encourage the new behaviour in real life.
- Be very specific and look at the situation with magnifying glasses

⇒ **„Please tell me in detail how you will do this?“**

⇒ Be careful, be specific and explore especially generalisations of the client or sentences which do not start with an „I“

- Ask directly if the client feels that he will able to do it

⇒ **“Do you feel that you have the possibility to behave in such a way? Is there anything you are afraid of, as a result of showing such a new behaviour?“**

⇒ This is a bit of a reality check by imagination the situation in advance.

- Last not least! Please use the language your client uses: Do not try to be smarter!

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Agree with the client on homework

Homework (Ideas of what the counsellor could ask the client to do):

- **Please observe which part of your life should stay as it is?**

⇒ **Purpose**: This question helps to shift the focus of attention from the problem to resources

- **Surprise your family with an unexpected behaviour. React differently to reoccuring problems and observe the reactions of the other family members and your own feelings.**

⇒ **Purpose:** To break the circle of habitual reactions and behaviour and open a door for new possibilities.

- **Please observe closely what you do normally shortly before the symptom (crying, yelling, complaining, and beating) appears.**

⇒ **Purpose:** To become more aware what triggers he appearance of the symptom. That will also help the client to develop strategies of how to avoid the trigger

- **Encourage new self-caring behaviour like doing some relaxation exercises before going to sleep, avoid self damaging behaviour and more: "Please try at least three times to do this exercise in the next week."**

⇒ **Purpose:** To make the task manageable and to encourage a slow habit building

**3) Reduction of damaging behaviour**

a) Reduce damaging behaviour or leave it totally

- For instance if the main theme the family talks about is the bad behaviour of the family of the wife then just try notto talk about them at all for the next three weeks.
- Questions will be:

⇒ What happens when the family does not talk about the in-laws for three weeks? What will they talk about instead?

⇒ Reducing damaging behaviour: Instead of smoking 10 cigarettes smoke only 5. (drugs, gambling, alcohol etc)

b) Paradox intervention: To be handled with care and only sometimes!

- Try to do more of the same
- The benefit for the client is that afterwards it is easier for the client to decide whether he wants to change this damaging behaviour or not.
  - *Casestudy: A young man has difficulties to decide even small issues. He thinks about it a lot, bothers himself and is stuck. He could be told :"When the next decision comes please discuss it with everybody extensly."*
  - *Or a man with sexual problems: „Do not touch your wife at all during the next months".*

c) Mark the transition from old damaging behaviour to a new behaviour by developing a **ritual**

- Rituals are symbolic actions which have a meaning and mark a transition from one stage to another. They convey meaning more than can be expressed in words.
- For example: Funerals, marriage etc...They happen according to a certain order, they involve doing something. Our every day life is rich with rituals: Greeting someone: „ Salam.....chub haste.....
- In counselling we use them to mark a symbolic change to emphasise the transition from one stage to another.
  - Casestudy: A young woman had been diagnosed schizophrenic because she talked to a Dschinn. Before she started talking to the Dschin she had had a very bad experience: A cousin had blamed her for being an immoral woman. He clued a photo of her together with a photo of a man the family knew and told everybody who wanted to hear it that she had a relationship with this man. The family luckily enough did not believe this story, investigated and found out that the cousin invented this story, because he himself had had a shameful experience and did not want to be alone with that. But nevertheless, the shame stayed with the young girl. The girl started to talk to the Dschinn, the Dschin always told her that she was a good girl. In the counselling session the counsellor proposed to write down the whole story and to burn it in the stove. The girl threw the paper with the written story in the stove and burned symbolically the shame. From this day on she stopped talking to the Dschinn and returned to her good moods.

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The ritual here was the writing down of the story, making it visible and then afterwards burning it in the stove, it disappeared in the fire.

- Casestudy: A man had a very bad conscience. His mother had died suddenly, while he was working in the provinces. He could not get home in time for her funeral. He also felt that he should have said some words to his mother which he had never said to her.

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An idea for a ritual here would be to write a letter to the dead mother and bury it as well.

**4) Reframing or how to change the perception of certain situations**

a) With this intervention the counsellor and the client try to observe the happenings from a different point of view, in a different light, and symbolically they put a different frame around it.

⇒ As a result the happenings or the momentary situation can get another meaning because the context of perception changes

⇒ And then the self-esteem increases and with it the ability to get out of the situation is higher.

b) An Example of the reframing technique

- *A woman who has had a very difficult life (forced marriage, when she was 16 years old, 4 children, overload of work in the house and a very bad relationship to the in-laws), is crying a lot and complaining about her bad luck and miserable life.*
- *The Counsellor uses the technique of reframing: „I find it amazing what a strong woman you are that you were able to cope with everything till today. You have given birth to 4 children, cared for them, supported them and you tried to be a good mother and wife. And now you are exhausted from this difficult life and had enough courage to come to us in order to find a solution of how to cope better with this difficult life.“*

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- It is important that such a reframing gives a significant different view to the existing perception of reality.
- For instance seeing something the client perceives as a failure in another context thus seeing it as a strong point of the client

c) A further example

- *A man is very insecure and doubty on his wife and as a result he controls her very badly!*
- Counsellor: *„I see that you really try everything to protect your family and be a good husband and father “,*then we can add after this:“ *but imagine you're your behaviour and control must feel for your wife and children?“*

d) It is important to:

- Differentiate the intention of the behaviour,
- Differentiate the perception of the behaviour,
- Differentiate the effects of the behaviour
- Have a look and explore the situation itself
- Then see it from different point of view.

**Task:** Please discuss in a small group how those points could possibly be applied to the example of the man, who is doubty on his wife.

**5) Life situations we need to accept because we cannot change them**

Interventions of the counsellor:

- Listen carefully and understand what has happened to the client
- Show empathy

  ⇒ Try to understand the emotions, to understand the emotional reactions, to understand the values of the person and the needs and wishes, but also try to understand the whole family system and the interests and emotional reactions of the other family members.

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⇒ Beware of being judgemental, as counsellors we must not share necessarily these feelings of the client but we must understand them. Even if they are not in accordance to our own value-system.

⇒ Remember, as a counsellor you have a professional helping relationship, in which you use all your knowledge, insight and empathetic understanding to help the client to cope better with the problems in his/her life.

**Task**: Think of a story about a person you have heard in your extended family, who has behaved in a way that you were judgemental about. Try to explore the reasons why this person behaved like this. Try to ask yourself how this person might have felt before and after doing what he/she did?

- Explore together with the client what this new situation means for his/her life
- Explore the resources of the client
- Try to help the client to develop an attitude with which it is possible to accept and cope somehow with the situation.
- Discuss what the client learns from these happenings

- Explore how those insights could change his attitude and behaviour

**6) Trying to transform negative feelings and energy into positive ones**

Casestudy: *A young woman was married by force to a mentally retarded man. 5 times she tried to kill herself. After having explored her deep values together with the counsellor. She found out that her main goal in life was to have a family and to care for them. Now she had a family, which was quit different from what she had imagined as a young girl. After she was able to accept this situation she started to shape her life with this family according to her own values. She started to care for her small son again and started to build a relationship with her husband as good as possible.*

**7) Transferring good and positive feelings into the present life situation**

- The problem is often, that the client feels better at the end of the session or during the session but looses this feeling of him as soon as he gets home.
- There are possibilities to anchor this good feeling:
  - ⇒ Make the feeling conscious. Talk about it.
  - ⇒ **Say: "You seem to feel much better in the moment? Where in your body can you feel it?"**
  - ⇒ **Ask the client to press the fingertip of the middle finger and thumb together, like forming a circle with thumb and middle finger. While doing this find the good feeling again in your body and reinforce it, talk about it.**
  - ⇒ **Connect the feeling and this small movement of thumb and middle finger. Do it slowly and make sure that the feeling is truly felt.**
  - ⇒ **Relax the body**
  - ⇒ **Repeat the movement of the fingers and reconnect again with the good feeling as before. Repeat this 3-6 times.**
  - ⇒ **Then reverse, first do the movement, then find the good feeling, the same one as before**

**8) Empowering the client**

- Search for the competence of the client, his strong sides
  - ⇒ Make them conscious. Talk about real life examples when the client used these strong sides
- Approach the problem with the attitude that usually there are solutions for such problems.
  - ⇒ **Danger**: When the client expects that the counsellor should solve the problem for him.

- Describe the problem in the end of the session in such a way that the autonomy and strength of the client is strengthened.
- At the end of the session offer the possibility to ask a last question:
  - ⇒ **„Is there something you have not said yet or asked me because you were not aware of it or because it is a difficult subject to approach and talk about?“**
  - ⇒ Often at the end themes which are emotionally important come up. So leave enough time for this question.

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**Important to note**

**Please use the language your client uses: Do not try to be smarter!**

**Focus on solutions and not on problems**

IV. Communication skills

In counselling it is not only important what you communicate but also how you communicate. We can easily become so absorbed in the challenge of trying to understand what is being communicated that we lose sight of how we as counsellors communicate with the client

**Being empathic** is a very important skill, which enables the counsellor to get a very differentiated and clear feeling of the inner-world of the client. It is fundamental to practise and use all the following communications skills in a successful way, as it enables the counsellor to get into a direct dialogue with the client's "real world". In afghan society empathy is a common used characteristic, as family-structures require and use it all the time! Daughters feel the pain of their mothers', when leaving the house very intensive; children also feel the expectations of there parents', as they were there own! And often these produce a very similar feeling in them-selves, so that they can understand the inner emotional world of their beloved! This empathic skill should be activated when talking to clients. Put yourself in the shoes of the client and try emotionally to understand and feel how the clients' feelings might make an impact on you. At the same time the counsellor has to be careful not to get involved to much. Being empathic does not mean to identify with the client and his problems (feeling as if you were in the same situation as the client.) At all times it is important for the counsellor to be able to discriminate between the client and his problems and his own life and problems. Therefore as a counsellor you must know yourself very well in order to be able to make this distinction. This is why we have self experience during the intensive training.

1) Attending skills

- Attending acts as a basis for listening to and observing the client
  - ⇒ Attending well to the client places you in a good position to listen to them, to both their verbal and non-verbal messages!
- There are different ways in which you can show that you are attending to the client:
  - a) **Posture**
    - ⇒ Your posture needs to be “open”, so that you signal that you are willing to engage with the client. Do not cross your arms in front of your chest
    - ⇒ Face the client directly, sit in a centred way, do not lean back in your chair
    - ⇒ Do not sit in a higher chair as your client or even behind a desk
  - b) **Eye contact**
    - ⇒ Maintain constant and direct eye contact, but do not fix the client with a stare! You should use the eye contact to demonstrate your availability
    - ⇒ Be natural and communicate your interest in you client in your own natural way

c) **Facial expression**

⇒ The client will be watchful of you and your reaction to what he says, therefore you need to be aware of the information that your facial expression might convey!

⇒ How you look should be consistent with what you are saying

⇒ You can also mirror clients by matching your expression with theirs! Letting clients see, by the concern on your face, that you have some sense of the pain they have experienced may free them to begin to access those feelings

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Attending to clients is a way of giving them your presence

2) Observing skills

- The way clients are dressed, their tone of voice, their gestures and postures will give you important information and will either confirm or conflict with their verbal messages. Use your own intuition and knowledge which comes from your feelings to gain a better understanding of the client.
- Observing clients carefully will help you to develop your understanding of them
  ⇒ You will learn to interpret the clues and cues that they give
  For example: *You will discover, while one client smiles when she is hurt, another narrows her eyes and talks angrily*
- Focusing on the incongruities and inconsistencies between clients' verbal and non-verbal behaviour makes the exploration much easier! Your observation can be communicated to the client in a careful way. This might help the client to dare to say something which he is afraid to say from himself for whatever reasons.
- Clients may not be aware either of what they are feeling or the significance of their feelings
  ⇒ You need to offer your observations in a tentative way rather than telling or informing!

Example:

⇒ **Client**: *(in a flat voice, looking round the room and sighing) Yes, I was pleased when she asked me if she could stay for three months. I get on well with my aunt.*

**Counsello**r: ***I notice that your voice sounded flat and I wonder that the sigh was saying***

**Client:** *(looking embarrassed) Well, I suppose it was saying I was pleased, and now this will sound awful, but now she's beginning to burden, and I wish she would go*

⇓

- The counsellor specifies what he/she notices and invited the client to explore the apparent incongruities between their verbal and non-verbal messages!

3) Listening skills

Listening is not just hearing what the client says. It involves attending to, receiving and understanding messages that clients are sending both by what they say and by what they do.

⇓

- Your purpose in listening is to reach a common agreement about:
  - ⇒ What concerns the client
  - ⇒ How the client experiences his/her concerns
- You will be listening "actively", which means that you are listening with purpose and communicating what you have listened to and understood

**Listening to silences**

- Communication between you and clients will continue even if one or both of you are silent
  - ⇒ You should pay attention to times of silence as they (in the same way as words) transport messages!
  - ⇒ By attending carefully in sessions, you will gain some clues about what the client might be thinking and feeling when he/she is silent. You will know whether they are uneasy, stuck, bored, or reflecting
  - ⇒ Using that information will help you to decide when and how to intervene
- You should give your client the time to be silent, as it may enable him/her to understand what is happening; provides space for reflecting; helps him/her to face their discomfort!

**Interrupting silences**

- You can break the silence by giving specific feedback on what you observed
- Or you might break silence by asking "process" questions about asking how the client is feeling in the here and now:
  - ⇒ **What are you feeling now?**
  - ⇒ **What are you thinking?**
  - ⇒ **What is going on for you at the moment?**

⇓

Process questions keep your focus on the client's current experiences in the here and now

**Listening to your own reactions**

- As you listen to the client, you yourself will be thinking and feeling!
  - ⇒ Listening to your own reactions may provide valuable clues for understanding what is happening in the session and for understanding clients themselves

- For example: ***You may be aware that you are irritated with a client and begin to pay attention to what happens between you when you feel irritated! You may share this at an appropriate time with your client, as it could help to explore the problem!***

**Hindrances to active listening**

- Issues in the counsellors' life
  - ⇒ When we have difficulties in our own life which preoccupy us, then we may be less open to others. For instance problems, which are there but which we do not want to face in our own life. Those problems are usually avoided and not addressed in the session.
  - ⇒ Be conscious about such problems in your own life, try to suspend them and thus create space for the client
- Values of the counsellor
  - ⇒ It is important that we are aware of our own values and, do not impose them on our clients
- Already preparing your reply to what the client is saying while the client is speaking
- Seeking confirmation for your hypotheses and ignoring information from the client which contradicts these hypotheses
- Becoming defensive when clients attempt to correct you
- Feeling obliged or pressed to find a solution quickly

4) Reflective Skills

Listening is important, but it is not enough! Clients need the counsellor to respond in order to know that they are being heard and understood!

- Reflective skills enable you to communicate your understanding of the client's perspective! You move in his world and you try to get a feeling for this world of your client (empathy)!
- These skills are important for building trust, encouraging exploration, and for discouraging premature judgement and focusing
  - ⇒ They enable you to communicate empathic understanding and acceptance; to check in a non-intrusive way that you have understood; with reflective skills you can structure the talk and also help to give a certain direction without imposing it on the client.

**Restating**

- Restating involves repeating back to clients single words or short phrases which they have used. This encourages the client usually to explore further

Example:

**Client:** *I felt so punished*

**Counsellor:** *Punished? (***RESTATING**)

**Client**: *Yes, I put thought and effort into that work and the reactions of the others were so cutting. I felt really down. I thought it deserved a higher mark too. I do not trust my judgement any more.*

⇓

⇒ The counsellor restated a word that was emphasised and emotionally loaded. This encouraged further response and enabled the counsellor to stay in the client's world

⇒ But it did not direct the client in a special direction, and it was not as intrusive as a question

**Paraphrasing**

- Paraphrasing is the skill of rephrasing what you understand to be the core message of the client's communication by using your own words!
  ⇒ Developing the skill involves both attending well and listening accurately
- Paraphrasing is a key skill, as it allows you to respond in an accepting and non-judgmental way
  ⇒ It also allows clients to "hear again" what they have said to you, and gives them the opportunity to understand and to modify what they have just communicated
- Paraphrasing intents to:
  1) **Check your perception of what clients have said**
  2) **Communicate the core qualities of acceptance and empathic understanding**
     ⇒ to show the client that you are with him/her, in pointing out the key statement of the client
  3) **Gain information about how clients see themselves and their concerns**
     ⇒ Gathering information without imposing a direction!
  4) **To build a trusting relationship**
     ⇒ Paraphrasing makes it possible to communicate free of judgment and evaluation, which could be really important to the client

Example:

**Client:** *I am useless! I have been arguing with myself all week. I can't make up my mind whether to take the job or not. Sometimes I think I would be mad not to take it. At other times, I think it isn't what I want.*

**Counsellor:** ***As I understand you, you are undecided. Now you have got the job, but you are not sure if you want it.***

**Client:** *Well! Now hearing you saying that, I realise I do want the job. But I am not sure I ought to take it. I feel scared of not succeeding in it. I don't want to fail*

⇓

- Paraphrasing is an excellent skill for helping clients to clarify for themselves what they mean

- Guidelines for paraphrasing:
  1) Be tentative and offer your perception of what the client has said
  2) Avoid telling, informing or defining for the client
  3) Be respectful! Do not judge, dismiss or us sarcasm
  4) Use your own words
  5) Listen to the depth of feeling expressed by the client
  6) Do not add anything to what the client says
  7) do not evaluate or offer interpretations!

**Summarising**

Using summaries enables you to bring together clear aspects of the session in an organised way, so that you and your client can look at it from the outside!

- Summaries focus on what the client has said and do not include sharing your own perception
- The most useful summaries are those which give some coherence and order to what the client has been saying!

For Example:

**Counsellor:** ***From what you have said so far, you seem to feel resentful and angry about the way in which you were treated unfairly by your inlaws. You also seem to compare yourself unfavourably with your sister in law and see your achievements as inferior to hers.***

⇓

⇒ The counsellor attempts both to review and to organise the core content of the session so far

- Summarising is a useful way to:
  1) **Clarify content and feeling**

⇒ Clients often present complicated issues and they are in distress. Therefore they usually do not organise their problems

⇒ You then might say "*I would like to check that I understand you", and then summarise what you think the client said*

2) **Review the work**

⇒ This gives the client the chance to correct or to add something

3) **End a session**

⇒ You may confirm what the client has agreed to do until the next session

4) **Priorities and focus**

⇒ Clients need help to identify what the important issues are, and to order priorities

⇒ You may draw a map that shows associations

5) Probing skills or challenging skills

- Probing skills are useful for gaining information and changing the focus in sessions
- Probes declare the counsellors perception of what is important to mention

⇒ When using probes, not the client decides on the content of the conversation anymore, as the counsellor gives the direction

⇒ The counsellor becomes more directive than when reflecting, paraphrasing or summarising!

⇓

As probing is very invasive, you should use these skills with great care! Be careful not to go into areas where you have not been invited!

- But probing is an important skill, as without it sessions may become vague or directionless

**Questioning**

- We can differentiate between the following types of questions:

1) **Open questions**

⇒ They allow to receive information and encourage clients' involvement

For example, a client who is talking about arguments with his wife, you might ask:

⇒ ***What usually happens when you argue and what happens usually shortly before?***

⇒ ***Where do you argue?***

⇒ ***How does it usually end?***

⇒ But do not ask questions, which are to broad, as they a very difficult to answer

⇒ Open questions are useful for the beginning of a session, as they give the clients' concern much space

2) **Hypothetical questions**

⇒ They invite clients to hypothesise and to become explicit about what they imagine

⇒ They are open questions that invite clients to speculate about future outcomes

⇒ They are useful for helping clients to articulate their fears and explore them in the relative safe place

⇒ They also help to visualise positive outcomes and to imagine acting differently.

- Example:

  ⇒ To a client who seems stuck and says *"I do not know"* ,

  ⇒ You might say ***"If you did know, what you would be doing?"***

⇓

⇒ The client is asked to construct an imaginary picture! Exploring that picture may give him some insight into aspects of his concerns that he is overlooking, anxious about or avoiding

3) **Why- questions**

⇒ These questions are unhelpful, as they put pressure on clients to justify or to find "causes" or "reasons"

4) **Closed questions**

⇒ These invite clients to answer "yes" or "no", and are mainly used to gain specific information therefore they have the capacity to silence the most talkative client.

⇒ There is no real exploration possible,

- You can see this in the following example:

  ⇒ **Counsellor:** ***Have you told your wife that you have applied for this job?***

  ⇒ **Client:** *No, not yet.*

  ⇒ **Counsellor:** ***Are you going to?***

  ⇒ **Client:** *Yes, eventually*

  ⇒ **Counsellor:** ***Do you think she does not like it?***

  ⇒ **Client:** *Yes, I do.*

  ⇒ **Counsellor:** ***Is it difficult for you to talk to her?***

  ⇒ **Client:** *Yes, I suppose so.*

⇒ Only use closed questions, when you want to establish certain facts or to check information!

5) **Leading questions**

- These communicate to clients that a certain answer is expected

⇒ **Client:** *Sometimes I feel so angry and frustrated when he won't stop crying, that I could scream and shake him.*

⇒ **Counsellor:** ***Are you saying that you feel like harming your son***

⇒ Leading questions do exactly what their label suggests! They control by suggesting a particular direction and by restricting the exploration

- In this way you should ask questions:

⇒ **Directly**
Avoid complicated language

⇒ **Concisely**
Be specific and brief

⇒ **Paraphrase** the client's response to check that you understand before asking another question

⇓

- Questions will have positive and negative effects
- Well-timed, clear and open questions will have several positive effects

- Positive effects of well-timed, clear and open questions:

**1)** Help clients to focus and to be specific
**2)** Help the clients to explore themselves
**3)** Assist information-gathering

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- Before using questions you should ask you yourself how the information you are asking for will help the client!
- Your purpose in questioning is to make available to clients the kind of information that will help them to gain a better insight and new perspective

**Making statements**

- Statements are often better than questions, as they are much gentler!

⇒ Use them, if you have the feeling that questions might be too intrusive

For example:
***Instead of asking: What does your husband think of the idea?***
***You might say: I wonder what your husband thinks of your idea?***

- Statements like questions are valuable for gaining information, for shifting the focus and for helping clients to be specific

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- But Statements enable you to direct the exploration with lighter touch than questioning
  - ⇒ You can be more sensitive
  - ⇒ This is useful when you are talking about themes with which the client is very uncomfortable

**Being concrete**

- This skill is important to the whole counselling process, as it helps clients to gain greater clarity about themselves, their thoughts, feelings and behaviour
  - ⇒ This is the basis for constructive change!
- The most direct ways of helping clients to talk concretely are to offer a **concrete example**

See following examples:

*A client has been talking about her lack of confidence and reports that a close friend told her that she "puts herself down".*

**Counsellor**: ***Could it be that telling yourself that you ask stupid questions is an example of how you put yourself down?*** **(closed question which offers a concrete example)**

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Being concrete also means to explore unclear situations in all aspects till they become clear to both of you.

- The key words here are:
  - ⇒ When
  - ⇒ Where
  - ⇒ How long
  - ⇒ Who else was involved
  - ⇒ What exactly happened
- Look at the situations from all sides and make sure that both of you have the same understanding.

⇓

**All these skills need to be exercised well.**
**In the counselling process they must come naturally!**
**Important is to use them in the right mixture**

## V. Resources

### What are Resources?

Resources are abilities, relationships, values and experiences, which give a person the feeling that the life is worth to live. They help to stand and to overcome difficult life-crisis. Unfortunately we often forget about the importance and power of our own resources, particularly in the moment we would need the most: when we feel overwhelmed with emotion or overstrained with all the problems and difficulties the life presents us! Instead of looking for own resources, we then tend to become desperate, negative and feel worthless, without self-esteem. To explore the resources of a client is a very efficient and powerful tool in psychosocial counselling.

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- Finding the resources of the client together with the client helps him to regain a balance which may connect him to his potential and which can bring positive changes in his feelings. If the clients perceive their internal potential and use it for themselves, then they can regain the feeling to have influence on their life again. The outlook on life changes and other people will start to relate different to them. This is a cycle of positive reinforcement.

**Types of resources in Afghan society**

**Types of resources**

| Relationships | | Religion & Spirituality | Education |
|---|---|---|---|
| ***1. Family*** | ***2. Social*** | ❖ Reliance/ Trust in ALLAH | ❖ Knowledge |
| ❖ Children | ❖ Friends | ❖ Belief in ALLAH | ❖ Understanding |
| ❖ Brother | ❖ Classmates | ❖ Submit to ALLAH | ❖ Skills and abilities |
| ❖ Sister | ❖ Teachers | ❖ Leading a religious life | |
| ❖ Husband, wife | ❖ Elders | ❖ Love | |
| ❖ Close relatives | ❖ Colleagues | | |
| ❖ Mother Father | | | |

| Culture | Natural resources | Material resources |
|---|---|---|
| ❖ Ethic/ moral values | ❖ Nature | ❖ Wealth |
| ❖ Tradition | ❖ Animals | ❖ Land |
| ❖ Art (poetry, stories, music, paintings, literature) | ❖ Beauty | ❖ House |
| | | ❖ Job |

| Positive resources | Task |
|---|---|
| ❖ Good family relations<br>❖ Education<br>❖ Having a good wife / husband<br>❖ Being brave<br>❖ Religious | ❖ Please make a list of your own resources and then explore the resources of your neighbour |

⇓

- Explore the client's previous experience and potential regarding all above mentioned types of resources.
  - ⇒ Achieving an understanding of the possible function of your client's resources can help you both to work with them! Encourage the client to use them!
  - ⇒ But never forget: the client is the expert of his life! You have the function to help the client to realize his own possibility to change and to become stronger.

**The importance of resources in changing the psychosocial state of people**

- The recognition of resources is such important, as they help:
  - ⇒ To see the positive aspects of ones life
  - ⇒ To focus not only on the negative experiences and aspects
  - ⇒ To be able to estimate what is there
  - ⇒ To feel connected to the world
  - ⇒ To increase self esteem and self confidence
  - ⇒ To recognize possible ways to get out of a desperate situation
  - ⇒ To feel that you can trust in something and that it is worth to go on
  - ⇒ To feel that there are people who love and need you

**Strategies for exploring resources**

- Look together with your client at his life in order to find happy and fulfilling moments and experiences. (memory of a family event; childbirth; an experience in nature)
  - ⇒ Therefore you could use the modified **"life-line-technique"**! (Compare to the trauma intervention). Just put a row (symbolizes the life of the client) on the floor and give the client flowers (fulfilling happenings and good experiences). Then the client can look back on his life and give attention to the positive experiences. Encourage the client to write or tell his positive biography!
  - ⇒ You also can encourage the client to sit down at the end of the day and to think of 2 small moments of the day, which were positive. If your client can not think of anything, make

suggestions! Let your client describe the day and help to find positive moments, even if it was just eating a good meal or a smile from a family member!

⇒ Always come back to the here and now by asking the client how he/she feels now and where in the body he/she feels the positive feeling. How exactly can you feel it, where.

⇒ Even evoke such good body feelings with an imagination exercise by first relaxing the client, then go back to the experience and imagine all details, guide your client by asking about the sensations, the light, the weather, who else was there. Then focus the client on his/her body

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⇒ The important factor is that the client practices the recognition of these positive experiences and starts to change his/her perception!

- Another possibility to find positive resources could be to explore who in the client's life is a trustworthy friend or relative and is willing to support your client

⇒ It is very likely that your client judges all his friends and his family in the moment due to his condition in a negative way, as your client might be in a negative or depressive mood himself! Therefore you should explore in a dialogue if the relatives are really so "bad", or if they could serve your client as a positive resource

A man describing his family in a negative way could be asked:

⇒ ***What are the wishes you have for your children's future?***

⇒ ***Do you remember how you felt, when your children were born?***

⇒ ***Can you remember moments, when you dearly loved your wife?***

⇒ ***How do you feel when you remember such moments?***

⇒ ***Can you imagine seeing your wife again in such a way as you described her now?***

⇒ ***Do you have any other way for solving the problems with your wife?***

⇒ ***Imagine how your children can change your life in future!***

⇓

⇒ By remembering the positive feelings and experiences the man might realize which huge resource his family could be to him! And he might use this as a positive resource for himself, but also tries to be a good father, and husband to his family! He might understand that the family relationships can serve as a resource to each member of the family.

- Another possibility to draw on past experiences could be to explore in which way your client coped with problems and barriers in his life so far

⇒ You could ask: **"Did you face such kind of problem in the past? How did you overcome it? Can you try that again?**

⇒ Make your client realize that he is not helpless! Demonstrate him on the past experiences that he proved his skills to cope with his life and that he can do it again

⇒ Your client should understand that staying active contains the chance to cope with problems

⇓

⇒ In this way, you remind your client of his conflict solving skills, which can have the function of a positive resource! He might feel able to transform situations, feelings, and thoughts into positive!

**Religion and spirituality**

- The holistic approach sees the human being as a unity which has an inner direction and possibility to integrate the different experiences by giving them meaning in the context of the personal life.
- Therefore it can be a possibility within the course of the counselling process to explore together with the client a possible meaning of the suffering. This meaning will greatly depend on the clients religious and spiritual values.
- Another issue in this context could be to understand the developmental tasks and chances which arise from this suffering.
- Furthermore it could be helpful to realise and discuss that the future is being created by our own lives now and by what is being done in the moment.
- In this context it might be meaningful to explore once more the resources in order to strengthen the coping mechanisms of the client and to enable him to participate actively in his life!

**Having no positive resources lead to low self-esteem and self-confidence**

- Self-esteem and self-confidence is the perception of someone about her abilities, emotions and thoughts
  - ⇒ Low self-confidence and losing self-esteem is a condition in which a person feels worthless and has lost trust in him. He might also feel in a lower position than others
  - ⇒ Often people pay more attention to negative happenings and situations in their lives!. Therefore it is very important to put the attention to positive experiences and resources!

An example may help you, how to increase self-confidence in exploring useful and available resources:

⇒ *A 35 years old woman graduated form the religious-law faculty of Kabul University. 14-15 years have passed from her marriage. She lives with her husband and her two sons*

*in an apartment. Her husband has relationships with other women. Most of the time, she is alone with her children. Her husband is paying no attention to his family (wife and children). He beats his wife, and frequently accuses her. She started to be very tired of this situation and is feeling very sad. She has lost her interest in life and cries all the time. She feels impatient, hopeless and helpless. According to her body language she looks depressed and tired. She is blaming her husband for all the issues in her life. She feels herself despised and lower than any one else.*

⇒ *A possibility could be to search for her own resources independent of her husband:*

***What are her abilities?***

***Does she have a person in the family she trusts?***

***What about her children?***

***Can she make use of her education?***

⇓

It is important to find the resources, to help the client to reduce the feeling of being worthless and helpless

# Interventions for professional counselling

## I. Intervention for depressive symptoms

### General information on depression

Symptoms of depression and unexplained somatic complaints are frequent in Afghanistan. This is shown in many studies and statistics. Behind those symptoms we often find certain life situations and psychosocial problems which are directly related to the appearance of the symptoms.

