



Desarrollo de Capacidades para Apoyo Psicosocial - Fortalecimiento  
de profesionales colombianos para proporcionar servicios psicosociales



SOCIETY FOR  
PSYCHOLOGICAL  
ASSISTANCE

## **Project: Capacity Development for Psychosocial Support - Strengthening Colombian care professionals for providing psychosocial services**

**Funded under European Union Trust Fund for Colombia Contract No.: T06.27  
(August 2018 – July 2020)**

## **Reader of Materials for Training of Trainers Program**

**(Lectures, Description of Workshops, Working Materials)**

Authors:

Prof. Dr. Dean Ajduković, Prof. Dr. Marina Ajduković, Dr. Dea Ajduković, Martina Čarija,  
Željka Čolović Rodik, Prof. Dr. Dinka Čorkalo Biruški, Prof. Dr. Margareta Jelić, Prof. Dr.  
Olja Družić Ljubotina, Prof. Dr. Trudy Mooren, Prof. Dr. Miranda Olff, Dr. Nika Sušac

Disclaimer: The opinions expressed in this document reflect only the author's view and reflects  
in no way the European Commission's opinions.



## **Contents:**

### **BACKGROUND**

### **MODULE 1**

#### **Lectures**

- Psychosocial approach to conflict affected communities ..... 11
- Resilience and empowerment of individuals, families and communities affected by conflict ..... 17
- Long-term psychosocial consequences of armed conflict ..... 23
- Process of change ..... 31
- Professional dialogue ..... 39
- Skills in professional dialogue ..... 45
- Dealing with resistance in a dialogue ..... 51
- Collaborative planning of change ..... 54

#### **Workshops**

- Identifying strengths and resilience ..... 57
- Identifying strengths and resilience (working material) ..... 58
- Psychosocial work and empowerment of communities ..... 59
- Psychosocial work and empowerment of local communities (working material) ..... 60
- Bronfenbrenner ecological system (working material) ..... 61
- Psychosocial consequences of armed conflict ..... 62
- Psychosocial consequences of armed conflict (working material) ..... 63
- Paraphrasing and reflecting emotions ..... 64
- Paraphrasing (working material) ..... 65
- Observing comprehensive dialogue skills ..... 67
- Practicing comprehensive dialogue skills ..... 69
- Dealing with resistance in a dialogue ..... 70
- Setting goals of change ..... 71

### **MODULE 2**

#### **Lectures**

- System orientation in working with families ..... 72
- Family assessment ..... 77
- Working with families with children ..... 82
- Motivational interview in promoting change in families ..... 92
- Family violence ..... 104
- Psychological consequences of working with victims and people exposed to trauma and violence ..... 110
- Prevention of professional stress and job burnout ..... 115

#### **Workshops**

- Participant's experiences in practicing skills from the previous module ..... 120
- Participant's experiences in practicing skills from the previous module (working material) ..... 121
- Family stressors and community relations ..... 122
- Family stressors and community relations – using eco-map (working material) ..... 123

• Family assessment .....	127
• Family assessment (working material) .....	128
• Practicing motivational interview .....	129
• Practicing motivational interview (working material) .....	130
• Practicing motivational interview (working material) .....	131
• Context of family violence .....	132
• Context of family violence (working material) .....	133
• Context of family violence (working material) .....	134
• Risk assessment and safety plan .....	135
• Risk assessment and safety plan (working material) .....	136
• Risk assessment and safety plan (working material) .....	137
• Identification and classification of professional stressors .....	139
• Identification and classification of professional stressors (working material).....	140
• Self-care techniques in preventing professional stress and burnout .....	141
• Preventing professional stress and burnout (working material) .....	142

## MODULE 3

### Lectures

• Mental health, disorders and trauma related mental health .....	143
• Violence and trauma in post-conflict communities.....	146
• Screening for trauma and mental health problems.....	152
• Neurobiology of psychological trauma.....	157
• Trauma informed and trauma focused care.....	162
• Complex trauma in conflict affected populations, IDPs and combat veterans .....	167
• Ambiguous traumatic loss of a family member and complicated grief .....	171
• Dealing with trauma and suicidality .....	175

### Workshops

• Trauma around us: Learning from experience of trauma and losses .....	181
• Learning from experience of trauma and losses (working material) .....	183
• Exercise screening for trauma and referral .....	184
• Exercise screening for trauma and referral (working material) .....	185
• Exercise screening for trauma and referral (working material) .....	187
• Exercise screening for trauma and referral (working material) .....	190
• Exercise screening for trauma and referral (working material) .....	193
• Exercise screening for trauma and referral (working material) .....	195
• Interventions for trauma cases by mental health non-professionals .....	197
• Interventions for trauma cases by non-professionals (working material) .....	198
• Mental health consequences of ambiguous loss and grief .....	202
• Mental health consequences of ambiguous loss and grief (working material) .....	203
• Recognizing risk of suicide and basic interventions .....	206
• Recognizing risk of suicide and basic interventions (working material) .....	208
• Recognizing risk of suicide and basic interventions (working material) .....	209
• Countertransference in work with trauma victims .....	210
• Disseminating knowledge about trauma and loss in traumatized communities .....	211
• Disseminating knowledge in traumatized communities (working material) .....	212

## MODULE 4

### Lectures

• Groups in psychosocial work.....	213
• Planning of group work .....	219
• Structuring group meetings and group rules .....	224
• Structure of group relations and roles .....	228
• Working with adolescents .....	232
• Psychoeducational workshops .....	242
• Example: psychoeducational workshop .....	247
• Planning and leading educational (training) workshops for helpers .....	256

## **Workshops**

• Workshop description.....	248
• Template ‘‘What do I do when I feel bad’’ (handout) .....	251
• Leaflet 1: What do you do when you feel bad? .....	252
• Leaflet 2 .....	253
• Planning of group work .....	273
• Form for planning group work (working material) .....	274
• Structuring group meetings .....	278
• Form for structuring group meetings (working material).....	279
• Co-leadership .....	281
• Co-leadership (handout) .....	283
• Co-leadership (working material) .....	285
• Form for the preparation for co-leadership (working material) .....	289
• Working with children and adolescents .....	290
• Working with children and adolescents (working material) .....	292
• Psychoeducative approach in group work .....	293
• Psychoeducative approach in group work (working material) .....	296

## **MODULE 5**

### **Lectures**

• Psychological crisis at individual and community level.....	300
• Psychological First Aid (PFA) in communities affected by conflict and other harmful events .....	305
• Psychological crisis interventions for helpers .....	313
• Community and social capital in time of distress.....	319
• Community recovery and community resilience.....	326
• Empowerment of local communities and social action .....	330

### **Workshops.**

• Experiences with community crisis events.....	337
• Elements of community crisis events (working material) .....	338
• Planning PFA in a community crisis .....	339
• PFA after a terrorist attack (handout first two days) .....	340
• PFA after a terrorist attack (handout from second day to end of first week) .....	341
• PFA after a terrorist attack (handout from second week to end of first month) .....	342
• Planning PFA for children and adolescents in a community crisis .....	343
• Psychological First Aid for children (working material).....	344
• Demonstrating interventions for helpers after a crisis event.....	345
• Effects of armed conflict on my community.....	347
• Effects of armed conflict on my community (working material) .....	348
• How functional is my community? .....	349
• How functional is my community? (working material).....	350

- Assessment of community needs and resources and social action plan ..... 352
- SWOT ANALYSIS of the community (working material)..... 354
- Planning social action in a community (working material)..... 355
- What can I do for my community? ..... 356

## **FOLLOW UP**

### **Lectures**

- Helping skills in a multicultural context..... 357
- Strengthening helping work through supervision ..... 363

### **Workshops**

- Awareness of own worldview ..... 371
- Understanding worldview of a client ..... 373

## BACKGROUND

This Reader includes the materials (lectures, workshop descriptions and working materials) that have been developed by the Society for Psychological Assistance (SPA), Zagreb, Croatia for the purpose of implementing the project “*Capacity Development for Psychosocial Support - Strengthening Colombian care professionals for providing psychosocial services*” in cooperation with the National Training Service (Servicio Nacional de Aprendizaje – SENA) and Ministry of Health and Social Protection of Colombia.

The project was funded by the European Union Trust Fund for Colombia under the contract number T06.27 and was implemented from August 2018 to July 2020.

The Overall Objective of the project was to make the quality psychosocial assistance more accessible and acceptable for the conflict-affected population in the Colombia through increasing the capacity for providing psychosocial services by Colombian care professionals.

The EU Delegation (EUD) in Colombia was responsible for managing the program while the Society for Psychological Assistance (SPA) was the main implementing partner. Meetings between EUD and SPA, as well as between SENA and SPA were regularly held before each of the training activities. In addition, meetings of the Steering Committee were held to monitor the program implementation, provide guidance and help resolve challenging issues. It comprised high representatives of EUD, Ministry of Health and Social Protection, and SENA.

### Geographical coverage

The training was delivered in the four cities: Bogotá, Barranquilla, Medellín and Cali, but it covered 21 departments of Colombia.

The four training locations were determined by SENA and the Ministry of Health and Social Protection and approved by EUD. Likewise, SENA and the Ministry of Health and Social Protection decided who to invite to the training and from which departments and municipalities, since they have the best knowledge and overview of the needs and priorities. This was in line with the plan to ensure potential for synergies with other EUTF projects, therefore this was done in cooperation among SENA, Ministry of Health and Social Protection and EUD. Therefore, 78 public institutions received technical support through this project for their improved services delivery to the victims of the armed conflict and to other users, by sending their employees to this capacity building project.

Regarding the institutional alliances which can potentially serve as facilitators of community integration and inter-sectoral collaboration, the training participants came from a variety of organizations: ICBF (52 people), institutions of the health sector (44 people), universities (12 people from Atlántico, Meta, Tolima, Boyacá and Bogotá), departmental and municipal health and social protection offices (11 people), SENA (9 people). Other institutions included psychology organizations and schools, city mayor offices, National Social Work Council and victim units.

Consequently, this training project covered 21 departments (Choco, Meta, Cauca, Valle del Cauca, Caquetá, Nariño, Guaviare, Guajira, Antioquia, Cundinamarca, Córdoba, Tolima, Putumayo, Cesar, Arauca, Huila, Atlántico, Boyacá, Caldas, Casanare, Risaralda, San Andrés, Santander, Sucre and Bolívar).

The project coincided with other EUTF projects in 12 departments from which 95 people were trained (Choco, Meta, Cauca, Valle del Cauca, Caquetá, Nariño, Guaviare, Guajira, Antioquia, Cundinamarca, Córdoba and Tolima). In these areas there is a potential for alliances with 47 institutions.

This training was delivered in other 9 departments in which 55 people were trained, where EUTF did not run other projects (Atlántico, Boyacá, Caldas, Casanare, Risaralda, San Andrés, Santander, Sucre and Bolívar). In these departments there is a potential of 31 institutional alliances.

### **Training modules and topics covered**

This capacity building project included 5 training modules each lasting three days and one 2-day follow-up meeting which were delivered at the four dedicated locations. The syllabus was developed in consultation with representatives of the target groups, Ministry of Health and social Protection and SENA. Furthermore, the topics were also refined during the training delivery in response to the needs of the training participants which were assessed at the end of each module.

The five training modules were delivered over a period of 9 months (from 13<sup>th</sup> February 2019 –14<sup>th</sup> November 2019) at the pace of about 6 - 12 weeks apart. This teaching format enabled the trainers to respond to the emerging needs of the training participants and allow the trainees to practice the new skills between the modules. They were invited to share their experiences from practice at the beginning of each following training module and receive feedback and guidance from the trainers.

The training format included short interactive lectures with slides in Spanish language, but the emphasis was on workshops with experiential exercises and application of workshop materials. The text from the slides, detailed description of the workshops and the workshops materials are compiled in this Reader.

The training syllabus covered the following topics:

- Psychosocial approach to populations affected by conflict and empowerment model
- Long-term psychosocial consequences of conflict
- Resilience and empowerment of individuals and communities affected by conflict
- Mental health and trauma related conditions
- Assessment of psychological trauma
- Triage and screening for mental health problems and trauma
- Trauma focused treatment approaches
- Complex trauma in the war affected populations, IDPs and veterans
- Ambiguous traumatic loss of family members
- Intergenerational transmission of trauma
- Needs and identities of victims in a post-conflict society
- Risk and protective factors from individual to cultural system
- Professional dialogue: skills and dealing with resistance
- Helping skills in a multicultural context
- Process of individual change

- Motivational interview in promoting change in families and individuals
- Collaborative planning of change
- Family assessment and interventions
- Systemic approach to work with families
- Family violence: prevention and interventions
- Child abuse in the life-long perspective
- Group work with populations affected by conflict
- Psycho-educative group work with traumatized individuals
- Group and individual work with children and adolescents
- Interventions for strengthening community resilience
- Inter-sectoral collaboration in helping victims of armed conflict
- Mental health of care providers and prevention of professional stress and burnout
- Crisis interventions for care providers
- Supervision in strengthening care providers and quality of their work.

The trainers in this program were highly experienced and internationally recognized experts provided by the Society for Psychological Assistance from Croatia and the Arq Psychotrauma Expert Group, The Netherlands. The total of 11 trainers worked in pairs at each of the 4 locations. These included: Prof. Dr. Dean Ajduković, psychologist, Prof. Dr. Marina Ajduković, psychologist, psychotherapist and licensed supervisor, Dr. Dea Ajduković, psychologist and psychotherapist, Martina Čarija, psychologist and counsellor, Željka Čolović Rodik, psychologist and senior advisor, Prof. Dr. Dinka Čorkalo Biruški, psychologist, Prof. Dr. Margareta Jelić, psychologist, Prof. Dr. Olja Družić Ljubotina, social worker, Prof. Dr. Trudy Mooren, psychologist and psychotherapist, Prof. Dr. Miranda Olff, psychologist and psychotherapist, Dr. Nika Sušac, psychologist.

Three months after the last training module two SPA consultants conducted follow-up meetings and outputs assessment with each of the four groups of training participants.

### **Evaluation of the training**

The participants assessed that the training as a whole provided them with high level of new knowledge and skills that they can use in their work with victims, as well as with other clients (mean score was 4.9 on a 5-point scale from 1 = poor, to 5 = excellent, completely). They were able to use new knowledge and skills in their practice to a very high degree (4.7), which should be considered in the light of the profile of the participants since some of them did not work in practice, but were university teachers or middle managers in the health sector.

Their feeling of being competent to train other care providers was assessed also as high (4.5), which is an achievement in itself since a number of them have never had any trainer experience. We believe that the training model that has been used throughout this capacity building program, which included a lot of participants' active engagement in demonstrations, role play and short presentations, helped them build the feeling of competence to train other providers.

### **Achieved learning outcomes**

After completing the full training program, the participants have reached the following learning outcomes and have enhanced their psychosocial knowledge and skills in the following areas:



- Understanding the psychosocial approach and use of empowerment model;
- Understanding of psychological trauma and complexities of trauma-related consequences of the conflict for individuals, families and communities;
- Ability to recognize and provide first assessment of trauma-related conditions, establish referral pathways for individuals who require expert level of mental health treatment;
- Implement the stepped-up model of trauma informed care in the community;
- Increased awareness of advantages and limitations of different treatments for psycho-trauma and related conditions;
- Competencies for user/client centered approach, and ability to use a range of psychosocial approaches;
- Ability to assess risk and protective factors and promote empowerment approach among the affected populations and communities;
- Ability to establish good rapport with users exposed to trauma and loss and deal with resistances;
- Implement assessment of needs of family members and provide enhanced psychosocial interventions;
- Ability to plan and lead group support treatments with different groups of users;
- Ability to initiate and maintain inter-sectoral collaboration among different services at the community level;
- Ability to care for own mental health, manage professional stress and prevent burnout;
- Ability to plan, initiate, develop, deliver and evaluate replication of the current training program and disseminate it to other care providers.

### **Direct project beneficiaries / training participants**

Direct project beneficiaries were Colombian care providers of psychosocial services who have been identified by SENA and invited to subscribe to the training. Out of 158 selected and initially registered candidates, 150 of them participated in the training (18 men, 132 women) from 21 departments (out of a total of 32 Colombian departments) and 52 municipalities. The project developed a potential for 78 institutional alliances (local, regional and national) from which the participants came.

The profile of the trained participants included 12 different professions: psychologists (75), social workers (28), nurses (23), instructors (4), medical doctors (3), physical therapist (2), university professionals (2) and other (such as occupational therapist, social development specialist, anthropologist and others).

### **Indirect project beneficiaries and strengthened capacity for psychosocial services**

The total number of users (clients) served by 140 training participants is 9,940 per month, with the average of 71 users per month per training participant. This means that on an annual basis they serve 199,280 people in 21 departments of Colombia.

The training participants reported that they are able to apply new knowledge and skills in most cases, which is 6,860 users per month (69% of the total number of users). On the annual basis 82,320 users benefit from the enhanced psychosocial competencies of the care providers trained within this project. Moreover, among the total number of users, 45% of them show obvious

improvements in their status and problems which was attributed to the enhanced competencies of the trained care providers. On the annual basis this is 53,760 users (clients).