- As already demonstrated in the initial phase of the psychosocial treatment, the assessment of the situation of the client is very important.
  - ⇒ After the exploration of the relatedness of the depressive symptoms to the psychosocial problems explain and assure the client that such symptoms are normal psychic reactions to such difficult situations.
  - ⇒ Please explain that the development of such symptoms is not the fault of the client.
  - ⇒ Acknowledge that the client with such symptoms is sick and cannot function normally. Explain that it is common that the client cannot function normally in daily life and fulfil all duties as before.
  - ⇒ Please explain that these symptoms are well known for all people all over the world and that these are called **depressive symptoms.**
- You could say the following to your patient:
  - ⇒ **„It is very important to understand that it is not your fault that those symptoms developed. It is very normal that such a difficult life situation causes the soul to suffer. When the soul suffers the body starts to develop some problems. So one effective way of treatment is to have a look at those problems and to explore together how those problems can be approached, that you yourself can start to feel better."**

**Frequent psychosocial stressors relating to depressive symptoms**

1) Family conflicts or other interpersonal conflict
2) Grief, loss of family members, loss of house and property
3) Difficult life transitions: marriage, children, loss of job
4) Personal difficulties

- Be sure to be exact and patient while exploring the following issues:
  - ⇒ Always ask for feelings, thoughts, behaviour in the different difficult situations in the present and past. Apply this careful exploration also to imagined future activities.
  - ⇒ And never forget: priority is to explore the clients experience and inner world that you should try to understand.
  - ⇒ Often, when it is painful clients start to talk about other issues or generalise. Politely stop this and show your interest in what as happened to them.
  - ⇒ Encourage the clients to be open, by establishing a trustful and safe atmosphere

Possible causes/problems/psycho-social stressors of depression

**1) Family conflicts or other interpersonal conflict**

Suggested interventions:

- Analyse the type of the family conflict and the reasons for family conflicts
- When did the problem start?
- When did the depressive symptoms start?
- Identify all involved persons as well as all key persons
- Identify how these persons interact with each other, who interacts with whom and in which way
- Which problems are declared by whom?
- Outside interests? Inside interests? Relatives involved?
- The mutual expectations?
- The desired result or resolution of the conflict?
- Explore the values, tradition, culture, believes of the people involved.
- Is this a matter of honour and shame?
- Explore the positive and negative aspects of the relationships of the people involved?

**Task:** Think of the last family conflict you heard about or think of a conflict you were involved. Please go through the above mentioned points and analyse the conflict accordingly.

Most important rule:

- Having empathy with the situation and suffering of your client is important.
- While exploring the conflict do not take sides

- Sometimes it is important to take sides if there is a clear violation referring to human rights.
- You really need to explore and understand the different positions, values and interests.

- Find the stabilizing factor of the problem
  ⇒ Does everybody for instance behave as if the problem is due only to one person's behaviour?
- Find out if domestic violence is involved.
- Explore who could be a person of trust and support within the family for the client.
- Put the conflict in relation to the values the involved people have
- Relate the appearance of the depressive symptoms to the situation of the conflict
- **Draw the map of the family at the white board**
  ⇒ It is helpful to have a look from the outside at the family system.
- **Next describe the situation as it is**
  ⇒ In order to be completely sure that the counsellor and the client have the same understanding of the situation and everything is explored and said.
- Explore together with the client the desired change
- Explore the possibilities the client has to reach the desired change.
- Try to encourage the client to change dysfunctional and self-damaging behaviour in the conflict
- Explore the personal and social resources
- If the client agrees, invite other members of his family. But first of all, discuss with the client if it makes sense to invite his/her family members. It should not mean that one expects the others to solve the problem.
- <u>When family members arrive:</u>
  ⇒ Try to define rights and obligations
  ⇒ Force and violence need to be made conscious
  ⇒ Try to agree on certain arrangements which enable the family to decrease violence (contracts, agreements)
  ⇒ Name the withdrawal and the conflict solution by cutting off relationships
  ⇒ Try to exercise a dialogue
  ⇒ Be patient
  ⇒ Explore the view of the other family members
  ⇒ Help the client to explain his understanding to the other family members in an acceptable way
  ⇒ Give some psychoeducation between the relatedness of the symptom and the problem

**Task:** Describe a case you know or have heard of.
Please analyse this case and draw a family map.
Discuss this conflict according to the above mentioned points

Discuss possible solutions.

**2) Grief, loss of family members**

- In a normal grieving process depressive symptoms disappear after some months (up to 14 months).
  ⇒ Also feelings of guilt and suicidal thoughts disappear normally after some time.
- If the depressive symptoms started with the death of a close person of the client and if the client cannot stop thinking about the dead person then the normal grieving process has been disrupted.
  ⇒ It could be that other problems as a result of the death of this person are disturbing (for instance to be remarried by force, bad relationship with the in-laws, poverty...)
  ⇒ It could be that a pathological grief has been developed

⇓

- The aims of the following interventions include the encouragement of active engagement in the grieving process

<u>Suggesteted interventions:</u>

- Explore the relationship: positive and negative sides, experiences, memories, emotions that are related to the lost person.
- Encourage the expression of the emotions which are connected with these memories. Make them conscious.
  ⇒ Encourage a description of events just before, during and after the death as well as their associated emotions
  ⇒ Again encourage the expression of those emotions.
- Explore what the client was not able to tell the dead person but would like to tell now?
- Talk about the funeral ceremony
- Explore if feelings of guild and shame were involved or are involved now.
- Encourage a discussion how the lost person is memorised today, how is his memory kept alive?
- If necessary create a ritual, for saying “good by” to the dead person
  ⇒ Writing a letter, going to a shrine, clarifying some issues, where others have been involved, if necessary.

<u>After facilitation the grieving process explore the future with the client:</u>

- Explore the wishes, aims, possibilities
- Explore the resources

- Encourage new interests and new social contacts
- Explore current problems. If necessary assess the current problem as described in the „stages of counselling“ and work on that problem.

**Task:** Please discuss in a small group which difficulties people face after the death of a close family member. Also explore the traditional and religious coping strategies

**3) Difficult life transitions**

- A transition in life is a period of a life change where life circumstances change dramatically
  - ⇒ The past life is disrupted, the new life situation not yet accepted and integrated.
  - ⇒ For example: marriage, birth, separations, divorce, disabling accidents, death, loss of job, house, land, living in a new place, with new people.

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- ⇒ Such transitions can be positive or painful experiences for the person.
- ⇒ Transitions can be voluntary or involuntary
- ⇒ Usually such transitions are experienced as losses.
- ⇒ The person experiences a state of mourning.
- ⇒ Often transitions have to do with a change in the social role

For example: *A wife becomes a widow; a daughter becomes a wife.*

- ⇒ Such transitions can cause fear and helplessness.
- ⇒ Fear not to be able to fill the new role, fear of the future, fear of not being able to cope with the values in the new environment (marriage, migration).

⇓

- If a transition is involuntary or forced then the probability that the person develops symptoms of depression and unexplained somatic complaints is very high! (forced marriage, death disability).

**Task:** Please name some transitions you have experienced yourself or you know from a close relative and try to describe the process of transition.

- Other factors:
  - ⇒ New role is unclear and too difficult in the moment
  - ⇒ New role is rejected, no possibilities are seen
  - ⇒ Client can‘t let go old roles and idealises the past

⇒ Client is afraid of the opinion of the others and does not dare to approach the transition internally

⇒ Client is afraid of the future, of poverty and of drastic changes the family might impose such as marriage

- Suggested interventions:
  - ⇒ Explore the causes of the transition, what exactly happened
  - ⇒ Explore how the client sees this event
  - ⇒ How can the client try to cope with the situation
  - ⇒ Explore the appearance of the symptoms to the specific situations: when do they appear, what happens around the client in this moment, what are the expectations of the others and what does the client feel in this situation.
  - ⇒ Discuss the values the client has related to this situation (family, future plan in life, children, and religious values).
  - ⇒ Explore the personal and social resources the client has which can support him in the new life situation.
  - ⇒ Encourage the client to take good care of his/her health in this difficult period of transition
  - ⇒ Similar to the mourning process help the client to let go of the old situation accept the new situation (HEALING)
  - ⇒ Explore the possibilities of the new situation. What can the client make out of it and what are the possible chances (RENEWAL)

⇓

**Relapse**

- Old feelings of despair and hopelessness come back after a period of stabilisation.
  - ⇒ Usually this happens when new difficulties arise or when the client is health-wise in a fragile state.
  - ⇒ Take this as something normal, encourage the client to come back to you, when this happens. Usually then you can come back to the coping strategies and resources you had developed in the initial therapy phase.

**Reasons for a relapse**

- Not being able to fulfil the expectations of the family
- Issues of honour and shame
- Low selfesteem, being shy
- Not being understood, not being seen
- Traumatic experience

⇓

Those problems usually lead to a social isolation of the client

**Task:** In small groups please find examples of such personal difficulties and discuss possible resolutions of such situations

**4) Personal difficulties**

Those difficulties usually can have two origins:

**a) An inner conflict of the client between his/her own ambitions and the expectations of the family**

Suggested interventions:

- When did the problem start? Relate the symptoms to the problem.
- Relate the actual behaviour to the problem and explore how this reinforcing itself and becoming a habit (social withdrawal, social isolation)
- Explore the own ambitions and dreams of the client
- Explore the family expectations
- Discuss his values and the values of the family
- Explore a possible solution
- Increase insight into the different persons viewpoints (relate this to the discussion of the values
- Explore the resources within the clients family to be able to cope with such a problem
- Encourage the client to communicate this issue in a good way with his family
- **Do a role play with the client to exercise such a communication**
- Explore if a possible dysfunctional behaviour of the client has to do with the avoidance of the main problem.
- Help the client to make a plan for his life with a possible acceptance and support from other family members.

**b) An experience in the past, which has consequences till today**

- Issues connected with honour and shame (having lost control [personal or social]), being put down by others in public
- Issues connected to a taboo
- Unfullfilled life expectations, disrupted life
- Extreme stressful life situations (working in immigration)

- ⇓

- To talk about such issues will be very difficult for the client.

- Be careful and understanding and be very alert to avoid any judgemental attitude.
- Even if you do not communicate it, the client will feel it.

- The aim of the following interventions is to encourage the client to explore the situation. Thus to be seen and felt by the counsellor and then encouraged to take active steps to integrate this experience into the life as an event which has happened in the past and from which the client has learned something.

**Task:** In small groups please discuss some cases you know. Discuss the personal consequences as well as the effects on the families. Discuss possible ways to restore normality.

Suggested interventions:

- Explore what happened exactly, why did it happen, when did it happen and relate this to the symptoms
- Discuss the values which were involved
- Discuss the reality and life circumstances at that time
- Discuss the clients behaviour, feelings hopes fears at that time
- Explore possible alternative behaviour at that time
- Explore feelings and behaviour today,
- Explore how this event affects the client today: When, where, with whom?
- Explore what the client has learned from this experience
- Name and explore the individual and social resources
- Explore ways to restore normality now and to avoid damaging dysfunctional behaviour as well as develop new strategies

II. Trauma treatment

Three phases of a successful trauma therapy

**1) Stabilisation**

- Building a trustful relationship with the client
- Explore resources
- Explore the symptoms, the thoughts and feelings which come along with the memories
- Teach self-calming techniques
- Teach distancing techniques
- Relaxation exercises
- Develop a safe place in your imagination

**2) Confrontation with the experience (= exposure therapy)**

- An exposure therapy can only be done:
  - ⇒ With the agreement of the client to go through the whole experience again
  - ⇒ If the client is in a relatively stabile psychic state.
  - ⇒ If the client has the ability to calm himself down
  - ⇒ If the symptoms are so pressing that there is a real need for the intervention
  - ⇒ If all 4 conditions are met then follow the NET treatment

**3) Integration**

- Integration of the traumatic event in the life history
  - ⇒ Discuss questions about the meaning of life
  - ⇒ Discuss values
  - ⇒ Discuss resources
  - ⇒ Explore new aspects of the personal life, family relationships and future activities which are now possible.
  - ⇒ Explore if the client needs further support, if so what kind of support.

What is important in trauma treatment?

- For the successful treatment of trauma the following connections are important:
  - ⇒ What has happened?
  - ⇒ What have I felt?
  - ⇒ What have I thought?
  - ⇒ How have I reacted?

⇓

Only if the client can include what has happened in the narrative memory (cold memory) he can develop the feeling: „It is over!"

- Otherwise a mix of intensive memory bits along with memory gaps are active within the client (hot memory) and will continuously keep up the symptoms of memory flashbacks, avoidance and hyperarousal.
  ⇒ More and more the client develops a fear and avoidance of such intrusive memories.
- Often the clients have developed fear and anxiety and cannot bring this into a connection with a traumatic event in their life, because it has been a long time ago or because it was such a shameful experience that it was suppressed.

Case:

⇒ *A man had such a fear at night that he could not be or sleep alone in a room, who could not walk alone in the streets anymore*

⇒ *He did not remember, when it started, but he noticed that during the last 10 years the symptoms got worse and worse. All medication did not help.*

⇒ This man suffered from a traumatic experience which happened 15 years ago when the soldiers entered his house by force and he was not able to protect his family

Suggested interventions to reduce emotional stress caused by disturbing memories and memory flashbacks:

- Evoke good feelings and differentiate between those good feelings such as pleasant memories or the imagination of a safe and beautiful garden
- Define which part (ego-state) of the person has experienced this or is experiencing it right now. Make a difference between parts of the person which are healthy and parts which are suffering from the traumatic experience
- Talk about all the good moments of the last week
- Physical relaxation
- Differentiate clearly between past, present and future.
  ⇒ Counsellor: **„You are sitting here now, look around, what do you see in this room?“** or **„Can you feel the weight of your body resting on the chair?“**
- When the client starts to accuse himself, because he/she has feelings of shame or guilt, then give some psycho-education about what happens to a person who experiences such a traumatic event. This is a cognitive re-structuring of the feelings after a trauma
- Teach the client to be able to identify and observe when such feelings are coming up. Search for ideas together with the client about what he/she can do when this feelings starts to come up.
- Search for the resources of the client and help to activate them

- If the fear is too big then medication might help as a transition

⇓

Make sure that the client can use such a technique for him-self to reduce emotional stress when a memory flashback comes during every-day-life.

Suggested interventions to reduce the symptom of avoidance:

- Give psycho-education and explain that avoiding is a self protection! The client wants to avoid such feelings which might come back when he remembers the traumatic experience
- Encourage the client that he/she built up again social relationships little by little. Social relationships are a factor which increases the resilience of the client.

NET Treatment (narrative exposure therapy)

**1) Lifeline exercise:**

- In this exercise the client tries to make an outline of his life with a rope, stones and flowers:
  - ⇒ Rope as a symbol for the life
  - ⇒ Stones as symbols for bad events
  - ⇒ Flowers as symbols for good events
- Instruction:
  - ⇒ **Today I would like to do a small exercise with you. I brought a rope and stones and flowers with me. The rope is a symbol of your life. Look here where the rope begins is the moment you were born. Look here we are today. This is your past and this symbolises your future.**
  - ⇒ **Now let us have a look at the stones and flowers. The stones are symbols for bad events. There are smaller stones and bigger stones. Take the big stones for the very difficult and bad events. The smaller stones for those events which were bad but not as bad as the big ones. The same goes for the flowers, there are bigger ones and smaller ones.**
  - ⇒ **Now we would like to ask you to think about your life and put the stones and flowers on the rope according to what you have experienced.**
  - ⇒ **Do you understand the exercise?**
  - ⇒ **Do you have any question?**
  - ⇒ **Do you want to start now?**
- There is a clear beginning (the birth) then the client follows his/her own life experiences and puts flowers and small or bigger stones on the rope in a timeline.
- In a next step counsellor and client look together at the lifeline the client has made. The counsellor makes a drawing of the lifeline and together with the client looks at it and they

put names to all the experiences which are symbolised as flowers and stones.

⇓

**The events, marked with flowers and stones, will be named but will not be discussed in detail!**

- In order to understand the life of the client better, the following questions must be posed for each flower and stone:
  - ⇒ Age
  - ⇒ Which emotions did the event cause: fear, sadness, happiness
  - ⇒ Duration of the event

⇓

The lifeline exercise should help the counsellor and the client to get an overview over all the important experiences in the client's whole life.

- As a counsellor be fearless and give confidence to the client to name the difficult situations.
- At the end of the session the counsellor can appreciate the client who had the courage to look at his life in such an honest way and how strong the client must be that he has coped with so many difficult times.
- The client together with the counsellor can draw the lifeline on a paper to keep the memory of it for the next hour.

**2) Narration**

- Look together with the client at the lifeline and encourage the client to start a narration of his life.
- The counsellor should guide the client through this process and explore all the important life events.
- Be careful not to jump back and forth in the life of the client, keep a chronological order.
- Write down the most important events, but ask for the permission of the client first and ensure him that this written document can be given to him after the end of the therapy.
- Instruction:
  - ⇒ **Thank you so much for doing the lifeline exercise.**
  - ⇒ **Now we have an important overview what has happened in your life. I can see from your lifeline that you have experienced some nice events but also some bad events. I know it is difficult to talk about the bad events because old bad feelings might come up. But at the same time I know how helpful it can be to**

**share those experiences and feelings with someone you can trust.**

⇒ **I would like to offer you to talk about your whole life now. What do you feel now? Would you like to start?**

⇒ **Let's start with your birth, what do you know about it?**

⇓

Let the client talk but at the same time use all your listening and attending skills and give your full attention to the client's story. Make sure that you really understand the different events and what they meant for the client‘s life, feelings, attitudes and his family!

- If the client speeds up the narration because a bad event is approaching or if he gets aroused while talking about a bad event
  ⇒ Slow him down; reassure the client that this experience is in the past.
- If necessary make a relaxation exercise!
  ⇒ The old feelings of fear and helplessness might come back strongly.
  ⇒ Be sure to offer the opportunity for the client to stop and calm down a bit for instance by focusing on body sensations here and now in that moment before you continue. (Use distancing techniques, breathing and relaxation exercises)
  ⇒ For example: **How did you feel in this situation? How do you feel here with me in that room right now? How did your body react in this situation - do you also feel the same way now? What did you think in that situation - take a deep breath, relax your shoulders, what do you think now?**

Coming to the hot spot, the most painful experience in the client's life:

- Ask for details some hours before it happened. This will help you to get a clearer picture and will put the event in a context.

⇓

Accept all emotional expressions of the client without a judgement. Be a safe container for it.

- Verbalise what you feel and observe (body sensations)
- Help the client to explore all feelings, body sensations thoughts and fantasies which were there at that time.
- Stay a bit in the **hot spot** until the client feels some relief.

⇓

Ask frequently how the client is feeling now. Ensure you follow the client's feelings closely and take responsibility.

- As long as there is a strong heartbeat or other signs of fear you cannot stop the narration.
- But continue with a subtle and soft exploration of this very same situation.
- Keep a good eye contact, even if it is also painful for you
- Give positive appraisal („you are doing very well“)
- Use expressive tools like painting the event or the feelings.

- Do not allow avoidance: If you start to talk about a bad event you have to talk about the whole event! Do not stop either because time is out or because the client wants to stop. Explain the client why it is important not to stop.

If you stop and allow avoidance you increase the fear of the client. This means you harm your client.

- In the end there must be a good closing down of the event and the narration of the event
- Do not restart again. Do not mix closure and exposure. One event at a time is enough, unless it was very short and your client wants to go on and you have enough time together.
- Once you start with another bad event, you must go all the way through.

⇓

- During the exposure it is normal that the client starts to get aroused. But never leave the client there. The client has to calm down, come back to the reality of the here and now.
- Make sure that the client is in control of the situation. Although you cannot stop during the exposure you also cannot force him but must find some ways how to calm the client down and ensure his further cooperation.
- Also explore with the client the meaning of the event for his life. Explore what the client has learned from this event for his life.

⇓

Be careful that the client leaves you in a calm mood without fear and anxiety.

**3) Summary: How to deal with traumatic bad events during exposition**:

- Recognize that you are discussing such a bad event by approaching a stone in the lifeline
- Slow down
- Try to connect the different memories, like in a movie
- Stay in the hot spot for a while (habituation)
- Reinforce reality, bring the attention to the here and now and put the event in the past
- Ask the client to verbalize emotions, bodily reactions, behaviour, and thoughts
- Use creative tools
- Reach a safe place at the end

- Ensure a good closure: Do not mix closure and exposure

⇓

**Never stop at the height of fear!**

Suggested techniques

**Imagination exercise to create a safe inner place:**

- Relax the client with a relaxation exercise
- Then you could guide the client into an imagination:
  - ⇒ **Now you are very relaxed, can you feel how your breath is flowing in and out all by itself?**
  - ⇒ **Observe how you are breathing out and wait till the breathing in comes by its own self**
  - ⇒ **Please, while breathing in and out calmly feel the weight of your body on the floor (chair)**
  - ⇒ **Close your eyes and imagine a wonderful garden.**
  - ⇒ **The light of the sun shines through the leaves of the Mulberry tree under which you are sitting or lying (Pause). You can hear the birds, you can smell the flowers. (Pause). In the distance you even hear someone singing a song (Pause). Can you even feel the soft and gentle breeze of the wind on your skin (Pause). Your body is warm and relaxed; you feel the peace and the joy of this place (Pause).**
  - ⇒ **This is now your garden, you are still under the tree, now you look around the garden and memorise what you are seeing (Pause). It is all yours; slowly you get up and walk to the door of the garden (Pause). You take out the key of the door and you look this garden carefully (Pause).**
  - ⇒ **Wherever you will be, in your imagination you always can come back to this garden.**

⇓

It is useful as a self-calming technique when the client starts to feel anxiety or when he gets nervous. Then he can step aside, calm himself with a breathing exercise and then imagine that he is a while in his garden.

**Muscle Relaxation Exercise (Jacobson)**

- Ask your client to sit in a comfortable position. And explain that you will put him in a state of deep relaxation. This will be achieved by teaching him how to tense and relax specific muscles in her body.
- Start by making him aware of his breathing (see breathing exercise)
- Ask the client to close his eyes and to concentrate fully on his breathing. Wait some moments!
- Then give her the following instructions:
  - ⇒ **Wrinkle your forehead. Make your eyebrows touch your hairline and hold the tension for 10 seconds. Then relax and try to feel this relaxation in your whole body. Observe where you still are feeling tense. Observe also your breath as a result of this relaxation; take your time to feel those body sensations after each of the following exercises.**
  - ⇒ **Close your eyes as tightly as you can for 10 seconds. Relax…**
  - ⇒ **Lips, cheeks and jaw: Draw corners of your mouth back and grimace for 10 seconds. Relax…**
  - ⇒ **Extend arms in front of you and clench fists very tightly for 10 seconds. Relax…**
  - ⇒ **Extend arms out against an invisible wall and push forward with all your strength your hand for 10 seconds. Relax….**
  - ⇒ **Bend elbows. Tense biceps for 10 seconds or more with increasing strength. Relax…**
  - ⇒ **Shrug shoulders up to your ears for 10 seconds or more with increasing strength. Relax…**
  - ⇒ **Arch your back off the floor or bed. In a sitting position, arch your back away from the chair. Do this 10 seconds. Relax…**
  - ⇒ **Tighten your stomach muscles for 10 seconds or more with increasing strength. Relax…**
  - ⇒ **Tighten thigh muscles by pressing legs together as tightly as you can for 10 seconds or more with increasing strength. Relax…**
  - ⇒ **Bend ankles toward your body as far as you can for 10 seconds or more with increasing strength. Relax…**
  - ⇒ **Curl toes under as tightly as you can for 10 seconds or more with increasing strength. Relax…**
  - ⇒ **Do all the last exercises now at once, contract all muscles, make some faces hold you breath while increasing the tension, hold this for as long as you can with increasing strength and then relax….and feel how all muscles are relaxing and your whole body is sinking into the floor, your shoulders touch the floor and feel**

**wide, open your mouth, the jaw falls down and start to yawn. Stay there and enjoy this feeling.**

⇓

**Ask the client if he/she feels relaxed. Ask him/her if she liked the exercise and if she learned where in her body she felt any tensions. Propose to the client to do this exercise at home.**

**Breathing exercise**

- Choose a quiet room with little noise where you will have no interruptions
- Give your client the following instructions:
  - ⇒ **Close you eyes or look at an object or on the wall. This will help you to concentrate**
  - ⇒ **After a moment, start concentrating of the rhythm of your breathing, observe your breath, especially the breathing out. Prolong gently the breathing out and wait till the breathing in comes all by itself**
  - ⇒ **Pay attention to how your body feels. Become aware of how your back feels, how you sit in your chair and in which way the bottom of your feet touch the ground**
  - ⇒ **Become aware of your breathing and inhale and exhale consciously**
  - ⇒ **Now concentrate on taking slow, deep, regular, steady breaths through the nose. Observe the rhythm of breathing in and out. Observe the pauses inbetween.**
  - ⇒ **When you exhale, imagine that you let go all tension in your body. If you feel while breathing somewhere is a barrier which disables you to breath through your whole body: then stay there! If you feel the pressure in your chest try to concentrate on it! Breath into this point and then let the pressure go in leaving the breath leave your body**
  - ⇒ **Imagine, that with every breath leaving your body: the worries, the pain, the thoughts also slowly leave you**
  - ⇒ **When you inhale, imagine that you take in new energy with each breath. You can take all this energy, as you own it!**

⇓

- **First explain the exercise, then instruct him in doing it, finally try to exercise together so that the client does not feel observed**
- **Explain that he can exercise this daily and after a while use it in a variety of**

**situations, when she/he needs to relax!**

**Distancing technique** (Especially if a flashback occurs and your client starts to really get aroused and become fearful)

- **Ask your client to observe something in the room: Colour of your shirt,**
- **Stand up and stretch together, shake out your arms**
- **Ask your client to see the event as in TV. Then with the remote control let him change the film to a black and white film, the picture becomes smaller and smaller and disappears.**
- **With the remote control bring it back but just as far as the client wants it and can bear it.**
- **Go on and play with this idea and technique. But always listen to the client and ensure that he/she is in control**

**Ensure the client of your support. Be empathetic**

## III. Interventions for obsessive-compulsive disorder (OCD)

### What is an obsessive-compulsive disorder?

**OCD**

People who suffer from OCD feel the need to check things over and over, or have certain thoughts or perform routines. This causes distress and gets in the way of daily life. This behaviour can be understood as a desperate attempt to gain control over repetitive, intrusive thoughts and feelings.

- These repeated, upsetting thoughts are called **obsessions**
  - ⇒ To try to control them, people develop rituals or behaviours, which are called **compulsions**
- People with OCD cannot control these thoughts and rituals
- Examples of obsessions:
  - ⇒ Fear of being hurt or of hurting others
  - ⇒ Troubling religious or sexual thought
- Examples of compulsions
  - ⇒ Repeatedly counting thing
  - ⇒ Cleaning things again and again although there is no obvious dirt
  - ⇒ Washing the body or parts of it over and over again
  - ⇒ Putting things in a certain strict order
  - ⇒ Checking things over and over again

⇓

- People who have these thoughts and do these rituals for at least an hour on most days, often longer
- They cannot stop the thoughts or rituals, so they sometimes miss school, work, or meetings

**Symptoms of OCD**

1) **Have repeated thoughts or images about many different things**
   - ⇒ Such as fear of dirt, or intruders
   - ⇒ Violence; hurting loved ones
   - ⇒ Sexual acts
   - ⇒ Conflicts with religious beliefs
2) **Do the same rituals over and over**
   - ⇒ Such as washing hands

⇒ Locking and unlocking doors

⇒ Counting

⇒ Keeping unneeded items

⇒ Repeating the same steps again and again

3) **Having unwanted thoughts and behaviours**

⇒ Which cannot controlled

4) **Not getting pleasure from these behaviours or rituals**

⇒ Just a brief relief from the anxiety which are caused by the thoughts

5) **Spending at least an hour a day on the thoughts and rituals**

⇒ Which cause distress and get in the way of daily life

There are different theories about why obsessive compulsive problems develop:

- One theory it that a lack of a brain chemical, serotonin, has a role in OCD
- Other theories suggest it is caused by personal experience
  - ⇒ The origins may lie in childhood
  - ⇒ One or both parents may have shown similar kinds of behaviour
- Or it may be linked to a trauma, such as being tortured, being in prison, being sexually abused.
- Personality may play a part
  - ⇒ Maybe people who are perfectionists by nature may be more prone to obsessions or compulsive behaviour

⇓

- There is no evidence for a certain theory, as many different conditions may play a role
- Try to find out when it started and what happened at that point of time in the life of the client. Such as perhaps a trauma?
- Then focus in offering the patient possibilities how to reduce this behaviour.
- In a second step look for the appropriate intervention for the other problem

Suggested intervention

The symptoms of OCD can clearly be very distressing, and if someone is performing endless rituals they will have serious impact on his/her life and on the emotional condition of your client! Therefore it is important to offer your client possibilities to reduce por even overcome the symptoms and to practise coping strategies.

**Exposure Therapy**

- First try to identify connections between thoughts, feelings and behaviour, and to help to develop practical skills to manage them

  ⇒ The behavioural element of exposure therapy should help your client to face fears and to reduce rituals (Systematic Desensibilisation)

**Systematic Desensibilisation**

- The principle of this method is the gradual imagination of feared or anxiety-producing situation, called trigger, plus the response prevention during relaxation
  - ⇒ First the client should be trained in using relaxation techniques
  - ⇒ Then the obsessive thought, feeling or compulsive acts are imagined
  - ⇒ The impulse of the usual response to the trigger is being suppressed, while relaxation is being reinforced

⇓

- This imaginal technique tries to dissolve the connection between the threatening cue and the responding act (obsessive or compulsive) in connecting the threatening cue with relaxation
- In this way the client experiences the threatening cue in a pleasant context, and may can stop the obsession to follow his/her distressing thoughts or acts!