Regarding the number of people who have been recognized as victims of the armed conflict, the trained participants serve on the average 2,660 of them per month, which is 29% of the total number of users they work with each month. This means that the participants in this capacity building project serve 31,920 victims each year. Since it is reasonable to expect that these care providers will continue their work over the coming years, it can be estimated that around 160,000 victims will benefit from their improved competencies to deliver quality psychosocial services over the next five years.

In sum, this project increased the professional competences of the psychosocial services providers to support the conflict-affected populations in Columbia, and that large number of end users will benefit from this project. Over the next 5 years the training participants will serve around one million users, among which there will be about 160,000 victims of the armed conflict.

Regarding the capacity for further dissemination of the present training, the total estimated potential for training new care providers based on the information from the training participants is over 10,000 individuals over one calendar year. If organizational support becomes available, it is reasonable to expect that this number can be multiplied over several years, as the new trainers become more experienced and recognized as trainers within the professional community, demand for them would probably grow, and their appetite to serve as trainers will increase.

# MODULE 1

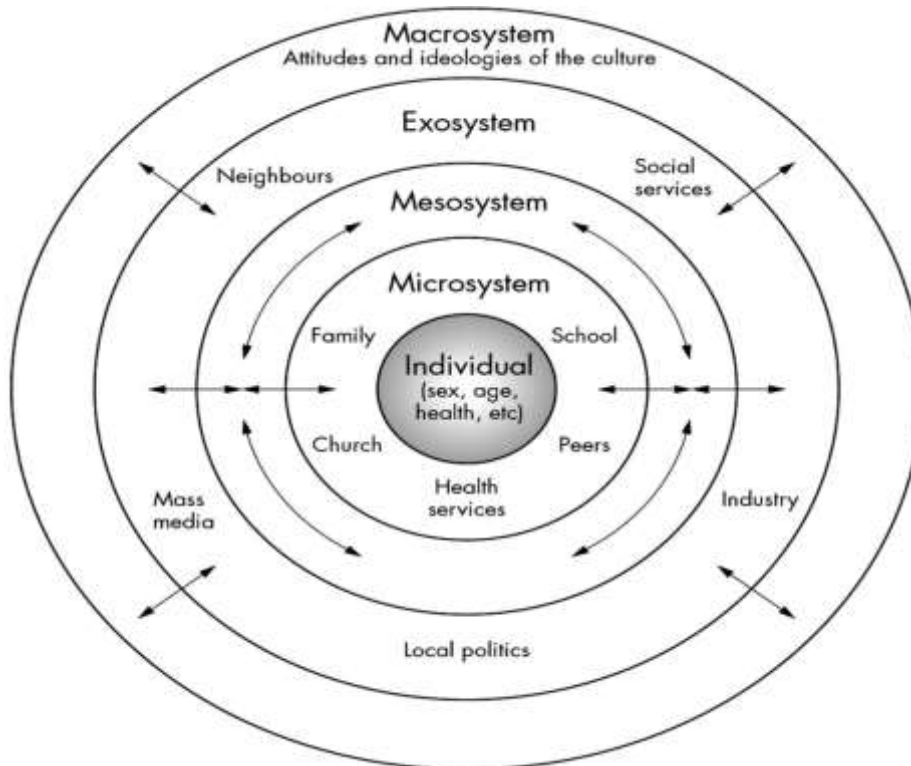
## Lecture

### Psychosocial approach to conflict affected communities

#### Definitions of psychosocial work

- Psychosocial = dynamic relationship between psychological and social influences, where each of them continuously influences the other
- Psychological components: thoughts, feelings and behaviors
- Social provides a context for the development of the individual → immediate social environment, culture, economy, spirituality, interpersonal relationships, life tasks
- Psychosocial work → focused on improving interpersonal relations and life situations

#### Bronfenbrenner's ecological systems theory:



#### Theory of psychosocial work

- The individual must be seen in his/her social context
- Individuals change and develop, their social relations evolve
- Roles of a helper in these relations change
- Approach is integrative and includes multiple perspectives: developmental, systemic/relational, constructivistic, humanistic, ecological

## **Methods**

- Actions reflect the theory of psychosocial work
- Preventive and treatment interventions
- Work with individuals, groups and communities

## **Focus on the system**

- Psychosocial work focuses on the social contexts and systems to which persons belong and/or which they consider to be relevant for their life

## **Ways of facilitating change:**

- Direct action: work on changing the person's environment and guiding the person to make necessary life changes
- Indirect action: empowering the person to take responsibility for his/her life, decisions and their implementation
- Helper is responsible for the process of empowering the person and creating an environment in which he/she will make the best decision

## **Psychosocial work includes**

- Helping individuals, families and communities recognize and formulate their needs
- Linking individuals and families with services in the community
- Identifying individuals who need specific services (e.g., psychiatric, medical or legal assistance)
- Developing an individual plan of support/change for a person using principles of case management
- Providing information to persons
- Supporting, understanding and being sensitive to the specific needs of a person
- Supporting persons' self-action to strengthen their resilience
- Supporting helpers in community services to better understand the needs of people

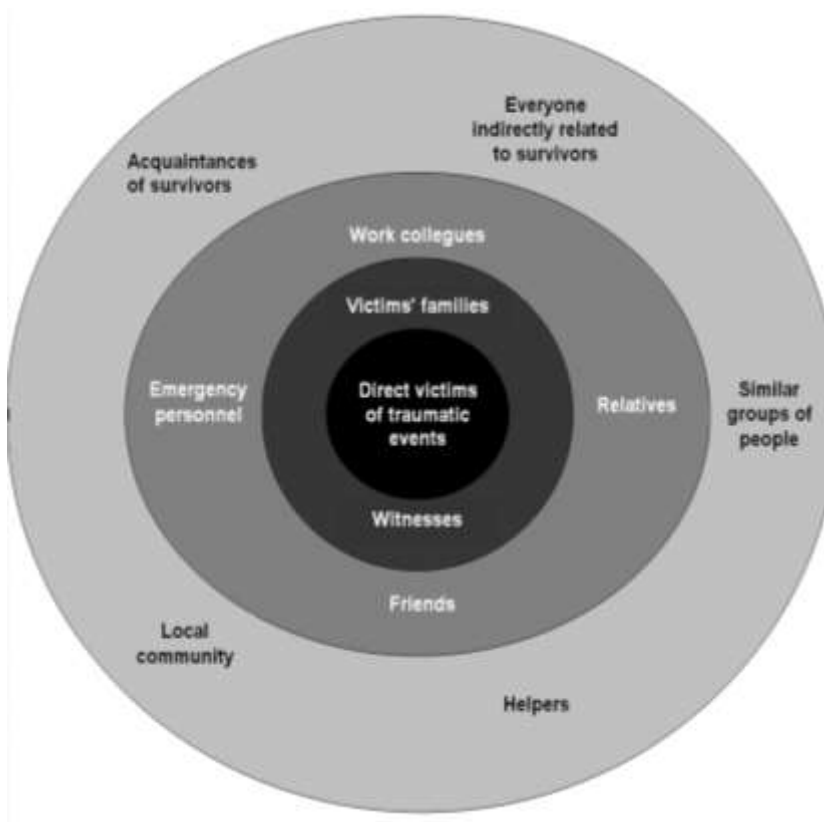
## **Uncertainty in planning and implementing psychosocial interventions**

- Differences in opinions what are the psychosocial needs
- Defining the threshold of needs depending on available resources and political priorities
- Different views on what are good outcomes and how to achieve them
- Conflicts of interest among different stakeholders
- Moral and ethical dilemmas

## **Target groups for psychosocial interventions**

- People who have been exposed to adverse and traumatic experiences of different intensity:
  - Those directly involved and their families
  - Witnesses, friends and “near misses”
  - Helping personnel
- These groups should have access to a range of interventions
- Some people have been exposed to single or small number, other to high number of events → cumulative effect leading to exhaustion crisis

### Circles of vulnerability



### Vulnerable groups requiring special attention

- Children and adolescents since their development can be affected by exposure to instability, life adversities, trauma
- Elderly who depend more on other people
- Pregnant women, single parent families who are more dependent on organizational support from the family and / or community
- People with chronic illness who may need special medical attention or assistance to access services

- Children and youth without parental support and supervision
- People who do not understand language, procedures, legal requirements (e.g. minority groups)

### **Children and adolescents have increased need for psychosocial care**

- Communities and families focus on rebuilding infrastructure, homes and jobs which absorbs most of their time and energy, neglecting the increased needs for support and care of distressed children and adolescents
- Highly distressed adults sometimes do not recognize increased emotional needs and internalized problems of children and adolescents, and provide too little support before psychological and/or behavioral difficulties externalize

### **Psychosocial interventions**

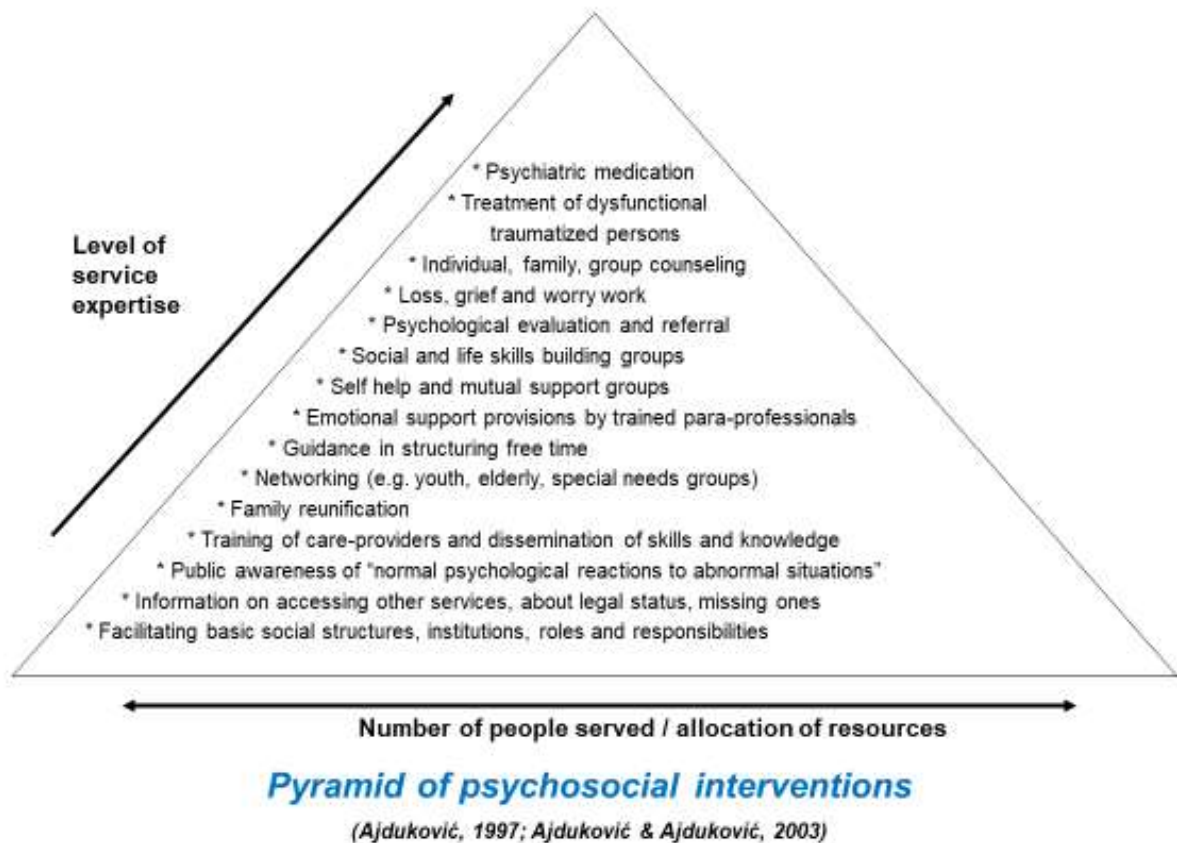
Psychosocial interventions should enhance the coping capacity:

- Individuals:
  - To deal with disturbing posttraumatic reactions and integrate traumatic experiences and losses
  - To deal with community changes due to the conflict
- Communities: To find culturally appropriate ways to deal with losses and ensure a safe environment which is conducive to healing

### **Approach in psychosocial interventions**

- Practical help given in an empathic manner
- Emotional support and reassuring of distressed individuals
- Providing information (e.g. tracing family members, accessing temporary housing, food, social benefits, access to health, psychological, legal services)
- Providing material assistance (e.g. housing, food, financial benefits, rebuilding infrastructure)
- Providing legal advice to victims
- Employment (e.g. training to increase employability and independence)
- Facilitating mutual support and special interest groups
- Providing specific psychosocial care to the affected population
- Organizing memorial events and building monuments with active participation of the community members
- Raising awareness about psychosocial consequences of armed conflict
- Providing information about available mental health services and referral procedures
- Collecting victims' questions and securing responses

- Psychoeducation about 'normal reactions to abnormal situations' for specific groups (e.g. adolescents, children, elderly, parents, teachers, community workers)
  - Support groups with special interests, backgrounds or experiences (e.g. survivors of family losses, families with missing family members, victims of torture)
  - Informal, recreational and creative activities using the local tradition and culture
  - Identification and referral of individuals with disturbing posttraumatic psychological functioning
  - Psychological counseling, grief work
  - Support and consultation by psychosocial providers to the staff in community institutions (schools, community clinics, churches, youth clubs) to help re-establish normal routines and support to highly distressed individuals
  - Advising community authorities on the psychosocial issues
  - Networking with providers in communities with similar experiences
  - Develop and put in place evaluation procedures that will demonstrate the effectiveness and accountability of psychosocial services
- ➔ This is represented by the Pyramid of Psychosocial Interventions in the following figure.



**Staff-related issues**

- Because of high workload, difficult working conditions and a large number of distressed individuals, the psychosocial staff is exposed to high levels of professional stress and vicarious traumatization
- Procedures should be provided that help prevent burnout, access to supervision, consultation with peers and outside consultants, opportunity for professional growth and facilitating supportive team spirit



## **Lecture**

# **Resilience and empowerment of individuals, families and communities affected by conflict**

## **Definitions of resilience**

- Successful adaptation despite risk and adversity (Masten, 1994 )
- English word derived from the Latin for “*bouncing back*”
- Different from invulnerable or invincible!
- Requires the presence of substantial risk or adversity

## **Individual and collective resilience**

- Individual: A person’s capacity for adapting psychologically, emotionally and physically reasonably well and without lasting detriment to self, relationships or personal development in the face of adversity or threat (Williams, 2007)
- Collective: Ways groups of people express and expect solidarity and cohesion, and thereby coordinate use of collective sources of support and other practical resources adaptively to deal with adversity (Drury, 2009)

## **Specifics of resilience**

- More than the absence of pathology and only surviving
- Sometimes even with improved functioning after adverse experience
- Dynamic process rather than a stable trait (e.g. an individual can be resilient to job difficulties, but vulnerable in close relationships)
- Good developmental outcomes despite high risk – “resilient child”
- Maintained competence under stress (e.g. displaced persons)
- Recovery from trauma, not only absence of post-traumatic symptoms but good functioning, sense of wellbeing

## **Psychosocial risk factors for resilience**

- Life situation still insecure or stressing
- Perceived high threat to own life or important others
- Exposed to dead bodies and grotesque circumstances
- Circumstance of low controllability and predictability
- Experienced great loss and physical injury
- Experienced higher degrees of community destruction
- Living in circumstances of continuous threat
- History of psychopathology in family

- Previous traumatic exposure of oneself or family
- History of relational / complex trauma
- Lack of social support / isolation
- Sleeping problems

### **Psychosocial protective factors for resilience**

- Interacting capacities and capabilities:
  - Social relationships and social capital
  - Economic resources
  - Institutional functioning
  - Community continuity and culture
- Individual psychosocial protective factors :
  - Safety, predictability
  - Social support
  - Sense of belonging
  - Sense of coherence, acceptance of reality, purpose and role
  - Sense of mastery, belief in oneself enhanced by strongly held values, ability to improvise, be active, take notice of the events

### **Resilience – example of street children**

- Psychological distress – no difference compared with poor children who do not leave home (Koller & Hutz, 2001)
- Enhanced development – development of cognitive skills useful for adaption and survival like divergent thinking and imagination (Dahlman et al., 2013)

Example: child street vendors have to buy in bulk and calculate sale prices to maximize profits; they have to quickly calculate total prices and change to be given to customers. Although not attending school, their arithmetic abilities surpass those of non-working urban school-attending children or rural-living children (Saxe, 1988)

### **Collective resilience**

- The capacity of a community or cultural system to absorb disturbance and reorganize while undergoing change so as to retain key elements of structure and identity that preserve its distinctness
- Culture as a resource for collective resilience → communities promote self-continuity

### **Resilience and vulnerability**



- Vulnerability can modify a person's response to risk (by intensifying it or weakening it)
- Economic, social, environmental, psychological vulnerabilities...
- Three levels of protective and risk factors: individual, family, community

### **Power and empowerment**

- A meaningful change in the experience of having power in social relations achieved through interaction in the social world (Cattaneo and Goodman, 2015)
- Power is a level of influence a person has in social relations
- Empowerment requires an understanding of people's priorities and values
- Resources enable actions towards achieving more power in social relations
- Empowerment includes promotion of active role of people and communities in the planned changes which should be based on recognition of their strengths, human dignity and self-determination (IFSW, 2012)