**The course of the session**

- On average, the desensibilisation treatment requires 60/90-minute sessions, and should not be interrupted
- <u>Imagine your client has fears of dirtiness, then</u> <u>you should follow the following steps:</u>

  **1)** At first make together with your client a hierarchy list of objects or situation that trigger the obsession (to always wash him/her-self)
  - ⇒ This list could like this:
    - ❖ Shaking hands
    - ❖ Using the toilet
    - ❖ Touching garbage

  **2)** Then your client should seat or lie in a comfortable position and relax

  ⇒ Please use one of the relaxation techniques you know or as explained before

  **3)** Carefully start with exposure to situation that cause mild to moderate anxiety
  - ⇒ For instance instruct your client to imagine shaking hands with someone
  - ⇒ Probably the client will start to get anxious and the obsession to wash will make him more and more nervous
  - ⇒ Instruct him to tolerate the anxiety and to resist the compulsive desire

⇒ While doing exposure always explore your client's thoughts and feeling so that any irrational ways of thinking can be discovered

**4)** As the client habituates to these mild situations, you can gradually work up to situations that cause greater anxiety

⇒ Give positive feedback for any progress that your client has made

**5)** After the session please discuss any obstacles that your client encountered during exposure to the feared situation

**6)** Finally give your client some homework to practise exposure at home!

**7)** It is also possible to confront and to habituate the client to these triggering situation in real life

⇒ For instance you could instruct him not only to imagine the situation but also to shake hands and then to resist washing his hand immediately

⇒ But you have to check if this real-life-exposure is possible and appropriate!

⇓

- The main goal during these exposure is that the client can stay in contact with the obsessional trigger without engaging in ritual behaviours
- The client who fears dirtiness responds to the anxiety by hand-washing or cleaning rituals, increasingly should be able to resist such activities not just in the session, but also at home

  ⇒ First for hours, and then days
- The therapy continues in this way until the client is able to abstain from ritual activities altogether or at least was able to reduce them to a tolerable level

IV. Crisis intervention in conflicts of domestic violence

Victims of violence often feel great shame about the violence and blame themselves. The society also judges victims often, believing that if a person (woman) is subjected to violence she must have done something to deserve it. Therefore it is crucial, that the counsellor does not in any way have a judgemental attitude or suggests that the victim could be responsible for the violence.

Being the counsellor

**The importance to support your client**

- Work from an understanding that domestic violence includes physical, sexual and emotional abuse, and that all forms of violence can have extreme consequences (being traumatised, being injured)
- Be fearless and explicit about your position on domestic violence
  ⇒ Name the violent behaviours
- Domestic violence is recognized as a pattern of behaviour used to dominate and control or out of complete helplessness
  ⇒ Explore together with your client this pattern of control and violence!
  ⇒ Do not focus on particular incidents of the violence
- Safety of your client is very important in your work as a counsellor
  ⇒ Therefore you should express your concerns for safety:
    - ❖ Find out the level of risk and whether the violence has escalated over time
    - ❖ The client should be able to identify warning signs of up-coming violence
    - ❖ Develop strategies together with the client how to avoid the aggression or what to do to get immediately out of it once it has started
    - ❖ Give your client "contact-details" so that she can ask you for help as soon as it is escalating

⇓

If the life of your client is in danger you have to act immediately!

**The social and psychological situation of your client**

- Victims of domestic violence need to have a counsellor who listens in a non-judgmental way without pressuring them to make decisions that they are not ready or able to make!
- It is important for you as a counsellor to be aware of possible consequences victims have when leaving the house of the abusive person, even if it is just moving to the house of relatives!

⇒ Maybe a woman who decides to leave the house of violence, will get no money from her husband anymore; she will be afraid of the possibility of poverty

⇒ Maybe after leaving, there will be a lack of a safe place to go

⇒ Maybe the woman will loose her children if leaving

⇒ Maybe the violence is so severe and constant that the victim has no opportunity to act or to make decisions for herself. The victim is helpless and feels powerless

⇒ Maybe the victim receives no support from family, and friends

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- Therefore you should be very careful in your advice and action!
- Firstly, check what is going on, and what possibilities does your client have to feel safer and to improve her situation

**The social and personal circumstances of the counsellor**

- You should be aware of your own social life, and present situation so that you can recognise potential problems that may interfere with your counselling
- You should try to focus on your client, try to understand the clients experience and not to compare with your own experiences or feelings!

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**Be professional!**

Suggested intervention

Victims benefit from counselling in a way that enhances their sense of entitlement to their own thoughts, feelings and perceptions, increases their sense of control, and encourages them to make their own decisions if necessary.

**Empowerment**

- Empowerment is a process of enabling your client rather than taking a position of power by determining decisions or outcomes for the client. It gives back the possibility and ability to act and thus to take influence, to take a stance. It means also getting out of victimisation

- The client, also clients as a victim are still considered to be "experts of their own lives"

⇒ You should support them to make choices about how they would prefer to be, in contrast to their present way of being

⇒ Here we talk about both sexes. Men are also frequently victims of violence. The interventions are the same

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- **Empowerment means that you firstly provide information on options and help to reduce a sense of isolation**

- <u>Furthermore it includes:</u>
  - ⇒ Together with the client name her/his experiences and feelings
    - ❖ Naming it gives the client a context in which she/he can understand what is happening to her
    - ❖ Maybe it will be the first time expressing her feelings and hurt about it; and this helps her/him to accept herself being abused and encourages her to identify with-her body and soul again!
    - ❖ To be seen in what one has experienced can help to regain a sense of identity and to reconnect with own feelings.
  - ⇒ Make her/him understand the dominant and strong traditions and beliefs in gender-rolls supporting violence and abuse of women
    - ❖ This could help her to feel that violence is not acceptable and not a normal part of every women's' life
    - ❖ This will also give a relief to her feelings of responsibility for the person's abusive behaviour relieves
  - ⇒ Identify strategies and forms of resistance your client has employed and that are available
    - ❖ Maybe she can go into the house of her parents or a supportive relative can come to live with her in the house of violence
  - ⇒ Identify ways of challenging violence
    - ❖ Encourage you client to think about possible solutions
    - ❖ If she can not leave the situation, work on possibilities which help her to cope with the situation
    - ❖ Give her back the feeling of self-esteem!
  - ⇒ And explore together with the client
    - ❖ What is important to your client
    - ❖ Explore the values of the client
    - ❖ What are the wishes for her future
    - ❖ What would make your client more satisfied
    - ❖ What can the client do to get closer to his/her aims and realise his/her wishes

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- ❖ You can draw a picture which shows everything that makes her life worth to live!

**Resources**

- Moreover you should search for resources your client could use to cope with the situation
  - ⇒ Family and friends
  - ⇒ Does she have some skills that she could use to work somewhere
  - ⇒ Does she have special talents

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- Your client needs to feel treated with respect and she has to be sure that she will be heard and understood!
- Never forget that it is your client's right to make her own decisions which should be encouraged and respected at all timed

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The three guiding principles are: **Safety**; **confidentiality** and **respect**.

**a) Safety**

- Ensuring the safety and security of the victim should be the number one priority for all actors, at all times. Remember that the victim may be frightened and need assurance of her individual safety. In all cases, try to ensure that she is not at risk of further harm by the perpetrator, her in-laws or by other members of the community.
- If necessary, ask for assistance from police, or other law enforcement authorities, field officers, or others. If the police have a poor reputation, ask for assistance from another authority and work together so that the woman has additional support.
- Be aware of the safety and security of the people who are helping the survivor, such as family, friends, shura, community workers, and health care staff.

**b) Confidentiality**

- At all times, respect the confidentiality of the woman, and her family members and relatives.
- Share only necessary and relevant information (not all the details), with others involved in giving her help. This should ONLY be done if it is requested and agreed upon by the woman herfself. Information about such cases should never be shared with others if it includes the individual’s name or other identifying information. Information about the survivor should only be shared with third parties after seeking and obtaining the survivor’s (or their parents,’ in the case of children) explicit consent in writing.
- All written information must be maintained in secure, locked files. Information on computers should be secured with passwords and access should be limited.

- If any reports or statistics are to be made public, all potentially identifying information needs to be removed and only aggregate numbers and data can be made public.
- In meetings, there may be times when a specific case is mentioned. Ensure that no identifying information is revealed, or details given which could identify the survivor.

**c) Respect**

- Conduct interviews in private settings and with same-gender workers, wherever possible.
- Always try to conduct interviews and examinations with female staff and professionals. Or, make sure there is female support available if the interview is with other male professionals, such as lawyers and police.
- Be a good listener.
- Maintain a non-judgmental manner.
- Be patient; do not press for more information if the survivor is not ready to speak about her experience.
- Ask only relevant questions as it relates to the case.
- Avoid having the woman to repeat her story in multiple interviews.
- Non-discrimination principle: Do not laugh or show any disrespect for the individual or her culture, family or situation.

**Certain groups of women more vulnerable to experience violence**

- Many health professionals are unsure whether they should ask about violence because they feel there is little they can do about it. Some believe that violence is not a health issue. In fact, violence is as much a health issues as dirty drinking water.
- Health workers that are well trained in supporting women affected by violence should always ask women about if they feel that violence is happening in a women's home. This might be the first and only chance for her to seek for – sometimes life-saving – help.
- All women in the following groups should be screened for violence or abuse – in order to provide adequate support and to prevent further violence:
  - ⇒ women with chronic physical complaints, sleep problems, and tiredness
  - ⇒ women with mental health problems, like symptoms of depression and anxiety
  - ⇒ pregnant women
  - ⇒ women who have unexplained injuries, like cuts or bruises
  - ⇒ women who have had a miscarriage, still birth or abortion
  - ⇒ women who are suicidal or have attempted suicide
  - ⇒ women who are disabled (mentally or physically)
  - ⇒ women who are not allowed to be alone with you but are watched by their husband, father, brothers or other male relatives

⇒ women with gynaecological complaints, like sexually transmitted infections and vaginal infections.

**How to help an abused woman**

- Look for signs of physical injury, such as bruises or cuts.
- If you are a health professional trained in dealing with violence against women - do not be afraid to ask about violence. It is your job as a health professional to ask about a woman about her experiences. Most women are relieved when asked because they are often scared or embarrassed to bring it up themselves.
- Refer her to a female health professional as she might feel more comfortable.
- Because violence is a difficult subject to talk about and women may be embarrassed or scared, you have to ask these questions when she is by herself. If her husband or other family members are unwilling to leave, you can say you need to examine the woman and need to be alone with her. If the woman does not want to be alone, ask her who she feels safe with.
- Do not be in a hurry to get the information.
- Do not take sides. Listen before you say anything about how to resolve the situation.
- Do not make judgments about whether the client is right or wrong in deciding to stay with or separate from her husband.
- Do not be in a hurry to "save" the client from her situation.
- Do not show your anger to the person who has been violent.

**What to do in a crisis situation with an abused woman**

- Many women blame themselves and develop negative feelings about themselves. Reassure the woman that she is not responsible for the violence.
- If the woman has symptoms of anxiety, depression, psychological trauma or PTSD, she needs to be treated appropriately. If the depression is severe she may need medication and you have to refer her to the doctor who can prescribe antidepressants.
- If the violence is severe and you feel that the woman's life is at risk, you have to tell her that you are worried about her life being at risk and talk with her about places where she can be safe.
- Ask her to talk to people she trusts and truly care for her to make plans for the future.
- If the woman has legal problems, or wishes to make a police complaint, refer her to the appropriate authorities. It can help if you write a note describing the health issues, since the woman may not get a sensitive hearing from the police. Refer her to get legal advice for her situation and how she can protect herself in the future.

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Clearly document what the woman reports, but leave it to her, what she will do with this documentation!

## V. Support-groups and Group-therapy

### Support group

- The aim of a support group is to help people who feel isolated with their problems in giving them the possibility to:
  - ⇒ Share these with others
  - ⇒ Learn from each other
  - ⇒ Profit from the feeling not to be alone with such problems.

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- Support groups do generally not try to identify and change personal problems.
- Through the increase of personal and interpersonal awareness, people will be more able to avoid and handle personal problems themselves.

**Role of the group leader**

- The group leader is more a facilitator than a counsellor.
  - ⇒ A facilitator guides the group members to openly address their fears and expectations
- The facilitator actively works to create a climate of safety and acceptance in which the participants trust each other.
  - ⇒ Provides encouragement and support as participants talk about very personal subjects and try out new behaviours
  - ⇒ Involves as many group members as possible in the discussions and group interactions
  - ⇒ Encourages open and direct communication end encourages the expression of controversial opinions

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- The goal is to decrease the dependency on the facilitator and to increase the responsibility of the group members.

- A support group is usually an open group where other members can join in at a later date.
- It runs regularly every week at the same time.

### Group therapy

- Group therapy incorporates what has been said about support groups but goes one step further.
- The aim of group therapy is:

⇒ To help with solving emotional difficulties

⇒ To encourage the personal development of the participants

- Groups of group therapy are closed groups.
  ⇒ The same participants meet regularly for 8-10 times.
  ⇒ Those groups have a clear beginning and a clear ending.
- In a group therapy the issues are more personal and also need more confidentiality.
- The group leaders must be trained psychosocial counsellors.

**General benefits of group-work**

- Group work focuses on interpersonal interactions, so that all relationship problems are addressed in groups well.
- Other participants can contribute through their life experience and can help to give another view on a situation or on a problem
- Exploring issues in a social context more accurately reflects real life, because the other group members can react to it.
- Group work provides an opportunity to observe and reflect on own and others' social skills.
- Group work provides an opportunity to benefit both through active participation and through observation.
- Group work offers an opportunity to give and get immediate feedback about concerns, issues and problems affecting one's life.
- Group therapy members benefit by working through personal issues in a supportive, confidential environment and by helping others to work through theirs.
- <u>How group work works:</u>
  ⇒ Members of the group share with others personal issues which they are facing. A participant can talk about events he/she was involved in during the last week
  ⇒ The participant can share his/her feelings and thoughts about what happened in previous sessions, and relate to issues raised by other members or to the leader's words.
  ⇒ Other participants can react to her/his words, give her/him feedback, encourage, give support or criticism, or share their thoughts and feelings following his/her words.

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⇒ The subjects for discussion are not determined by the leader but are such issues which are mentioned and concerns of the group members.

**Skills of the group leader**

- A group leader must have the same skills as a psychosocial counsellor.

⇒ Special attention must be on active listening skills where the counsellor also absorbs the contents, notes gestures and subtle changes in voice or expression and senses underlying messages.

- Reflecting, clarifying, summarizing are most important.
  ⇒ The group leader must make sure that everyone in the group is attentive, present, heard and recognised.
  ⇒ The messages should be understood by everyone
- The attention must be all the time on the whole group.
- Additional he must know the rules for a good group work

**Overview of some general rules for the Group leader and the group**

- Try to start on time and finish on time
- Be clear if it is a closed therapy group or an open support group
- Always in the beginning establish some basic rules that are clear and obligatory:
  ⇒ Absolute confidentiality
  ⇒ Being honest
  ⇒ Being non judgemental
- Be careful that you start the group with a round in which everybody says how he/she feels; at the end of the session you should repeat that!
- Be careful that the group does not fall into a general depression through identifying with the problem of a group member
- Try to end the group with summarizing what has happened.

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**The best ending is an encouraging message which comes from a participant or from the group leader when he summarises the session for all members.**

- Encourage the participants to talk to each other and not only to you
- Structure the group meeting by carefully listening and observing the participants and the time.
- Try to always come back into the here and now.
  ⇒ This means to ask:
    - ❖ **What relevance this event has for the member today or**
    - ❖ **What relevance others can see in it for today's life.**
    - ❖ **What has been learned from this?**
    - ❖ **How could a different behaviour find better solutions for such a problem?**
  ⇒ Try to follow up also real life of the group members:

- ❖ **What is happening now or what has happened last week?**
- ❖ **Were there any effects the participants noticed after the group session?**

**Confidentiality**

- As mentioned above it is very important that the group facilitator or counsellor reminds the participants in every session that everything said in the group must be kept confidential.
- Confidence can be broken by carelessness or by malicious gossip.

  ⇒ If confidentiality is violated, the group members need to talk about it and discuss, if they can go on with this member.
- When group members talk about the group to family members who are important to them they only may talk about what they have learned in the group but they are not allowed to share personal issues of others
- Group members must establish clear rules about maintaining confidentiality. They also need to reach an agreement with each other about potential consequences of intentional or unintentional breaches.

**How to start a group session**

- In the first round everyone says how they feel and what they have in their mind in the moment

  ⇒ It is important to make clear that they should express themselves in two or three sentences.
- From those first messages the group leader usually can pick one which is either shared by more than two people or which seems to be most pressing for one member.

  ⇒ The group leader needs the agreement of the other group members that this theme should be the subject of the session.
- The Participants share what they were able to practice from what they had learned in the last session.

  ⇒ Also they may address the difficulty of adapting the learned behaviour or attitude.
- Don't forget to ask if something is still unresolved or stayed on their mind from the last session.
- <u>The following remarks can be used as a start:</u>
  - ❖ **"How is each of you feeling today?"**
  - ❖ **"Lets start to think about what has happened in your life between our last meeting and today. Is there anything important you want to share with the group?"**
  - ❖ **"What were you thinking and feeling before coming to this group?"**

**How to close a group session**

- The group leader can explore what the participants have learned from this session for their own situation.
  ⇒ It is important to make the connection between the difficulties of others and own problems.
- Participants can give each other encouraging feed back especially regarding the progress they have made.
- Topics for the next session can be discussed.
- Homework for the next session can be discussed.
  - ❖ **"What affected you at the most today and what did you learn?"**
  - ❖ **"What kind of changes you want to make until the next session?"**
  - ❖ **"Is there anything from what you have learned you want to try out till the next session?"**
  - ❖ **"What was it like to be in this group today?"**

**How to work continuously with a group**

- The group leader must be careful that the members do not repeat in cycles the same stories and difficulties without taking into consideration what already has been said and discussed and learned in the group.
- The members should exercise how to give and receive feed back from each other
- Sometimes some relaxation exercises for the whole group are useful. Afterwards you should how everybody felt and where it could be useful

**How to end a group**

- The group leader should announce in advance the date for the last group session
- Revision of what has been learned, what was the benefit of being a member of this group?
- Referrals for participants if necessary
- Important: Participants have to be reminded that changes and improvements may be slow and need constant work. Being in a group will not suddenly turn their lives around. Each participant has to take responsibility for their own lives and has perhaps seen and learned in this group that it is possible to have influence.

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- Ensure the group members that they always can come back to the health facility centre if they need further support

**Stages of development in group therapy**

- A group can go through different stages of development.
    - ❖ Usually in the beginning the communication between members seems not to be so important. Close relationships within the group do not exist. Personal feelings are not being recognized much.
    - ❖ Participants talk about their experiences and feelings as something which is in the past and which does not touch them anymore
    - ❖ Feelings and their personal meaning are being described, talked about and recognized as my own feelings.
    - ❖ Denied feelings start to be recognized and are allowed to become conscious.
    - ❖ Conflicts between the own experience and meaning for the person and the official meaning start to be accepted and seen.
    - ❖ The conflicts, which result from this, are being addressed.
    - ❖ The participants starts take the risk to relate to each other on the basis of his/her feelings
    - ❖ Participants start to be able to express their in the moment they come up. Denied feelings become conscious and accepted.

## VI. Further interventions

### 1) Prevention of suicide

Many of us feel, at some time in our life, that we have had 'enough' of living. For most people thoughts of suicide pass quickly, and are often a reaction to a recent unhappy event. For some, however, suicidal thoughts or plans become more persistent and are associated with mental illnesses and severe life difficulties.

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Suicide attempts are a part of self harm, but not all self harm are suicide attempts

- Suicide: ending one's own life.
- Suicide attempt: behaviour that was intended to die, but has not led to a fatal outcome
- Suicidal ideation: thoughts of killing on-self
- Deliberate self-harm: wilful self-inflicted acts that cause pain or injury without intent to die.

The following mental health illnesses are associated with suicide:

- **Depression:** This is the most important cause of suicide. Depression can make a person feel miserable, lose interest in life and lose hope for the future.
- **Alcohol and drug misuse:** Although many people drink alcohol and take drugs to feel better, in fact these substances make people feel worse.
- **Long-term health problems**
- **Severe mental disorders***:* People with a psychosis and mania are also at a risk of ending their life through suicide.

Further reasons:

- **Psychosocial stressors** such as forced marriages, poverty, issues of honour and shame, seeing no bright future, loss of a loved one

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**Important to note!**

If the client seems to be very depressed or desperate and if the client mentions suicidal ideas or intentions then you must be very alert and address the theme.
The worst mistake would be not to talk about it out of fear that the theme is too sensitive!

To find out if a person is suicidal, ask some questions directly but gently:.

- Do you think life is not worth living?

- Would you prefer to be dead?
- Have you thought of killing yourself?
- Have you thought about how you would do it?
- Have you tried to kill yourself or do you have plans to kill yourself?
- Ask about previous suicide attempts. Previous attempts increase the risk of further suicidal behavior

**Attempted suicide**

Questions to ask the person who has attempted suicide:

- What happened? Did you want to end your life? Why?
- Did you have a plan? How long were you planning it? Did you tell anyone else about your plan?
  ⇒ Attempts that have been carefully planned and kept secret from others are more serious.
- How do you feel now?
  ⇒ Many people are relieved that their attempt did not lead to death.
  ⇒ Those who are not relieved are more likely to try again.
- Have you been feeling depressed recently? Have you lost interest in life? (Ask these questions to detect depression)
- What reasons are there for you to continue living? This is an important way of trying to get the person to think of the good things in life. Some people are so depressed that they cannot see anything positive. This is a sign of how serious the illness is.

Judging the likelihood of further suicide attempts:

It is difficult to predict whether a person will attempt suicide again. Factors that should make you concerned about the risk of repeated attempts are:

- A serious, planned attempt, where there was an effort to hide the attempt from others and a dangerous method was used;
- Continued suicidal thoughts;
- Hopelessness about the future;
- Evidence of severe depression;
- Evidence of severe life difficulties and losses;
- Lack of social support;
- Alcohol misuse or severe physical illness;
- Previous suicide attempts;
- Older age of the person attempting suicide.

**How to proceed**

1) **The first necessity** is to gain time and to make a contract with the client that he will not kill himself within the next 4 weeks while you two are working together. Tell him that you will work together to find out how he can feel better and how the problems, which cause his suicidal ideas can be reduced.
2) **After having agreed on the contract** you can explore together the client which part of himself he wants to kill.
   ⇒ Use the idea of having different ego-states to show the client that there a parts of him which might want to live, which have plans, which enjoy being alive. Perhaps you find out that parts of the client love to see their children or love the early morning sunshine.
3) **Identify the main problem and the main complaint** start working accordingly with the client. But make sure that you always are informed about the development of his suicidal ideas. Renew the contract if necessary.
4) **Refer the client to the medical doctor to find out about an underlying mental health illness**
5) **If you feel he is at risk of harming himself again**, ask relatives to spend time with him and ensure that he is not left alone.

**Screening the suicidal risk**

- A further possibility to find out, if your client is at risk of suicide is the following screening
- Your client could fill it in at the beginning of the session

**Screening the suicidal risk**

**In the past month did you:**

C1 Think you would be better off dead or wish you were dead?
**NO YES** (1)

C2 Want to harm your-self?
**NO YES** (2 )

C3 Think about suicide?
**NO YES** (6)

C4 Have a suicide plan?
**NO YES** (10)

C5 Attempt suicide?
**NO YES** (10)

**In your life time:**

C6 Did you ever make a suicide attempt?
**NO YES** (4)

……

IS AT LEAST **1** OF THE ABOVE CODED **YES**?

IF **YES,** ADD THE TOTAL NUMBER OF POINTS FOR THE ANSWERS (C1-C6)

**……**CHECKED 'YES' AND SPECIFY THE LEVEL OF SUICIDE RISK AS FOLLOWS:

**…….YES-POINTS**

***CURRENT SUICIDE RISK***

1-5 points ⇒ Low Π
6-9 points ⇒ Moderate Π
> 10 points ⇒ High Π

2) Sleeping problems

Sleep problems can either be the difficulty falling asleep or the difficulty staying asleep (also known as restlessness). There are a number of factors that can cause insomnia and other sleep problems, such as emotional stress, physical health (medical conditions, menopause, pregnancy, obesity, etc), lifestyle issues (workload, travelling) or even one's sleep environment (noise, light, temperature, bed).

**Main causes of insomnia**

- Daily stress: Concerns about work, school, financial issue, health or family can keep the mind too active, and make someone unable to relax.
- Anxiety: Everyday anxieties as well as anxiety disorders may keep the mind too alert to fall asleep.
- Depression: A Person may either sleep too much or have trouble sleeping if she/he is depressed. Some people may initially sleep but get up very early in the morning, and are not able to sleep again.
- Medical conditions that cause pain e.g. arthritis, stomach problem etc.
- Some prescription drugs such as some antidepressants, high blood pressure and corticosteroid medications can interfere with sleep.
- Long-term use of sleep medications.

**How to improve the sleep?**

- The key to feel refreshed after having slept, is a regular sleep-pattern

- If you go to bed before you're really tired, and then sleep badly, you'll tend to stay longer in bed in the morning, which will affect the next night's sleep.
- Therefore it is important to establish a good sleep-pattern.

**Establishing a routine**

- Go to bed only when you really feel tired enough to sleep.
- Don't read or watch television in bed. These are waking activities.
- If you don't fall asleep within 20 minutes, get up and relax/do something soothing, until you're tired enough to go back to bed.
- Repeat this process, if you are awake for long periods.
- Try to wake up (set the alarm) at the same time each morning. Don't sleep in. This will only make it harder to sleep the following night. You may need to follow this program for several weeks, to establish a regular pattern.
- Avoid taking a nap during the day. But if you really are overtired, taking a short nap after lunch can be beneficial.

**Sleep aids**

- Look at your sleeping arrangements. Is your bed and bedding comfortable? Do the temperature and light levels suit you? Is there enough fresh air in the room? If you are easily bothered by noise, try using earplugs.
- Try setting aside some time during the early evening for reflecting on your day. Think over any difficulties and write down your next step. Making an action list early in the evening may help you to avoid focusing on problems when you go to bed.
- Try to relaxe during the later part of the evening. Avoid any complicated work or activity.
- If your brain is still busy with daytime concerns, listening to the radio quietly for a while may distract you.
- Practice a relaxation technique before you go to bed. Breathe slowly and deeply: four seconds in, hold for four seconds and then four seconds out. Consciously tense and relax your muscles, in turn; start with your toes and work up or use any relaxation exercise you know.
- A hot, milky drink may encourage sleep.
- If you feel physically exhausted, but your mind is full of racing, intrusive thoughts, don't try to force sleep, it will only make you feel more anxious. Instead, try to keep your eyes open, and as they start to close, tell yourself to resist. The more you try to stay awake, the sleepier you’ll become.

- Interrupt unwanted thoughts by repeating a soothing word (such as 'peace') over and over to yourself.
- Try visualizing a scene or landscape that has a pleasant association for you.
- If you wake up during the night, go through your relaxation routine.

3) Sexual problems

Sexuality is an important aspect of intimate, loving relationships between couples. Therefore sex is such a personal and private aspect of live that it is rarely discussed in public. For many people, there is ignorance about what "normal" sexual behaviour is and what the types and causes of sexual problems are.
However research suggests that sexual problems are common (43% of women and 31% of men report some degree of difficulty); and fortunately, most cases of sexual problems are treatable! So it is important to talk about sexual concerns.

What you should know when dealing with sexual problems

- Sexual problems are often the result of an unhappy relationship or a lot of stress and high expectations on each other. They can cause further problems in the relationship
  ⇒ Ideally in the end there could be a talk with both partners!
- Some sexual problems are related to physical diseases (e.g. diabetes). Abnormal sexual behaviour can also be caused by severe mental diseases
- Depression, anxiety, and alcohol misuse can cause sexual problems
- Many sexual problems are the result of ignorance about sexual performance
  ⇒ Try to educate the couple; inform them about sexuality!

⇓

- Often Afghan women and men will not complain about sexual problems; instead their main complaint may be a physical one (tiredness)
  ⇒ Do not force the couple to talk about their sexuality; try to ask simple questions, such as *"how has your relationship been recently", "how do you feel about your partner"*
- **Remember:** Confidentiality is very important! You have to respect your client's wishes, especially if she/he does not want you to talk to the partner about his/her sexual problems.

Sexual problems in men

- **Impotence**
  ⇒ The man is not able to have sexual intercourse, as his penis does not become or stay hard and erect

- **Premature ejaculation**

  ⇒ This is when the man ejaculates (passes semen) so quickly that neither partner is able to enjoy the sexual act

**Causes of these sexual problems**

a) Physical causes

- Diabetes, heart and vascular disease, neurological disorders, hormonal imbalances
- Alcohol misuse, as it can make a man impotent
- Cigarette smoking, which can affect the blood supply to the sexual organs
- Some medicines such as antidepressants and medicines for high blood pressure

b) Psychological causes

- Tension about sex; typically when a man is having sex for the first time with a particular person
- Nervousness over how well he will perform during sex
- Strict religious background that causes the man to view sax as sinful
- Misconception about the size of the penis, having had sexual intercourse with a woman during her menstrual period
- Depression and tiredness; it is not possible to enjoy sex
- Work-related stress
- Loss of interest in sex, if the man e. g. does not find the partner attractive
- Marital or relationship problems
- Feeling under pressure to perform well

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- As a counsellor you should try to address feelings of anxiety, fear or guilt tha may have an impact on sexual functions!

Sexual problems in women

- **Pain during sexual intercourse**

  ⇒ This may occur if the woman's sexual passage (vagina) is dry, or when a man tries to have sex before she is ready or when he forces sex on her!

- **Loss of interest in sex**

**Causes of these problems**

a) Physical causes

- Infection in the sexual organs

b) Social and psychological causes

- Tension of fear about having sex
- Lack of control over sexual decision-making
  - ⇒ In Afghan society often woman does not have the same control over her body and sexual life as her husband!
  - ⇒ She may not be able to choose if and when she has sex; she may have to have sex whenever her husband desires!
- Sexual abuse in childhood or other unhappy or painful sexual experiences, making enjoyment of sex difficult

Homosexuality

- Homosexuality means sex between men and men, or women and women
- There are strong views about this sort of sexual behaviour and in many places this is seen as a mental problem or even a criminal act
- It is very important that you treat same-sex relationships in the same way as a relationship between a man and woman, as homosexuality is not a mental health problem!
- Just as sexual problems can arise in male-female relationships, so can they in same-sex relationships

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- As people who are attracted to their own gender are often persecuted, some may suffer loneliness, guilt, fear and unhappiness!
- If you are sensitive to this situation and offer a space for their concerns, they will experience an atmosphere of trust and you could get the permission to help them.

How to deal with sexual problems

**Be careful**

- Interview the person in private first; if she/he agrees, invite the partner to join the interview later
- Allow some time to build rapport and trust, as talking about sex is not easy;
- Do not be in a hurry! Give your client time!

**Possible questions to ask the person with a sexual problem**

- **What is the problem? When did the problem start? What have you already tried to solve it?**

- **Tell me about your relationship. How long have you and your partner known each other? How much do you love each other? Have you enjoyed sex with each other before? What sorts of things do you enjoy doing?**

  ⇒ Create an atmosphere of trust, so that you client feels free to talk about his/her sexuality
- **Have you been feeling tense or worried recently? Do you feel as if you have lost interest in daily life?**

  ⇒ Check if she/he may is depressive or anxious
- **Have you had any infections of the sexual organs?**
- Further questions to a man:

  ⇒ **Do you suffer from diabetes, high blood pressure or any other medical disease?**

  ⇒ **Are you taking any medicines, or drink alcohol, or smoke cigarettes**

  ⇒ **Do you get erections in the morning?**

  (Usually, if a man does not get any erections at all, then you should suspect a medical cause for the impotence)
- Further questions to a woman:

  ⇒ **How much control do you have over having sex?**

  ⇒ **Does your husband force you to have sex with him?**

**What to do, if someone is impotent**

- You should explain your client that this is a common problem and that is usually short-lived
- Advise not to smoke cigarettes or to drink alcohol before having sex
- Discuss possible reasons why the man may be tense or worried and explain the links between these emotions and impotence

**What to do, if someone suffers from premature ejaculation**

- Again, explain that this a common problem and is most often caused by tension
- Ejaculation can be delayed by the squeeze technique (squeezing the penis with the fingers) or the stop-start technique
- The man is asked to recognise the sensation that he is soon going to ejaculate; in this moment he should stop sexual movements

**What to do, if a woman has pain during intercourse**

- Explain her that this is common and most often due to tension or it could be because she is not sexually excited

- If she agrees, counsel the man to explain the need to stimulate the woman so that she feels sexually excited an her vagina is wet, and explain to him the need to have sex when both of them want to have sex
- Explore if the woman was sexually abused before.

## Useful counselling rules

1) Stay focused on the clients experience and do not jump too often from one topic within the clients problems to another
   ⇒ For instance to the problems or opinions of other family members.
2) Do not explain and talk too much yourself
   ⇒ Your knowledge is the basis for your actions. You do not have to show off your knowledge to the client
3) Be clear for yourself and also as much as needed in an encouraging way to the client about what you as a counsellor can do and what you cannot do
4) Try to find the most important facts about the biography of the client
   ⇒ What was the key experience
5) Always remember, you cannot solve the problems of the client! They are in charge of their life and will have to live with the decisions and actions they take
   ⇒ You can help with different skills like probing, role play, exploring consequences with imagination to find the best way how to deal with the situation
   ⇒ If you identify with this delegation of the client that you should solve his problem, then you are in big trouble, as there will be unrealistic expectations or later you will be blamed if it does not have the expected result
6) There is a problem if you as counsellor only react to what the patient is saying
   ⇒ It is equally important that you carry a vision within yourself, which somehow contains a value system as a basis for your work. This does not mean to impose those values on the client. This may seem like a contradiction. Important as counsellors: We always have to know the difference between the life and the values of the client and of our own values and life with all problems.
   ⇒ Take a position if there is a violation of human rights or criminal acts.
   ⇒ There also needs to be a certain structuring and guidance from your side
7) Together with the client try to find someone who is a person of trust and help within the family for the patient
   ⇒ In doing this we strengthen the self-helping system of the family
8) It is important to help people to realize that they have more potential then they have ever thought they had.
9) Follow the course of what is emerging in the patient
10) Be careful to explore what is really happening and refrain from quick judgements such as:
   ⇒ A woman comes, is being beaten by her husband and the counsellor tells her to be more obedient, without really knowing the reality and circumstances of the woman’s life
11) Try not to get stuck within the story too much

⇒ Try to find the theme/problem behind the story

12) Within the counselling session there has to be an emotional development

⇒ The client should leave the room in a better condition than he came.

## Working in a team

1. Interdisciplinary

- The mental health system (BPHS) established in Afghanistan, offers the possibility to work as an interdisciplinary team! This team consists of illiterate Health workers, midwifes, nurses, MD's and psychological counsellors
- Each group has a specific scope of duties, and a well-coordinated collaboration across these groups has the potential to be successful in treating patients
  - ⇒ Each group should uses the knowledge and the skills offered by the other groups
  - ⇒ A counsellor who is not sure about the physical condition of his patient should ask the MD for advice!

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**Advantages of Interdisciplinary**

| For patients | For staff |
|---|---|
| • Improves care by increasing coordination of services, especially if the problem is complex<br>• Integrates the care for a wide range of problems and needs so that the cause of the problem can be identified!<br>• Uses time more efficiently<br>• Gives the patient the possibility to trust the system, as the patient experiences being important! | • Increases the satisfaction of each professional<br>• Enables the professionals to learn new skills<br>• Encourages each professional to find a creative and innovative solution<br>• Maximizes resources and facilities<br>• Offers the possibility to improve and to correct mistakes in advance |

2. Characteristics of the team

As a team you have overlapping tasks, namely coordination, communication, shared responsibility and collaboration

1) For **coordination** it is necessary to learn and to understand the roles and responsibilities of the other team members, so that your team can function effectively
   - ⇒ Therefore try to get familiar with the roles, functions and skills of the different groups
   - ⇒ As the focus of the team should be on the needs of the patient, it is important to gather skills and knowledge of all team members
2) There has to be an ongoing **communication** among team members and with patients and families to ensure that various aspects of patients' needs are integrated and addressed
   - ⇒ Communication is the process of transmitting and understanding information and ideas; so the team develops shared understanding!

⇒ Therefore the team should meet regularly, in order to discuss and to help each other in treating the patients

⇒ The social value of face to face contact should not be underestimated, as trust, respect, team identity and familiarity with one another's way of working are all developed here

⇒ Members who work too much on their own and who loose touch with how their work relates to others can reduce the whole team effectiveness!

3) It should be very clear, in which way the **responsibility** for the work is shared

⇒ Knowing who is responsible for what creates a clear working atmosphere and enables and obligates each member of the team to do his work carefully

4) **Collaboration** works best when team members share values and vision, and learn to work well with each other. It is important that team members know that when they pass the ball their team mates will not drop it

⇒ In order to be successful members do whatever is needed!

⇒ The team should be encouraged to recognise that the project is not just one person's effort, as all members are needed

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- Effective teamwork is possible if the members identify with the team, share visions and team objectives, communicate in a proper way, collaborate, and reflect the work of the team and themselves!
- Successful teams are characterised by a team spirit based around trust, mutual respect, helpfulness and – at best – friendliness

3. How to use the potential of a team

- If you are working in a team in order to discuss for example a special problem of a case, you may find it helpful to follow this **guideline**:
  (1) Define the problem and decide on goals
  (2) Gather information about the problem from everyone in the team
  (3) Seek opinions about the problem from appropriate team members (maybe you need the advice of a doctor)
  (4) Develop potential solutions or further treatment plans
  (5) Offer opinions about each potential solution
  (6) Evaluate potential solutions and choose the best one or integrate several into one
  (7) Summarize the plan
  (8) Set deadlines for members to produce information needed by others

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- Minutes should be taken, with decisions and actions recorded! Each member should receive these as soon after the meeting as possible

4. Barriers and conflicts in a team

- Working as a team challenges each member, as teams are composed of people who have a variety of emotional and social needs which the team can either frustrate or help
- Failure to deal effectively with conflicts, may lead to low morale, withdrawal, anger, and burn-out
  ⇒ problems could be disorganisation, poor communication, misunderstandings, different expectations, ambitions, or priorities
  ⇒ disagreements can arise from power struggles, when members compete for a particular role in the team, or critic each other in front of others
- On the other hand, differences of opinion and conflict are not only inevitable but are in fact necessary and helpful
  ⇒ Discussions with differing opinions may encourage innovation and creative problem-solving, and successful resolution of differences may create increased trust and understanding among team members

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- How a team behaves and what it achieves is a result of the collective behaviour of its members!

- **Strategies** that team members may use to maintain group collaboration and resolve conflicts should be practiced:
  ⇒ Identify norms for team behaviour
  ⇒ Encourage less talkative members to give their opinion
  ⇒ Seek harmony when conflicts occur by listening carefully and respectfully to all opinions
  ⇒ Give and receive feedback without hurting or feeling criticized
  ⇒ Be honest to each team member and attend the open exchange of information within your team
  ⇒ focus on positive outcomes and put less weight on problems
  ⇒ use constructive questioning to identify the causes of conflict
  ⇒ avoid confrontational responses and be non-judgmental of others' opinions and assumptions
  ⇒ When conflicts are resolved, celebrate the success of the resolution

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- In this way each member can develop pride and loyalty to the team as well as giving support to each other

5. Evaluating and reflecting teamwork

- Finally it is really important that team members reflect on how well the team is functioning
- Therefore you may ask yourself:
  - ⇒ What is the team's mission?
  - ⇒ Who is the team's leader? How is leadership determined? How is it shared?
  - ⇒ What are the roles and qualifications of team members?
  - ⇒ What is the climate for the team's functioning? Is it constructive and open?
  - ⇒ Do team members see themselves as part of the team
  - ⇒ What are the team's communication patterns
  - ⇒ How does the time make decisions?
  - ⇒ How does the team review and evaluate its progress and decisions?

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As a team you should ask yourself: "Did we do well as a team?"

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**Psychopathology**

Mental Health Department of the MoPH
Kabul-group-08
Responsible for the content of this draft:
Inge Missmahl, technical advisor for Mental Health from the Ec for the MoPH

**Table of content**

# Common mental disorders

## I Depression

Everyone feels sad or less interested in life occasionally. But if person does not have the energy for favorite activities, or they don't give you the satisfaction they used to, or if person feels sad most of the day, every day, it could be depression. Depression is a common disorder seen more in women but can be seen in any age group. Sadness or depressed mood and loss of interest are core symptoms of depression. Sadness usually described by patients as: “Jigarkhooni”, “Diqiyat”, “Dilum siyah ast”, etc.

### Symptoms of depression

Depression comes with variety of symptoms, usually patient present with physical symptoms, commonly tiredness, headache and body pain in health facility. Further enquiry reveals sadness or loss of interest. Another common symptom is irritability and anger, sometimes as the presenting problem. Not everyone experiences every symptoms of depression. Some people experience a few symptoms, some many. Severity of symptoms varies with individuals and also varies over time. Common symptoms in depression are as follow:

- Low or sad mood
- Loss of interest or pleasure
- Tiredness or decreased energy or being slowed down
- Sleep problems e.g. early morning awakening or oversleeping
- Loss of appetite if severe weight loss
- Difficulty concentrating, remembering, or making decisions
- Loss of sexual desire
- Irritability, anger towards family members and others
- Thoughts of hopelessness, helplessness
- Feelings of guilt, worthlessness and uselessness
- Thoughts of death or suicide; suicide attempts
- Social withdrawal
- Physical symptoms that do not respond to treatment, such as headaches, digestive problems, back pain, and chronic pain
- Symptoms of anxiety are also frequently present.

**Depression comes in many different types, but each type has its own unique symptoms and treatments. Common forms are:**

Severe depression: This type of depression lasts more than two weeks and may increase the risk of suicide.

Mild and chronic depression is helped best with psychosocial intervention to decrease the impact of illness on daily activities.

Postpartum depression: After giving birth to a baby some mothers may have feelings of sadness, anger, anxiety, irritability and worthless.

Psychotic depression: A severe form of depression which is characterized by not only by symptoms of depression but also by hallucinations or delusions. This type responds poorly to antidepressants alone.

Bipolar disorder: This condition involves episodes of depression and mania. Some people may have episodes of depression before having another manic phase, or vice versa.

Causes of Depression

Many factors are involved in depression. Some people are at higher risk (e.g., those who have recently given birth or had a stroke, those with chronic physical illnesses and taking multiple medications like anti-hypertensive, steroids etc). Very often a combination of biological, psychological, and social factors are involved in the onset of a depression.

**People at risk of depression**

- Parents' depression is a risk for their children.
- Living in an insecure environment
- Substance abuse, especially opium, heroin or alcohol
- Psychosocial problems: financial problems, family problems or unemployment
- Chronic, life-threatening physical illness,
- Shyness and being dependent on others
- Negative thinking about self, future and the world
- Diseases of central nervous system e.g. stroke, Parkinson's disease
- Living alone or is isolated
- Loss of close relatives
- Developmental changes or role transitions such as retirement
- Medication e.g., for family planning, or for high blood pressure etc.

**Course of Depression**

Depression can have a chronic course without treatment. With early diagnosis and treatment the course would be shortened and in most of the cases person would continue to function as usual. Psychosocial interventions would significantly reduce the risk of relapse. Recurrent episodes of depression can lead to a chronic course with no improvement intervals after wards.

**Treatment of depression**

Taking an active part in the treatment would help person to overcome problems soon and making changes easier. Many patients with hopelessness and helplessness ideas would refuse to accept the treatment e.g. to take medication. Working with such patients and making them to accept treatment, requires some skills and knowledge. Patients with depression can benefit from a variety of helpful interventions such as pharmacotherapy, psychosocial interventions etc. As a rule, the most effective treatments of depression involve a combination of pharmacological and non-pharmacological interventions.

1. **Psychosocial interventions** are effective in most of the cases. Psychosocial interventions are first considered at first stage in mild and moderate cases of depression. In severe cases of depression psychosocial intervention is helpful when at the same time symptoms are improved with medication. If psychosocial interventions are not helpful, the patient should be referred to a doctor to be assessed for pharmacotherapy. Combining psychosocial interventions and pharmacological interventions are more effective then either one alone. Psychosocial interventions will be discussed in the part of psychosocial interventions and counseling skills.

2. **Biological treatment:** Medication for depression can be very effective. Use of medications is considered in severe and resistant cases where doctors prescribe antidepressants. Many antidepressants are available such as Fluoxetine, Amitryptaline. Antidepressants have many side effects common side effects are: dry mouth, constipation, nausea, drowsiness or dizziness, blurred vision, low blood pressure while standing etc. At times side effects can make patient stop the treatment.
    - Another medication is Fluoxetine which can be used as single dose. Side effects include: nausea, vomiting, loss of appetite, diarrhea, headache, sexual problem, sleep problems, nervousness, and anxiety. In psychotic depression along with antidepressant an antipsychotic will be added to control psychotic symptoms. Cases of psychotic depression must be referred to doctor for further management.
    - Tips about medication:

⇒ Side effects are usually mild
⇒ Disappear after few days but at time it can be difficult to bear
⇒ Side effects can result in discontinuation of the treatment
⇒ Antidepressants should be avoided if possible in pregnant or breast feeding mothers
⇒ Duration of the treatment is roughly about 6 months and sometimes longer
⇒ Treatment should not be stopped without consultation with doctor
⇒ When on medication, patients should avoid taking substances or alcohol.

3. Combining psychosocial interventions and medication is more effective. An important thing to remember is that there are no instant solutions to problems in life. Solving problems involves time, energy and work. Taking an active part in the treatment would help person to overcome problems soon and making changes easier.

**What the Psychosocial Counselor would do?**

1. Assessment:
   - Exploring symptoms of depression
   - Exploring the severity of the symptoms
   - Previous episodes, durations and treatments.
   - Exploring psychosocial stressors
   - Impact of symptoms on patient's daily life
   - Family involvement and support
   - Most importantly information about:
     ⇒ Depression in the family
     ⇒ Physical diseases
     ⇒ Use of medication
     ⇒ Use of substances e.g. opium, heroin or alcohol
     ⇒ Person's personality before illness began
     ⇒ Changes in the person's life before depression
     ⇒ Risk of suicide or suicide attempts
     ⇒ Use of traditional remedies
     ⇒ Willingness to accept treatment

2. Psychoeducation:
   - Educating patient and the family on the nature of symptoms, duration and its changes over time, possible risk factors, psychosocial stressors, consequences, suicide risk, treatment issues, follow up, relapse and its prevention. Psychosocial counseling is helpful if the case is mild or moderate and psychosocial stressor is present. After antidepressant psychosocial counseling encouraging family support in either case is essential. Important tips about medication:
     ⇒ Remember that there are no instant solutions to problems in life.
     ⇒ Patients often try to stop medication soon.
     ⇒ They may feel better and think they no longer need the medication.
     ⇒ They may think the medication is not helping at all.
     ⇒ It is important to keep taking medication until it has a chance to work
     ⇒ Side effects may appear before antidepressant activity does
     ⇒ Side effects are usually mild and temporary
     ⇒ It is important to continue the medication for at least 6 months
     ⇒ Prevention of recurrence of depression
     ⇒ Antidepressants do not cause dependence

3. Counseling:
   - Please follow the steps for the basic counseling. Then assess if there are other psychosocial problems in the background. Then follow the counseling according to the indication

4. Referral to a doctor when
   - Symptoms are severe
   - There is high risk of suicide
   - There is associated physical illness
   - Initial counseling was not effective
   - Psychotic symptoms are present

5. Follow up:
   - Either for further counseling or assessing improvement, or side effects of medication, family support, medication and counseling together.

II Anxiety disorders

Anxiety is part of our normal life which is called normal anxiety and is experienced daily by all. The normal anxiety helps people manage daily life or overcome difficulties in their life. In fact, a moderate amount of anxiety can be good. Anxiety helps people respond appropriately to real danger, and it can help motivate people to do well at work and at home. If anxiety continues beyond certain period of time and without any apparent reason, it is abnormal. Anxiety affects thoughts, feelings and behaviors of the person.

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Anxiety affects both the body and the mind. Abnormal anxiety is a state of uneasiness and worries with physical and psychological symptoms.

- Common physical symptoms: restlessness, shivering, dry mouth, sweating, rapid heart beat, abdominal discomfort, tensed muscles, rapid breathing etc
- Common psychological symptoms: worries, fear, feeling of happening the worst event, alertness, difficulty concentration, forgetfulness, negative thoughts, difficulty in decision making etc

There are many forms of abnormal anxiety, the followings will be discussed here:

- **Panic attack (PA) and panic disorder (PD)**
- **Generalized Anxiety disorder (GAD)**
- **Phobias**
- **Obsessive Compulsive disorder (OCD)**
- **Conversion (Dissociative) Disorder**

**1) Panic attacks**

Panic attack is a sudden overwhelming attack of anxiety characterized by palpitation, chest pain, shortness of breath, dizziness, fear of death. The attacks often starts with physical symptoms such as palpitation, chest pain, sensations of choking, stomach discomfort, dizziness, feelings of unreality, or fear of personal disaster. Panic attacks can occur for no reason at any time, and people may not be able to understand why. The attack usually lasts less then 30 minutes but it makes people fearful as if they are going mad, or having a heart attack. Even they may be convinced that they are going to die in the course of attack, making this a terrifying experience.

Common symptoms of panic attack are:

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- Palpitation
- Shortness of breath
- Feeling of suffocation
- Increased sweating
- Dizziness and vertigo
- Cold or hot flushing
- Numbness of hands
- Nausea and abdominal discomfort
- Chest pain, fear of having heart attack
- Feelings of unreality ( Derealization)
- Fear of losing control or going mad

Symptoms begin suddenly which is interpreted as heart attack, stroke etc. The attack increases worry and tension, often person expects the worst attack, even when there is no apparent reason for concern. Person having panic attack makes numerous visits to emergency rooms, and doctors' clinics when they get attacks. The attack often leads to fear of another attack and avoidance of places where attacks have occurred. The overwhelming anxiety would force person avoid certain food, medicine, situations etc which restricts person life. Some patients may avoid exercise or other activities that may produce physical sensations similar to those of a panic attack.

When there is worry for having a next attack, this is called anticipatory anxiety. Panic attack with anticipatory anxiety and avoidance of certain places is termed as panic disorder. In panic disorder there is fear of getting attacks in certain situations e.g. crowded places, in a bus, in mosque etc. Patient avoids going to such places in fear of not getting help if gets an attack.
Panic attack has similar symptoms to many medical illnesses such as heart disease, thyrotoxicosis etc which should be ruled out before diagnosing panic attack. In such cases, consultation with a doctor helps to exclude such possibilities.

<u>Some consequences of panic attack:</u>

- Isolation and restricted social life
- Depression and suicidal ideation

- Loss of job
- Family conflict
- Substance or alcohol abuse

Without treatment panic attack runs a chronic course which in turn makes treatment difficult. There are effective treatments available for panic attack. In severe cases medications such as benzodiazepines, Fluoxetine, etc are helpful but combining medication with psychological interventions will have a greater chance for recovery. Psychosocial interventions are more helpful in panic attacks and have no side effects like medication.

Psychosocial interventions:

- Psychosocial interventions are very useful in the management of panic attack, can be administered alone or jointly with pharmacotherapy.
- Some important points to encourage patient to follow below steps during attack:
  - ⇒ Not to shout for help.
  - ⇒ To stay where attack has occurred until the attack passes.
  - ⇒ To concentrate on controlling worries, not on physical symptoms.
  - ⇒ To practice slow, relaxed breathing. Controlled breathing will reduce physical symptoms.
  - ⇒ To encourage self that the attack and frightening thoughts and sensations will soon pass.

Pharmacological treatment:

For most patients counseling is helpful and medication is not needed. If attacks are severe and frequent antidepressants would be helpful. Also if there is depression with panic attack, then antidepressants can be started. In milder cases anxiolytic such as Alprazolam 0.5-2 mg per day can be useful if administered for short period because continuous use of this medicine cause dependence. Antidepressants such as Amitryptaline (50-150 mg/day) or Fluoxetine (20 m/day) can be used. Antidepressants manage coexisting depression also.

**What a Psychosocial Counselor would do?**

1. Assessment:
   - Exploring symptoms of panic attack also depression if present
   - Exploring nature of the symptoms, frequency, timing and location of attacks.

- Exploring the help seeking behavior e.g. asking family members for going to hospital, going to doctor or emergency room, etc.
- Impact of symptoms on patient's daily life.
- Exploring avoidance behavior such as not leaving home alone, avoiding crowded places e.g. buses, weddings, funeral ceremony, and fatiha etc.
- Exploring presence of psychosocial stressors
- Exploring family support

Most importantly information about:

- Similar illness in the family
- Other physical diseases
- Use of substances e.g. opium, heroin or alcohol
- Person's personality before illness
- Changes in the person's life before the depression
- Risk of suicide or suicide attempts
- Use of traditional remedies

2. Psychoeducation:

- Either initially or after being treated by a doctor. Educating the patient and the family on the nature of symptoms, duration and changes over time, possible risk factors, psychosocial stressors, consequences, treatment, follow up, relapse and its prevention is important. Some essential information for patient and family are:
  - ⇒ Panic attack is common and can be treated.
  - ⇒ Anxiety often produces frightening physical sensations. Chest pain, dizziness or shortness of breath is not necessarily signs of a physical illness; they will pass when anxiety is controlled.
  - ⇒ Panic attack also causes frightening thoughts: fear of dying, a feeling that one is going mad or will lose control. These also pass when anxiety is controlled.
  - ⇒ Mental and physical anxiety reinforces each other. Concentrating on physical symptoms will increase fear.
  - ⇒ A person who withdraws from or avoids situations where attacks have occurred will only strengthen his/her anxiety.

3. Psychosocial interventions:

- Psychosocial interventions are very useful in the management of panic attacks, can be administered alone or jointly with pharmacotherapy.

- Please follow the steps for the basic counseling. Then assess if there are other psychosocial problems in the background. Then follow the counseling according to the indication.

Some important points to encourage patient to follow below steps during attack:

- Not to shout for help.
- To stay where attack has occurred until the attack passes.
- To concentrate on controlling worries, not on physical symptoms.
- To practice slow, relaxed breathing. Controlled breathing will reduce physical symptoms.
- To encourage self that the attack and frightening thoughts and sensations will soon pass.

4.. Referral to a doctor if

- Symptoms are severe and attacks are frequent
- Depression coexists
- There is risk of suicide
- Counseling was not effective
- There is possible associated physical illness

Important tips:

- Patient avoids unnecessary medical consultation
- Patient tries talking about his/her problem with trusted friends
- Support of family members without helping to perpetuate the person's symptoms
- This is panic attacks not really heart attacks
- Medication is to cure symptoms and is not toxic to heart or brain
- Side effects means medication started acting on symptoms
- Time is needed for medication to improve symptoms.

5. Follow up:

- Either for counseling or assessing improvement, side effects of medication, assessing depression and suicidal ideation.

**2) Generalized Anxiety Disorder (GAD)**

Generalized anxiety disorder is persistent, excessive, and unrealistic worry about everyday things. If a person often feels very anxious without reason and such worries disrupt daily life, this may be generalized anxiety disorder. Generalized anxiety disorder causes excessive or unrealistic anxiety and worry, beyond what's appropriate for a situation. Having this disorder means always anticipating disaster, often worrying excessively about health, money, family, or work, even though, the source of the worry is hard to pinpoint. Person is unable to stop the worry cycle and feels as if it is beyond control.

Initially presenting symptoms are usually physical e.g., headache, rapid heart beat or difficulty sleeping.

- A person with GAD experiences some or all of the following symptoms:
  - ⇒ Excessive worry and tension
  - ⇒ An unrealistic view of problems
  - ⇒ Restlessness, inability to relax
  - ⇒ Irritability and anger
  - ⇒ Difficulty concentrating
  - ⇒ Muscle tension
  - ⇒ Headaches
  - ⇒ Sweating
  - ⇒ Nausea and abdominal discomfort
  - ⇒ Easy tiredness
  - ⇒ Sleep problem
  - ⇒ Trembling
  - ⇒ The need to go to the bathroom frequently
  - ⇒ Being easily startled
- Unlike panic attack symptoms of GAD is continuous with fluctuation and is not episodic in nature but in certain situations symptoms severity increase. Some medical conditions have similar symptoms to GAD especially e.g. thyroid overactivity (thyrotoxicosis) or use of substances may cause anxiety symptoms.
- Some consequences of GAD are:
  - ⇒ Substance/alcohol abuse,
  - ⇒ Depression,
  - ⇒ Difficulty in maintaining a job,

⇒ Medication dependence,

⇒ Relationship problems

⇒ Suicide

⇓

Living with generalized anxiety disorder is difficult, but treatment is available. Psychosocial and pharmacological treatment can help to improve symptoms and the patient can learn skills to control anxiety and take back his life. The goal of treatment is to help the person function well. The success of treatment usually depends in part on how severe the generalized anxiety disorder is.

**What Psychosocial Counselor would do?**

1. Assessment:
   - Exploring physical and psychological symptoms of GAD,
   - Exploring severity and frequency of the symptoms.
   - Interference with daily activities
   - Exploring psychosocial stressors
   - Exploring main worries due to GAD.

   Most importantly information about:
   - Anxiety disorder in the family
   - Physical diseases in patient
   - Current use of medication and past treatments
   - Use of substances or alcohol
   - Person's personality before illness
   - Changes in the person's life before illness
   - Risk of suicide or suicide attempts
   - Use of traditional remedies

2. Psychoeducation:

Either initially or after being treated with medication with a doctor. Psychoeducation should focus on educating patient and the family on the nature of symptoms, duration and changes over time, psychosocial stressors, consequences, risk of suicide, treatment, follow up, relapse and its prevention.

Some tips:

- Feeling anxious is not patient's fault
- GAD is a treatable condition
- This is not sign of weakness
- Worries are not real but related to daily life which are unrealistic
- If one treatment doesn't work, another one will
- Daily relaxation to reduce physical symptoms
- Routine activities and exercise
- Medication is used when psychosocial intervention is not helpful
- Side effects are temporary and tolerable.

3. Psychosocial counseling:

- Please follow the steps for the basic counseling. Then assess if there are other psychosocial problems in the background. Then follow the counseling according to the indication.

4. Referral to a doctor if

- Symptoms are severe
- There is risk of suicide (if depression is present)
- Other physical illness is suspected
- Initial counseling was not effective

5. Follow up:

- Either for counseling or assessing improvement, monitoring side effects of medication and counseling together and in the presence of depression for suicidal ideation assessment.

**3) Phobias**

Phobia is a strong, irrational fear of something that poses little or no actual danger. Fear is a natural phenomenon experienced in daily life by all human beings. But in phobia, fear brings on symptoms of overwhelming anxiety including palpitation, abdominal discomfort, dizziness, shortness of breath, sweating and trembling. Almost in all forms, if severe, phobia restricts life, and may force person to take extreme measures to avoid whatever triggers it.

**Social Phobia**

- Excessive fear of social situations in which embarrassment is possible
- Feeling uneasy of being watched or at risk of being judged by others
- Anticipatory anxiety
- Significant distress and anxiety in the following situations:
  - ⇒ Being introduced to other people
  - ⇒ Being teased or criticized
  - ⇒ Being the center of attention
  - ⇒ Being watched or observed while doing something
  - ⇒ Having to say something in a formal, public situation
  - ⇒ Meeting people in authority
  - ⇒ Feeling insecure and out of place in social situations
  - ⇒ Embarrassing easily e.g., blushing, shaking
  - ⇒ Meeting other peoples' eyes
  - ⇒ Doing things in public e.g. eating, writing, talking, making phone calls

Severity can range from mild to severe and can result in difficulty to work, travel, or interacting with others. Some people may suffer from more then one type of phobia. Some consequences of phobias are: isolation, loss of job, depression, suicide, substance abuse. Without treatment phobias will run a chronic course and can become life long problem. Phobias are helped with psychological intervention techniques but at time there may be a need for some medications along with psychological treatments. Specific phobias respond best to psychosocial treatments. For social anxiety disorder both pharmacotherapy (Alprazolam, Diazepam, Propranolol, and Fluoxetin) and psychosocial interventions are useful.

**What a Psychosocial Counselor would do?**

1) Assessment:
   - Exploring history of symptoms and related problems
   - Exploring the severity of the symptoms.
   - Impact of symptoms on patient's daily life.
   - Exploring psychosocial stressors

   Most importantly information about:
   - Similar illness in family

- Physical diseases if any
- Treatment history
- Use of substances or alcohol
- Person's personality be
- Changes in the person's life before illness
- Presence of other mental disorder
- Risk of suicide or suicide attempts
- Current social functioning
- Use of traditional remedies

2) Psychoeducation:

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

Tips for Psychosocial Counselor:

- Ensure patient that phobia is a treatable condition
- Most phobias develop during childhood and eventually disappear.
- Those that persist into adulthood rarely go away without treatment.
- Majority of patients can completely overcome their fears and be symptom-free
- Social phobias generally develop after puberty, without treatment, can be lifelong
- Confronting the object of fear rather than fleeing, the person becomes accustomed to it and can lose the fear, panic, and dread he or she once felt
- Medications control the anxiety symptoms experienced during a phobic situation
- Discuss ways to challenge these exaggerated fears e. g., patient reminds him/herself, "1 am feeling a little anxious because there is a large crowd. The feeling will pass in few minutes."
- The patient should avoid using alcohol or benzodiazepines to cope with feared situations.