### **Empowerment**

- Adaptation processes that occur in adverse contexts
- Strengths-based approaches
- Identifying resources within an individual and community
- In accordance with local values and cultural contexts

- Aims towards improving quality of life, functioning, and promoting positive outcomes

### **Helpers can empower a person by:**

- Clearly explaining own role and professional practices
- Setting clear expectations
- Providing optimal challenges
- Supporting development of skills and providing information-rich feedback
- Providing feedback in a timely, consistent and outcome-related way
- Supporting identification of personal and social resources
- Supporting clear definition of goals
- Having “good faith” in the person’s resources
- Clearly naming situations where there is lack of power (eg. being a victim of abuse)

### **Helpers can show involvement by:**

- Devoting time to what is important to the person
- Showing concern for the person
- Knowing the person and what is going on with him/her
- Expressing understanding for the person
- Sharing with the person resources: time, attention, energy, interest and emotional support

### **Relational competences for empowerment**

- Relational competences are limited to professional relationships: those in which one side is a competent helper and the other is not
- A relationally competent helper is able and willing to:
  - „See” each person in his/her own terms and adapt own behavior without losing leadership
  - Remain authentic in contact with the person
  - Assume responsibility for the quality of the relationship with the person (Juul & Jensen, 2002)

### **Responsibility of a helper for the relationship**

- The relationship defines mutual roles / positions / values of two or more people
- In a collaborative relationship people feel important, valued and beneficial to the other person
- Challenge is to establish a collaborative relationship when a hierarchical relationship exists based on social norms, as is the case with helpers and clients

## Type of responsibility in a helping relationship (Juil & Jensen, 2010)

1. Internal responsibility: responsibility of a person to oneself, own boundaries, needs, feelings and goals
2. External responsibility: responsibility of a person to social and cultural values that are beyond the individual, responsibility to an organization or to some other social role

*Is a helper's responsibility for the  
relationship with a person internal and / or external?*

## Shift towards empowerment in psychosocial work

- Shift in: Focus on individual persons → Focus on persons within families, communities, workplaces, schools and groups of strangers
- Shift from: Viewing people's responses to adversities and trauma as helpless victims, unpredictable, and/or driven by competition and panic → People as innovative problem-solvers

## Models of providing psychosocial support

TRADITIONAL MODEL	EMPOWERMENT MODEL
<b>General approach</b>	<b>General approach</b>
Focus on insufficiencies/defects	Focus on strengths and advantages
Individual responsibility	Individual and institutional responsibility
Programs for individuals	Programs for individuals, families and communities
One type of „right“ treatment	Broad scope of interventions Prevention and promotion of wellbeing
Fragmented programs	Integrated, comprehensive programs
<b>Status of people using services</b>	<b>Status of people using services</b>
Passive	Active
Individuals	Individuals, families, communities
Relatively helpless, without abilities, skills and aptitudes	With abilities to direct their own life
<b>Psychosocial services and organizations</b>	<b>Psychosocial services and organizations</b>
Formal support systems (services and professionals)	Formal and informal support systems (natural helpers, extended families, friends, religious organizations, civil society)
Competition among services	Cooperation and partnership with other services
<b>Role of a professional</b>	<b>Role of a professional</b>
One who <i>knows everything</i>	One who knows, encourages, facilitates, catalyzes
Works <i>for</i> the client	Works <i>with</i> the client /community members
Protects the clients	Encourages, supports and also challenges clients / community members
Expert as the „key player“	Expert as partner of clients / community members
One-way relationship	Mutual, two-way relationship
Provides answers and seeks solutions	Asks questions, helps identify opportunities

## **Methods of empowerment**

- Listen carefully to the person
- Ask questions rather than tell the person what to do
- Encourage the person to express own unpleasant emotions (e.g., anger, fear) and acknowledge concerns
- Encourage the person to identify own needs and define problems
- Help the person develop own goals and vision of change
- Identify strengths and lead the process of change based on existing resources and strengths
- Train and develop skills, especially of analyzing, planning and taking action
  - Help the person develop and strengthen critical thinking
  - Expose the person to alternative ways of thinking and understanding of the social reality
  - Help the person reflect on possible consequences of own decisions or actions
- Educate and share information
  - Encourage the person to make informed choices
  - Share your expertise and opinions without imposing or manipulating
- Identify and help strengthen the person's social network and the natural support system
- Help the person understand the institutional power relations
- Provide support once the decision is made and action is taken

## **Lecture**

### **Long-term psychosocial consequences of armed conflict**

#### **Armed conflict**

- Armed conflict (war) is the prototypical case of organized violence that challenges the basic human and moral categories, questions the existential meaning of the self and others
- War-related suffering of civilians involves the need for finding the meaning of the enemy's behavior which has consequences for one's mental wellbeing

#### **Areas of life affected by armed conflict**

- Losses – personal, communal; people, property; values; health; ...
- Displacement
- Distrust between groups in community / society
- Poor health and mental wellbeing; traumatized individuals
- Disappeared family members
- Increased family violence
- Increase in crime rate due to the conflict
- Land „infected” by anti-personnel mines
- Children out-of-schooling

#### **Human casualties in Colombia (Wikipedia, October 2018)**

- Total casualties: 218,094
- Total civilians killed: 177,307
- People abducted: 27,023
- Victims of enforced disappearances: 25,007
- Victims of anti-personnel mines: 10,189
- Total people displaced: 4.7–5.7 million

#### **Registered child victims in Colombia since 1985 (UNICEF 2016; Source: National Victims Registration Unit)**

- Death threats: 73,000
- Enforced disappearance (missing): 8,000
- Forced displacement: 2.3 million
- Number of children killed 43,550
- Abductions 615

- Tortured 320

### **Sexual violence against children in conflict (UNICEF 2016)**

- Nearly 18,000 cases of sexual violence against children and adolescents in 2013, representing over 80 per cent of all reported cases
- 70 % of cases involved girls under the age of 14
- Use of sexual violence against women and girls as a weapon of war
- In the conflict areas sexual violence was a major cause of displacement
- Prevalence of sexual violence may affect communities for long time

### **Long-term mental wellbeing after armed conflict**

- Long-term mental wellbeing consequences studied in many countries affected by conflicts: Lebanon, Algeria, Gaza, Ruanda, Cambodia, Ethiopia, Balkans ...
- Key finding: strong connection between war experiences and increase of mental health disorders many years later, especially PTSD and depression
- Data on prevalence vary between countries: 16% to 37%
- Prevalence of mental health disorders are always higher among the population exposed to the armed conflict than the unexposed population

### **Long-term mental wellbeing after armed conflict in the Balkans**

- Mental health disorders 10 years after ending of the war: PTSD: 20,1% (10,6% - 35,4% in different countries), Depressive disorders: 19,9% (4,1% - 37,3%)
- Prevalence in the non-affected population 3%
- Considerable comorbidity: 14,4% - 26,9% with one disorder, 7,1% - 35,3% with 2 or more disorders

### **Predictors of disorders in civilian population**

- PTSD and depression:
  - Older age
  - Female gender
  - More traumatic experiences during and after conflict
  - Unemployment
  - Lower education
- Dependency disorder:
  - Male gender
  - Individuals without a partner/wife

### **Are these findings relevant for other countries?**



- Assessment of mental wellbeing should be done for each country based on population studies
- Not possible to generalize the prevalence of disorders from one country to the other because of specifics of and armed conflict, culture, infrastructure to help victims ...
- But: the risk factors for appearance of a mental health disorder are the same / universal

### **Children exposed to armed conflict**

- At high risk of developing mental-health problems, which can have long-term impacts on their wellbeing, their sense of happiness, and their ability to deal with the past
- Children exposed to violence events causing horror, terror, or helplessness can be prone to display anger, suffer from separation anxiety, nightmares, and fall behind in their schoolwork
- If left untreated, these problems affect not just the child, but can also have profound implications for their family and community
- Colombian government's Institute of Family Welfare reported that the impact of the armed conflict on children has been particularly pronounced and can have long-lasting impacts on their psycho-social development

### **But people are agents of own recovery**

- In the post-conflict period affected people use available resources to the best of their capacities
- People differ in the capacity to use such resources → resilience:

Most people (80%) recover from trauma after some time

Some people need professional care, but many recover without it

### **Key questions in the post-conflict**

- How long-lasting, intentionally inflicted suffering affects functioning of groups – from a family to a community?
- How past and current social context relates to recovery of communities and individuals?
- How the conflict affects the relations between different groups who were in conflict?

### **Mass victimization**

- Terms “social trauma”, “collective trauma” or “mass trauma” refers to repeated and sustained violence (Ehrenreich, 2002)
- Affects individuals and communities in which these events happened
- Violence is intentional, to achieve specific purposes
- Violence is inflicted at selected groups and individuals in order to send a symbolic message to other people

- Support mechanisms are not adequate to meet the needs
- The search for meaning of what has happened is extremely difficult
- People feel that gross injustice has been done to many of them and that their basic *rights as human beings* have been violated
- People seek trials against the individuals they see as perpetrators of human rights, not only as perpetrators who have inflicted extreme pain and threatened their life

**Victimized people struggle to recover in social contexts that are not conducive to healing because:**

- Lack of stability and safety hinders recovery
- Psychological loss of capacity to predict life (which is a consequence of trauma) is enhanced by the unstable environments
- People have experienced a whole range of losses in addition to trauma
- Communities may be fragmented and divided
- Such context increases likelihood of transgenerational transmission of violence

**Post-conflict care system may be limited in scope**

- Prevailing medical model in treating traumatized individuals?
- Focus almost exclusively on PTSD?
- Treating the individual apart from the social environment in which the recovery should progress?

**Community psychosocial interventions**

- Help facilitate psychosocial reconstruction of communities
- Decrease social tensions among groups that have been involved in a conflict
- Provide treatment for the traumatized individuals
- Work towards re-connecting community members
- Help create the environment perceived as safe enough to facilitate recovery

**Controversies in psychosocial work after conflict**

- Victims in a community: acknowledgment vs. hindrance
- Perpetrators in a community: truths vs. myths
- Perspectives on impunity: justice as a healer vs. stressor
- Recovery from trauma: treating symptoms vs. safety, embracing life roles and relations
- Victims and family: burden vs. recovery catalyst
- Evidence-based therapies vs. contextual and long-term psychosocial perspective

### **Long-term attributions of recovery**

- Social attachment and support
- Different coping strategies
- Personality hardiness
- Mental health treatment / therapy
- Received material support
- Normalization of everyday life
- Psychological safety
- Community involvement

Recovered participants identified as important for their recovery:

- *reciprocal* social relations (receiving and giving social support)
- determined and outgoing personality (positive attitude and hope)
- strong orientation towards the future
- meaningful activities that ensure social recognition
- supportive cultural-contextual environment

### **Perception of justice and accountability for crimes**

Assumption: if the truth about who did what in the past becomes known:

- Individuals who were terrorized can begin to heal
- Facilitated reconciliation between former adversaries
- Trials will attribute individual responsibilities and guilt to perpetrators
- This will help separate them from the attributed guilt to a whole group
- All this should contribute to psychological, moral and spiritual reconciliation and social reconstruction

### **Definition of social reconstruction**

*Process within a community which brings the community's damaged social functioning to a normal level of interpersonal and groups relations and renews the social fabric of the affected community (D. Ajdukovic, 2004)*

### **Psychosocial obstacles to recovery of individuals and communities**

- Social obstacles
- Psychological obstacles due to individual and collective experiences

### **Social obstacles to recovery**

- Economic instability and lack of resources
- Political messages that question normalization between the groups in former conflict
- Inefficient, discriminating and corrupt authorities
- Feelings of unfulfilled promises by leaders

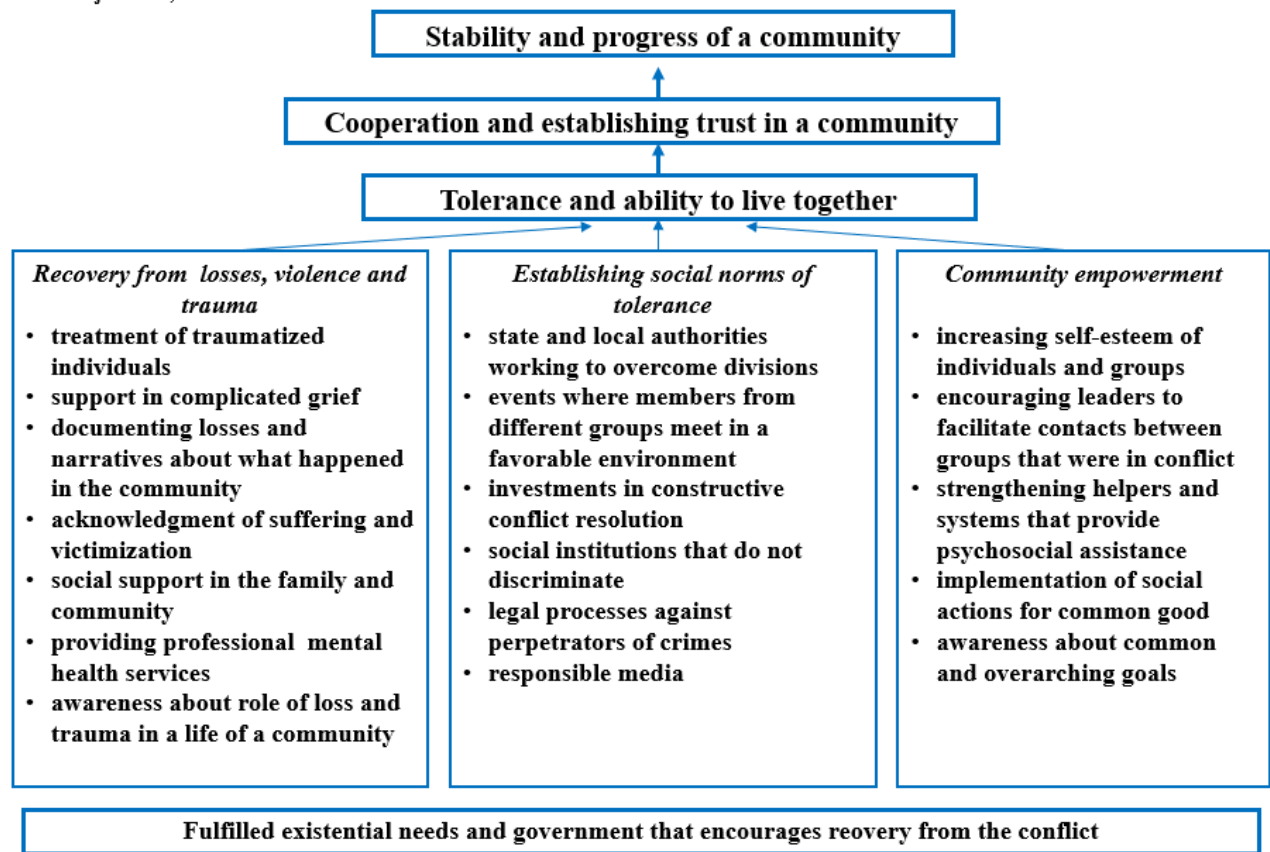
- Lack of trust in other groups
- Social norm of non-establishing contacts with people from the former enemies
- Belief that own group should have more rights than other groups

### **Psychological obstacles to recovery**

- Psychological state because of loss of important persons
- Effects of other losses (material, symbolic, status)
- Unfinished / complicated process of mourning / grief
- Disturbing trauma symptoms and poor functioning in daily life
- Changed world view as a relatively safe and predictable environment
- Perception of inefficient legal procedures against perpetrators of violence
- Feelings of lack of safety
- Feelings of being discriminated because of social or other group membership
- Status of non-acknowledged victim

### **Individual and social recovery are two parallel and related processes**

- Individuals need to deal with disturbing posttraumatic symptoms, integrate adverse experiences and accept losses
- Communities need to deal with painful collective history, overcome conflicting narratives about "who-did-what-to-whom" among various community groups



### Path to social recovery

- For communities to rebuild sense of *communality* the interpretation of the past conflicts which is acceptable to all parties is important
- Suffering and losses should be respected by the entire community, regardless of the group membership
- Empathy for other people's losses and suffering is a very powerful bridge to other persons and groups

### What can be done?

- Interventions during which people from community groups in conflict discuss together events of collective violence, learn about consequences of traumatization and mechanisms of recovery, and share personal experiences, lead to positive change (Staub, 2002)
- Such changes are key for social reconstruction, because they diminish traumatic symptoms, increase cooperation with the other groups and readiness to accept sympathy and apology if the other group expressed it

**Example: Community intervention "Mental Health, Conflict Management and Social Action"** D. Ajdukovic, M. Ajdukovic & D. Corkalo, 2002

- Program during which the key figures from two groups in conflict from 3 divided communities came together for the first time in 10 years
- Format: 3 days, 25 participants; experiential learning and sharing of personal experiences

**The intervention addressed:**

*Socio-emotional reconciliation* → to overcome conflict-induced feelings

Contents: understanding own psychological processes related to loss and trauma,  
sharing experiences about losses

*Instrumental reconciliation* → steps in which both sides need to cooperate to accomplish a shared goal

Contents: recognizing options for constructive conflict resolution, planning of a joint community social action

**Outcomes of this intervention**

- Decreased traumatic symptoms
- Increased cooperation with the other group
- Readiness to accept sympathy and apology from the other group
- Empathy for the suffering of individuals from the other group
- Reports of crossing the inter-group lines by key figures

## Lecture

### Process of change

#### Change

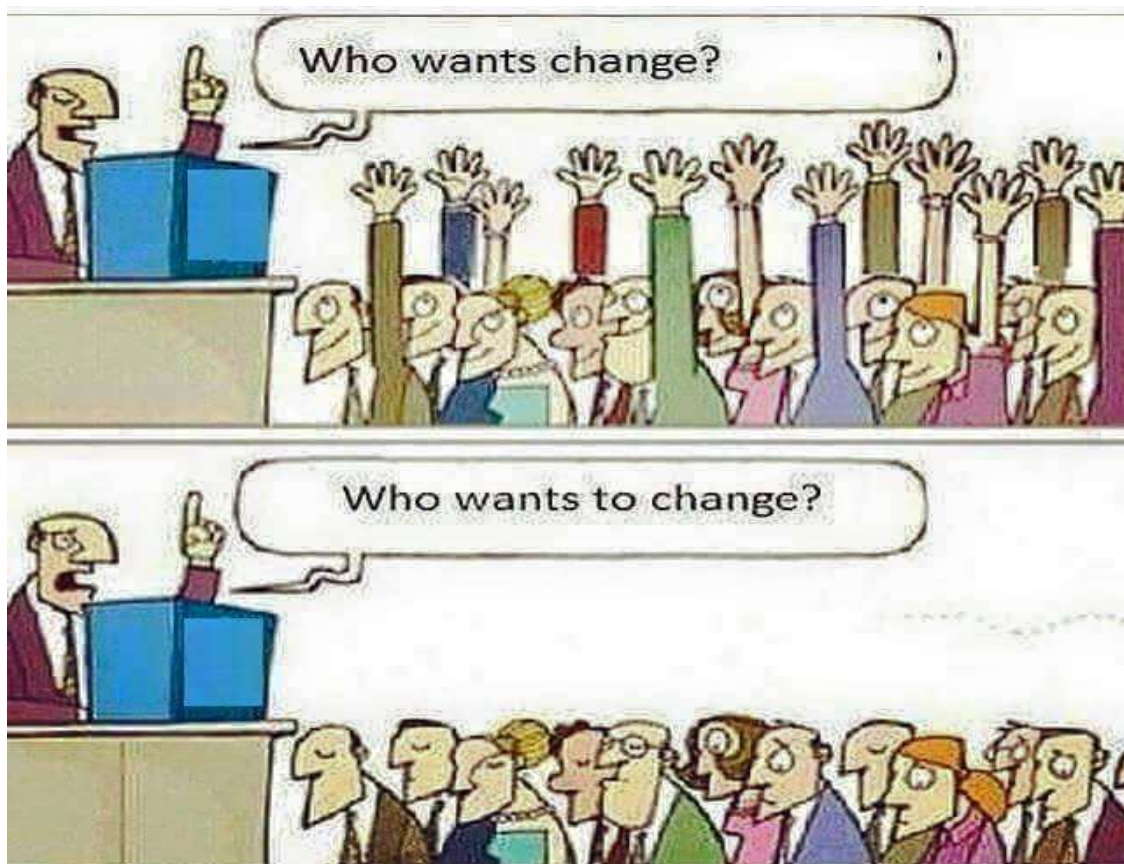
- Desirable outcome of interventions in psychosocial work is change in behavior or life circumstances
- Individuals differ in their motivation for change
- Basic and universal psychological needs related to individual's change:

Need for autonomy: feeling of having choice in making decisions, desire to determine own actions (not to be limited or pressed by other people or circumstances, desire to behave according to own interests, preferences, wishes)

Need for competencies: to be effective in interactions with different aspects of own life

Need for closeness: to establish close emotional and social relations, attachment to people

→ How to lead process of change with different groups of people in psychosocial work?



## Two groups of beneficiaries of psychosocial work

### 1. Voluntary beneficiaries

- People who seek services because they face obstacles which prevent them from achieving their goals

### 2. Involuntary beneficiaries

- People who refuse or avoid services, but interventions are necessary because:
  - Their behavior is contrary to legal rules or regulations
  - They are at a high risk to own or others' well-being
  - They are under pressure to change to keep significant relationship or roles

### Important!

- Conflicts between beneficiaries, helpers, public and media about the type of interventions and expected outcomes usually refer to the second group of beneficiaries



## Common ideas about motivation and change

1.	<i>Change is motivated by discomfort.</i>	CORRECT	INCORRECT
2.	<i>If you make a person feel bad, it will motivate her to change.</i>	CORRECT	INCORRECT
3.	<i>People rarely choose change, until they experience a serious crisis.</i>	CORRECT	INCORRECT
4.	<i>Every change is stressful and person's ambivalence can be expected.</i>	CORRECT	INCORRECT
5.	<i>Resistance to change is determined by some internal conflicts or by some stable personality traits.</i>	CORRECT	INCORRECT
6.	<i>Motivation for change is best challenged by confrontation, especially about dangerous consequences of the problematic behavior.</i>	CORRECT	INCORRECT



## Contemporary view on motivation and change

- Every change is stressful → ambivalence can be expected → resolution of ambivalence is a key for achieving change
- Motivation for change is multi-dimensional → motivation depends on the person's perception if:
  - the change is important
  - he/she believes change is possible
  - he/she is ready to change
- Change is an *evolving process*
- The plan for change has to be individualized and take into account the phase of change in which a person is → readiness for change, strengths, limitations, the context and environmental factors.

## Ambivalence of users

- Even voluntary client/user seek help with instable and conflicting motivation → at the same time they wish to change and do not wish to change
- Low motivation is a challenge to a helper and questions helper's skills → it is not the beneficiary's „mistake” → work on ambivalence is the core of the person's change

## Little exercise

Think about one aspect of your professional behavior which is important for you or for your relations with other people, but which you **really want to change**.

Define for yourself what specifically you would want to change.

Thinking about this that you want to change, decide on a scale from 1 to 10:

1. How really important is this change for me?
2. How much strength / capability I have to achieve this change?
3. How ready and willing am I to start this change now and persist in pursuing this change?

## Transtheoretical model of change (Prochaska & DiClemente 1983; 1986)

- Assumptions of the model:
- Change is not an event but a process
- Change takes place through recognizable phases
- Progress through the phases is not linear but spiral
- In order to achieve the planned change, conscious and deliberate commitment is needed

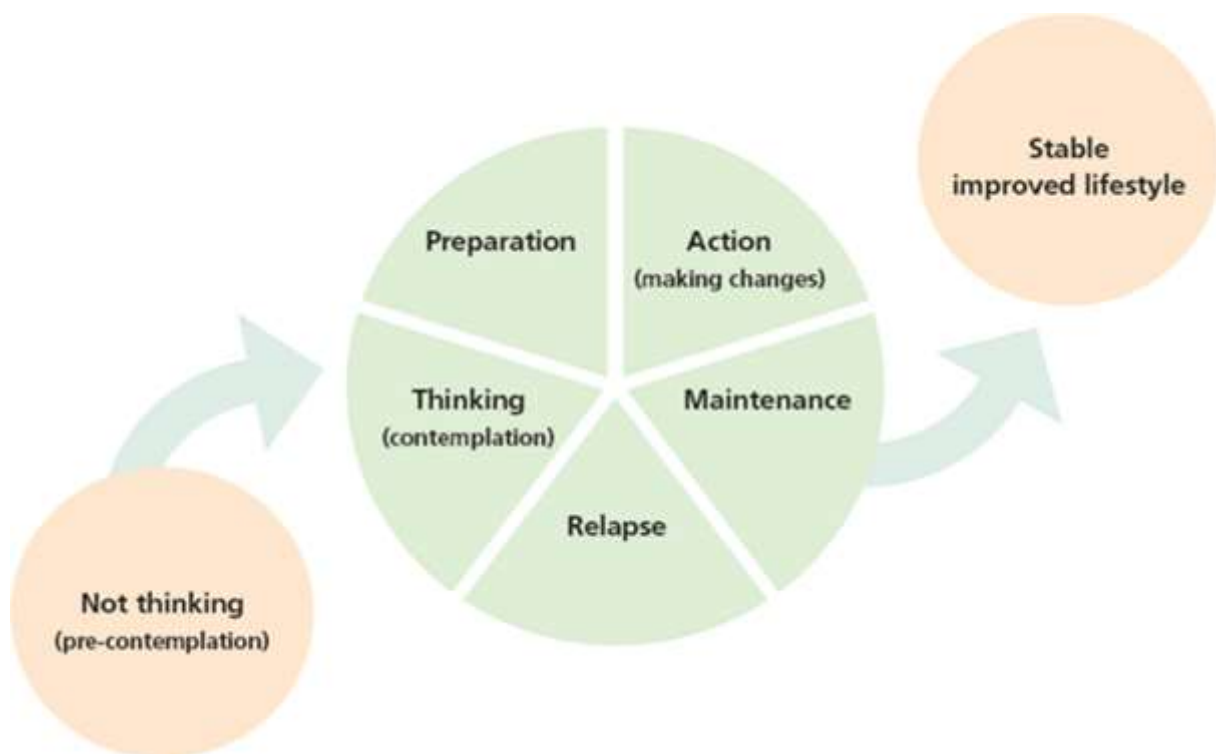
- For a change to be effective, it is necessary to apply adequate strategy at the right time
- A small portion of people are willing to take concrete action, most of the people only intend to change

### **Stages / phases of change**

Quality of involvement of family members is related to stages of change, i.e. their readiness to accept the changing situation

1. Not thinking / pre-contemplation about a change – initial refusal of any change, not aware of the existing problem or difficult situation
2. Thinking / contemplation about a change – there is awareness that there is a problem ili nothing is done to resolve
3. Preparation for change – only intention to do some action is present that will lead to change
4. Action – a person changes behavior and influences the environment
5. Maintaining change – prevents return into the difficult situation / problem and puts effort to maintain the achieved change

### **Stages of change**



<p><b>Pre-contemplation stage about a change</b></p> <p>“I did nothing bad and see no reason to change / enter into a treatment”</p>	<ul style="list-style-type: none"> <li>• A person does not see, ignores, negates or diminishes the problem situation (which is obvious to other people – family members, friends, doctor, social worker, psychologist ...)</li> <li>• Because of this, there is neither need nor intention to change behavior – consequences are:</li> <li>• Refusal to change</li> <li>• Blaming other people for the own problem and behaviors or anger because other people do not understand what is the „real problem”</li> <li>• Sometimes there is partial awareness of the problem but there is need to defend oneself and pessimism regarding outcomes of change which prevent the change</li> </ul>
--	---

<p><b>Contemplation about a change</b></p> <p>“I know I have to dedicate more / less to ...”</p>	<ul style="list-style-type: none"> <li>• There is awareness about the problem, but the person does nothing to resolve it</li> <li>• Sometimes a person is „stuck in chronic thinking” (analysis of the problem, roots of the problem, possible solutions, seeking who is responsible for the problem, self-pity due to difficult life circumstances etc.)</li> <li>• Thinking and talking as a substitute for doing</li> </ul>
--	--

<p><b>Preparation for change</b></p> <p>“Tomorrow I will stop/start ...”</p> <p>„This cannot happen to me any more”</p>	<ul style="list-style-type: none"> <li>• There is intention to change, but intention should be distinguished from real action and concrete steps.</li> <li>• Justifications are often regarding what prevents the person to undertake what has been agreed to do</li> <li>• Beneficiaries in this stage show some small changes in behavior, but have ambivalent relation toward possibilities of own change and the purpose of change</li> <li>• Sometimes this stage can be recognized with the wish to „do too much in too little time” (unrealistically high goals) or lack of capacity to jointly with the helper determine the clear goals or criteria of success</li> </ul>
---	--

<b>Action</b>  „I started to do / use... and in this way I achieve / control ...”	<ul style="list-style-type: none"> <li>• People show energy and commitment to change, and some changes are visible to other people (opportunity for support and acknowledgment!)</li> <li>• Risk – action itself does not mean sufficient and realistic change</li> <li>• If the action is enforced on the beneficiary, then after the action follows failure and return to the previous behavior or the previous stage of the change</li> </ul>
---	--

<b>Maintenance of change</b>  “I did not repeat .. I still do / do not do ...”	<ul style="list-style-type: none"> <li>• Beneficiary undertakes whatever is needed not to find oneself in the difficult situation and strives to maintain the achieved change</li> <li>• Review of benefits and advantages of the undertaken actions and achieved change (if there is no benefit and support, the change is not likely to be maintained)</li> <li>• Maintaining change is not a passive state, but rather continuous practice of new behaviors</li> <li>• Maintaining new behaviors can demand more energy than initiating the change, because it is a long-standing task which does not receive the same recognition from other people and the feeling of achievement decreases over time</li> </ul>
--	---

### Change processes

1. Increasing awareness about the problem - very often not enough
2. Recognizing and expressing emotions related to the problem
3. Change in the self-evaluation/self-appraisal
4. Change in the appraisal of the social environment – it is activated towards supporting the change
5. Self-determination – belief that the change is possible and the commitment to act accordingly
6. Increasing awareness about the problem - very often not enough
7. Recognizing and expressing emotions related to the problem
8. Change in the self-evaluation/self-appraisal
9. Change in the appraisal of the social environment – it is activated towards supporting the change
10. Self-determination – belief that the change is possible and the commitment to act accordingly

## **What the people care about when they intend to change behavior?**

### ***(Theory of planned behavior)***

- Behavioral intention precedes true behavior
- Behavioral intention depends on three components:
  - Own attitudes toward the concrete behavior
  - Subjective norms of oneself and important other people regarding the behavior
  - Perceived own control over the behavior

## **Range of helping techniques to support process of change**

- Paraphrasing
- Reflecting emotions
- Confrontation
- Clarification
- Reflecting
- Self-monitoring
- Providing information
- Psychoeducation
- Feedback
- Making a contract
- Homework tasking
- Guided visualization
- Assertiveness training
- Dairy writing

→ Adapt the techniques to the stage of change of the beneficiary

## **How to empower the person for starting the process of change?**

- Talking about the ambivalence and what are the best and the worst things that can happen
- Help in planning the steps in the process and clear definition of goals
- Motivating the client to imagine their changed life
- Identifying what does the client need for starting the change process
- Defining client's expectations from the process of change
- Preparation for possible reactions of the environment

## Helpful questions for helpers in planning the change process

- What are the expectations of the beneficiary?
- How does the beneficiary define his/her goal?
- What has the beneficiary tried until now to achieve change? What were the outcomes?
- Can the beneficiary imagine the change? Does she/he already have a plan?
- What are the fears, insecurities, worries about how the changed behavior will look like in his/her life?
- How might the change affect the beneficiary's environment (family, career, friends...)?
- Will the other people support the process of change or is there a risk it will sabotage the change?
- Does the beneficiary feel competent and self-efficient enough?
- What does the beneficiary need to reduce the ambivalence towards change and to try out different behaviors?

## Talking about change

Helper should encourage the beneficiary to talk about the change. The more a person talks about a change, the more likely it is that it will happen.

- *Examine goals and values.* Ask what a person wishes in the life, which values guide him/her in life? How does his/her current behavior relate towards these goals and values? Ask about both positive and negative aspects of current behavior
- *Ask for elaboration/examples.* Ask for details („Tell me more about this” „When was the last time that this happened”)
- *Look back.* Ask about time before the current behavior started. Were the things in his/her life different before?
- *Look forward.* Ask what would happen in the future if nothing changes. How might the life of the person look if he/she succeeds in the change and achieves the goal of the change?
- *Ask open ended questions* which encourage answers that lead to talking about the change (“What could you do so that such situation does not happen again?”)
- *Analyze the balance of decision.* Ask for pro and contra reasons related to maintaining or changing the current behavior
- *Explore the extremes.* What could be worst thing to happen if the person does not change the current behavior? What are the best things could happen to the person if he/she changes the current behavior?
- *Bring closer one side of the ambivalence.* “Is your ..... (mention the concrete behavior or attitude of the beneficiary) so important that you do not want to give it up regardless of the consequences?”

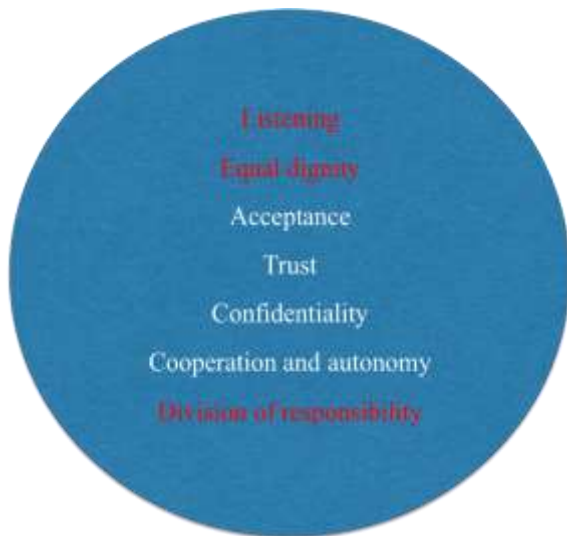
## Lecture

### Professional dialogue

#### Definition of a professional dialogue

A communication process led by a helper, directed towards a specific purpose related to the person's wellbeing.