3) Psychosocial counseling:

- Please follow the steps for the basic counseling. Then assess if there are other psychosocial problems in the background. Then follow the counseling according to the indication.

4) Referral to a doctor if:

- Symptoms are severe
- There is risk of suicide
- There is possible associated physical illness
- Psychosocial care was not effective
- Other mental disorders are present

5) Follow up:
   - Either for counseling or assessing improvement, side effects of medication and risk of other mental disorders.

**4) Obsessive Compulsive Disorder (OCD)**

Obsessive-compulsive disorder is an illness that causes to people unwanted thoughts (obsessions) and to repeat certain behaviors (compulsions) over and over again. We all have habits and routines in our daily lives, such as brushing our teeth before bed. However, for people with OCD, patterns of behavior get in the way of their daily lives. In OCD the person has the inability to control certain thoughts, idea or urges, which seem to force themselves into the mind, repeatedly. These thoughts are disturbing, uncontrollable and unacceptable to the person, which person can not ignore or share with others. Such thoughts create unbearable anxiety which makes person feel helpless to do anything except perform the particular ritual which reduces the severity of the thought and anxiety. The irresistible urge to carry out such rituals is called compulsion. Most people with OCD know that their obsessions and compulsions make no sense, but they can not ignore or stop them.

**a)** Obsession: Recurrent, persistent, unwanted thoughts or images causing intense anxiety, some common obsessions are**:**
   - Fear of dirt or germs and contamination
   - Fear of harming a family member or friend
   - Fearing aggressive urges
   - Excessive doubts
   - Concern with order, symmetry and exactness
   - Needing things to be perfect
   - Worry that a task has been done poorly, even when if person knows this is not true
   - Fear of thinking evil or sinful thoughts
   - Thinking about certain sounds, images, words or numbers all the time

- Doubts that person has not locked the door or turned off the stove

b) Compulsion: Repetitive behavior for reducing high level of anxiety due to obsession, common compulsive behaviors are:
    - Checking doors, drawers, switches, shop and appliances to be sure they are shut, locked or turned off
    - Washing and cleaning, such as washing hands, showering or brushing teeth over and over again
    - Counting of things again and again
    - Repeating certain words or phrases
    - Repeating actions such as going in and out of a door, sitting down and getting up from a chair
    - Ordering or arranging items in certain ways
    - Touching certain objects several times
    - Praying again and again
    - Saving newspapers, mail or containers and other things they are no longer needed
    - Seeking constant reassurance and approval

Person with OCD feel compelled to do these actions over and over again, because of the fear that he/she didn't do it properly last time, or because the unwanted thoughts may intrude again. The relief from the anxiety is only temporary. People with OCD can often have other kinds of anxiety, like phobias or panic attacks, and may also have depression. Similar symptoms of OCD can be seen in depression, schizophrenia, tic disorder (presence of abnormal involuntary motor behavior) and some habit problems, such as nail biting or skin picking.

Consequences of OCD can be substance abuse problems, depression, suicide, social isolation, family problems and decrease of life quality.

Without treatment OCD runs a chronic course. There are a number of different treatments for OCD which are useful when symptoms are very distressing. Different approaches work for different people.

Useful methods are psychological interventions which will be discussed in other section latter. Some people find medication helpful for OCD, either alone or combined with psychological treatments. The medications prescribed commonly are SSRI antidepressants, such as Fluoxetine (20 mg) and clomipramine (75-150 mg). These medications have many side effects, including nausea, dry mouth, constipation, headache, dizziness, blurred vision, sleep disturbance, stomach upset and increased anxiety.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms of OCD
- Exploring the severity of the symptoms and duration
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Origin of patients thoughts (coming from where?)
- Actions/behaviors to get rid of the thoughts
- Time spend for such behavior

Most importantly information about:

- OCD in the family
- Physical diseases
- Use of medication
- Use of substances or alcohol
- Person's personality before illness
- Changes in the person's life after illness
- Risk of suicide or suicide attempts
- Use of traditional remedies

3) Psychoeducation:

- Educating patient and the family on the nature of symptoms, obsessions and compulsions, changes over time, psychosocial stressors, consequences, types and duration of treatment, follow up, relapse and its prevention.

Some tips to consider:

- OCD is a common problem
- Is a treatable condition
- OCD sometimes runs in families
- Friends can support finding help
- Hiding problems makes their treatment difficult.
- Medication and psychosocial interventions are more helpful
- Sticking to treatment plan, even if it's sometimes uncomfortable
- Avoiding substance or alcohol as coping mechanisms

- Involvement in social activities, rather than isolating yourself

4) Psychosocial counseling

- Please follow the steps for the special intervention technique for OCD patients. Then assess if there are other psychosocial problems in the background. Then follow the counseling according to the indication.

5) Referral to a doctor if

- Symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective

6) Follow up:

- Either for counseling or assessing improvement, side effects of medication and progress of counseling.

**5) Conversion (Dissociative) Disorder**

Conversion is a mental process in which the connection between sense of identity, feelings, thoughts, sensations, perceptions and memories are altered. The result can be change in memories, body functions, sense of who he/she is, or the way surroundings are seen. Onset is often sudden and is related to psychological stress or difficult personal circumstances. is a mechanism that helps people to survive traumatic experiences such as bomb explosion, sexual assault etc. It can occur at any age but is common in children and young people. Usually it happens after a stressful event and may last for days.

Some common causes are:

- Childhood traumatic experiences
- Loss of a loved one
- Sexual assault/rape
- Kidnapping
- Torture
- Accidents

- During war
- Use of substances

There are many types of, most common symptoms are:

- Inability to move a limb (arm or leg paralysis)
- Sudden blindness or deafness
- Abnormal gait or movements or loss of balance
- Loss of sensation in parts of the body e.g. numbness
- Loss of consciousness and unresponsiveness
- Gaps in memory of past events or self identity
- Forgetting important information and learned talent or skill
- Feeling that a known environment is unfamiliar
- A sense that known people are strangers

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Most common form is loss of consciousness which is interpreted as a life threatening event by family members and patient is brought to emergency rooms. Symptoms usually appear suddenly and may follow a stressful experience. Some people express emotional distress through physical signs and symptoms. Symptoms cause significant distress or impairment in social, work or other settings.

Some risk factors include:

- Having a history of similar problem in family
- Having experienced severe emotional stress
- Having a stressful home or work life
- Physical or sexual abuse as a child
- Having a family member who is seriously ill or in chronic pain
- Suffering from depression or anxiety

⇓

The physical manifestations appear involuntarily, and a medical examination does not show any clearly defined physical cause for the dysfunction. Early recognition is important because it can be treated easily, early in the course of illness but failure to do so may lead to symptoms which eventually become harder or impossible to cure. In chronic cases, patients may appear calm despite the seriousness of the complaint.

Such people are at increased risk of:

- Self-harm and suicide attempts
- Substance or alcohol abuse
- Sleep problems, including nightmares
- Development of another mental illness, such as anxiety or depression
- Difficulties in relationships and at work

Conversion disorder with fainting and unresponsiveness may be misdiagnosed as epilepsy! Following table helps to distinguish them:

| | **Epilepsy** | **Conversion** |
|---|---|---|
| Aura | Abdominal discomfort, unusual smell or taste, | Upset after anger, change of mood, or argument |
| Onset | Sudden | Slow |
| Location | Any where | In presence of others |
| Starting factor | No factor | Usually after arguments |
| Fall | Sudden | Gradual |
| Involuntary movement | Tonic-clonic, symmetric | Irregular |
| Frothing | Present | Absent |
| Incontinence | Present | Absent |
| Tongue bite | May be | Absent |
| Cyanosis during attack | Present | absent |
| Injury during attack | Present | May be |
| Memory of attack | No | Partial |

There effective treatments for and the aim of treatment are to bring about increased connection between feelings, thoughts, perceptions and memories, and to foster a sense of empowerment. Effective treatment for is the combination of many methods, but always includes psychosocial interventions. Medication may be helpful in treating symptoms of depression, anxiety, or insomnia, but there is no medication to treat itself. On the other hand medication has many side effects.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms of
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Explore risk factors.

Most importantly information about:

- The family
- Similar illness in past
- Use of substances or alcohol
- Person's personality before illness
- Changes in the person's life before illness
- Risk of suicide or suicide attempts
- Use of traditional remedies

2) Psychoeducation:

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

Important tips:

- Patient to talk about recent stresses or difficulties
- Patient has no voluntary control over symptoms
- Positive reinforcement for improvement.
- Reinforce of symptoms should be avoided.
- Return to usual activities as soon as possible.
- Avoiding prolonged rest or withdrawal from activities.
- Improving coping style

3) Psychosocial counseling:

- Please follow the steps for the basic counseling Assess carefully the connection between the symptom and the situation in which the symptom usually appears. Analyse the problem behind and together with the client search for possible resources and solutions.

4) Referral to a doctor if

- If the diagnosis is uncertain

- There is possible associated physical illness
- Initial counseling was not effective

5) Follow up:

- Either for counseling or assessing improvement, side effects of medication.

**Severe mental disorders**

I Psychosis

Psychosis is a severe mental disorder that causes abnormal thinking, perceptions and behavior. Main change in psychosis is, lose of touch with reality. Two main symptoms in psychosis are delusions and hallucinations. Delusions are false unshakeable beliefs that other people would regard as groundless such as being poisoned or plotted against, possessed by jins, some has done black magic or Jado etc. Hallucinations are false perceptions, such as hearing, seeing or feeling something that is not there. For many people, these experiences can be very disturbing and disruptive; interfering with everyday life, with their relationships, and finding or keeping a job. During a psychotic crisis person may not trust others. Patient may not accept that other people find such beliefs strange.

The exact cause of psychosis is unknown but there are many factors which make people vulnerable to psychosis. In most cases a combination of factors contributes to its development.

Some risk factors for psychosis are:

| | |
|---|---|
| Biological | |
| | • Having a family history of psychosis |
| | • Use of substances e.g. cannabis |
| | • Abnormalities in brain structure |
| | • Malnutrition during pregnancy |
| Psychological | |
| | • Stressful life circumstances, |
| | • Family conflicts, |
| | • Traumatic experiences, |
| | • Being sexually abused |
| Social | |
| | • Bereavement, |
| | • Displacement, |
| | • Migration. |
| | • Witnessing a violence, |
| | • Being subject to violence, |

There are different types of psychosis:

- **Acute psychosis**
- **Schizophrenia**
- **Psychosis caused by substances such as cannabis or alcohol**
- **Bipolar disorder, mania**
- **Depression with psychotic symptoms**
- **Postpartum psychosis**

**1) Acute psychosis**

- This type usually starts suddenly and lasts for weeks.

Common symptoms of psychosis are:

- Severe behavioral disturbance such as agitation and aggression
- Abnormal thoughts and bizarre beliefs or delusions such as:
  - ⇒ Being poisoned or plotted to be harmed,
  - ⇒ Being under black magic (Jado),
  - ⇒ Possession by jinn, being controlled by unknown forces,
  - ⇒ Being cursed or abused.
- Hallucinations e.g. hearing voices or seeing things others cannot or feeling as if insects crawling under skin etc
- Disorganized speech or talking nonsense
- Fearful emotional state or rapidly changing emotions
- Bizarre behavior e.g. collecting rubbish
- Neglected self care
- Talking, laughing to self

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- Acute psychosis needs immediate referral to a doctor, at times there is need for hospitalization.
- Especially if patient is aggressive towards others, ensuring safety of patient and others are crucial. The goals are to reduce patient and family sufferings and to prevent consequences.
- Because of the short duration of acute psychosis, the treatment is brief and focused on being least restrictive.
- Antipsychotic medication will reduce psychotic symptoms (e. g., haloperidol 2-10 mg/day or chlorpromazine 100—400mg/day, Olanzapine 5-10 mg).

- Sometimes there are severe side effects with these medications, some of them are:
  - ⇒ **Parkinson** symptoms such as tremor, stiffness in body, slow movement, maintaining one posture, can be managed with Antiparkinson medicine e.g. Trihexyphenidyl or Biperidin.
  - ⇒ **Dystonia** or spasms of neck muscles and tongue, can be managed with inject able benzodiazepines or antiparkinsonian medication
  - ⇒ **Akathisia** or severe motor restlessness in which patient keeps on moving, can be managed with dosage reduction of the antipsychotic or giving a beta-blocker.
- After the acute episode is resolved psychosocial counseling may be considered to cope with stressors, resolve conflict, and improve self-esteem and self-confidence. Generally, acute psychosis has a good outcome and its course runs about a month.

Important tips:

- Violent behavior which is dangerous to the patient, the family or the community requires hospitalization
- Encourage resumption of normal activities after symptoms improve.
- Educate family on stigma and social exclusion
- Most patient who have one psychotic episode never have another one
- Some cases might be recurrent or run a chronic course without treatment
- Early intervention help people to recover soon and prevent chronic course

II Schizophrenia

Schizophrenia is a severe and persistent debilitating mental disorder. The cause of schizophrenia is not well understood and probably many factors are involved. Patients with schizophrenia have lower rates of employment, marriage, and independent living than other people. Schizophrenia usually occurs in adolescence, without early treatment runs a chronic course.

Common symptoms of schizophrenia are:

- Hallucinations: Hearing voices e.g. people are talking to patient, jinn talking to patient, or seeing things which are not present
- Delusions e.g. persecuted or poisoned, being plotted, having animal or unusual objects inside one's body, having snakes inside brain, Person's thoughts being broadcast or read by others etc
- Inappropriate affect or blunted affect or lack of emotions
- Problem with concentration and paying attention
- Low motivation and self-neglect
- Agitation or restlessness
- Loss of interest in everyday activities
- Social withdrawal
- Reduced ability to plan or carry out activities
- Physical immobility

Important tips:

- Agitation is symptom of a mental illness.
- Patients may be suspicious about people around
- Symptoms may come and go over time.
- Anticipate and prepare for relapses.
- Medication is a central component of treatment; it will both reduce current difficulties and prevent relapse.
- Family support is essential for compliance with treatment
- Patient may need rehabilitation
- Patients may not know they are ill
- Risk of suicide

Consequences:

- Substance abuse and dependence, suicide, depression, stigma and discrimination, isolation, interruption of studies, loss of job, family conflicts. Schizophrenia without treatment runs a chronic course with relapse of symptoms.
- Most of the patient show significant improvement with medication and later with psychosocial counseling.
- Treatment is initially pharmacological and is similar to acute psychosis; the difference is duration which is longer for schizophrenia.
- Many patients may need psychosocial rehabilitation.

***Post-partum Psychosis***

Postpartum psychosis is characterized by hallucinations, delusions, disorganized and bizarre thinking, homicidal and suicidal impulses. Postpartum psychosis is the most severe form of postpartum mental illness. It has a sudden onset, as early as the 48-72 hours after delivery, but in most cases symptoms become obvious in the first 2 weeks after delivery. If mother is left alone she may harm herself or the baby, or neglect the baby. A woman with post-partum psychosis and her baby require immediate attention and families need to take the mother to the hospital as emergency intervention is necessary. The ultimate goal of the treatment is to keep the baby and mother safe. Family members should be instructed to remain with the patient at all times.

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Women with a personal history of psychosis, bipolar disorder or schizophrenia have an increased risk of developing postpartum psychosis. Likewise, women who have a family history of psychosis, bipolar disorder or schizophrenia have a greater chance of developing the disorder. Treatment is pharmacological similar to other psychosis and the mother will completely recover.

Some important tips:

- It is important that family members be present with patient
- Affected individual should not be labeled as bad mother.
- After treatment mother will continue good caring for her baby
- There is risk of psychosis in future pregnancies.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms of psychosis e.g. delusions, hallucinations.
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Previous episodes and its treatments
- Patient's readiness for treatment.

Most importantly information about:

- Mental illness in the family
- Physical diseases of the mother
- Use of medication for current episode
- Person's personality before illness
- Risk of harming the baby
- Risk of suicide or suicide attempts
- Family attitude toward illness
- Chaining the patient at home
- Use of traditional remedies

2) Referral to a doctor:

- All cases of postpartum psychosis.

3) Psychoeducation:

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

Important tips are:

- Family support and educating the family regarding what has occurred
- Treatment plan to be shared with family members and obtain their support for it.
- Medication will prevent relapse and has side-effects.
- Patient to start daily activities as soon as symptoms improve.
- Patient to respect community standards and expectations
- No argument with psychotic patient
- No confrontation or criticism
- High risk of suicide for mother

4) Psychosocial counseling:

- Here it is more a support for the client as well as for the family about everyday difficulties and psychosocial stressors which are either already there or are caused by the illness of the family member.

5) Follow up:

- Either for counseling or assessing improvement, side effects of medication, compliance, risk of suicide and family support.

III Mania

Everyone has occasional highs and lows in their moods. But people with bipolar disorder have extreme swings of mood. They can go from feeling very sad, despairing, helpless, worthless, and hopeless to feeling as if they are on top of the world, hyperactive, creative, and grandiose. In between these mood swings, people with bipolar disorder are able to function normally, hold a job, and have a normal family life. This is called bipolar disorder, the first phase is depression and the second one is mania.

A person with mania experiences some of the following symptoms:

- Excessive happiness without reason (euphoria or elation)
- Unusual irritability and anger
- Easy distractibility
- Decreased need for sleep
- Grandiose ideas e.g. that he has special powers or is God's chosen person or helps President Karzai.
- Persecution e.g. that others are trying to harm him
- Talking very fast and jumping from subject to subject
- Racing thoughts or flight of ideas
- Inflated self-esteem
- Increased energy or being unable to relax
- Starts doing many things but not managing to complete anything
- Poor judgment
- Denying that there is any illness at all
- Unrealistic plans, increased sexual affairs, other reckless behaviors, such as wild driving, taking excess substance or alcohol.

Extreme mania can lead to aggressive behavior, potentially dangerous risk-taking behaviors etc. Patient is unaware of what is happening to him. Initial episodes may last 1-3 months but with passage of time episodes last longer and the patient may have mild mania throughout year. In some places in Afghanistan such chronic patients are believed to possess especial ability as expressed through delusional thinking and speeches and odd behavior. Mania has a periodic course and can appear any time again and again. Along with mania patient may have episodes of depression which is usually not troublesome. Mania is a difficult case and should be managed

by a doctor or mental health professional. Generally, people with severe mania will not seek medical care on their own. Most patients may need admission in hospital but patients do not accept hospitalization.

Consequences of mania:

- Substance and alcohol abuse
- Legal problems
- Financial problems
- Relationship problems
- Suicide
- Poor work or school performance
- HIV/AIDS

The initial treatment of mania includes antipsychotic medications such as haloperidol or chlorpromazine to control symptoms. When symptoms are controlled prophylactic treatment with medications can be continued. Prophylactic medications control episodes of mania and depression and is considered when patient has more then three in a year. All medications have side effects which needs a close follow up by doctor for many weeks. When symptoms severity decreased psychosocial intervention is useful for patients and the family.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms of Mania
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life
- Exploring risk-taking behavior.

Most importantly information about:

- Bipolar disorder in the family
- Physical diseases in patient
- Use of medication
- Use of substances or alcohol
- Person's personality before illness

- Changes in the person's life before the illness
- Use of traditional remedies
- If the patient is chained

2) Referral to a doctor if

- Symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective
- Psychotic symptoms are present

3) Psychoeducation:

- Educating patient and the family on the nature of symptoms, duration of episodes and changes over time, risk taking-behavior, psychosocial stressors, consequences including suicide, treatment, follow up, relapse and its prevention.

Important tips:

- Changes in mood and behavior are symptoms of an illness
- Avoid confrontation with patient, unless to prevent harmful or dangerous acts
- Effective treatments are available
- Hospitalization is for the safety of patient and family members
- Long-term treatment can prevent future episodes.
- With no treatment, patient may become disruptive or dangerous.
- Mania often leads to loss of job, financial problems or high-risk sexual behavior etc.
- Caution about impulsive or dangerous behavior
- Close observation by family members is often needed
- Treatment is more successful with strong support from family
- Stress may put people, who had mania in the past, into extremes mania
- Signs of relapse can be identified by family members
- Regular appointments for follow up is very important
- Stigma and discrimination

3) Psychosocial counseling

- Important is the support for the client as well as for the family about everyday difficulties and psychosocial stressors, which are either already there or are caused by the illness of the family member. After the symptoms are decreased the counselor can explore the psychosocial stressors which, are connected to the symptoms.

4) Follow up:

- Either for counseling or assessing improvement, side effects of medication and signs of relapse.

**Childhood mental disorders**

I Mental retardation (MR)

Mental retardation is not a disease and not a mental illness. Although it is not a mental illness but, some people with mental retardation may also develop mental illness. MR is a condition in which there is delay or deficiency in all aspects of development, i.e. in development of motor, cognitive, social, and language functions. Mental retardation is a life-long condition. To understand mental retardation, it helps to know what intelligence is.

Intelligence is a way of describing someone's ability to think, learn, and solve problems. In MR person has lower than average intelligence. Those affected continue to have diminished intellectual capacity throughout their lives. Intelligence tests are used to find level of intellectual abnormality which is through standardized psychological tests called IQ tests.

Based on IQ, mental retardation can be classified into different degrees as follows:

| IQ | Category |
|---|---|
| 85-100 | Normal |
| 70-85 | Normal but not retarded |
| 50-70 | Mild mental retardation |
| 35-50 | Moderate |
| 20-35 | Severe |
| Below 20 | Profound |

The cause of mental retardation is not always clear, but any illness or injury which affects brain while baby is growing inside his or her mother, during the birth, or after the baby is born can be responsible for mental retardation.

Some causes of mental retardation are:

- Brain Infections e.g. meningitis etc
- Head Trauma during labor or latter in life
- Chromosomal abnormalities
- Nutritional problems e.g. lack iodine etc.
- Genetic abnormalities
- Metabolic disturbances
- Toxic agents

The major characteristic of mental retardation is delay in development including mental development, whereas the major characteristic of mental illness is disturbance in the mental functions of thinking, feeling, and behavior. Mental illness can occur at any age, whereas mental retardation is present from childhood.

Common features in mental retardation are:

- Delays in achieving milestones such as sitting up, walking and speaking
- Continued infantile behavior
- Decreased learning ability e.g. difficulties in school, difficulty in learning new things etc.
- Failure to meet intellectual developmental markers according to age
- Lack of curiosity
- Difficulty in self care
- Behavior problems e.g. temper tantrums, head banging, bedwetting, etc

Since some parts of brain may not be affected, during childhood those parts continue to grow and till adulthood person can acquire some skills based on unaffected areas of the brain e.g. speech, self help skills etc.

Adult attainments in different degrees of mental retardation:

| Degree | IQ range | Adult attainments |
|---|---|---|
| Mild | 50-70 | Literacy +<br>Self-help skills++<br>Good speech ++<br>Semi-skilled work + |
| Moderate | 35-50 | Literacy +/-<br>Self-help skills +<br>Domestic speech+<br>Unskilled work with or without supervision + |
| Severe | 20-35 | Assisted self-help skills+<br>Minimum speech+<br>Assisted household chores + |
| Profound | Less than 20 | Speech+/-<br>Self-help skills +/- |

+/- a little, + some, ++ average

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There is no cure for mental retardation. The primary goal of intervention e.g. training and special education is to develop the person's potential to the fullest. Special education and training should begin as early as possible. This includes social skills and self care to help the person function as normally as possible. If there are other problems such as epilepsy, abnormal movements, speech problems, case should be referred to a doctor.

| Degree of Mental Retardation | Maturation/ Development In preschool age (0-5) | Training/Education in school age (6-20) | Social/Vocational Adequacy in adult (21 and over) |
|---|---|---|---|
| **Mild** | • Can develop social and communication skills;<br>• Minimal retardation in sensorimotor areas;<br>• Often not distinguished from normal until later age | • Can learn academic skills up to 6-grade level by late teens | • Can achieve social/ vocational skills adequate to minimum self-support but may need guidance/ assistance when under unusual social or economic stress |
| **Moderate** | • Can talk/learn to communicate<br>• Poor social awareness<br>• Fair motor develop.<br>• Profits form training in self-help<br>• Can be managed with moderate supervision | • Can profit from training in social skills<br>• Unlikely to progress beyond 2-grade level in academic subjects<br>• May learn to travel alone in familiar places | • May achieve self-maintenance in unskilled work under privileged conditions<br>• Needs supervision/ guidance when under mild stress |
| **Severe** | • Poor motor develop.<br>• Speech is minimal<br>• Unable to profit from training in self-help<br>• Little/no communication skills | • Can talk or learn to communicate<br>• Can be trained in elemental health habits<br>• Profits from systematic habit training | • May contribute to self-maintenance under complete supervision<br>• Can develop self-protection skills to a minimal useful level in controlled environment |
| **Profound** | • Gross retardation | • Some motor develop. | • Some motor/ speech |

| | | | |
|---|---|---|---|
| | • Minimal capacity for functioning in sensorimotor areas<br>• Needs nursing care | • May respond to minimal training in self-help | develop.<br>• May achieve very limited self-care<br>• Needs nursing care |

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring early difficulties and current problems
- Exploring the severity of problems
- Exploring psychosocial stressors
- Impact of problems on person's daily life.

Most importantly information about:

- Similar problem in family
- Use of substances or alcohol
- Risk of self harm
- Use of traditional remedies

2) Referral to a doctor if:

- Symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective
- Psychotic symptoms are present

3) Psychoeducation and psychosocial counseling:

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

Some important tips:

- Early training can help towards independence and self-care.
- There is no cure for mental retardation
- Mental retardation is not the fault of the child
- Mental retardation is not a punishment for the sins.

- Some children may be disruptive or overactive
- A mentally retarded child can learn many things; it just takes them more time and effort than other children.
- Teaching the child requires a lot of patience and encouragement.
- Praise the child when s/he is doing something well than to punish her/him when a mistake is made.
- These children are capable of loving relationships.
- Families may feel great loss or feel overwhelmed by the burden of caring for a retarded child.
- Children and adults to be allowed to function at the highest level of their ability in school, work and family.
- Parents can share practical advice and emotional support.

4) Follow up:

- Either for counseling or assessing improvement, side effects, medication and counseling together.

**Substance abuse and dependence**

Substance abuse is a pattern of harmful use of any substance for euphoric purposes. Using substances are a way for coping with unwanted feeling and emotions. When repeated in many occasions dependence can occur. Common substance of abuse in Afghanistan is narcotics such as opium and heroin. Other common substance is hashish also some sedative and sleeping medicine.

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Substance dependency is a complex problem that has biological, psychological, and social aspects. There is no single factor that can explain why a person becomes an addict.

1. Biological factors:
   - Genetic factors make certain persons more vulnerable to substance dependence
   - Positive effects of a substance are initially stronger than the negative effects which are the path for dependence.
   - Substance use can induce changes in certain chemicals in the brain.

2. Psychological factors:
   - Being lonely or depressed
   - Having frequent worries and anxiety
   - Difficulty coping stresses

3. Social factors:
   - Availability of substances
   - Peer pressure
   - Family factors: use in family, or abuse is not properly corrected by the family
   - Environmental factors such as financial problems, family conflicts, unemployment etc.

Substance dependence has following characteristics:
   - Frequent use of a substance
   - A strong desire to use substance
   - Difficulty in controlling the amount of use
   - Experiencing withdrawal symptoms after substance is stopped
   - Need for more and more to achieve the same effect tolerance

- Decreasing interest in other activities
- Continuing use, despite the harmful effects

Traditionally opium has been a common remedy for pain and cough in Afghanistan for centuries. Such practice is a way of abuse and dependence for people in rural areas where modern health service is lacking. Narcotics use is considered abuse when people use them to seek feelings of well-being apart from the pain-relief applications. The most commonly abused narcotic is heroin. Other narcotics include morphine, codeine, etc. Opium is eaten or smoked while heroin and hashish is smoked. Heroin can be injected also. Some people use more then one substance. On other hand some people may have a mental illness with substance abuse or dependence which needs to be handled when treating dependence.

Signs and symptoms of narcotic abuse:

- Feeling no pain
- Sedation
- Euphoria
- Respiratory depression (shallow breathing)
- Small pupils, bloodshot eyes
- Nausea, vomiting
- Itching skin, flushed skin
- Constipation
- Slurred speech
- Confusion, poor judgment
- Needle marks on the skin if used injections

A person who uses heroin will experience some of the following symptoms:

- Skin infections and ulcers if he injects substances
- Breathing problems, such as asthma or lung infection
- Feeling helpless and out of control
- Feeling guilty about taking substances
- Feeling sad and depressed
- A strong desire to take the substance
- Continuous thoughts about the next occasion of use
- Thoughts of suicide

- Sleep problems
- Anger and aggression
- Stealing money to buy substances; getting in trouble with the police
- Decreasing academic or work performance
- Withdrawal reactions if not taken, such as nausea, anxiety, tremors, diarrhea, stomach cramps, sweating

Withdrawal occurs 24-48 hours after stopping substance or reducing the amount. During withdrawal period people experience unpleasant symptoms which can be unbearable and is the reason for continuation of the substance.

Common withdrawal symptoms of opium and heroin are as follow:

- Body pain
- Restlessness
- Sleep problems
- Abdominal pain
- Diarrhea
- Trembling muscles and muscle cramps
- Anxiety
- Enlarged pupils
- Tremors
- Lack of appetite
- Depression
- Sneezing and yawning
- Irritability
- increased pulse rate
- Rapid breathing
- Salivation
- Nasal stuffiness
- Vomiting
- Strong desire to use again
- Sweating
- Confusion

Many complications can result from narcotic abuse, the most common being infectious conditions. Effects of chronic use are lowered sexual desire and impotence in men. Injecting heroin can cause infections of the blood. In communities of heroin users HIV/AIDS can be rapidly spread. Infections of the skin and deeper layers are the common infection in heroin dependence.

- Abscesses in skin, and other organs e.g. lungs
- Pneumonia
- Fluid in the lungs
- Liver dysfunction
- Intestinal slowdown
- Seizures
- Loss of menstruation
- Premature and slow growth infants
- Baby withdrawal symptoms if mother is using substance
- Mental disorder e.g. depression

Treatment of substance abuse and dependence is difficult and needs special interventions. When forced by family members, most substance abusers say they can stop using substances on their own, but majority who try do not succeed.