#### Preconditions for a successful professional dialogue



#### Listening

The conversation should be specific and precise, don't presume you understand

Person: "You can imagine how I felt when he threatened me."

Helper: "Of course, you must have been very angry."

vs.

Helper: "I can imagine, but please tell me more about how you felt."

#### Equal dignity and acceptance

Acceptance - be mindful of the way the person's characteristics affect him or herself; accept the person for who he/she is, not who he/she should be.

The goal is equal dignity of the helper and the person – both the helper and the person are equally valuable and equally respected.

*"In order truly to help someone else, I must understand more than he, but certainly first and foremost understand what he understands. If I do not do that, then my greater understanding does not help him at all."*

*(S. Kierkegaard, 1964 from Žižak, A.; Vizek Vidović, V.; Ajduković M, 2011.)*

### **Trust in the professional relationship**

Most common worries of people under stress, crisis or trauma are:

- *What can I expect from the helper? Will he/she think less of me if I talk about my trauma/problems?*
- *The helper can't understand how it is like to go through such awful things.*
- *What kind of a person is he/she?*
- *Will he/she make me do something I don't want?*
- *Is the helper advocating my best interests or somebody else's (e.g. my spouse's)?*
- *Will the helper accept me and support me when I need it?*
- *If I trust the helper, that means admitting I need help and he/she is more competent than me.*
- *If I can't talk about what happened to me, will the helper lose interest/give up?*

### **Ways people question the helper's trustworthiness**

<b>Person's observable behavior/ question</b>	<b>Person's actual question</b>	<b>Example</b>
Asking information	Are you different/similar to me? Can you understand/accept me?	"How old are you?" "Do you have any children?"
Confiding a personal secret, sometimes even made up, to avoid telling the real difficult story.	Can you handle the dark or shameful part of me?	"When I was a child, I hurt my cat." "My mother is mentally ill."
Asking for favors	Are you reliable and honest?	"Can you lend me some money?" "Can you talk to my son's teacher for me?"
Talking negatively about oneself	Can you accept me?	"I always start yelling at my child when he cries." "I often lie to my boss."



Creating awkward situations for the helper	Are your boundaries clear?	Often or always arriving late at the appointment, changing the date, commenting on the helper's appearance, putting their feet up on a chair...
Asking about other persons the helper is working with and the difficulties of the job	Do you really care about me?	<p>“How do you manage to remember all of us, you must mix us up sometimes.”</p> <p>“It must be hard to listen to all our problems all day long.”</p>

### Confidentiality

- The helper maintains an absolute level of confidentiality in his/her work.
- Everything said in the process and the helper's impressions are not to be shared outside of the relationship with the person.

Exceptions:

- If a person shares information about criminal acts, especially when somebody is in danger.
- Supervision/Intervision – colleagues are also obliged to keep the confidentiality.

### Cooperation and autonomy - “Let's make a deal!”

“We have to talk about what happened to you during the conflict in your village.”

vs.

“Do you want to talk about what happened in today's meeting?”

The helper respects the person's autonomy and offers possible interventions tailored to the person's needs, but the person decides for him/herself. The helper supports person's decisions.

### Cooperation and autonomy - Take care of your own boundaries

The person is always late and insists that the session takes place in the remaining time.

“It doesn't matter that you are late.”

vs.

What would you say to this person, based on the principle to *take care of your own boundaries*?

### Division of responsibility

- The helper assumes responsibility for clearly defining roles in the process and for the relationship
- The helper is primarily responsible for the relationship with a person

- The helper is NOT responsible for the person's actions

### **Be a model for taking personal responsibility**

“It is difficult to plan when people arrive late.”

vs.

“For me it is important that you arrive in the agreed time so I can plan my other duties.”

### **Principles of a professional dialogue:**

#### **Preconditions for a successful professional dialogue**

- Focus on the person and their conversation
- Take into account the context in planning the intervention
- The helper is skilled in leading the interactive process with a person.
- The helper understands how stress, crisis and trauma affect individuals, family systems and local communities

#### **Helper is responsible for preparing the setting**

- 1) Establishing a relationship of trust – the person knows that the helper is there for him/her and won't do anything to do harm him/her
- 2) Assessing the psychological status (stress, crisis, trauma) and determining optimal approach
- 3) Initial assessment based on the empowerment model
- 4) A security plan in case the threat/danger is still present (eg. family violence)
- 5) A plan for empowering the person to deal with stressors, events that caused the crisis and traumatic event

#### **Helper is responsible for managing level of emotional engagement in sessions**

Protection from retraumatization - watch for:

- How easy and quickly the person becomes overwhelmed, over stimulated
- Increased resistance (avoidance, sabotaging the sessions, anger towards the helper...)
- Regression
- Dissociation
- Increase in out-of-session symptoms

Decreasing the intensity of emotional engagement:

- Ask questions not related to trauma, refocus on the cognitive
- Use calming voice tone
- Stop the person from talking about different things and focus on the present

- Repeat and rephrase what the person has just said
- Get the person to open eyes and describe the current setting
- Use relaxation and breathing techniques
- Ask the person about activities before and after present session (“*How are you going to spend your day tomorrow?*”)

### **Only one person comes to the session**

Person: “My main problem is my husband, he doesn't clean after himself, he is lazy, he drinks and he yells all the time. He is impossible.”

Helper: “Well that's just awful, tell me more about it.”

vs.

“It sounds like you are having a hard time at home. Tell me how all that makes you feel.”

or

“I understand that you are not satisfied with his behavior, and I would like to talk about what you would like to do with the whole situation.”

### **Every session has to have a structure (i.e. a set of logically related phases)**

1. Introduction
2. Definition of the problem and defining the goal of the session
3. Working on the goal/problem
4. Finishing the dialogue

→ The helper is responsible for coordinating all these phases within the time frame of the session!

### **Introduction**

- Establishing the relationship, focusing on the “here and now”.

At the beginning of the session:

“So, does your husband still abuse you?”

vs.

...

What would you say to this person, based on the principle that *every session should have an introduction?*

### **Finishing the dialogue**

- wrapping up, summarizing the results of the session, evaluation.

At the end of the session:

“So, we are done for today, see you next week.”

vs.

...

What would you say to this person, based on the principle that  
*every session should have a conclusion?*

### **Always focus on one issue**

Persopn: "My life is so messed up, I don't have enough money to feed my family, I don't speak to my wife and my children are having trouble at school, what should I do?"

What would you say to this person, based on the principle to *always focus on one issue?*

### **Help the person activate his/her potential**

Person: "I don't know what to do with my anger."

Helper: "Maybe you should express it more loudly."

What would you say to this person, based on the principle to *help the person activate his/her potential?*

### **Observe your feelings**

- Good contact with the person entails a good contact with oneself and constant evaluation of what should be done next
- This means that if we get the impression that the person is not ready to hear e.g. a confrontation, it is ok to postpone it for a later moment and to focus on strengthening the person
- This is especially important for managing the process related to a traumatic event!

## Lecture

### Skills in professional dialogue

#### Active listening

- Helps in understanding the person better
- Encourages the person to talk about his/her inner world
- Shows that the helper is trying to understand how the person feels
- Strengthens the counseling relationship
- Builds trust in the relationship
- Helps the person to recognize, name and express feelings
- Communicates support

#### In active listening:

- Let the person tell his/her story.
- Allow silence.
- Avoid interrupting the person's story.
- Not jump to conclusions.
- Avoid interpreting and explaining.
- Check if we understood correctly (*"Here is what I understood / heard..."*).
- Hear the content, try to understand what the person is saying, try to empathize with how the person feels about it, and communicate what we understood from the person.
- Requires two skills:
  - Listening
  - Showing empathy and understanding through paraphrasing and reflecting emotions

#### Paraphrasing

- Repeating of the verbal content in own words without interpreting paraverbal and nonverbal communication
- Paraphrasing is not interpreting the person's words or explaining his/her actions
- Goal: that the person hears what the helper heard and to encourage the person to add or correct the content

*Person:* Sometimes I like working there, but at times I am not sure.

*Helper:* Sometimes you like working there, but other times you have mixed feelings about your job.

*Father:* I didn't know what to do anymore, I was so angry that I told them to go to hell.

*Helper:* You weren't sure what to do, you were so angry with them that you cursed.

### **How to paraphrase?**

- Listen carefully to what the person is saying, try to remember as much as possible
- Repeat what the person said, slightly altered, in your own words
- Repeat it in a slower manner so that you can have time to think about what you heard

### **People express their feelings in different ways...**

- They convey the feeling without naming it: "When I saw them, I wanted to explode!"
- They show the feeling through nonverbal or paraverbal: "And then I saw them stealing! Can you imagine?!"
- They name their feeling: "I was so angry when I saw them stealing!"

### **Reflecting of emotions**

- "I form" of communication - we show that this is OUR understanding and impression of what the person said.

"I have the feeling that..."

"It seems to me that..."

"My impression is that..."

"If I understood you correctly..."

- We express the main thought/feeling of the person's message.

*Person:* All we do is fight and fight, not moving anywhere. It's so frustrating. I don't know what to do anymore. It seems to me that I can't handle our relationship.

*Helper:* You are very frustrated by the useless arguing. You are not sure if you can be in this relationship.

### **Pay attention to the person's mixed feelings**

*Person:* I was sorry, but also relieved when they didn't give me that promotion.

*Helper:* I heard that you are not glad that you stayed in the same position, but you also like that you weren't promoted.

*Person:* I like hanging out with my boyfriend, but I also like my alone time.

*Helper:* I understand that you like being with him, but you also appreciate your alone time.

### **Take into account person's verbal, paraverbal and nonverbal messages**

*Helper:* When I listen to you, I hear different things: on one side you say you don't mind, but I see that you are talking about it with tears in your eyes.

### **Make the message as simple as possible**

Say what you understood in the simplest way possible, so as to reduce communication noise and misunderstandings.

### **Make sure that your nonverbal, paraverbal and verbal messages are congruent.**

**Comment** on the causes of the person's feelings only if he/she has mentioned it. Reflecting is saying what we see and hear, not an analysis of the person.

*Person:* If I don't do what he is asking, my husband could be really angry with me.  
Sometimes he can be really aggressive!

*Helper:* I understand that you are afraid that your husband will be aggressive towards you if you drop out of college.

### **Asking questions**

“Listening questions” should be asked with a purpose:

- To help the person better explore their point of view and situation
- To help the helper assess the situation, to analyze the problem
- To help the helper better understand the person's point of view
- To help the person discover and reevaluate discrepancies in his/her reasoning
- The helper has to be able to explain why he/she asked a particular question
- Create an atmosphere in which the person feels free to talk
- Questions should encourage the person for active participation
- When possible, instead of asking questions, use paraphrasing and reflecting of emotions

### **Asking questions vs. paraphrasing and reflecting**

*Person:* We are getting divorced. My children will not be able to cope with this.

*Helper:* Why do you think your children won't be able to cope?

vs.

*Helper:* I hear that you are worried that your children won't be able to hear this news.

### **When and how to ask questions**

The question has to be relevant to what the person is saying

*Person:* We are getting divorced. My children will not be able to cope with this.

*Helper:* How is your husband dealing with the divorce?

vs.

Why do you think your children won't be able to cope?

A question can lead to insight through creating cognitive dissonance between person's basic assumptions

*Person:* My father was a really strong and moral person. He respected his own opinion so much and sometimes he would get strict and aggressive with me.

*Helper:* Did I understand correctly that you see your father's strictness as a part of his strength and morality?

**“WHY” questions can be replaced with “What” and “How” questions.**

*“Why did you do that?”; “Why didn't you tell him?”*

vs.

*“How come you did that?”; “What was your goal when you didn't tell him?”*

**Open questions stimulate dialogue, closed questions seek only for answers**

*“Now that you are living in a new village, do you plan to look for employment?”*

vs.

*“Now that you are living in a new village, do you plan to look for employment or to continue your education?”*

vs.

*“Now that you are living in a new village, what are your plans?”*

**Avoid making suggestions masked as questions**

*“And has that been on your mind for a long time?”*

vs.

*“How long has that been on your mind?”*

**Questions should be clear, avoid euphemisms**

*“Did you ever try to do something to yourself?”*

vs.

*“Have you ever thought of suicide?”*



### **“Question-answer” loop**

*Person:* “I have a terrible fear that we are never going to find my husband.”

*Helper:* “Why do you think he is not going to be found?”

*Person:* “Because there are so many who haven’t been found.”

*Helper:* “Do you have contact with families with lost members?”

*Person:* “Yes.”

### **“Question-answer” - exit out of the loop**

*Person:* “I have a terrible fear that we are never going to find my husband.”

*Helper:* “You're worried that you will never see your husband again or find out what happened to him. Please, tell me more about that.”

*Person:* “Yes, I suppose he is not alive, but I really want my family to be able to say goodbye to him. I don’t know how to move on otherwise.”

*Helper:* “You want to find him so that you and your family can say goodbye and continue with your lives. You are worried you will not be able to move on with your life without this”

*Person:* “I feel like my whole future depends on it.”

*Helper:* “You have the feeling that this situation is "all or nothing". Please tell me more about that.”

### **Types of questions**

#### **Open and closed questions**

- Open questions enable the person to answer in the way he/she wants and/or to add something to the answer
- We send the message that we are interested and ready to listen.

Are you going to leave your abusive husband?

vs.

What would you like to do in this situation?

#### **Explaining questions**

*“When you say he is a moral person, what do you mean?”*

*“Can you explain this in more detail?”;*

*“Do you have anything to add?”*

### Questions about specific details



### Questions about the person's personal opinion

*“(I wonder) What kind of a meaning does it have for you?”*

*“How do you see that situation?”*

*“How come it is so important to you?”*

### Questions about the person's strengths

Good for establishing the person's strengths and coping skills

*“What do you consider your strengths to be?”*

*“How did you handle similar situations before?”*

*“What has helped you to cope with similar situation before?”*

## Lecture

### Dealing with resistance in a dialogue

#### Resistance to change

- To resist = to oppose something or somebody
- Way of self-protection, can be important against other person's domination in a relationship
- All people resist a change to a certain degree because it requires to give up something
- Persons we work with can be:
  - reluctant - do not want to work with the helper
  - resistant - do not recognize the problem or do not want or do not know how to change
  - ambivalent - see disadvantages and advantages in a change

#### How do people show resistance?

- Silence/talking a lot/talking too little
- Often changing the subject; avoiding to talk about certain topics
- Cancelling the appointment, coming late or early the session
- Seeming emotionally "empty"
- Constantly complaining
- Talking about other people, avoid talking about oneself
- Creating awkward situations for the helper: e.g. commenting their outfit or looks

#### Possible triggers of resistance

- The person's goals are different from the helper's
- The helper does not respect the person's rights and imposes own views
- Fear of what a change would bring, how much effort a person has to invest in the change
- The person doesn't trust the helper, tests his professional competences and willingness to provide support
- Person doesn't like or **trust** the helper but **doesn't know how** to talk about it openly
- Helper doesn't take the person seriously, minimizing the problem, or doesn't trust the person
- The person is afraid, ashamed to show emotional reactions

### **Inefficient ways of responding to resistance**

- Taking over responsibility for the person's resistance and trying to appease the person
- Showing impatience and hostility
- Doing nothing
- Reducing expectations and working with the person with less effort
- Blaming the person and power struggle with the person
- Victimization
- Giving up on the person

### **Efficient ways of responding to resistance**

1. Understand and accept person's resistance
2. Accept the pace of the person – people have own specific pace and a ceiling that can achieve in a process of change which don't have to correspond to the helper's pace/goals
3. Explain the counseling process, the role of the helper and the person, this can lead to a quality *working alliance*.
4. Be aware of your personal feelings or resistance to the person
5. Don't take the person's resistance personally
6. Have access to supervision and nurture critical thinking about own work

### **Confrontation in the professional dialogue**

- Can provide insight when applied at the appropriate moment and manner
- Otherwise, it will provoke resistance
- Appropriate when we do not understand how verbal, non-verbal or para-verbal information the person gives us and the person's behavior fit together
- It should never be used out of negative emotions towards the person.

### **How to use confrontation in the professional dialogue?**

Helper may not agree with the person's views, but does he/she understand it from the person's point of view?

*"Please help me understand how..."*

*"Did I understand you correctly that...?"*

*"When you put it that way, it seems to me contradictory..."*

### **Confrontation – example**

A mother tells the helper that she loves her daughter very much, but she uses severe physical punishment when the daughter misbehaves.

At that moment the helper can feel anger or disapproval towards the mother and could use confrontation to show her that her behaviors are wrong, which would not be appropriate reaction.

Instead, the helper uses confrontation because he/she doesn't understand how love and physical punishment fit together, and will ask for clarification instead of presuming:

*“You love your daughter very much, so how do you feel when you to hurt her?”*

*or*

*“Usually hurting is not a sign of a loving relationship. I heard you that you love your daughter very much, so could you clarify how physical punishment fits into this?”*

### **Using confrontation in a professional dialogue**

- Check if you understand correctly or ask for an explanation, without evaluating or judging.
- Confrontation is NOT an evaluation of the person's behavior, thoughts or emotions, but confronting the person with discrepancies in his/her reasoning and/or behavior
- Use confrontation with persons for whom you already know how they may react to it
- Confrontation can have negative consequences when used with persons with very low self-esteem
- Therefore, it is important to make sure that the person can handle confrontation
- Use confrontation with persons with who you have established good relationship, so that they don't feel threatened
- Use confrontation when you feel it will not negatively affect the relationship
- Use confrontation with persons whom you can accept as a person, with all their specific characteristics - anger, disappointment, disapproval are not signs of accepting, but of judging a person

*Helper:* “Usually, hitting is not a sign of a loving relationship. I heard you that you love your daughter very much, so could you clarify how physical punishment fits into this?”

*Person:* “Of course it fits, making her feel pain will teach her to respect rules! Even though I feel awful when I do it and she cries, which breaks my heart, no other method is as good as physical punishment.”

*Helper:* “I hear that physical punishment is the best method that you know of, but both your daughter and you feel awful when you have to do it. You want to have a relationship with your daughter in which she respects you and listens to you. What do you think about exploring some other ways that you can create a good relationship with your daughter?”

*Person:* “I would love it if I could get her to listen to me, without having to hit her. I hated when my parents would punish me like that, if only I could find another way.”

## Lecture

### Collaborative planning of change

#### Desirable outcomes for the person

1. Better understanding of the problem.
2. Accepting responsibility for own problems, so that he/she can work on handling them.
3. Adoption of new ways of coping with the problem and new solving skills.
4. Improvement of relationship skills.
5. Empowerment and self-determination

#### Planning of the intervention

1. Identification of the problem and person's strengths – goal is to explore and better understand what the person is struggling with
2. Definition of the problem in cooperation with the person
3. Setting of goal of change

These will often contribute to the process of change itself - cognitive processes that help the person increase the feeling of direction, capacity for action and control over own life.

#### 1. Identification of the problem and strengths

- Before starting the identification process, explain:

"In order to understand you better, it is important for me to gather some initial information about you. That's why I'll ask you some questions about your education, work, family, etc."

***Before starting work on the problem, we need to identify and understand person's strengths, limitations and motivation!***

- Who the person is (name, age, marital status, employment status...)
- Person's way of life (how does he/she spend his/her days, personal values, goals...)
- Family and personal history (relationship with family members, history of health and mental problems, schooling history...)
- Difficulties that the person is dealing with in everyday life
- Person's motivation (What would you like to change? What are the reasons?)

#### In order to understand the person's difficulties better, ask about:

- The problem (how does it manifest: emotions, thoughts, behavior, physical reactions, relationships with other people...)

- Pattern of events that contribute to the manifestation of the problem (what happens before, during and after the problem, who is most often involved...)
- Duration and incidence of problem manifestation, possible increase over time
- How does he/she cope with the difficulties (strengths, potentials, available support, failures...)

## **2. Definition of the problem in cooperation with the person**

*Husband (upset):* "My wife is impossible, she complains all the time, she shouts, she is stubborn, just impossible. I hit her because I just can't get her to shut up. I have to hit her or she will drive me crazy!"

- The helper can define the problem as a "violent husband" or can try to identify what is the problem with the relationship between the husband and the wife. In other words, to better understand what is the pattern that leads to these problems, and how do BOTH of them feel.
- The goal of identifying and defining the problem IS NOT assigning guilt, but better understanding the person in order to help her more efficiently.

## **3. Setting of goal of change**

### **Definition of specific ways in which the person wants to resolve their problems.**

Previous example:

Identification and definition of problems led to the conclusion that the wife feels helpless because she has the feeling he doesn't respect her, and the husband feels helpless because she doesn't respect his boundaries and is always dissatisfied. Both react from the feeling of helplessness, feel sorry and deeply hurt afterwards and lack non-violent communication and conflict resolution skills.

### **Definition of specific ways in which the person wants to resolve their problems.**

Previous example:

Both the husband and the wife realize that they want to learn conflict management skills that would help them to communicate their needs to each other and to show respect.

### **Goals of change process need to be:**

- Specific

*Person:* "I want to be nicer to my children." (imprecise, general goal)

*Helper:* How would it look if you were nicer to the kids?

*Person:* "I wouldn't hit and yell at them when they don't listen to me. I want to find another way to get them to listen to me." (Precise, specific objective)

- Clear for both the person and the helper
- Defined in a positive and constructive manner

Example:

*"I don't want to hit my wife and daughter anymore."*

vs.

*"I want to learn to control my rage."*

- There has to be a way to evaluate their accomplishment - talk with the person on how he/she will know that the goal is completed.
- Also, check during and at the end of the process to what extent has the goal been accomplished. Evaluation is a crucial part of finalizing the dialogue.

Example:

*"When my daughter doesn't listen to me, I will control my rage and tell her what is making me angry."*

- The person's motivation needs to be communicated
- Agreed upon in a cooperative way- the person has to choose his/her goals
- Realistic within the context of the person's life and within limitations of a professional dialogue
- Basic question is: *"What do you want? What do you need?"*

### **Key ways for helping the person define the goal**

- How would this situation look like if you managed to cope with it?
- What are the changes in your life that would be important for you?
- What actions, feelings and thoughts would you like to change?
- What do you want to achieve?
- Unfinished sentences – “I don’t want...”: “I don’t need...”
- Imagination and role playing – the person can imagine/show what he wants.
- Telling people what and how they should do is rarely effective in supporting change and achieving desirable behavior.
- The alternative is a motivational interview.



## **MODULE 1 – WORKSHOPS AND MATERIALS**

### Module 1, Workshop 1

#### **IDENTIFYING STRENGTHS AND RESILIENCE**

(75 minutes)

**Goal:** To identify strengths, resources and resilience of individuals, families and communities.

**Expected outcomes:**

- Participant will be able to identify strengths and resources at different level of ecological systems and key factors associated with resilience.
- Participant will be able to analyze factors that contribute to resilience in the face of adversity and discuss what new resources are needed to foster a resilience-based approach in their communities.

**Materials:**

- Pens, working material 1 *Identifying strengths and resilience* (40 copies)
- Post-it papers (about 300)
- Flipchart with drawn template, markers

**Methods:** Participants work in two groups. In each group they are divided in small groups of 4 to 5 members according to work organization / system / communities they come from (4-5 small groups).

**Description:** Each person will get a template *Identifying strengths and resilience*. Each small group will get about 30 post-it papers. Each group member will complete own template. (10 minutes)

Members of the small group will briefly compare their responses in the template. Based on shared experiences, the small group will write on post-it papers their answers for each area of the template, which will be used to present their conclusions to the whole group. (15 minutes)

The whole group will come together and a representative will briefly present their conclusions focusing on protective factors, strengths and resilience sticking post-it papers to the flip-chart on which the trainer will previously draw the template. (5 min. per group, 30 min. for all presentations).

Discussion about identified common strengths, resources and resilience identified by the group. The trainer connects the group analysis with the lecture, keeping in mind that the training is focused on strengthening participant's competences for implementing trainings in their local communities. (20 minutes)

Points to facilitate the discussion: How can you as a care-provider contribute to the strengthening of person's and community resilience factors? What new capacity (knowledge, skills, beliefs, practices) is needed among care-providers (and their organizations) to implement a resilience approach in their practice? What can you do to foster a resilience-based approaches in your community?

## IDENTIFYING STRENGTHS AND RESILIENCE

Thinking about your local community or populations you work with please: 1) briefly describe events or circumstances that are a threat to their healthy development, functioning families and community; 2) list available protective and risk factors; 3) briefly describe resources that enhance their individual and community resilience.

<p align="center"><b>Adversity</b> (events or circumstances that are a threat to the healthy development and functioning of individuals, families and communities)</p>	
<b>Protective factors:</b>	<b>Risk factors:</b>
Individual level	Individual level
Family level	Family level
Community	Community
<p align="center"><b>Strengths and resilience</b> What strengths people in this community have to enhance their individual and community resilience?</p>	

## PSYCHOSOCIAL WORK AND EMPOWERMENT OF COMMUNITIES

(75 minutes)

**Goal:** To analyze needs for psychosocial work in the local community to empower individuals, families and communities and available initiatives

**Expected outcomes:**

- Participants will be able to recognize the needs for psychosocial work and capacity building in their local community.
- Participants will exchange ideas on initiatives that could strengthen resources in their respective communities.
- Participants will be able to identify psychosocial initiatives based on the empowerment approach and differentiate them from those based on the traditional helping approach.

**Materials:**

- Working material 2a *Psychosocial work and empowerment of local communities* (with questions)
- Working material 2b *Bronfenbrenner's ecological systems*
- Flipchart with drawn ecological systems model

**Methods:** Participants work in two groups. In each group they are divided in small groups of about 5 individuals according to work organization / system / communities they come from (4-5 small groups). These should be the same groups as in Workshop 1.

**Description:** Each small group will get 5 questions (template 2a), and a printout of the Bronfenbrenner's ecological systems model from the presentation (template Working material 2b). (10 min)

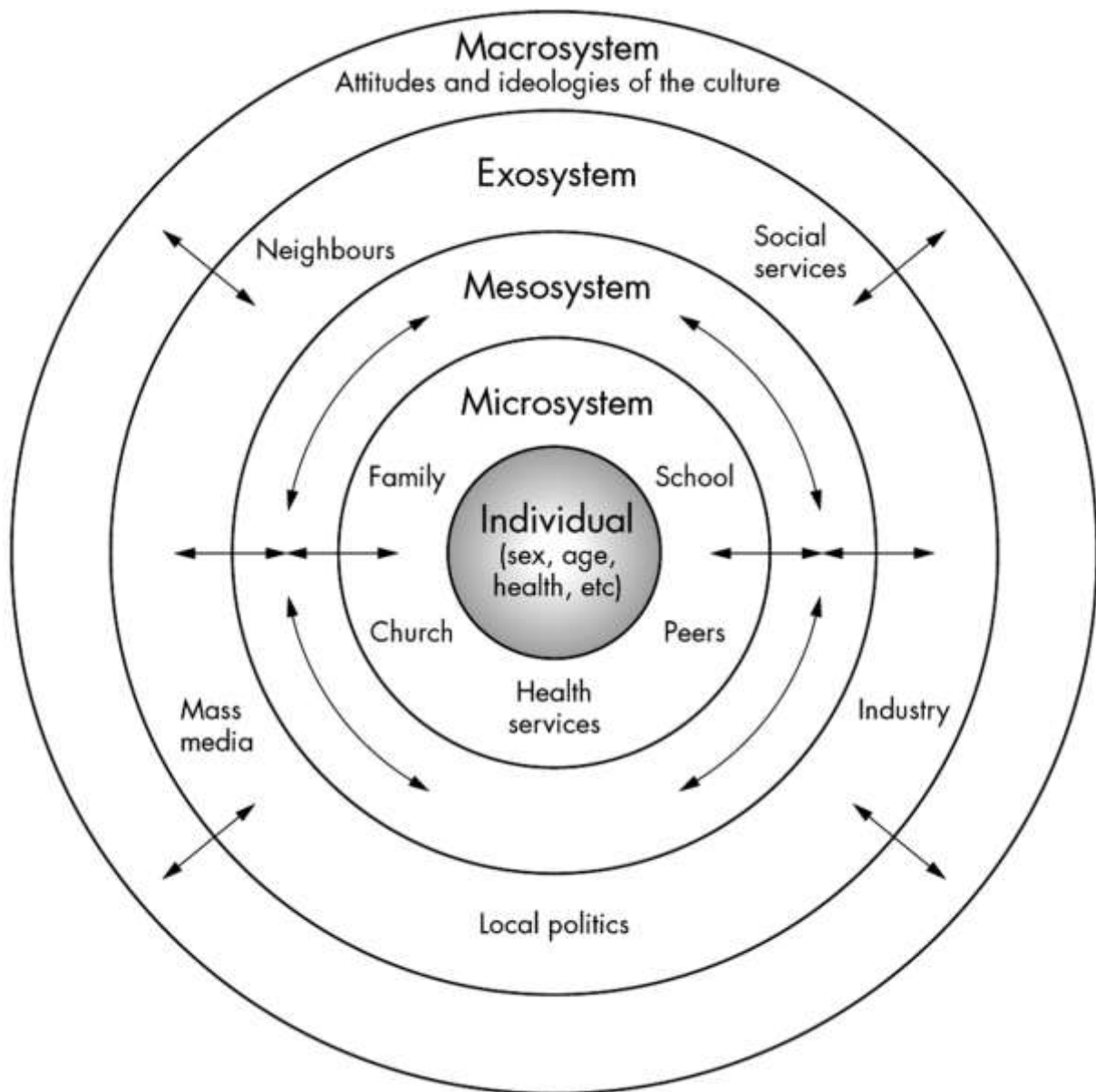
The groups will discuss the questions and first write their responses into the Working material 1a. After they complete this task, they will write the psychosocial initiatives they could contribute in their respective communities into their ecological systems model. (30 min)

The whole group will come together. A representative of each small group will present and another person will write the initiatives onto the flipchart with the ecological systems. During the discussion, the trainer will connect the analyses of the needs for psychosocial work in the local communities with the key points of the lecture, ask about the new initiatives and how will they reflect the empowerment model of strengthening resources in respective communities, keeping in mind that the training focuses on strengthening participant's competences for implementing trainings in their local communities. (35 min)

## **PSYCHOSOCIAL WORK AND EMPOWERMENT OF LOCAL COMMUNITIES**

1. What needs can be met through psychosocial work in your community?
  
  
  
  
  
  
  
  
  
  
2. Which psychosocial initiatives / programs for people affected by armed conflict are already offered in your community?
  
  
  
  
  
  
  
  
  
  
3. Which components of those programs reflect the traditional model of providing support, and which components are empowering for the users of these initiatives / programs?
  
  
  
  
  
  
  
  
  
  
4. Looking at the Bronfenbrenner's ecological systems model, think about psychosocial initiatives which you could contribute / initiate to strengthen the resources in your community. Write your initiative in the appropriate place in the ecological model and name the concrete group that this initiative would serve.
  
  
  
  
  
  
  
  
  
  
5. What are the needs of local care-providers and how could their capacities be strengthened?

## Bronfenbrenner ecological systems



## PSYCHOSOCIAL CONSEQUENCES OF ARMED CONFLICT

(60 minutes)

**Goal:** To understand and discuss long-term psychosocial consequences of armed conflict.

**Expected outcomes:**

- Participant will be able to identify long-term consequences of armed conflict.
- Participants will exchange ideas how to respond to these consequence in their local community

**Materials:**

- Working material 3 *Psychosocial consequences of armed conflict* with questions for each participant (40)
- Flipchart, markers

**Methods:** Participants work in two groups and then divided in triads as they choose (about 6-7 triads).

**Description:** Each group member receives a working material *Psychosocial consequences of armed conflict* with questions. Each member first individually writes brief answers to the questions (10 min)

The members form triads (and discuss and compare their answers. Each triad chooses a representative who will report the findings from the triad to the whole group (20 min).

The triads will come together. The trainer will invite representatives of triads to present outcomes of their discussion based on the questions from the templated and help connect these observations with the theory presented in the previous lecture. One of the interpreters will write the key issues on a flip chart (30 min).

## **PSYCHOSOCIAL CONSEQUENCES OF ARMED CONFLICT**

1. Please list the impact of the armed conflict on the whole society
  
  
  
  
  
  
  
  
  
  
2. Please list the impact of the armed conflict on your community
  
  
  
  
  
  
  
  
  
  
3. What kind of losses have people suffered in your community?
  
  
  
  
  
  
  
  
  
  
4. How were the families affected by the armed conflict?
  
  
  
  
  
  
  
  
  
  
5. Which groups of people are at special risk for their mental wellbeing?
  
  
  
  
  
  
  
  
  
  
6. What strengths and resources groups at special risk for mental wellbeing still have?
  
  
  
  
  
  
  
  
  
  
7. What kinds of actions might help people cope with these consequences of armed conflict?

## PARAPHRASING AND REFLECTING EMOTIONS

(60 minutes)

**Goal:** To practice using paraphrasing and reflecting emotions in a professional dialogue the lecture.

**Expected outcomes:**

- Participants will learn to paraphrase client's sentences and reflect emotions.

**Materials:**

- Working material 4 *Paraphrasing and reflecting of emotions exercises* (40 copies)

**Methods:** Participants work in two groups

**Description:** Each group member receives the working material *Paraphrasing and reflecting of emotions exercises*. First, each person writes sentences which paraphrase the contents of the original sentences. Second, then they write a sentence that reflects the emotions expressed in the original sentence. (20 min)

The participants will form pairs and compare their paraphrased and reflected sentences. (20 min)

The trainer will ask some participants to read aloud some of the paraphrased and reflected sentences and comment how was this task completed. (20 min)



## PARAPHRASING

How to paraphrase:

- Listen carefully to what the person is saying, try to remember as much as possible
- Repeat what the person said, slightly altered
- Repeat it in a slower manner so that you can have time to think about what you heard.