There are three phase in substance dependence treatment, for a successful treatment all three phases should be completed:

a) Motivations in which psychosocial methods are used to prepare patient for detoxification and reduce the amount of substance until withdrawal symptoms are appeared.
b) Detoxification here patient stops the substance completely and takes prescribed medication for controlling withdrawal symptoms. Different methods are available for detoxification of opium and heroin dependence.
c) Rehabilitation and aftercare. In this phase patient will be rehabilitated and integrated into community. First 6 months after detoxification has the highest rate of relapse, to prevent relapse psychosocial care and family support is very important. Support groups especially joining self help groups are very helpful for people who are recovering from substance dependence.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms when substance is taken
- Exploring withdrawal symptoms
- Exploring the severity of the symptoms.
- Mode and frequency of use
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life.

Most importantly information about:

- Substance use in the family
- Physical diseases in patient
- Use of other substances or medication
- Social and financial difficulties
- Person's personality before dependence
- Changes in the person's life before dependence

- Risk of suicide or suicide attempts
- Associated mental disorder

2) Referral to a substance treatment center if:

- Withdrawal symptoms are severe
- There is a suicide attempt or risk of suicide
- There is possible associated physical illness
- Initial counseling was not effective
- Mental disorder is present
- Use of traditional remedies

3) Psychoeducation:

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

Important tips:

- Patient should not be blamed for substance abuse and related problems
- Controlling or stopping substance use often requires several attempts.
- Stopping or reducing substance will bring mental and physical benefits.
- Using substances during pregnancy will harm the baby.
- With intravenous substance use, there is risk of getting or giving HIV infection, hepatitis or other blood borne infections.
- Relapse is common within first six months after quitting the substance.
- Mental illness can coexist with substance use

3) Psychosocial counseling:

- If addiction is caused by difficult life situations, or is one of the consequences of traumatic stress then psychosocial counseling is indicated and helpful especially in the aftercare. Otherwise it is an important support for harm reduction.

4) Follow up:

- Either for counseling or assessing improvement, monitoring for relapse, family support, coping with stressors and prevention of relapse.

**Other problems**

I Self harm and suicide

Self-harm happens when someone deliberately hurts or harms him or herself. Someone who self-harms will usually do it in a state of high emotion, distress and unbearable inner turmoil e.g. after a serious discussion with family. Self-harm is a way of expressing very deep distress. It's worth remembering that most people behave to self-harm at times, even if they don't realize it. In Afghanistan self harm cases have been reported among women in recent years.

People use different methods to self-harm,

Some common methods used in Afghanistan are:

- Burning the body with kerosene
- Hanging
- Drowning
- Swallowing pesticide
- Cutting skin or throat
- Punching the body
- Taking tablets ( medicine overdose)
- Throwing self from height

Some people self-harm only once or twice, but others may do it regularly. Some people harm themselves in less obvious but serious ways. They may behave in ways that suggest they don't care whether they live or die; they may take excess substances, drive recklessly, and drink more alcohol.

Some facts about self harm:

- More young people will self-harm but it can occur at any age.
- It is more common in young women than men.
- Sometimes if someone self harm the chance of doing so increases for other family members
- People who self-harm are more likely to have experienced physical, emotional or sexual abuse in the past.
- With relationship problems with spouse, friends and family people may self harm
- People who feel depressed and helpless may self harm
- Someone who has mental health problems is more likely to self-harm.

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Although, there is a relationship between self-harm and suicide, more people self-harm than kill themselves. Suicide is considered a great sin in Islam, but there is no legal punishment for the person who attempts suicide.

Some people are more likely to harm themselves seriously or self-harm regularly; they may be socially isolated or have a mental illness. They should be assessed by someone with experience in self-harm and mental health problems. For such cases in emergency rooms/hospital the help is just to save person e.g. treatment of burn or stomach wash in poisoning etc. After improvement person is discharged with no attempt to workout underlying psychological problem. Availability of psychosocial care opens a new window for people who have harmed or will harm themselves.

There are ways to cope with thoughts of self-harm and suicide which will help people calm down and find solution for the problem.

Some of them are:

- Talking to someone, a friend, family member
- Distracting thoughts with other activities e.g. visiting relatives, prayers, helping others such as neighbors.
- Relaxing and focusing on something pleasant
- Finding another way to express feelings
- Focusing mind on positives things.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms of mental illnesses
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life.

Most importantly information about:

- Circumstances self harm happened
- Self-harm or suicide, depression or other mental disorder in the family
- Previous attempts and consequences
- Current physical diseases
- Use of substances or alcohol

- Person’s personality before current problem
- Changes in the person’s life before self harm
- Current psychosocial problems
- Attitude of family members

2) Referral to a doctor if:

- There is a suicide attempt or high risk of suicide
- Mental disorder is present
- There is possible associated physical illness
- Initial counseling was not effective

3) Psychoeducation:

- Educating patient and the family on the nature of self-harm and suicide, risk factors, psychosocial stressors, consequences, role of family members in prevention, follow up.

Some important tips:

- Self-harm should not be taken easy
- Person should not be blamed for self harming
- There is a greater risk for self harm after first attempt
- Asking about suicidal thoughts or plans does not put the idea in the person's head
- Friends and family members can help to reduce the risk of self harm
- Self harm can be in response to stressful events
- Self harm often brought about by sudden, unexpected change in life
- Suicidal thoughts can be part a serious illness.

4) Psychosocial counseling:

- Follow the counseling steps as described in psychosocial interventions and skills, in the section of suicide.

5) Follow up:

- Either for counseling or assessing improvement in suicidal thoughts, family involvement, and change in coping with stressors.

II Epilepsy

Epilepsy is a disease of the brain with a variety of causes; it is also called “Mergi”. In epilepsy, patients have brain cells that create abnormal electricity which cause attacks. Frequencies of attacks differ in people and the intervals between attacks are irregular. Attacks come on irregular intervals and most of the time attacks are similar. Between seizures, a person with epilepsy is no different from anyone else. A single attack is not considered epilepsy. Epilepsy is not a mental illness, and it is not a sign of low intelligence. It is also not contagious.

Epilepsy is common in children but can occur at any age. Childhood infectious illnesses and head trauma are risk factors for epilepsy. There are many causes for epilepsy at times it is difficult to find a cause for it.

Some common causes are:

- Brain injury
- Brain infections
- Abnormal brain development
- Brain tumor
- Stroke and other vascular diseases
- Childhood infections

Symptoms of epilepsy vary depending on the type of seizure.

There is two type of epilepsy: generalized and partial:

a) **In generalized form,** patient may have jerking, uncontrolled movements and loss of consciousness which may lasts minutes. People with epilepsy have repeated episodes of attacks. During an attack, the person may fall down, shake, stiffen, throw up, drool, pass urine, or lose control of their bowels. The attack can produce temporary confusion, complete loss of consciousness, a staring spell, or uncontrollable jerking movements of the arms and legs. When attack ends, the person may feel sleepy and won't remember what happened. Many patients have some symptoms before actual attack which alarms patient of the attack. This is called aura and is common in generalized epilepsy. Common auras are: abdominal discomfort, feeling uneasy, mood change, and feeling of change in surrounding, unusual smell etc.

   Common symptoms of generalized attacks are:

   - Sudden fall
   - Unconsciousness
   - Shaking and abnormal movement

- Turning blue
- Tongue bite and frothing
- Injuries in limbs, face, head
- Urine incontinence
- Up rolling of eye balls

b) In partial form the person may just stare into space or have jerking movements in one part of the body without loss of consciousness. The attack is brief and can be repeated many times in a day. In other cases, attack cause only confusion, a staring spell or muscle spasms which usually lasts few seconds or a minute.

**In most cases,** a person with epilepsy will tend to have the same type of attack each time, so the symptoms will be similar from episode to episode. After attack person is drowsy, has body pain and may go to sleep for a while. But awake can not remember the attack. During attack some people put a hard object into person's mouth which is dangerous and can cause mouth injury or break teeth. Some people press a hard object between fingers of the person which is not helpful at all. Similarly smelling objects e.g. a shoe does not help the person and should be avoided. Some people try to stop movements by holding persons arm and legs which can cause more injuries to patient.

Tips to help person during attack:

- Don't try to keep the person from moving or shaking.
- Don't try to wake the person by shouting at or shaking them.
- Take away items that could cause injury if the person falls or bumps into them.
- Don't move the person to another place.
- Slowly turn the person on his or her side so any fluid in the mouth can safely come out
- Never try to force the person's mouth open or put anything in it.
- Place something soft such as a pillow, under his or her head.
- Most attacks are not life-threatening.
- When the attack ends, watch for signs of confusion. Allow the person to rest or sleep if he or she wishes.

In many cases with proper history diagnosis is not difficult. Epilepsy needs to differentiate from conversion disorder, for differential diagnosis see table under conversion disorder. Once epilepsy is diagnosed, it is important to begin treatment as soon as possible. If not treated, epilepsy restricts the life and person faces social stigma. Attacks can be controlled in up to 80 percent of cases with antiepileptic medicines. Common antiepileptic medicines are:

All medicine used for the treatment of epilepsy has some side effects which may include mild fatigue, dizziness and weight gain. Epilepsy needs a long term treatment which should be continued under a doctors' guidance. Many epilepsy patients also their family members need psychosocial counseling.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms before, during and after attack of epilepsy
- Exploring the severity of the symptoms
- Exploring frequency and duration, of attack
- Exploring psychosocial stressors
- Impact of symptoms on patient's daily life.

Most importantly information about:

- Depression in the family
- Physical diseases
- Use of medication
- Use of substances or alcohol
- Change in person's personality after illness
- Risk of suicide or suicide attempts
- Use of traditional relief

2) Referral to a doctor if:

- Attacks are frequent
- There is a risk of suicide
- There is possible associated physical illness
- Medication was not effective
- Mental disorder is present

3) Psychoeducation and psychosocial counseling:

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

Important tips:

- Epilepsy is not a mental illness
- Epilepsy patient can get mental illness
- Most cases start at childhood
- Medication controls attacks
- Coping with stress reduces number of attacks
- Counseling improves anxiety or depression and prevent attacks
- Attacks occur any time including during sleep
- Stigma and discrimination is high
- Treatment duration is about three years

4) Follow up:

- Either for counseling or assessing improvement, side effects, medication and counseling together.

III Unexplained somatic complaints (USC)

Unexplained somatic complaints can be seen as an symbolic expression for personal or psychosocial problems. This can be connected with the fact that there is no awareness, it also can be a kind of helplessness to express difficult subjects or to talk about taboo themes. Persons with unexplained somatic complaint have no genuine physical disorder. If the somatic complaints have a long history with the person, they can get chronic. These people are usually more sensitive than other person to changes in the way their body works. This is a common problem, but people working in health care don't fully understand it yet. These patients are a clinical challenge for physicians, generating fundamental questions about the nature of symptoms and the relationship between mind and body. This complaint seems to be more common among women. Family members may be role models for somatic symptoms. Most patients with depression and anxiety disorder present them with somatic complaints.
Some common,
Unexplained physical problems are seen as:

- Headaches
- Lower back pain
- Pain in arms, legs or joints
- Nausea and vomiting
- Body pain and muscle discomfort
- Difficulty in swallowing
- Chest pains
- Frequent urination
- Abdominal pain
- Dizziness
- Fainting spells
- Palpitation or rapid heart beat
- Painful menstruation
- Excessive menstrual bleeding
- Irregular menstrual cycles

With USC there is sleep problems, anxiety, depression etc. People with USC usually have long, complicated medical histories and psychological distress and interpersonal problems. The medical history is often circumstantial, vague, inconsistent and disorganized. They have been to many physicians, done different lab tests, had a variety of diagnosis, taken different medicine but with no recovery. Patients make frequent medical visits in spite of negative investigations.

It is important to remember that physical symptoms in USC are real and they are not intentionally produced. The cause of USC is not specific but symptoms begin or worsen with stress.

During the illness a vicious circle can develop:

- Emotional stress can cause physical symptoms or make them worse.
- Physical symptoms can lead to more stress.
- Emotional stress can make physical symptoms worse.
- Symptoms may vary widely across cultures.
- Complaints may be single or multiple and may change over time.

Person with USC needs both, psychological and medical treatments. The treatment goal is to improve coping and function rather than to eliminate the symptom completely. Important components of general management include effective initial reassurance, a positive explanation, and practical advice. At times medications such as antidepressants may help person to relieve symptoms of depression and anxiety. Some patients may be primarily concerned with obtaining relief from physical symptoms. Others may be worried about having a physical illness and be unable to believe that no physical condition is present.

**What Psychosocial Counselor would do?**

1) Assessment:

- Exploring symptoms of unexplained somatic complaint
- Exploring the severity of the symptoms.
- Exploring psychosocial stressors
- Impact of symptoms on patient’s daily life
- Review history of functional symptoms.

Most importantly information about:

- Unexplained somatic complaint r in the family
- Identify patients' concerns and beliefs
- Suicidal thoughts or attempt
- Use of substances or alcohol or narcotic pan killers
- Person’s personality before current problem
- Changes in the person’s life before current illness
- Current psychosocial problems and coping styles
- Attitude of family members towards unexplained somatic complaint
- Use of traditional remedies
- Ask questions about patients' reaction to and coping with symptoms

- Consider interviewing relatives

2) Referral:

- When USC is diagnosed avoid referrals to specialists. Such patients are best managed in primary care settings. Remember patients may be offended by referral to a psychiatrist and seek additional medical consultation elsewhere.

3) Psychoeducation:

- Educating patient and the family on the nature of illness, risk factors, psychosocial stressors, consequences, role of family members in prevention, follow up, mind-body relationship.

Some important tips:

- Care for USC rather than cure
- Try not to eliminate symptoms completely, you can't
- Focus on managing the symptoms, not on discovering their cause.
- Chronic USC is not dangerous, even though they cause great discomfort.
- Symptoms are real, and they cause real problems in life
- Symptoms can get better when these people get help for their emotional pain
- Focus on coping and functioning
- Depression, anxiety disorder have similar somatic symptoms
- Narcotic medicines will not cure the problem and can be abused
- Appropriate reassurance e.g., abdominal pain does not indicate cancer.
- Regular exercise makes person feel much better

4) Psychosocial counseling:

- Explore carefully the original connection of symptoms and psychosocial stressors. Explore the function of the symptom for the patient. Follow the counseling steps as described in the manual.

5) Follow up:

- Either for counseling or assessing improvement, assessing suicidal thoughts, family involvement, and change in coping with stressors.

# Basic knowledge of Psychology

Mental Health Department of the MoPH

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Responsible for the content of this draft:

Inge Missmahl, technical advisor for Mental Health from the Ec for the MoPH

## Foreword

The challenge here was to define the knowledge that is necessary and useful as well as serves a direct purpose for the better understanding of the client and his/her situation. Next we needed to integrate the knowledge which would help the counsellor to define the indicator for the right intervention.

Considering the given situation in Afghanistan which through tradition is connected to magic thinking and traditional beliefs some of the basic concepts about consciousness and unconsciousness from depth psychology seemed to be appropriate and important and have proved to help Afghan counsellors to gain a better understanding for their clients as well as for themselves. Those concepts help to understand phenomena such as projections, changes in mood as a complex reaction or difficulties with self esteem through the understanding of the concept of the “persona”.

Knowledge and understanding of what is happening in the body and soul as well as the psychological and physical short term and long term consequences for persons who have been exposed to traumatic experiences is obligatory for health staff in a country which has been exposed to war, deprivation and insecurity for 30 years.

Developmental psychology helps to understand normal and abnormal development of a child and explains the needs children have.

The biggest and most frequent psychosocial stressors in Afghanistan today are rooted in family conflicts. To understand the nature and dynamics of family conflicts may prevent the counsellors from quick judgements and help to explain the complexity of such situations.

We are aware that those topics are choices, which leave out many other equally important themes. The chosen topics have been tested in a pilot and proven to be helpful and meaningful for the everyday challenges a counsellor will face.

In the text the reader will find tasks in yellow boxes. They want to encourage the reader to explore and apply the knowledge to own life experience. Only if one understands what these concepts mean in real life, the knowledge will be valuable. For a future counsellor it is a necessity to understand how these concepts relate to his own life experience. Then the knowledge can be valuable and can be applied for the counselling.

**Table of content**

# Consciousness and unconsciousness

## 1. The conscious mind

The conscious mind is the part of our mind which we are aware of.
We can be aware of our actions, thoughts, feelings, intentions, of our environment and other people, the feelings and moods of other people. Being conscious means being aware of the world around and of our-selves. In the centre of our conscious mind is what we call the Ego.

### Ego

- Through the Ego we become conscious of who we are, how the world around us functions, how to gain orientation in this world which we perceive. The ego is connected to what we feel, think, know and experience referring to our own self.
  We get the information through three different ways:
  - ⇒ Through our **body** we experience feelings, which can be painful (fear) or enjoyable (relaxing). For example it could happen that we are frozen and cannot move anymore out of fear or that we are smiling, relaxed and feeling that the world around us is friendly (joy)
  - ⇒ Through **feelings and knowledge** we can experience our self in many different ways (imaginations, ideas, wishes, inner pictures, facts)
  - ⇒ **With our senses and knowledge we** perceive the outside world. On the one hand we receive information through watching other people or we are getting a feedback about our self; on the other hand we can influence our environment through acting.

- Everybody can feel that our ego is not static! How we are feeling about ourselves sometimes can change very quickly, depending on the outside situation.

**Task:** Please explore and write down a situation during the last days when your feelings suddenly changed.
Explore why this has happened?
What has happened in your environment?
What came to your mind by itself and you had not expected this?
Please share what you have found in a small group!

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As we have seen the feelings we are experiencing depend on outside or inside stimulus. They are not stable. We can say that we experience different ego-states.

**Ego-states**

- Our Ego is connected to different ego states, depending on the situation of our environment, our inside perception, feelings and thoughts
  - ⇒ Being at home with our family produces a special kind of feeling in our self. We then identify our ego with this state
  - ⇒ Being at work may produce a completely different feeling in our self. We have other ideas, pictures and needs, which reflect another state of our ego
  - *A young woman has a lot of responsibility for her younger sister, her old mother and father. Therefore she behaves in a very competent way, and never feel being overextended. She feels strong and capable. A special ego state seems to be present, and helps the young woman to cope with the situation in a proper way. But being with her older in-laws produce completely different feelings and needs in her! Suddenly she feels weak and feels the need to be cared for. Another ego state is know present!*

  The identity of the Ego is formed by the autobiographical memory and it is connected with the body

**Task:** Try to think of at least three ego states you know of yourself and connect them with situations in your life. Can you identify certain ego states in one of your family members in connection to a certain situation? Describe that ego state, which you identify with your ego. Try to describe the feelings and locate them in your body!

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- The idea of having different ego states is very useful for psychological counselling, as it offers the possibility to identify different parts of the person as either healthy or difficult instead of identifying those parts with the whole person!
- Every person always has a part which he/she likes best; or a part which knows what is the best for her/she. To identify this part can be helpful in counselling, as this part can be focused! It alos helps to restore self-confidence!

- Another effective method would be to ask the client to start an inner dialogue between different egos states. For instance an inner dialogue between a hurt part and a very healthy part or between the hurt and fragile inner child and the adult person today.

**Persona**

- Originally the word “persona” meant a mask worn by actors to indicate the role they played. Taking this into account the idea of the persona reflects a social identity on the one hand and an ideal image on the other. The persona is often identified with the position or status a person has in society.

  ⇒ People often idealize aspects of themselves that they present to the outside world, in society people interact with each other through this persona identity

- Persona is that what people want to show to the world in certain situations, and how they interact on the basis of this idea with others. Not only behaviour represent persona, but also the appearance (cloths, hairstyle, posture, movements)

*For instance in Afghanistan most people want to look strong and courageous. To reach this goal they walk in the villages keeping their heads high, wearing special clothes and carrying a gun. In the city, young men copy the hairstyle and clothing of famous actors or athletes. Equally women want to appear with dignity to gain a good reputation. They wear cloths according to Islamic and cultural rules, cover their heads and speak with a soft voice.*

⇓

In Afghan society a good Afghan should be fearless, courageous, modest, shy, cheerful, religious!

- Persona has to be regarded as a part of our identity, which tries to create a balance between the inner and the outside world
- The persona enables a productive interaction with other persons and functioning in society
- It is important to attend to such personas and their function for the person, as persona not only covers un-liked parts of the ego, but also can serve as a protective covering

**Task:**

Try to describe the persona of people you know.

Try to describe aspects of your own persona.

Which difficulties might arise from a persona, which is not flexible at all? Can you find examples from people you know?

## 2. The unconscious mind

Sometimes as we all know, we might do something or say something and we are surprised by our own actions the impulse for the action was not conscious to us. Often this happens when we are aroused; we then act out of an affect, without thinking of the possible outcome of our behaviour in advance.

**Task:** Please describe a situation when this has happened last time to you!

In general we are conscious of the contents of our psyche which are connected with the Ego. But there is a big part of our psyche which we are unconscious of.
We might have access to a part of these unconscious contents when we are dreaming at night or during the day by having imaginations or fantasies.

Psychological concepts make a distinction between:

1. **Personal unconscious**
2. It contains personal suppressed, forgotten or repressed happenings of our life. This can be ideas or feelings or happenings, which are not acceptable for the family or society, it can be shameful experiences of it can include feelings of guilt. That means that our personal unconscious is influenced by our culture, society and personal environment, the attitudes and values.
3. **The collective unconscious**
   ⇒ The contents of the collective unconscious are patterns and possibilities of the human instinctual behaviour and reactions. These are the psychic structures, which are all humans share. For instance all humans feel certain tenderness and the need to protect a small baby or a helpless child.

## 3. Contents of the personal unconsciousness (shadow)

Light responding to consciousness and darkness responding to unconsciousness belong together

- The psychological concept of the shadow talks about those aspects of the personality, which should not bee seen by others, which are in the dark. Those parts, which are not acceptable and would cause shame and fear, if they would be seen by others and be accepted by ourselves.
- Those parts of our psyche are parts, which are in the moment not in the realm of our consciousness.[1]
- The shadow of a human being develops at the same time as other sides of the personality like the idealised ego and persona. We can say that mostly unaccepted attitudes, ideas, behaviour are contained in the shadow.

  ⇒ Those unloved, unaccepted and suppressed aspects of oneself are pushed and stored in the personal unconscious and develop from there their own often destructive psychodynamic.

⇓

- People can be ashamed of those aspects, because they contradict the idealised view of themselves. Or they can not see them as belonging to themselves because their self-esteem is so low. What can happen is that some of those rejected aspects are projected on others.
- We can say that behaviour which, is recognised in others could also be an unaccepted part of the observing person.

- The personal shadow also contains positive aspects which are not yet seen by the person and which can be developed. This can be undiscovered resources.
- Sometimes positive aspects are projected. This happens mainly when the self-esteem of a person is rather low.

*A student who admires a classmate so much for his knowledge and intelligence might not see the possibilities he has within himself.*

- One of the chances of our own personal development is to become more conscious of our feelings, fears, wishes, ideas. It can be helpful to accept that these parts belong to us as well, although we might not like them or they are not in line with our idealised image which we have about ourselves. Then it might be better to take the responsibility for our behaviour, attitudes and temptations.

**Task:** Please try to write down your own idealised view of yourself.

[1] The concept of shadow was first created by Sigmund Freud and then further developed by C. G. Jung.

Discuss how the idealised view relates to and is connected with collective values.
Find the opposite side, the “shadow” side of these collective values

- In Afghan culture the shadow or „saya“ has the following meaning
  ⇒ It is projected on people and ghosts (Dschinns). The similarity could be that it is located in the dark; it is dangerous, because it is not visible. Only the effect of the shadow is visible. (compare the chapter about Afghan traditional beliefs)

4. Projection

Projection is a psychological process, which happens automatically. In this process, personal psychic aspects, which are usually not conscious, are being projected on persons, groups, situations or things. They become visible as a quality of someone or something in the outside. And thus are recognised by the unconsciously projecting person as part of the others.

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- Projection is usually an unconscious act. Often unacceptable behaviour or attitudes of the person or the collective are projected to the outside.

**Projection in Afghan society**

As we know, in Afghan society exists a lot of fear and shame. People often don’t have the courage to express their ideas and believes directly. One way to express their wishes and desires may be by projecting them on others.

- *A young girl wants to get married, to have her own house and to start a new life. It is impossible to express this directly. She will try to express it in another way for example by saying: „Dear parents, my brother is young now , he should get married , let us think about his future, and find him a good girl who could help you in the chores around the house, too.“*
  ⇒ She projects her own wish to get married onto her brother while in her heart she herself wants to get married but dares not to express it. As counsellors we should consider this possibility. It will be the skill of the counsellor to help the client to be able to explore these personal aspects and to dare to express his/her wishes openly and discuss them with the counsellor.

- Another example is the projection of taboos or wishes on “jinns” or other dangerous creatures.

- *A woman used to tell everybody that Jinns are talking about her, saying that she is a good and*

*moral woman.*

⇒ In reality she is not at all an immoral woman but suffers from the gossip of others who are saying that she is a prostitute. And therefore cannot accept to be seen as such a woman. So through projection she creates another world where she is seen in a positive way.

⇒ This also can be regarded as a resource, which helps this woman to keep a positive self image.

⇓

- Projection is a normal psychic activity, which prevents our-selves from seeing negative or unacceptable parts of ourselves or of seeing resources and possibilities. It also is a way of expressing taboos and explaining unexplainable happenings by creating a cause. It also has a very dangerous aspect, which can happen if one projects own intentions and wishes on others. And then might harm others by fighting against those projected intentions.

  ⇒ *A miscarriage sometimes will be explained by attributing it to the negative shadow of a Jinn.*

  ⇒ A further example: *men being doubty on their wives*.

**Task:** Please find examples for projection from your own experience**.** Think of some judgemental attitude towards someone you had recently

Can you discover parts of these qualities in yourself?

5. Complex

Complexes are contents of the psyche, which can be conscious or unconscious. They consist of emotionally charged contents around an important emotional experience.

- A complex develops out of an experience with which the psyche had at the given moment difficulties and was unable to cope. It also is possible that many small continuously bothering experiences cause a complex.
- They are psychic structures which can have a big influence on how we react to others or percept the world.

  ⇒ Authority complex:

  *A man with an authority complex seems to be unable to deal with authorities in a good way. Perhaps he always is very submissive, does not say to his boss openly what he thinks or*

*wants, rather complains behind his back or feels victimised by the boss and acts aggressive behind his back.*

- In this case an authority complex is constellated.
- Why is he unable to deal with an authority? It might be that we find the cause in a situation of his earlier life: *Perhaps his father was very strict and has beaten his child frequently. The child was unable to cope with this situation, felt hurt, victimised and was afraid but was too small and too weak to defend himself in this situation. The child was unable to respond to this situation in an adequate way. The child was dependent on the father and wanted to be accepted and loved by the father as well as wanting to love the father himself. As a consequence the child suppresses all these unpleasant and fearful emotions and splits them off and pretends consciously that everything is ok.*

⇒ The beginning of this complex might be the above mentioned overwhelming negative experience with the father. All following experiences in which this person feels helpless in a similar way will add to the first experience with the strict authoritarian father and form the emotionally charged centre of the complex. This will happen mostly when this man is confronted with an authority.

⇒ When our man has to deal with his boss, who is an authority for him and on whom he is depending regarding his benevolence and acceptance, then the complex is constellated and reacts autonomously. The man will start feeling like a victim again, his expectation will be that he will be treated unfairly he might have the feeling that he cannot cope with the situation. He reacts unconsciously from the emotion that is connected with the authority complex.

⇒ Consciously he feels like a victim.

⇒ When our man is in a position to exercise power over others or when he is a father himself, he might behave how his father did without being conscious of it. And so harm others and his own children.

- Complexes are condensed emotional experiences of relationships with people, connected through the similarity of information and of the emotions, which are involved. The person is usually unconsciously identified with the part of the complex which is connected to the experiences during the childhood or those experiences which had a very big impact. That means that the feelings and relationship patterns which were involved at the time of the experience then are now being transferred to the new situation:

⇓

- A complex can loose its emotional power when it becomes conscious. Example: The man with the authority complex is today not anymore a helpless child in front of the father, but an adult man who has knowledge and skills. Becoming conscious of why he is feeling in such a way when he enters the office of his boss can help him to react different and connect to his stronger adult part of himself.

**Task:** Please sit comfortable and relax, close your eyes and observe your breath:
Try to remember the last situation when you have overreacted. Try to look at this situation like an observer. Try to remember how you have felt what caused the feeling, which were your intentions and what did you do in the end. Discuss it in a small group and try to find out why you have reacted in such a way and explore which other situations like this do you know from your life. Perhaps you also can find the underlying emotion which goes along with it.

## 6. Polarity of the psyche

Polarity emerges out of the original unity.
Neither can exist without the other! The law of opposites keeps everything in balance!

- In other words: Darkness implies light and light darkness; sound stillness and stillness sound; life and death; active and passive; yes and no.
  - ⇒ Other pairs of opposites are love and hate; aggressor and victim; male and female; right and left; up and down;
- In psychology, the law of opposites helps us to understand how people process information and function in the world.
- C.G. Jung classified people into being extroverted or being more introverted.
  - ⇒ These are two opposite attitudes towards the outer world of objects and the inner personal world. This differentiation characterises the interaction and relationship to the environment.
  - ⇒ The extroverted person being more attracted to issues in the outer world, being stimulated by the outside world, outgoing and interactive.
  - ⇒ The introverted being more attracted to his inner world, being rather shy and retreated.
- Within our own psyche the polarity is always there.
  - ⇒ Usually one side is conscious the other more unconscious.

⇓

One of the benefits in counselling can be that the client becomes more conscious about this polarity in his own psyche and can differentiate better, which kind of behaviour and feeling is acting at the given moment.

- Example: *As we have seen, a person suffering from an authority complex feels consciously easily victimised. But often people seem to complain that this person is quiet aggressive. This person is not aware of this own aggressive behaviour. We can explain this with the polar structure of the psyche:*
  - ⇒ *Aggressor and victim are two sides of the coin. The other side of the aggressor is the victim. When the victimised state is conscious the aggressive side might be in the unconscious but acts from there.*

**Spirituality and mental health**

Spirituality and religious experiences are a fundamental part of the human nature. Without such experiences people feel an absence of meaning in their lives, leading to major psychological difficulties and problems.