Please paraphrase the following sentences:

**"I have always wanted to be a person that is strong and intelligent. Do I seem like such a person?"**

---

---

**"I don't want to talk about my father; I think he is not worth it. I don't feel anything towards him."**

---

---

**"My daughter is very stubborn, she disobeys everything I tell her to do, and sometimes I think I'm a bad mother."**

---

---

**"He is just impossible, he shouts and calls me names every time I mention that he lost the job again. I just don't know how to talk to him."**

---

---

**"If only my mother would leave me alone. I am sure that then I could find a job easy. Now, I just can't think because of her constant nagging."**

---

---

## Reflecting emotions

How to reflect emotions:

- Use „I form“ of communication
  - Pay attention to the person's mixed feelings
  - Take into account person's verbal, paraverbal and nonverbal messages
  - Express the main thought/feeling of the person's message
  - Express the person's feelings at the beginning of the sentence
  - Make the message as simple as possible.
  - Make sure that the your nonverbal, paraverbal and verbal messages are congruent
  - Comment on the causes of the person's feelings only if the person has mentioned it.
- Reflecting is saying what we see and hear, not an analysis of the person.

Please reflect the following sentences of the persons:

**"I have always wanted to be a person that is strong and intelligent. Damn it, this is exactly how my mother sounds!"**

---

---

**"I don't want to talk about my father. I don't feel anything towards him, he's not worth it."**

---

---

**"My daughter is very stubborn, she disobeys everything I tell her to do, and sometimes I think I'm a bad mother." (as she talks, she shakes her head and looks into the floor)**

---

---

The person comes storming into our office, sits and says (louder than usual):

**"He is just impossible, he shouts and calls me names every time I mention him losing the job again! I just don't know how to talk to him!"**

---

---

**"If only my mother would leave me alone. I am sure that then I could find a job easy. Now, I just can't think because of her constant nagging."**

---

---

## **OBSERVING COMPREHENSIVE DIALOGUE SKILLS**

(75 minutes)

**Goal:** Observation and discussion about active listening skills in a professional dialogue, exploring the challenges of implementing active listening in a „real-life“ situation.

**Expected outcomes:**

- Participants will observe professional dialogue and discuss active listening skill as a comprehensive skill.
- Participants will observe and discuss process of forming questions that will encourage establishment of the client-helper relationship and contribute to the achievement of professional dialogue goals.
- Participants will observe and discuss process of forming paraphrasing and reflecting sentences, according to the presented theory.

**Methods:** Participants work in two groups, case presentation with fishbowl (40 min) + feedback and discussion (30 min)

1. Fishbowl – case presentation (40 min): The trainer explains that the goal of the workshop is to practice using active listening in a professional dialogue and explore the challenges of implementing active listening in a „real-life“ situation.

The trainer asks for a volunteer who will role play one of the persons they work with in their practice. The "volunteer client" is instructed to choose one of the persons from their professional experience and to identify with him/her, i.e. to imagine that for half an hour they are that person. The participant should choose a person he/she is not sure how to provide support to. After choosing a person, the participant is asked to describe this person's situation and their relationship in only a few sentences. The trainer emphasizes that the participant role playing as the "client" is responsible for taking care of oneself, so if the identification with the role becomes too disturbing for the participant, they can stop the exercise. The other participants are instructed to observe the dialogue and identify the skills the trainer is using (paraphrasing, reflecting emotions, showing dignity towards the person, providing emphatic support, etc. (5 min)

The trainer role plays a professional dialogue with the volunteer participant. They show a 30 minutes professional dialogue and a 10-minute mutual feedback regarding their roles as client and helper.

2. Feedback and discussion (35 minutes): Before starting the feedback, the trainer will explain principles of giving an effective feedback:

*In giving feedback it is important to focus on the behavior instead on personality traits, instead of evaluating and assuming motives, just describe what you noticed; use I communication and description of your experience of the behavior.*

*In receiving feedback listen to it, and if it is useful for you use that what is useful, avoid responding to, or correcting the feedback.*

The trainer asks for feedback and questions from the group. The participants provide feedback and discuss the dialogue they have seen and illustrate the skills that the trainer has used. The trainer helps them connect the experience with the presented theory and facilitates discussion using the guiding questions.

Guiding questions: What do participants see as a challenge in using this kind of dialogue in their practices? How is this dialogue different from the usual way they work with users? What is their impression of the fishbowl teaching technique?

## PRACTICING COMPREHENSIVE DIALOGUE SKILLS

(90 minutes)

**Goal:** Practice using professional dialogue skills, explore the challenges of implementing active listening in a „real-life“ situation.

**Expected outcomes:**

- Participants have experienced active listening as a comprehensive skill.
- Participants will practice forming questions that will facilitate the client-helper relationship and contribute to the achievement of professional dialogue goals.
- Participants will practice paraphrasing and reflecting sentences.

**Methods:** Participants work in two groups. Role playing in triads (55 min) + discussion (35 min)

1. Role playing in triads (55 min): The trainer gives instructions how the participants will role play a professional dialogue. They should use the principles and skills of the module; reflecting, paraphrasing, asking questions, equal dignity... Again, the trainer emphasizes the importance of taking care of oneself and repeats what identification is and the principles of giving feedback. (5 min)

Participants form triads (6-7), one of them will be the “helper”, the other the “client” and the third one the observer. The "clients" are instructed to choose one of the persons they work with, shortly describe them to the „helper“ and to identify with them, the "observers" are instructed to observe and record all verbal, paraverbal and nonverbal communication of the client, the way that professional dialogue was conducted (focus on forming questions, paraphrasing and reflecting sentences, and etc.). (10 min)

Every triad role will play a professional dialogue for 25 minutes. Then they will give feedback too each other, first the „client“, than the „helper“, than the observer (15 min).

2. Group discussion (35 min): The triads come together, and each triad presents their impressions, dilemmas with the trainer. The trainer helps them connect the experience with the presented theory.

Guiding questions: What do participants see as a challenge in using this kind of dialogue in their practice? How is active listening different from the usual way they work with users? How was it for the observers to notice dialogue skills?

## DEALING WITH RESISTANCE IN A DIALOGUE

(75 minutes)

**Goal:** Practice recognizing and addressing resistance in a dialogue.

**Expected outcomes:**

- Participants will recognize and be able to address resistance in a professional dialogue.
- Participants will practice the use of confrontation in the professional dialogue that will encourage establishment of the person-helper relationship and contribute to the achievement of professional dialogue goals.

**Materials:**

- Pens, paper

**Methods:** Participants work in two groups. Role playing in triads (50 min) + Group discussion (25 min)

1. Role play in triads (50 min): The participants will role play a professional dialogue. They should use the skills of reflecting, paraphrasing, confrontation, equal dignity... Again, the trainer emphasizes the principles of giving feedback.

Participants stay in the same triads from the previous workshop. The participants will continue working on the same case from the previous workshop. The "clients" are instructed to go back into the role of the client from the previous workshop, while the helper and observer from the previous workshop switch the roles. The "observers" are instructed to observe and record communication of the "client", the way the professional dialogue was conducted (focus on recognizing and addressing client's resistance, helper's responses to the client's resistance, confrontation and etc.). (10 min)

Every pair role plays a professional dialogue for 25 minutes. Then they give feedback too each other, first the „client“, than the helper, than the observer for 15 minutes.

2. Group discussion (25 min): The triads come together and each triad presents their experiences and impressions, dilemmas. The trainer helps them connect the experience with the presented theory.

Guiding questions: What do participants see as a challenge in working with the person's resistance? How is active listening different from the usual way they work with users? How did the "client" show resistance? What was possible triggers of resistance? How did the helper respond to the "client's" resistance? How was confrontation used in the professional dialogue? Did they notice also "client's" strengths?

## SETTING GOALS OF CHANGE

(60 minutes)

**Goal:** To practice cooperative goal setting with a person.

**Expected outcomes:**

- Participants will experience and practice cooperative goal setting.

**Materials:**

- Pens, paper

**Methods:** Participants work in two groups, role playing in triads (30 min), group discussion (30 min)

**Description:**

1. Role playing in triads (30 min): The participants will work in the same triads as in the previous workshop. They will role play defining the problem and the objectives of the professional dialogue. Members of a triad change their roles: the observer becomes the helper; the helper becomes the „client“, the „client“ becomes the observer.

The task is to set / define one goal in cooperation with the „client“, according to the principles from the previous lecture. Also, the participants are reminded to use skills that were presented in the first 2 days of the module. Again, the trainer repeats principles of giving feedback by the observer. The "clients" are instructed to role play the same person from the Workshop 6. The observer observes and records all verbal, paraverbal and nonverbal communication in the dialogue and everything else he/she notices. Every pair role plays a professional dialogue for 20 minutes during which the “helper” leads the process of identification of the problem and cooperative goal setting with the “client”. Then they give feedback too each other, first the „client“, than the „helper“, than the observer (5 min).

3. Group discussion (30 min): The triads come together and each triad shares their impressions, dilemmas with the group. The trainer helps them connect the experience with the theory presented in the lectures.

Guiding questions: What was the biggest challenge for each participant? How is cooperative goal setting different from the usual way they work? What did the observers notice in the client's behavior?

## MODULE 2

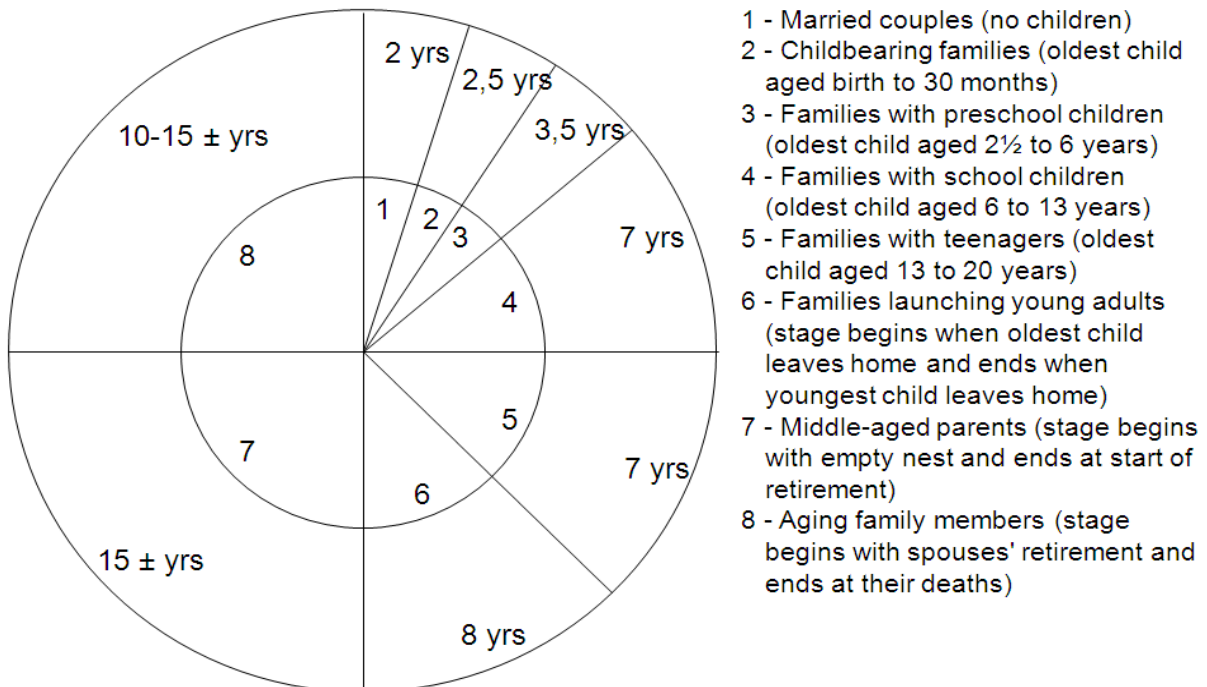
### Lecture

#### System orientation in working with families

##### Objectives of psychosocial work with vulnerable families

- Increase family strengths to prepare families for interventions
- Facilitate concrete changes in family routine daily functioning that are independent from formal helpers
- Support families to maintain positive functioning
- Build relationships between families and support systems to ensure that basic needs of family members are met
- Deal with crisis needs of families in time, so they can focus more on long-standing issues

##### Developmental family life cycle





## **Disruption of family life cycle**

Developmental family life cycle can be interrupted by stressors:

- separation
- loss of work, loss of social status
- divorce and remarriage
- war situation, displacement, migration
- exposure of family members to crime
- death or illness of a family member
- ....
- Stressors are predictable and unpredictable or traumatic events
- All families experience stressors, some of them even crisis, during transition from one stage of family development to the next

## **Characteristics of a family as a system**

Basic concepts for understanding the family as a system:

1. Family as a system is more than the sum of its individual members
2. Family system performs functions
3. Family develops system and subsystem boundaries
4. Family system constantly changes → balance between change and stability
5. Family behaviors are best understood from a circular causality rather than linear causality

## **Use of family systems approach in practice**

Family system interventions require from a helper provider to:

1. Build on the existing resources within the family and community
  2. Focus on the family - environment interactions
  3. Recognize the effects of environmental factors on functioning of the family and every family member
  4. Recognize that each family member's perspective is unique and valuable
- begin with examining family relations and circumstances → what happens between individuals in a family also influences family functioning and outcomes
  - consider three components:
    - family characteristics
    - family relationship patterns

- family exposure to stressors

### **Family characteristics**

- Personal characteristics of family members
  - Family of origin experiences (historical events and current connections → visualized in a genogram)
  - Available resources such as competencies, social status, economic (in)stability
  - Social and material support from the environment (relatives, friends, peers, helpers...)
- ➔ These influences are both positive and negative, and contribute to development of risks and resilience in families

### **Relations in the family**

Relations in the family are determined by following factors:

1. Ideas that everyone has of self and feelings of self-worth
2. Ways in which family members seek to be together and make sense of it - communication
3. Rules about how one should act and feel - common name for them is a family system
4. Ways in which family members relate to individuals and institutions outside the family - bonds with society

### **Relationship patterns in a family with problems**

- Sense of self-worth of one or more members is very low
- Communication is indirect, vague and in fact dishonest
- Rules are rigid and unchanging
- Relationship with society is colored by fear, distrust, blaming

### **Family stressors**

- Stressors and adverse life events or demands on family member's resources influence the family's ability to function optimally - may lead to poor outcomes

### **Exploring family**

- Attachment and bonding
- Family structure
- Family beliefs, values
- Family tradition and rituals
- Family culture

## **Attachment**

- Exploring family relationship patterns, connections and attachments gives a picture of the quality of interpersonal relationships within the family. Categories of family patterns correspond to types of attachment: adaptable families = secure pattern; disengaged families = insecure/avoidant patterns; enmeshed families = insecure/ambivalent patterns.