- Holistic approach to understanding individuals includes exploration of spirituality as one dimension of the cognitive, emotional, behavioural, interpersonal and psychological facets that make up a human being. Spirituality is said to enable human beings to realize all their potential, including material potential.
- Spirituality means different things to different people and people express their spirituality in varied ways. They may interpret it as their religion or faith, a sense of “connectedness”, their belief in god as a higher being or force greater than any individual. The concept of spirituality is inclusive and affects everybody.

⇓

- Spirituality can play an important role in helping people maintain good mental health and live with or recover from mental health problems.
  - ⇒ It can help them cope with everyday stress and can keep them grounded.
  - ⇒ It can bring a feeling of being connected to something bigger than them-selves and it can provide a way of coping in addition to relying on your own mental resilience.
  - ⇒ It can help people to make sense of what they are experiencing.

- A principle of spiritual approach to healthcare, and mental care in specific, is that while we all face adversity in our life, it is possible to overcome it. As result, people often become stronger, more resilient and more mature through facing significant obstacles. In addition, the spiritual approach can enable reaching beyond human limitations, thus provide positive attitude even under worst of circumstances.
- Evidence points to positive relationships between spirituality and mental health in relation to a number of mental health problems – depression, anxiety, PTSD:
  - ⇒ Religious activities as well as belief in a transcendental being are associated with reduced depressive symptoms as well as anxiety or stress;
  - ⇒ Research shows that yoga and meditation are also associated with improvements in mental health and reduction of anxiety
  - ⇒ Research into links between religion, spirituality and trauma-based mental health problems show 3 main findings –
  - ⇒ One, religion and spirituality are usually, beneficial to people in dealing with aftermath of trauma;
  - ⇒ Two, trauma experiences can lead to deepening of religion or spirituality; and
  - ⇒ Three, positive religious coping, openness, readiness to face existential questions, religious participation and intrinsic religiousness are typically associated with improved post-traumatic recovery.
- Looking into the link between spirituality and mental health, it is important to understand how potential benefits (may) happen. Some research has been done, discussing mechanisms like coping styles, locus of control, social support and social networks, physiological mechanisms. It has been found that –
  - ⇒ Religious belief may allow person to reframe or reinterpret experiences and events that are seen as uncontrollable in such way that make them less stressful or more meaningful,
  - ⇒ Religious or spiritual support, like other forms of social support, can be a valuable source of self-esteem, information, companionship and practical help that enable people to cope with stress and negative life events,
  - ⇒ Many spiritual traditions encourage expression of emotions like hope, contentment, love, forgiveness, which in consequences may have positive effect on physiology affecting mental health (linking endocrine and immune system)
- Potential benefits of spiritual and religious expression and activity for mental health should not be overlooked by those in mental health services. They should consider using the healing aspects of different spiritual or religious activities and help those seeking assistance to identify

those aspects of their life that provide them with meaning, hope, value and purpose; and avoid dismissing or ignoring the religious or spiritual experiences. In such a way, religion and spirituality are a big resource.

1. The importance of spirituality in Afghan society

Spirituality and religious activities can serve Afghan people as a source of comfort and can bring relief of unwanted thoughts, feelings of guilt, or enormous stress. Muslims use many different orders طریقت and paths to ask Allah for relief. Many people, who give their religion and spirituality an important role in their life, seem to be able to cope with the difficulties of their life and experience many benefits to their health and well-being.

- In praying to Allah (**Namaz**) the Muslim man/woman asks for relief, forgiveness and help.
- **Namaz** is one of five pillars of the Islam, and is practiced five times a day with an additional one on Fridays.
- Moreover, special religious festivals, Samaa, Riyazat, Urs, Friday night rituals etc. can also serve the Muslim man/woman to ask Allah for support
- Being religion and spiritual is often linked to:
  - ⇒ Health improvements
  - ⇒ Less hypertension
  - ⇒ More positive feelings
  - ⇒ Less depressive feelings
  - ⇒ Greater psychological well-being
  - ⇒ Superior ability to handle stress

- There are a lot of religious communities in which Muslims can help and support each other in acting out their belief
- Example: **An effective spiritual activity for reducing stress**
  - ⇒ Praying to Allah, Monajat, etc.
  - ⇒ Asking for forgiveness when praying or in shrines
  - ⇒ Expressing gratitude to Allah
  - ⇒ Releasing inner discomfort through praying
  - ⇒ Charity activities: Zakaat, Fitr etc
  - ⇒ Expressing optimism

⇒ Using written verses of the Quran e.g. Tawiz etc

**Asking other Muslims for support**
Isolation to get closer to God (Riyazat)

⇒ Muraqaba or Meditation

⇒ Samaa gatherings

- **In the psychosocial intervention** it is very important to support the clients in their religious and spiritual beliefs.
- Muslims believe that life, death, joy and happiness are derived from Allah, who is the one who will strengthen them to overcome their sufferings. Therefore, clients should be encouraged to cry and to express grief over the death of a loved one.
- Some of the values emphasized in Islamic spirituality practice are:

**Support for the poor people**
**Search for peace**
**Reparation of the heart**
**Healing power of the Quran**
**Praiseworthy traits**
**Prevention of sin**
**Promoting helping power**
**Purifying one's inner self from filth**

# Basics revealing developmental psychology of a child

## Developmental stages of childhood

The term development in its most general psychological sense refers to certain changes that occur in human beings and it is helpful to divide it into several aspects, namely physiological, personal, cognitive and social development.

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Development can not be seen as a process, which is the same for all children, as a child's culture shapes development by determining its way of living. The younger the child, the more plastic the brain and the more easily the child's brain can adapt to damage!

### 1. Infancy (1-2 years)

**Physical development**

- An infant's first month after birth is a risk time, when biological systems, namely breathing and eating must function independently
- Newborns pay attention to their environments and notice the onset of sights and sounds
- They actively explore with their senses and select things to focus on

**Cognitive development**

- In this stage memory becomes more cognitive, as infants begin to control what they look at, listen to, and pay attention to
- Infants try to assimilate new objects and experiences into their personal schemes
- They start to enjoy playing and pretending
- In this stage they speak their first words

**Personal and social development**

- Infants try to communicate with persons around them by facial expressions and bodily gestures
  - ⇒ When mothers interpret infants expressions and show reaction, the infant does learn to communicate
  - ⇒ Feeding, speaking and playing games is the opportunity to teach the infant rules and to stabilize the emotional attachment
- In their interaction with adults, infants begin to learn their culture's rules about when and where they may display emotions

⇒ For example infants use other people's expressions of emotions to guide their own behaviour

- The starting social communication is not so easy for mothers and infants, as some mothers may be overstimulating, anxious, insecure, depressed, and some infants are temperamentally difficult, irritable and rejecting, when the mother attempts to socially communicate
  ⇒ To some extend the course of any infant's development (e.g. temperament) depends on parents´ expectations and behaviour
- The most important personal and social development is the formation of a lasting and loving tie with the person it interacts with the most
  ⇒ Mothers who are loving, responsive and sensitive, offer their infant appropriate levels of stimulation and a secure attachment can grow in their child. This enables the child to be able to develop relationships and attachment.
  ⇒ Insecure infants avoid contact with their mothers or act in an ambivalent way towards them
  ⇒ Mothers who are tense and angry produce avoidance in their infant
- Securely attached infants become children who are socially and emotionally competent!

⇓

- In this stage the infant develop trust, and once this stage of building trust is successfully resolved, the infant will learn to trust others, which will then help the person with later relationship building.
- But chronic environmental stress or even a single trauma can produce mistrust in the infant!
  ⇒ e.g. parents who are emotionally unavailable, due to their own difficulties who or are inconsistent, continually negative, or abusive

2. Early childhood (3-6 years)

**Physical development**

- During early childhood, children grow more competent in a wide range of physical skills, and many of their earlier physical sensitivities and physiological vulnerabilities diminish

**Cognitive development**

- Children start playing games in which they act out roles

**Personal and social development**

- As children get older, they become more autonomous, get less upset at brief separations from their parents and need less physical contact with them
  ⇒ Yet children remain strongly emotionally attached to their parents.

⇒ Parents who are too authoritarian, who punish their child a lot, who do not value independence in their children, tend to produce a suspicious, withdrawn, unfriendly, and unhappy behaviour in their child

⇒ Parents, who are too permissive, who do not lay down meaningful rules or show a compassionate authority, tend to produce an immature, dependent, and unhappy behaviour in their child.

⇒ Moderate authoritative parents who also show their love to their children present a good way to cause a friendly, competent, socially responsible, and happy behaviour in their child, as they hold conversations with their child, set few but firm limits, and keep conflict to a minimum

- Parents´ interpretations of their children's behaviour and children's way of understanding their parents´ disciplinary style interact very intensive
  ⇒ Mothers of difficult children do more controlling, warning, and forbidding than mothers of easy children
  ⇒ And those "difficult" children ignore, protest, and talk back more to their mothers than other children
- As children's social understanding improves, they understand other people's emotions better, are able to modulate their own emotional expressions, and communicate more effectively
- In this stage boys and girls begin to act differently
- In this stage boys and girls acquire knowledge about sexuality and gender roles, as they develop their gender identity
  ⇒ TV is one way that children get information about gender roles. They also learn from watching TV what kinds of behaviour are acceptable. If they watch violent programs, they are more likely to be aggressive

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- Violent behaviour often originates in learning and imitating what children see and experience
  ⇒ Children living in domestic and community violence are at high risk of becoming both a violent themselves.
- Growing up in a violent environment causes emotional distress, immature behaviour, somatic complaints, and regression in behaviour and language
- As infants do not understand the cause of violence, trauma occurs and they show symptoms, including sleeplessness and disorganized behaviour

3. Middle childhood (7-10 years)

**Physical development**

- These years are characterizes by very different growth patterns depending on nutrition, environment, genetics and hormones
- Children loose their baby teeth
- Some show first signs of puberty
- Sleep disorders (sleepwalking, nightmares, tooth grinding, and bed-wetting) are common among children

**Cognitive development**

- Children start to understand the conversation of matter
- Children of this age see rules as inviolable instructions from authorities
- Children understand that moral behaviour means following social rules and conventions
- Children differ in their cognitive styles of perceiving and responding to the environment
  - ⇒ Some are more reflective and others more impulsive

**Personal and social development**

- School-age children feel deeply about their families, and need and want rules and restrictions, but not in a overly controlling way
- School-age children form friendship cliques, with leaders and followers
  - ⇒ Girls have an intensive style of interacting with each other; they play with one other girl, express intense feeling about her and share experiences and fantasies with her
  - ⇒ Boys have a more extensive style of interacting; they play noisily in a group and focus on a games outside
  - ⇒ In this stage, boys and girls rarely mix
- Cooperating, helping, and showing concern for others increase during early childhood but decline toward the end of middle childhood
  - ⇒ Competitiveness, individualism, and generosity increase
- Children learn aggression from parents who are aggressive, rejecting, and unloving and who punish the children for aggression, but do not reward them for sharing or cooperating
  - ⇒ Peer groups reinforce, model or absorb aggression
  - ⇒ Children who watch a lot of violent TV programmes and who think that these shows are real, can easily identify with aggressive TV characters or are reinforced for their own aggressive behaviour, and become objects of aggression.
- As they get older, children get better at understanding other people's feelings, moods, intentions, and motives
  - ⇒ Their social understanding and competence increase

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- School-aged children who witness violence often show more aggressive, delinquent and anxious behaviour
- Overall functioning, attitudes, social competence, and school performance are often affected negatively

4. Adolescence (11-19)

**Physical development**

- Puberty is the set of biological changes and children become sexually mature young adults
  - ⇒ This stage marks the beginning of adolescence, and is characterized by social, emotional, and cognitive changes
- The biological changes make males physically stronger than females, and cultural attitudes intensify these biological differences
- The changes affect adolescents´ behaviour and self-image
  - ⇒ Those who mature early may differ from those who mature late not only physically but also socially, emotionally, and in their behaviour

**Cognitive development**

- Once adolescents can reason abstractly, they understand and can discuss social, political, and moral issues
- Achievement in school is predicted by factors in the school, the family, and the person
- Now they have a more highly developed sense of personal guilt and social justice
- They start to base their moral judgments on their own personal values

**Personal and social development**

- In this stage all adolescents go through heavy ups and downs in their moods and feelings about themselves
  - ⇒ From age 11 to 16 the physical and psychological pressures are more intense, family arguments are most heated, and adolescents' feelings of self-doubt and unhappiness are acute
  - ⇒ After that, adolescents' moodiness, irritability, and self-consciousness are more stable, and they search for a personal identity in a very intensive way
  - ⇒ Adolescents need time to resolve their identity crisis and to find the necessary roles, work, attitudes, and social connectedness
- Once adult, they face the task of achieving autonomy from their families without removing themselves so far that they feel isolated, depressed, or guilty

⇒ Therefore, they test their parents' limits and oppose their parents' attempts to control their behaviour

- During adolescence parents still influence their child, and the amount of emotional support they give influences how successfully their children resolve their identity crisis.

⇓

- For adolescents, who have experienced exposure to significant violence, high levels of aggression and acting out are common, accompanied by anxiety, behaviour problems, school problems, and revenge seeking
- When adolescents give up hope, they may become numb to feelings and pain, which results in constrictions in emotional development; or they may attach themselves to peer groups as substitute family and use violence as a method of dealing with disputes and frustration.

**Task:** Please, try to observe the children in your family or the children of your friends. Search for above mentioned characteristics and try to identify those. Then discuss your observations and related thought in a group

# Memory, learning and habits

## 1. Memory

### Definition

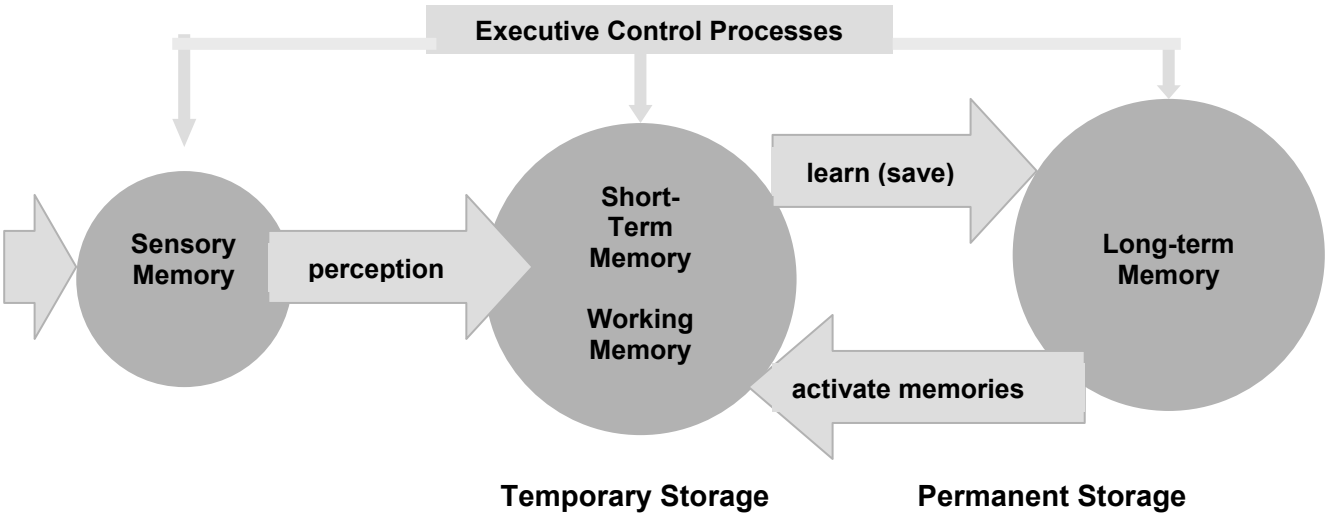
- The ability to store, retain and retrieve past events or knowledge.

Information processing: Three memory stores

- Like a computer, the human mind takes in information, performs operations on it to change its form and content, stores the information, retrieves it when needed, and generates responses to it
  - ⇒ Processing involves: 1) Gathering and representing information *(encoding)*
    2) Holding information *(storage)*
    3) Getting at the information *(retrieval)*
  - ⇒ The whole system is guided by control processes that determine how and when information will flow through the system

### The Information Processing System

- The three stages of the information processing system are the sensory register, short-term memory, and long-term memory
  - ⇒ Information is encoded in the sensory register where perception determines what will be held in short-term memory for further use
  - ⇒ Thoroughly processed information becomes part of long-term memory and can be activated at any time to return to working memory



**Sensory Memory**

- Stimuli from the environment (sights, sounds, smells) constantly bombard our receptors
  ⇒ Receptors are the body's mechanisms for seeing, hearing, tasting, smelling, and feeling
  ⇒ The sensory memory holds all theses sensations very briefly
- The capacity of sensory memory is very large, but the sensory information is only held between one and three seconds
- The meaning we attach to the raw information received through our sense is called perception
  ⇒ This meaning is constructed based on both objective reality and our existing knowledge
- As not all information can be perceived, there is the mechanism of paying attention
  ⇒ By paying attention to certain stimuli an ignoring others, we select from all the possibilities what we will process

**Short-Term Memory**

- Once transformed into patterns of images or sounds, the information in sensory memory can enter the short-term memory system
- Its capacity is limited by about five to nine new items that can be held at one time
- The duration of information is short, about 20 to 30 seconds at the most
- **The working memory** is associated with the short-term memory, as its content is activated information (what you are thinking about the moment)
  ⇒ This activated information may be knowledge from long-term memory that you are currently thinking about or something new you have just encountered
- As information in short-term memory is fragile and easily lost, it must be kept activated to be retained
  ⇒ Activation is high as long as you are focusing on information, but activation decays quickly when attention shifts away
  ⇒ Therefore most people rehearse the information mentally
- <u>There are two types of rehearsal:</u>
  1) Maintenance rehearsal
     ⇒ Repeating the information in the mind
  2) Elaborative rehearsal
     ⇒ Associating the information which you are trying to remember with something you already know (from long-term memory)
     ⇒ This kind of rehearsal not only remains information in working memory but helps to move information from short-term to long-term memory
- Through interference short-term memory could be forgotten

⇒ Interference means, remembering new information interferes with the way of remembering old information, and the new thought replaces the old one

⇒ Information is also lost from short-term memory by time decay. If you do not continue to pay attention to information, the activation level decays

- Forgetting is very useful. Without forgetting, people quickly overload their short-term memories and learning would stop!

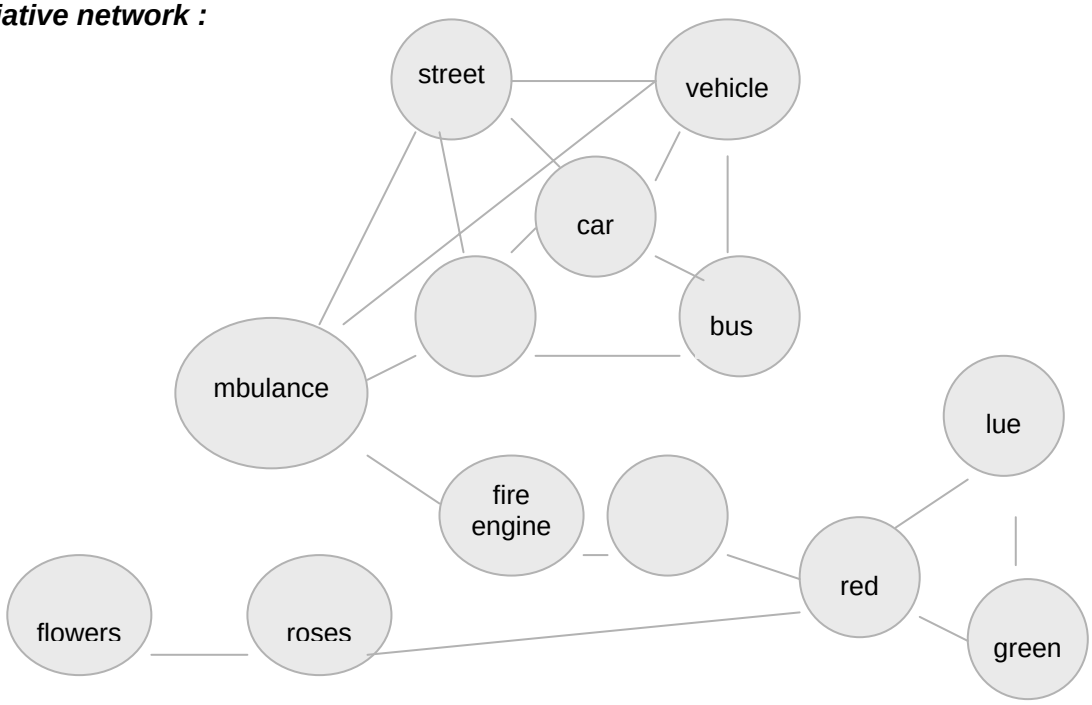
**Long-term memory**

- Long-term memory holds the information that is well learned
  ⇒ Well-learned information is high in durability
  ⇒ Long-term memory hold an unlimited amount of information
- Information may be coded verbally and visually as part of the explict or implict memory
- <u>In long-term memory we can differentiate between:</u>
  1) ***Explicit (declarative) memory*** is the conscious, intentional recollection of previous experiences and information
     ⇒ Remembering a specific lesson in school or at home with father or mother
     a) ***Episodic material***
        ⇒ Refers to autobiographical memories, which consist of the recollection of singular events in the life of a person
        ⇒ It is the memory of life experiences centred on your-self
        ⇒ Episodic memory enables you to remember the past and to imagine the future
     b) ***Semantic material***
        ⇒ All explicit memory that is not autobiographical
        ⇒ Knowledge of historical events and figures; knowledge of the world
  2) ***Implicit (procedural) memory*** is an unconscious, non-intentional form of memory
     ⇒ Improving certain skills during the lesson by repeating the action
     a) ***Skill-learning***
        ⇒ Previous experiences aid in the performance of a task without conscious awareness of these previous experiences (riding a bike, writing)
     b) ***Priming***
        ⇒ A process whereby a person show improved performance on tasks for which he/she has been subconsciously prepared before

- In long-term memory, bits of information are stored and interrelated in term of associative networks and schemas
  ⇒ In order to deal with the fact that much of our knowledge seems integrated, the idea of a schema/associative network was developed

⇒ Schemata/associative networks are basic structures that help to perceive, organize, process and use information

⇒ ***Associative network :***




- Storing information in long-term memory requires that you integrate new material with information already stored in long-term memory

  ⇒ Elaboration helps to give new information a meaning by connecting it with already existing knowledge (using old knowledge to understand the new!)

  ⇒ Organization also helps to improve learning, as material that is well organized is easier to learn and to remember

  ⇒ Context also influences learning, as aspects of physical and emotional contexts (places, how we are feeling) are learned along with other information. Later, if you try to remember the information, it will be easier if the current context is similar to the original one

## 2. Learning

**Definition**

- Learning occurs when experience causes a relatively permanent change in an individual's knowledge or behaviour
  - ⇒ The change may be on purpose or unintentional, for better or for worse
  - ⇒ Learning, means a permanent change through experience by the interaction of a person with her/his environment
  - ⇒ Changes due to illness or hunger are excluded from the definition of learning, as a child who has gone without food for two days does not learn to be hungry. But of course, learning plays a role in how we respond to hunger or illness

### Behavioural theories of learning

Behavioural theorists emphasize the role of environmental stimuli in learning and focus on behaviour. These behavioural learning processes include contiguity learning, classical conditioning, operant conditioning, and observational learning.

**Contiguity and classical conditioning**

- In contiguity learning, two events that repeatedly occur together become associated in the learner's mind
  - ⇒ Later, the presence of one event causes the learner to remember the other
- In classical conditioning (by Pavlov[2]), a previously neutral stimuli is repeatedly paired with a stimulus that evokes an emotional or physiological response
  - ⇒ "*a child having difficulties studying math, is usually scolded or hidden by its father (neutral stimuli = studying math)"*
  - ⇒ Later, the previously neutral stimuli alone evokes the conditioned response
  - ⇒ "*every time the child tries to study math, it starts shaking, and getting afraid"*
- This learned behaviour can gradually disappear again, when the learned association between the conditioned stimulus (to be hidden by the father) and the unconditioned stimulus (learning math) cease to be pared. The response will eventually be extinguished

[2] In a series of experiments Pavlow rang a bell always when the dogs were fed. The dogs learned that the ringing of the bell was associated with food. After a while the sound of the bell alone provoked salivation.

**Operant conditioning**

- In operant conditioning (by Skinner) people learn through the reactions of their environment.
- For a person, the effects of consequences following an action may serve as reinforcement or punishment
  - Positive reinforcement strengthens a behaviour or response
  - Punishment decreases or suppresses the behaviour or response
  - *"When parents take away privileges after a child has behaved inappropriately, some children will stop showing certain behaviour (suppressing behaviour), and others will decrease the frequency of certain behaviour (decreasing behaviour)"*
  - Positive and negative reinforcement and punishment are widely misunderstood. Punishment involves getting something "bad" or loosening something valued or "good". Reinforcement involves (+) getting something good, or (-) loosing or avoiding something bad. Most people use the term "negative reinforcement" as a synonym for punishment but this is not correct. A reinforcement (+ or -) is defined as any event that closely follows the action of the person that tends to increase the likelihood that the action of the subject will occur again. Negative reinforcements, in practical terms, tend to involve escape or avoidance of "bad" punishment events.

**Observational learning**

- Modelling and Imitation can have a powerful effect on learning (by Bandura).
- For learning by watching, people must focus their attention, construct images, remember, analyze, and make decisions that affect their behaviour
  - ⇒ For children this could mean that they are learning from paying special attention to parents, older brothers or sisters, or teachers, or popular peers, or TV idols being their models
  - ⇒ Practice is necessary in order to remember the elements of the desired behaviour
  - ⇒ People may acquire a new skill or behaviour through observation, but they may not perform that behaviour until there is some motivation to do so.

**Self-regulation in learning**

- Self-management helps to gain control over learning by self-observation, self-judgement and by comparing intented outcomes with achieved results.
- Children must learn to manage their own life's, set their own goals, and provide their own reinforcement

<u>Learning environments</u>

Learners in supportive environments have high levels of self efficacy and self-motivation!

**Creating positive learning environments**

- Determining learning procedures helps children to focus and to get a routine in learning
- Giving rules produce discipline and can be motivating
  ⇒ Rules specify expected and forbidden actions
- Consequences should be established for following and breaking the rules and procedures so that everybody knows what will happen
- To create a positive environment and prevent problems, individual differences must be taken into account, the motivation of the children must be maintained, and positive behaviour should be reinforced

**Social and emotional climate**

- Good and cooperative communication is essential when problems arise
  ⇒ All interactions between people, even silence, communicate some meaning!
- A non-threatening atmosphere is important for all children
  ⇒ The children should feel safety and acceptance; therefore teachers and parents should model respect and care for each other
- Mistakes should not be punished, they should be treated as necessary part of learning

<u>Individual differences in learning</u>

**Physical and health impart children**

- Children with visual and hearing impairments require early detection to prevent lingering problems that may affect performance
  ⇒ The cognitive development will tend to follow a normal range, so that the expectations for them should be similar to others
- To ensure normal cognitive development children with physical and health impairments need to be integrated into the same activities as others, as much as possible and provided with special educational services to address and minimize their limitations.!

**Behaviour disorders**

- Characteristics of behaviour disorders are
  ⇒ An inability to learn that cannot be explained by intellectual, sensory, or health factor
  ⇒ Inappropriate types of behaviour or feelings under normal learning conditions
  ⇒ A tendency to develop physical symptoms or fear associated with personal or school problem

- Problems in learning due to behaviour disorders can be grouped into two general categories, namely environmental conflict and personal disturbance
  - ⇒ Environmental conflicts causes aggressive-disruptive behaviour, hyperactivity, and social maladjustment
  - ⇒ Personal disturbance includes anxiety and withdrawal

## 3. Habits

**Definition**

- Habits are learned sequences of acts, behaviour, thoughts, emotional responses that become automatic responses to specific situations in a specific context
  - ⇒ Habits develop by repeating a certain action often or by responding to certain stimuli always in the same way
  - ⇒ Habits are learned in the sense that they are gradually laid down in procedural memory through repeated performance
  - ⇒ Habits are automatically performed without full conscious reasoning at that point of time
  - ⇒ Habits are set in motion by features of the context that were associated with the behaviour during previous performance (Context = physical or social setting, temporal cues, internal states/moods). The presence of these features activates a disposition to perform the response automatically

**Examples**

- Driving or walking one's daily route from home to work or school or the mosque
- Recurrent automatic habitually recurring thoughts or imaginations. Usually they occur as a response to a certain situation in the family or outside: (The detection of such automatic thoughts can be relevant for the counselling especially in case of depressive symptoms)

**Task:** In a small group explore habits you know from yourself and write them down.
Discuss if those habits or are helpful habits or if they are rather damaging habits?

**The strength of habits**

- Habitual responding can be cued independently of people's intentions
  - ⇒ If habits strength increases, intentions as predictor of behaviour declines
  - ⇒ A person's intention guides actions when a habit has not been formed
  - ⇒ Habits can take years to develop, depending on the frequency of their performance and the strength of the stimulus

⇓

- The pervasive effect of habits in everyday behaviour is a key to understanding the difficulty people experience in changing their behaviour
- Cues such as time of day and location trigger repetition of past responses, thus habits develop

- Failures to change do not necessarily indicate poor willpower but instead the power of situations, which trigger past responses!
- Habits keep doing what we have always done, despite our best intentions to act otherwise
- Under Stress people tend to fall back into old habits

**Task:** Please discuss in a small group the difficulties and advantages of habits.
Find examples for efforts of changing habits.

# Trauma knowledge

1. What is “being traumatized”?

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

**Examples of traumatic events which can cause traumatic stress**

1. Natural disasters
   - Earth quacke
   - Tsunami
   - Flood
   - Storm
2. Social problems
   - Domestic violence
   - Torture
3. Sexual aggression
   - Rape
   - Sexual abuse
4. Incidents
   - Traffic accident
   - Suicide attack
   - Bomb blast
   - Seeing a dead body
   - War, combat exposure
   - Threatened with a weapon
   - Sudden violent death
   - Serious injury/harm the client caused
   - Attack of wild animal etc.

⇓

- The impact of such an experience depends on:

⇒ Length of the experience
⇒ Unpredictability
⇒ Having no control over the situation

**Reaction on threat**

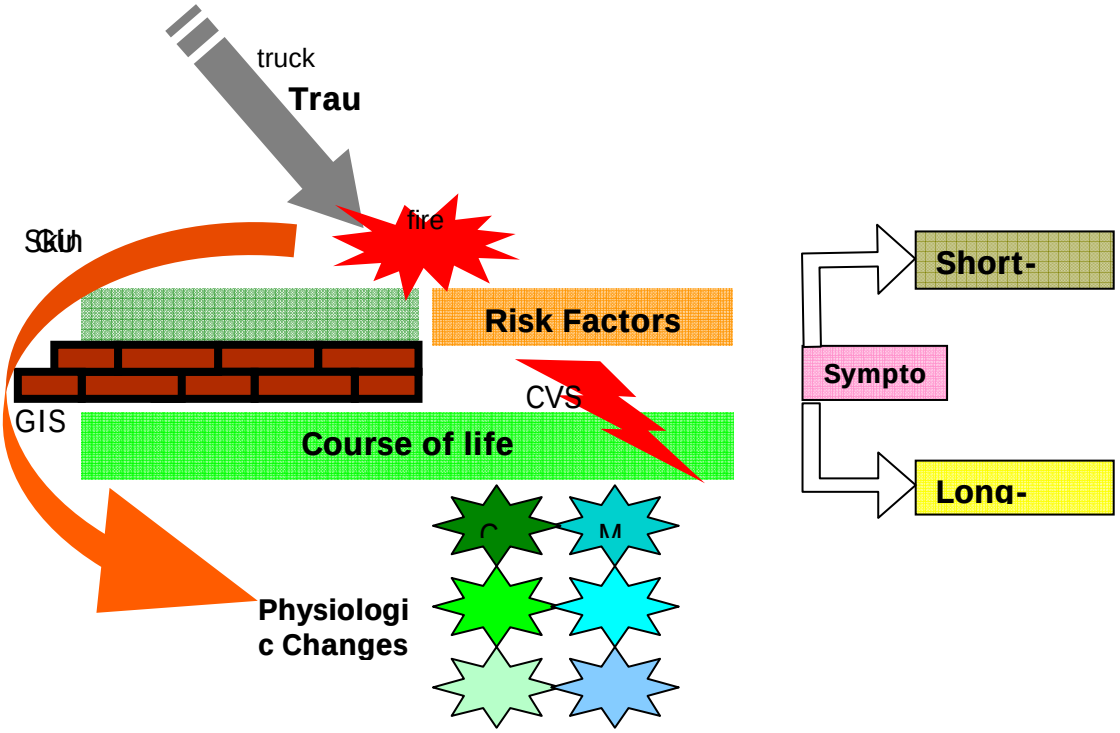
- We are reacting in three ways when are facing a danger (summarized as 3-F):

  ⇒ Flight
  ⇒ Fight
  ⇒ Freeze

- These are normal reactions of our psyche in response to those abnormal events.
- As a result we can observe some physiological changes in our body such as:
  - ⇒ Secretion of some hormones like electron, Cortisol, Epinephrine, Norepinephrine
  - ⇒ Activation of the autonomic stress reaction
- Through above mentioned changes, the normal function of the body is affected and resulting in some changes in the following systems:
  - ⇒ Cardiovascular system: Palpitation, Shock
  - ⇒ CNS: Dizziness, Paralysis
  - ⇒ Urinary system: Urinary retention, frequency, uncontrolled urination
  - ⇒ Gastrointestinal system: Diarrhea, Constipation
  - ⇒ Skeletal-muscle: Muscle weakness, relaxation
  - ⇒ Skin: Pallor

⇓

- The above mentioned symptoms, signs and reactions can partly be related to the familiarity of such symptoms of a person's psyche and body in advance to the event.
- The alert which is demonstrated during the event by the body and psyche is called **alarm response.**

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- Example: *We have the knowledge of a wild animal such as wolf, being dangerous. Therefore whenever we are facing this animal, suddenly our psyche is activated in order to give alarm and to find out the way to taking ourselves out from the danger.*
- Example: *At night you walk and all of a sudden you hear a frightening noise. You feel paralysed and seem to be unable to move.*

**Task:** Please remember have you yourself ever experienced such a situation? Or have you observed people in such a situation? Describe what you observed and experienced.

**Body reaction in the brain**

- A large amount of Cortisol is destructive for the part of the brain which is called Hippocampus
- Epinephrine and Norepinephrine boost the activity of a part of the brain called Amygdala.
  - ⇒ Under the condition of traumatic stress the Amygdala (responsible for emotional associations) is extremely active
  - ⇒ While the functionality of the Hippocampus (responsible for the semantic knowledge about the world) is dramatically reduced.
  - ⇒ This is due to the stress hormones.

2. Memory theory as a model for the explanation of Post traumatic stress syndrome

**Autobiographic Memory under normal conditions**

- <u>All of us store the following aspects in our autobiographic memory:</u>
  - ⇒ General events ( a sunny day in out childhood)
  - ⇒ Lifetime periods (the time we went to school)
  - ⇒ Specific events ( our first evaluation in school)

⇓

Normally those information are a mixture about facts and emotional, sensory and physiological information:

„*I can remember it was a cold day in February, there was still snow on the streets. I was so happy that I got a good position in class that I was running all the way home*“

**Autobiographic memory under the condition of traumatic stress**

- Once a traumatic event has occurred the enhanced activity of the Amygdala is responsible that all the information of the so called **hot memory,** the sensory-perceptual-emotional reüpresentation of the traumatic event is stored in detail and with very strong connections.
- At the same time (because of the decreased function of the Hyppocampus) the so called **cold information** (facts about the happening in a certain order and connection) is not stored well and the connection between the hot and the cold memory is missing.

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- Such a person has just a fragmentized knowledge of the traumatic event. The feelings connected with the event are stored very strong and intense.

- The scattered bits of memories are connected in a **fear network**.
  - ⇒ That means that if one element, a so called trigger, of this network is activated all the other elements with all emotions are also activated due to the strong connection between the elements. (Compare the chapter on memory.)
  - <u>Example</u>*: A woman whose husband had been killed during the war in her garden. She found him lying on the green grass in the sunshine on a summer day. She does not want to see any green grass again and consequently avoids to go to the garden during the summer.*
  - ⇒ As a consequence if this woman is exposed to a green lawn in a sunny garden, the garden functions as a trigger and she has the feeling as if the traumatic event would happen again. The person re-experiences the same fear and panic and helplessness again
  - ⇒ Consequently people get aroused, memory flashbacks happen and they understandably try to avoid such inner situations or feelings. Or they try to avoid certain places which remind them on the happening.
  - ⇒

<u>3. Characteristics of a trauma</u>

**Risk factors for suffering of a traumatic event**

- Low socioeconomic status
- Bad psychological and physical health
- Bad psychological condition
- Being very young or old
- Chronic sickness, chronic pain, addiction, experience of loss (death, divorce), loneliness etc.

**Protective factors**

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

**Symptoms of trauma**

- What we can observe is that in the long run people change through traumatic experiences in perception, in thinking, in relating to other people about their environment and about themselves.
- They often feel like a stranger to themselves and they feel emotionally numb.

**1) Short term consequences** are Symptoms which appear immediately after a traumatic experience

- Physical reactions: Heartbeat, high blood pressure, tension in the muscles, breath is going high, trembling, digestion problem
- Emotional reactions: Being fearful, desperate helpless and upset, aggressive, shame (because of loss of control), uncontrolled mourning
- Thinking: Difficulties to concentrate, not being able to think, chaos or emptiness in the head, wondering ( what would have been if???), accusing oneself, being disorientated
- Behaviour: Is a picture of the emotional state: Restless, nervous, aroused, acting without an aim or plan, numbing behaviour (drugs etc)
- Dissociation: Seeing the happenings from the outside like through a glass wall, believing it is not true.
- Depersonalisation: Own feelings are not considered to belong to oneself, functioning like an automatism

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- Corrective factors to treat short-term consequences**:**

⇒ Physical and psychological help and resources

⇒ To create a narrative memory of the event
⇒ To put it in the life context
⇒ To realise its subjective meaning
⇒ Acceptance of change of lifestyle

**2) Chronic symptoms** can develop some time after the traumatic event, and can be categorized in intrusive and constrictive symptoms:

- **Memory flashbacks:** Sudden appearance of painful memories of the traumatic experience where the person feels the same threatening situation with all the related features of fear from death, panic, escape and preparedness to fight
- **Hyper arousal syndrome:** Hyper vigilance, a constant feeling of escape and preparedness to fight, nervousness, nightmares and somatic symptoms like sleep disorders, increased blood pressure, heart palpitation, shivering.
- **Avoidance syndrome:** Active avoidance of people and places that remind of the events and a passive avoidance of feelings due to being afraid of experiencing intensive feelings the same as those experienced during the traumatic experience.
- **Dissociation**
- **Persistent concentration disorders**
- **Somatization, physical illness, chronic pains**

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One of the characteristics of these symptoms is that they are uncontrollable. The person experiences it as if it is part of him/herself, which he does not really know. It acts by its own self. This causes again fear and panic.

**3) Complex Posttraumatic Stress disorder (PTSD)**

People who stay in a traumatic situation (prolonged trauma) or experienced repeated trauma are likely to develop a complex type of PTSD, which is much more distressing than the above described type!

- The symptom picture in clients of prolonged trauma often appears to be more complex, diffuse, and tenacious than in simple PTSD
- Also characteristic personality changes are developed, including deformations of relatedness and identity
- These clients also show vulnerability to repeated harm, both self-harming and at the hands of others

**Symptoms of complex PTSD clients**

- Clients present a great number and variety of complains
  ⇒ Somatic, cognitive, affective, behavioural, relational
- These clients also tend to develop depression, general/phobic anxiety, paranoia, psychoticism, drug addiction, alcoholism
- Key symptoms
- **1) Somatization**
  - Repetitive trauma appears to amplify and generalize the physiologic symptoms of PTSD
  - Clients are always hypervigilant, anxious and agitated, and do not experience a state of calm or comfort

**2) Dissociation**

- Clients learn to switch into another state of consciousness, which gives them the chance to stand the pain associated with the trauma
- Through the practice of dissociation they learn to alter an unbearable reality
  ⇒ Clients use this skill to stand a life-threatening situation as hunger, cold, pain (e.g. being In prison or being abused)
  ⇒ Or they use this skill to cope with up-coming re-experiencing symptoms (e.g. when they get the feeling that it is happening again)
- They can even be able to dissociate some parts of their own personality
- While dissociating they show disturbances in time sense, memory, and concentration
  ⇒ They are not there! Have no autobiographical memory of the actions while dissociating
- Clients often feel being out of their body and numb
- They experience them-selves as being divided

**3) Affective changes**

- Often such clients suffer of depression
- Clients need a very structured way of life and being

- **Complex PTSD produces changes in identity**:
  ⇒ All the structures of the self - the image of the body, the images of others, and the values and ideals are invaded and systematically broken down
  ⇒ While the victim of a single acute trauma may say she is "not herself" since the event, the victim of chronic trauma may lose the sense that she has a self!
  ⇒ They often feel guilty and evil and their sense of self is broken into many parts, as the client is not able anymore to integrate all the different feelings of heart, anger, and not knowing who to be
  ⇒ Their skill to dissociate could develop into a state of being always dissociative, which means that they experience them-selves as being different states of ego at the same time

- **Often self-harming occurs:**
  - ⇒ But the purpose it not to attempt suicide
  - ⇒ It is more a compulsive from of self-injury which appears to be strongly associated with a history of prolonged repeated trauma
  - ⇒ It also can be regarded as a desperate attempt to feel oneself

**Trauma and domestic violence**

During the three decades of war, the level of domestic violence has been increasing both in quantity and quality. According to our experience, increasing level of domestic violence can be a result of PTSD.

- One of the characteristics of PTSD symptoms is that they are uncontrollable and the person experiences it as if it is part of him/herself, which he does not really know that it acts by its own self.

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Example: A man who beats his children and regrets it afterwards and does not know why he acted in such an uncontrolled way reports:

- ⇒ *"During the day I am getting more and more nervous and at a certain point, I loose control and when something falls to the ground or someone is shouting loud, I loose control and start beating my children."*
- ⇒ Through counselling the man can discover how his nervousness is connected to his past traumatic experiences. He can learn to identify the signs of the upcoming arousal and find a way together with the counsellor how to control it.
- ⇒ Also by treating the PTSD the symptoms diminished to such an extent that they did not have such a negative impact on his life anymore.

- Another characteristic of these symptoms is the feeling that the threatening situation is still there

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- ⇒ The experience is not integrated into the biography and narrative memory of the person.
- ⇒ Moreover there is no coherent memory of the experience; it is split into different parts.
- ⇒ This is why such a person always reacts as if he/she is still threatened.

- The whole system of stress regulation is out of balance.
- In a way we have to see that such reactions to such horrible experiences are normal reactions to an extraordinary situation.

- But the impact disrupts family interaction and relationships and damages so the most important resource for Afghan people.

**Trauma and social isolation**

- These symptoms frequently cause people to retreat within the family and from society.
- They fall into social isolation and cut them off from their most important resource (the family).
- Another point which can be observed if someone feels unable to control his inner life, he starts in a compensatory way to control his outer life. This often hurts the women and children in the family.

**Trauma and addiction**

- In regard to reduce internal feeling of restlessness and tension, some people are starting to use alcohol or drugs

# Family conflict

## 1. What is a family?

### Family

- The joint living of father, mother and children is called a family.
- The family starts from the marriage of two persons.
- A family can be established based on a family relationship or a social relationship.
- Sometimes financial issues make the base for establishing a family.
  - ⇒ This means that girls are exchanged for money. Sometimes power (force) can also play major role.

### Family system

- The family system is the structure of a family which shows how the family it is built up:
  - ⇒ Individual family system which is common in western countries
  - ⇒ Collective family system which is common in Afghanistan. Collective family system means that many people or many small families live together in one compound or house.

### Family conflict

- In a family conflict the involved persons or parties have opposite opinions, they do not understand each other anymore and have lost trust and understanding on each other. Many factors in Afghan society can cause such conflicts

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Family conflicts seem to be one of the fundamental problems in Afghan society!

## 2. Types of conflicts

### 1) Economic problems

- Poverty
- Indigence
- Joblessness (unemployment)

### 2) Social problems

- Not having a home
- Security problems
- Family interference
- Inequality between the rights of women and men

- Changing role of women and men
- Migration
- Joint living of many families, living together too closely
- The influence of media like TV and radio on society
- War
- Not having same opinion among family members and difference in the mental growth of family members

**3) Natural factors**

- Flood and storm
- Extreme heat or cold
- Draught

**4) Psychological factors**

- Psychological problems which can play an important role in family conflicts are
  ⇒ Depression, Anxiety, Obsession, PTSD and Schizophrenia.
- Long term traumatic symptoms (active and passive avoidance, hyper arousal, memory pressure and flash backs) isolate the client in family and society.
  ⇒ If the client has an important role in his family like being the father or eldest son, the situation becomes even more difficult.
  ⇒ In order to compensate we can observe that this suffering man turns all his attention to his family as the only controllable place. This affects then all family members and often causes violence and conflicts inside the family.

**5) Cultural factors**

- Losing social and cultural identity
- Invasion of foreign culture
- Negative tradition and culture is the basic factor in many family conflicts. Such issues affect many aspects of the people's social life

  a) <u>Forced marriage</u>:
  ⇒ To exchange a woman for a bad deed of relatives
  ⇒ To engage a woman in childhood or even before birth
  ⇒ Marriage in childhood
  ⇒ Marriage of a widow woman with a family member (brother in law) and not giving her the right to marry again out side the family
  ⇒ Marriage with force of money
  ⇒ Marriage based on parents or relatives desire in which the boy and girl do not have any kind of understanding with each other or desire to marry each other

  b) <u>Some other traditional points like useless competition (seyalee):</u>

⇒ Extravagant expenses and imposing extravagant expenses on others during wedding etc.

⇒ Imitating others and showing themselves bigger than they are

⇒ Family competition

c) Limiting individual and social freedom of women according to ruling traditions in society:

⇒ Keeping women at home (women should not leave the house without having the permission)

⇒ Women going out to work as an element of shame for men in the family and can cause family conflict

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**On top of the above mentioned cultural issues,**
**Taboo and Shame play an important role in family conflicts!**

- Any kind of discussion about taboos inside the family ends often in violence and a family conflict. We all know many examples about shame and taboo, where the glory and grace of the family was injured. These mostly ended in violence.

**6. Some other factors of family conflicts**

- Defectiveness and disability
- Migration
- Having sick people in the family with chronic or refractory diseases
- Talking back behind people
- Having addicts in the family

3. Characteristics of family conflicts

**People's reactions in family conflict**

- Verbal reactions (declaration)
- Emotional reactions
- Behavioural reactions
- Usually the people involved in conflict show the following reactions against each other:
  - ⇒ Sadness
  - ⇒ Verbal quarrel
  - ⇒ Aggression
  - ⇒ Violence
  - ⇒ They do not talk or do not participate in their daily work with the people who participate the conflict

⇒ Compensatory reactions *(a woman has a conflict with her husband; she beats her children and insults them*)

⇒ Leaving home (to separate sleeping place, or to separate the room)

⇒ Careless or headless about children and others work

⇒ Careless about her family members' sayings and feel herself without any responsibilities

**The process (stages) of a family conflict**

1) Usually it starts from lack of understanding between each other, difference in opinions, or not having trust
2) Afterward, establishment of bad feeling for both sides
3) Meaningless discussion with high sound
4) Verbal quarrel
   ⇒ Giving taunt or irony, insulting, using bad language
5) Doing physical violence practically
6) Break or failure of one side
   ⇒ Injured, going to shock, losing resistance and even death of one side

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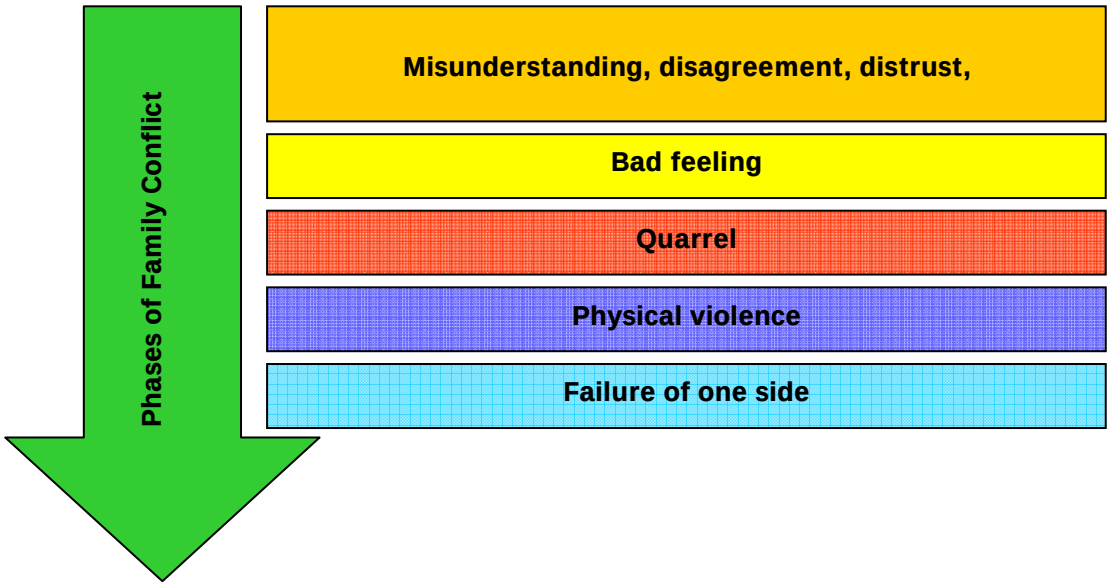
- Family conflicts rarely reach the end stage when we use counselling and the resources of the family (friends, relatives, shura meetings).
- The conflict stops then at the end of one of the first stages, or it is possible that it remains for years in one stage.




4. The consequences of family conflict

A family conflict affects people on many levels. Family members show psychological problems during or after the conflict, the social net of the family suffers, people don't feel safe anymore. And we even can observe somatic consequences in some family members!

**1) Psychological consequence**

- Depression and anxiety
- Feeling blame and guilty
- Feeling themselves worthless and despised
- Development of psychological problems, even PTSD especially in children
- Having tendency for drugs (especially children)
- Memory disorders like amnesia, problems in orientation
- Problem in learning
- Developing mental stresses
- Children feel themselves alone
- Children grown up aggressive, stubborn and careless

**2) Social consequence**

- Destruction of family tie and regulations
- Destruction of secure environment of family
- Weakening family economy
- Sometimes family conflicts cause separation of husband and wife which has direct effect on personality and authority of the person in society
- Family conflict cause some psychological stresses which has direct effect on social relation and social responsibilities of the person

**3) Somatic consequence**

- Somatic and psychological diseases become chronic and severe
- Injury
- Premature birth
- Abortion
- Death
- Thin and weak

**Task**: Choose a family conflict you have heard of or know and analyse the conflict by reasons, process and consequences.
Think of possible interventions at different stages of the conflict

5. Types of violence

**Violence**

- Intentionally use of physical force and threat against own self, the second person or the society which can cause injury, death, psychic injury, mental and growth retardation and deprivation.
- All kinds of violence (physical, psychological, somatic) which can occur among people who are living together and have the same responsibilities in a family environment is called **Domestic violence**

  ⇒ For example: violence between husband and wife, sister and brother or father and mother.

**1) Physical violence**

- In such violence the injured person gets physical injury in his/her body.

  ⇒ This kind of violence is very dangerous.
- Example: Somatic or physical torture in different types like beating, burning, strangling, and killing.

**2) Psychological violence**

- It is psychological injury to the injured person
- For example:

  ⇒ To ridicule someone

  ⇒ To despise someone

  ⇒ To control action of the injured person like using abusive or foul language

  ⇒ To stop talking to someone

  ⇒ To ignore the rights and interests of someone

  ⇒ To control someone above the normal extent

**3) Sexual violence**

- To force someone physically without his/her willingness to a sexual action

**The importance of the intention of the aggressor**

- We have to discriminate between a behaviour which is the expression of helplessness and uncontrolled inner pain, which just by chance hurts another person and between a behaviour which intends directly to harm another person.
- The transition might not always be clear. A sign might be eye contact or a verbal fight before the aggressive act
- There are some preaggressive emotions such as a bad mood, arousal, stress, frustration, total helplessness

**Task:** Please discuss and analyse this discrimination and connection between inner feelings, emotions which precede the aggressive act and the aggressive act it-self in small groups of three. Take your own experience first and then try to find some examples from your clients, Write it down

**Preconditions of domestic violence**

- Cultural acceptance
- Individual factors such as dispositions, education, temper
- Social situation (Poverty, joblessness)
- Interpersonal relationships between aggressor and victim
- Personal experience of being a victim
- Inner process of the aggressor determined by the perception of his life, thoughts, feelings motivation

**Task:** Please find examples and perhaps some explanations for all points from your afghan point of view. Discuss it please in small groups and write it down.
According to your own experience and insight, find possible ways of stopping aggressive behaviour in the family. First, discuss it in small groups, then in the big group, and write it down.

6. Causes of violence

- Economic problems
- Psychological disease like depression, PTSD etc.
- Jealousy and anger
- Using alcohol and drugs
- Children learn violence from their parents
- To accept violence as a way for solving problems
- Desire for having power
- Negative and wrong culture and tradition
- Useless competition

**Gender-based violence and violence against women**

- Of all the human rights violations, gender-based violence is perhaps the most widespread and socially tolerated. This term is used to stress that both males and females suffer from specific forms of violence.
- Whilst, men and boys are also affected by family and state violence – the way violence affects women is disproportionately higher because they are women
- Because the vast majority of victims of these acts of violence are women, the following part is about women being violated by members of their families, mostly by their husbands. However,

there are many situations where women have been abused by their fathers and brothers and as widows by their brother-in-laws. In some cases women have experienced also violence through their mother-in-laws

- The way, types and categories of violence against women (VAW) vary is dependent on local context. VAW is a global problem; cultural/traditional practices vary depending on particular issues confronting a country. For example, in India dowry and related dowry deaths are huge issues and in Afghanistan forced and child marriages.
- VAW not only a social problem it is also a criminal act. Dowry death, child marriages, murder of women, sexual abuse and exploitation are not a social problem or a private matter within the family but are criminal actions that should be punished like all other crimes.
- Women who have been physically or emotionally assaulted tend to be intensive long-term users of health services and they suffer typically from a range of mental health conditions. These range from chronic headaches to self-mutilation and suicidal behaviour.
- The impact of violence may also extend to future generations: Children who have witnessed abuse of their mothers are more likely to also be child victims of family violence, often suffer lasting psychological damage, and are more likely to become victims and perpetrators of violence in adulthood.
- The health of mothers is a major determining factor in the health of their children, which indirectly affects the formation of human capital. Children who are orphaned at birth, an uncommon consequence of violence against mothers, are three to ten times more likely to die than those with mothers who survive. Mothers are normally the ones responsible for the health, nutrition and education of their children. A mother who does not have access to good health, nutrition and education is more likely to pass bad habits and poor general well-being onto her children. For instance, stunted growth in underfed girls increases the risks of obstructed labour later in life. Malnourished mothers and their babies are vulnerable to premature death and chronic disability. Anaemia, which can lead to post-partum haemorrhage, afflicts 50-70 per cent of pregnant women in developing countries.
- Spacing of children can dramatically reduce maternal and infant mortality; however lack of information and the right to family planning, lack of access to services and traditional social norms exclude women from using proper contraceptive methods. Little or no education often leaves women with no understanding of childbearing risks, nutritional value and other health matters which could directly affect their own health or that of their children.
- <u>Possible signs, symptoms and social consequences of VAW on the women:</u>

| Physical | Psychosocial/emotional | Social consequences |
|---|---|---|
| Homicide<br>Suicide<br>Maternal mortality<br>Infant mortality | Post traumatic stress<br>Depression<br>Anxiety, fear<br>Anger<br>Shame, insecurity, self-hate, self- | Blaming the victim<br>Loss of ability to function in community (e.g., earn income, care for children)<br>Social stigma |

| | | |
|---|---|---|
| AIDS-related mortality<br>Injury – broken arm, cuts<br>Shock<br>Disease<br>Infection<br>Disability<br>Somatic complaints<br>Chronic infections<br>Chronic pain<br>Gastrointestinal problems<br>Eating disorders<br>Sleeping Disorders<br>Drug abuse<br>Miscarriage<br>Menstrual disorders | blame<br>Mental illness<br>Suicidal thoughts, behaviour, attempts<br>Lack of confidence<br>Nightmares | Social rejection<br>Isolation<br>Rejection by husband and family<br>Shame<br>Fear |

**1) Impact of violence against women on children in the family**

- In Afghanistan, the impact of violence on children is wide ranging, as girl children are subjected to child marriages, as well as *bad* and exchange marriages. While this is illegal in Afghanistan, the consequences of child/forced marriages are tremendous on the psychological/emotional well being of girls and the physiology of the girl child – including implications from being raped, having a body which is not fully developed and complications with pregnancies. In addition, to customary and traditionally practices, children are also particularly vulnerable in war and post war conflict situations. During these times not only are rights of children to education, health, welfare, basic survival needs difficult to access or denied, but children are overtly exposed to the impact of war and violence in their daily lives. Therefore the family home which should be a place of safety, security and happiness for children is also denied to them as there is often violence both inside and outside of their home.
- It is important to understand the impact on children who witness violence against their mothers and women in their extended family, and interventions need to be in place to stop the cycle of violence from becoming an inter-generational problem.

**a) The effects of VAW on the mother-child-family relationship**

- When abuse/violence against the mother occurs, there will be added strain on the relationship with her child/ren. This strain will impact on the ability of the mother to cope with the normal stresses that arise in child rearing. As a result, the child will feel added pressure. This pressure may result in increased behavioural and emotional problems suffered by the child (which only add to the existing maternal stress). In addition to the stress that these behaviour problems will have on the mother, the child's behaviour may increase the likelihood of further violence, as the mother will be blamed for the child's behaviour.

- In the Afghan context whilst martial discord is widespread, separation and divorce are extremely difficult options for the women to take – these are all highly stressful events for the children. Children in other countries who have been witness and abused by their father often say they wished their mother had left the father.

**b) What children learn from witnessing abuse/violence against mothers and other women in the family**

- Children's roles model what it means to be an adult are primarily learned in the family, so the violence and abuse has a profound impact on children. Over time, even if children recognise violence is wrong they internalize strong messages and may be unconscious of how they are repeating similar patterns.
- Children who repeatedly witness violence directed towards their mothers and other female members of the family, learn and internalize perceptions such as:
  - ⇒ Mothers/girl child are not deserving respect.
  - ⇒ Those who love you also hit and abuse you.
  - ⇒ It is socially, culturally, traditionally and morally acceptable to use violence against female members of the family for control and compliance purposes.
  - ⇒ Violence is an acceptable conflict resolution strategy.

⇓

It is important to recognize that there are gender differences in the way children internalise the violence they witness. Boys will learn behaviour in adult relationships that the use of violence is acceptable, girls as adults will tolerate the abuse because her mother and other female members did. The social and cultural environment will either reinforce this message or provide alternative models of adult behaviour. In Afghanistan, the social and community environment provides few alternative models of non-abusive and equal relationship models between

**Addiction and domestic violence a psychosocial problem**

- Addiction is one of the negative consequences of family conflict and domestic violence.
- <u>The reasons for addictions in such cases are as follows</u>:
  - ⇒ Due to long term PTSD and related symptoms, a person can not perceive his own self, his abilities and resources. He thinks that he can't do something effective in his life (he is not effective in his life). He suffers all the time and in order to be delivered from such kinds of sorrow, grief and inner tensions starts to take drugs to forget the reality for a while and reduce the inner tensions
  - ⇒ Such people have some kind of restlessness or internal excitation. Therefore, for relieving themselves, they try a self medication with drugs and easily get addicted

⇒ Domestic violence again often causes psychological problems which isolate a person within his family and society. Often he cuts his relation with the society. And that makes his condition worse. In order to forget such grief and sorrow they start to use drugs!

⇒ Addiction of children: sometimes we talk of a learned behaviour

- Here are some more psychosocial and economical factors that besides have an important role in domestic violence and conflict, they have direct or indirect role in addictions:
  - ⇒ Poverty and unemployment
  - ⇒ Having enough money without facing any kind of inconvenience
  - ⇒ Having easy accessibility to drugs
  - ⇒ Psychological weakness
  - ⇒ Vulnerability
  - ⇒ Having low position in society
  - ⇒ Losing his nearest and dearest ones
  - ⇒ Chronic and untreatable diseases
  - ⇒ Defectiveness and inabilities, etc

**The consequence of addiction**

- Losing social position or identification
- Isolation from society
- Economy problem
- Psychological problem
- Somatic disorders
- Family conflict, and etc

**Misunderstandings, disagreements and distrusts are not only destroying the family-tie but also damage the psychic of the people**

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