## **Family structure**

- Multiple internal and external stressors associated with losses and family reorganization in the family of origin and the current family helps understand the current family structure, experiences of children and other family members and their current pattern of behaviors

## **Family beliefs and values**

- Identifying and clarifying beliefs held in the family helps families and helpers understand the interactions and alliances within families → explains family behaviors and family functioning
- Beliefs and values develop from family experiences and are closely connected to behaviors
- Over time family members learn rules that may lead to the development of family myths
- Identifying beliefs can increase solution options when problems arise
- How families adapt to stressors is related to their beliefs
- Beliefs of a helper about the family and their stressors affect how the family is approached, engaged by, and receives services

## **Family tradition and rituals**

- Families have traditions (narratives and behaviors) shaped by culture and experience → customary ways of doing things, thinking or feeling learned from family and wider culture
- Exploring family traditions uncovers roles, assumptions and expectations about who supports and who blocks a change in family patterns
- Tradition nurtures and sustains the family in meaningful and continuous ways, structures behavior in a predictable way
- Tradition may also work against family members or there may be a lack of tradition of successful coping within the family
- Family rituals and tradition arise from religions, culture, ethnic identity and reinforce boundaries of the family system

## **Family Culture**

- Culture impacts family's structural, developmental and functional aspects

- Culture is a distinct way a family behaves, thinks and communicates, shapes families customs, beliefs, and values

Cultural sensitivity is a critical element in obtaining a comprehensive understanding of a family's situation → diversity is a good thing and that having different ideals, customs, attitudes, practices, and beliefs does not, in and of itself, constitute deviance or pathology

### **Significance of symptoms in the family**

- Particular behavior of a family member typically represents a symptom (e.g. problems of a child in school, psychosomatic problems, problematic behavior of an adolescent, family member's refusal to work)
- Symptom is generally offered to helpers as an explanation of the crisis in the family, but this is regularly an attempt to solve the crisis or to reduce its intensity
- Family members typically do not see the real function of the symptoms and typically request a helper to help them eliminate the symptom, without the need and readiness to change their relations and roles in the family
- The symptom appears in one of the five places: one of the parents, relations between the parents, relations between parent and child, between the children, with one of the children
- A symptom or symptomatic behavior is a consequence of poor congruence between beliefs and behaviors of family members
- Crisis or family problems happen when old and new contexts are in conflict, or when one member acts contrary to family beliefs
- If the family is ready to change the relations, it will find a new harmony; if it is afraid of change, it will persist in the same behaviors and beliefs even though they are no longer functional
- The symptom evolves as a response to a conflict between two contexts of the family – the old and the new

### **Families with healthy relations vs. families with difficulties in relations**

Healthy relations	Difficulties in relations
Constant adjustments of the subsystem, roles and interactions	Rigid interactions, subsystems and roles
Free exchange of values	Limited exchange of values
Readiness for new balance	Tendency for old „normal“ situation

## Lecture

### Family assessment

#### Objectives of assessing family as system is to identify:

- Patterns of interaction among family members
- Patterns of interaction among the roles
- Power assumed by individuals
- Examining the family member boundaries is important to identify family interaction patterns, roles, and power and parenting issues

#### Assessment tools

- Self-report instruments - questionnaire measuring beliefs, strengths, risks and behaviors
- Observational tools - enabling professionals to examine personal and family dynamics
- Mapping tools

Genogram - diagram resembling a family tree completed with the family's assistance

Eco-map - diagram linking the family with outside systems and resources

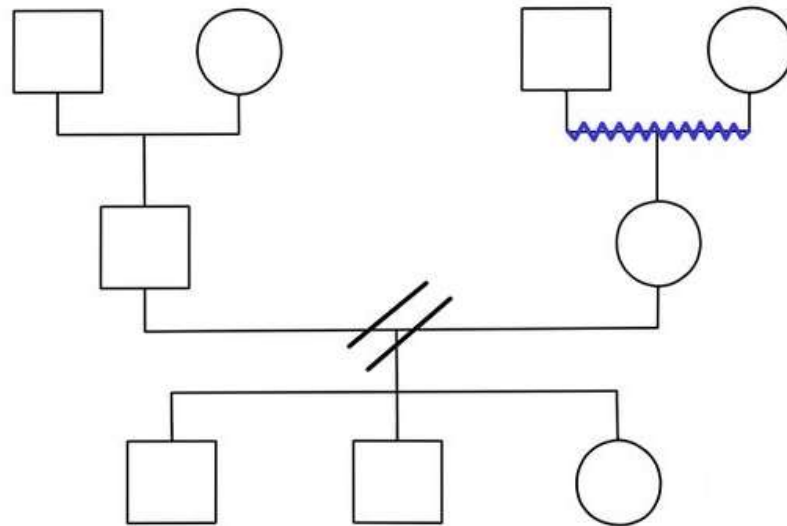
Family space/territory – visualization of the family home territory

#### Mapping tools

- Mapping techniques called **genograms, eco-maps and family territory/space** provide a conceptual view of family systems and subsystems interacting with the family
- These tools enable helpers and families to understand various systems (spouse subsystem, parent-child subsystem, sibling-subsystem, family-community subsystem)
- A visual model of the family's structure, interaction and functioning gives more complete picture of the family system and its social environment and understanding of complex influences among family members

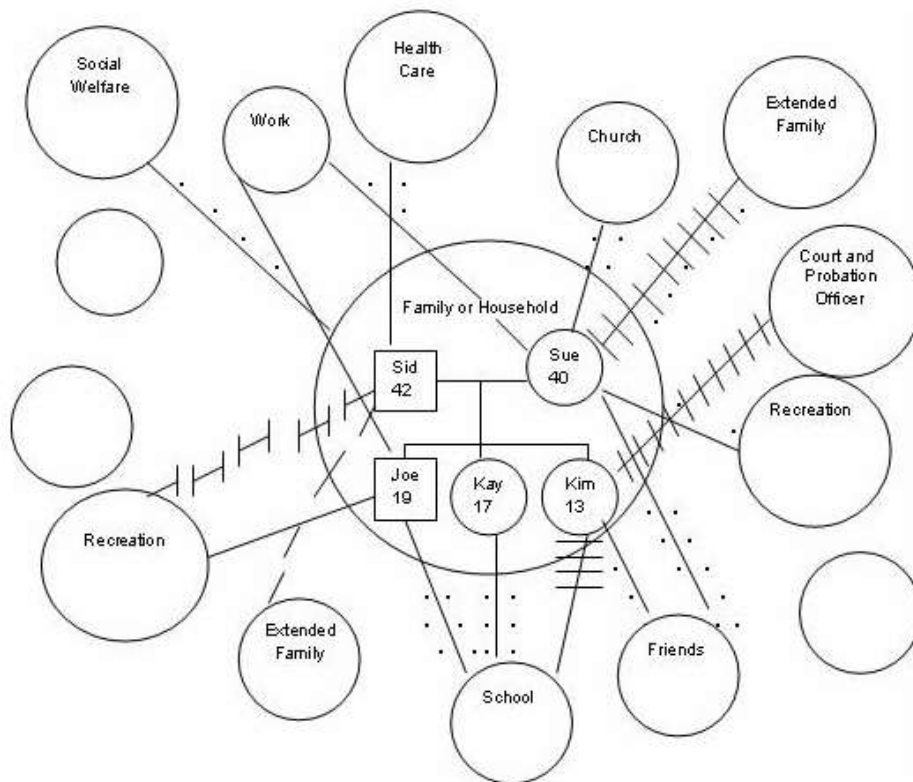
## Genogram

- Genogram: visualization of family history that includes three or more generations, important family events and secrets that might influence current functioning of the family and its members



## Ecomap

- Ecomap: visualization of relationship between family members, families, and their connections with others



### **Family territory / space**

- Drawing of the home space the family uses (rooms, kitchen, yard, garage, ...) and indication which space is used by which members of the family:
  - shared spaces
  - „private” spaces
  - exclusively „owned” spaces
- Visualization of the family space / territory provides information about crowdedness at home, distribution of space which each family member uses or „owns” as a reflection of power of subsystems and their relations

### **Information needed for family assessment**

- What are the risk factors and needs of the family that affect safety, permanency, and well-being?
- What are the effects of risks (eg. Abuse) that affects safety, permanency, and well-being?
- What are the individual and family strengths?
- What do the family members perceive as their problems and strengths?
- What must change to address the effects of abuse and to reduce or eliminate risk?
- What are the parent’s or helper’s level of readiness for change and capacity to assure family safety, permanency, and well-being?

### **Helpful questions when assessing family: Systemic approach to intervention**

- Who asked for help at this time?
- Who does this person represent in the family, who this person does not represent?
- What happened in the family that this person wants a change at this time?
- Who is of critical importance to the problem?
- Who is least involved in the problem?
- Who wants most to be included in the solution?
- When the symptoms first appeared and what was going then in the family?
- Which unusual event / circumstance occurred in the lives of family members prior to the onset of symptoms?
- What has changed in the family after the onset of symptoms?

### **Initial dialogue with the family based on systemic approach**

#### **1. What is the problem**

- At the initial meeting the care provider has active role and raises simple questions:

*What brings you here?*

*How can I be of help?*

*Your were referred by school psychologist, would you tell me what this is about?*

- It is important to ask each family member:

*How do you see what is the problem of the family?*

*What effect has this problem to you?*

- By asking all family members, they often have opportunity for the first time to hear what other members think about the problem and how it affects them
- Family members will not agree with all of what they hear → important to stay focused on what is going on when they disagree. Who does what then?

## 2. How was this problem resolved before

- What is the context of problem development and how the family tried to resolve it
- Observe how family members tolerate diversity, what are their communication patterns, who is representing whom, who is responsible for what in the family
- In this stage the most useful are circular questions which invite family members to talk to each other

## 3. Reshaping the problem

- Problem is reformulated in a way that no one is blamed and that every family member sees how this affects his or her life
- Helper leads the family towards understanding that this is a common problem, a problem of the system, not in the individual
- Practical consequence is that agreement for further work with the whole family is done, though this may include working with members in different combinations
- Danger to continue working only with "identified patient" is that it will confirm the beliefs of the family that this person is a problem and „should be corrected / fixed”
- Exception: if there is reasonable suspicion that this person is in danger or could not speak freely (e.g. abused child)

## **Increasing family skills**

Methods to increase skills:

- Reinforcing effective or desired behaviors
- Helping family members deal with hurt and anger more effectively
- Developing more effective parenting skills and child management techniques



- Teaching parents how to observe and track children's behavior, use time-outs when family conflict or child behaviors become unmanageable or too stressful
- Practicing positive behaviors by using techniques such as role-playing
- Focusing on development of social skills for parents and children
- Teaching relaxation techniques to increase coping with stress and learn to self-nurture more effectively

## Lecture

### Working with families with children

#### Families at low psychosocial risk

- Average sociodemographic characteristics
- Relatively good parenting competences (knowledge, skills and attitudes regarding child rearing)
- Adequate social connectedness with the community and an available social network
- Presence of medium-risk psychosocial stressors; family resources surpass stressors and risk factors
  - E.g. Change of occupational or financial situation of the family (such as loss of employment of one parent), parental separation or divorce, lower-intensity family conflicts, birth of child with chronic health difficulties or is at neurodevelopmental risk
- Low to medium-intensity support to the family is needed
- Voluntary participation

#### Families at high psychosocial risk

- Adverse sociodemographic characteristics (poverty, low education, intermittent unemployment)
- Poor parenting skills (parents sickly or have cognitive impairments, underage parents)
- Poor social interaction with the community, small or non-existent social network
- High and chronic psychosocial stressors
  - E.g. Chronic unemployment, drug addiction in the family, violence as a pattern of communication and of resolving day-to-day conflict, children exhibit behavioral difficulties, criminal behavior
- Psychosocial risks surpass family resources
- Intensive support and help to the family is needed
- Voluntary and/or obligatory participation

#### What is most difficult for helpers?

- Families with multiple problems and needs, with multiple difficulties, *families with complex needs* → breadth / numerosity, depth / seriousness of needs
- Level of family risk significantly affects the level of child risk (children and youth with complex needs)

### **Other side of the medal of living at risk**

- Focusing on family deviance can “blind” the helpers for the normalcy that is present in the families from marginal groups
- Individuals who have faced greatest hardships often have the greatest strenghts

### **The resilience of high-risk families**

- Family resilience – **a long-term process** that consists of several phases: survival, adjustment, acceptance, empowerment, helping others
- It may seem that a family is at risk not only when they are in survival phase, but also when they are transitioning from phase to phase

### **„Hidden resilience” of children and youth with behavioral problems:**

- Young people choose the identity that has the most power. In one way or another, high-risk youth seek acceptance, and do so by challenging social norms.
- Young people resistance to various systems is often an expression of their resilience

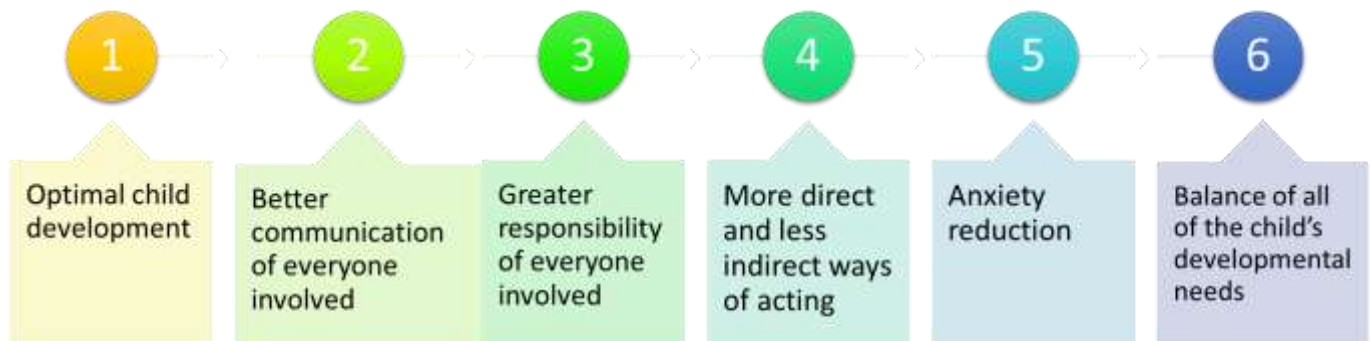
### **Characteristics of children/youth with behavioral problems**

- Having experienced many difficult life events
- Both types of behavioral problems are present: externalized (violent behavior, breaking norms...) and internalizing (depression, anxiety, self-harm...)
- Poorly developed academic, social and other competences
- Low level of empathy
- Low capacity for self-control
- Proneness to taking risks
- Low tolerance to frustration
- Lack of readiness to change
- Resistance...

### **Child behavioral problems from a systems perspective**

- Child as “scapegoat” or “identified client” can:
  1. Be the expression of the inability of the whole family to function well, especially in transitional developmental phases
  2. Be a symptom of dysfunctional patterns transmitted from generation to generation
  3. Have a function or purpose for the family
- Focusing on child behavioral problems helps the family maintain resistance to change – this is why it is important to evaluate the readiness or resistance to change of all family members

## Goals of intervention planning with families with children



### How to start? Developing a change plan

- A change plan should be made together with the family members to which it applies (child, parents, all those who will be involved in working with them)
- Necessary steps:
  1. Establish a list of problems and difficulties
  2. Evaluate every problem in terms of its significance
  3. Establish the priority of individual problems and difficulties
  4. Create a work plan for every problem, i.e. difficulty, including:
    - define specific goals and actions for every problem that is chosen for change
    - choose approach – e.g. interventions in the environment, in the family, group work, individual work
    - duration of treatment and its final goal, i.e. expected outcome
    - Define roles of individual helpers in implementing interventions, who will coordinate the implementation of the plan – which agency or institution in the local community will coordinate the work with the child and its family
  5. Establish ways of assessing the effects of the change plan (evaluation)

## Planning changes with focus on child

<b>RISKS / NEEDS</b>	<b>Three basic goals</b>	Define needs	Strenghts/ potentials	Obstacles	Means
Family / Parenting					
Education / employment					
Relationships with peers					
Substance abuse					
Free time /recreation					
Personality / behavior					
Attitudes /orientations					

## Clarification of elements of planning

- It is important to choose three greatest risk factors for continuing problem behavior, which are agreed upon with the family/child. What is urgent? These are the basic goals i.e. areas of change.
- Define the needs from which each of the chosen goals arise. E.g.: if behavior in the school is a risk factor, the goal is what needs to be changed (aggressiveness, disobedience to teachers)
- Identify all strengths or protective factors for a particular environment (e.g. a teacher willing to work on the child's behavior at school, a friend who will support the clients efforts, or starting to realize the damage the client is doing to him/herself)
- Identify barriers to achieving goals (e.g. poor anger management as a barrier to reducing aggressiveness)
- Define the type of intervention to reach the goal that needs to be specific, concrete, time-bound, and agreed upon with the client

## Setting goals with the family/child

- „What is the biggest problem?“
- „Choose what gives/causes you the most problems.“
- „What would you like to change or wish were different?“

- „What do you want to achieve in the following period (e.g. the next month) so that the whole problem or part of the problem is solved? “

### **Goals of interventions in the family**

- Reducing the recurrence of unwanted behaviors
- Better family atmosphere and family emotional climate due to stress reduction
- Increasing the capacity of family members for recognizing problems and their adequate resolving
- Reducing the feelings of anger and guilt in the family
- Keeping realistic expectations
- Working on desirable changes in the behavior of family members (e.g. better conflict resolution, better coping with stress)

### **What is a crucial in working with families with children at high risk?**

- Resilience: Increasing problem-solving skills can help family members increase their capacities for coping with stressors
  - Methods?
  - Needed competences of helpers?
- Social relationships: Broadening the support network that is crucial in difficult periods
  - Methods?
  - Needed competences of helpers?
- Concrete support: Families that have better access to material resources and services to meet their basic needs can focus more on their various roles (e.g. the parental role)
  - Methods?
  - Needed competences of helpers?

### **Methods and techniques of working with families**

- Leading (not directing) (e.g. by planning changes together with the parents and child)
- Providing supportive feedback (commendations, reassuring, noticing small changes)
- Modeling desirable behaviors and skills
- Motivating (motivational interviewing)
- Informing on regulations and rights
- Psychoeducation and providing knowledge
- Advocating and mediating for the interests of the family
- Negotiating the goals and ways of achieving them

- Counseling (not preaching)
- Evaluation as intervention

### **Evaluating achieved change**

Generally, the evaluation of the effects of change needs to be based on:

1. data on behavioral changes
  2. child's verbalization of the achieved change
  3. helper's assessment of change
  4. assessment of what the change can be attributed to
- In psychosocial work with clients and families it is useful to conduct evaluations with them in various phases of work, not only at the end
  - Evaluation helps solve problems because it gives new ideas on how to exit a seemingly hopeless situation
  - Evaluation gives the helper a more clear picture of what the family members want, but it also gives the family members a clearer picture of what they still want, and what they have already achieved

### **Evaluation as intervention**

- When the process of change has stalled (nothing is happening)
- The helper feels insecure in their work
- The parent does not express that the work is helpful and that it brings about desired changes
- The parent and the helper have differing views on what is happening
- The helper wants to clarify the resources that the parent or extended family have, and to point out the positive shifts in the process of change
- The helper needs ideas on how to continue with the work
- The helper gives the parent the opportunity to express their view of the work and to give own initiatives for its continuation
- When the helper is interested in the parents' opinion and their experience of what is useful in the work and what is not

### **What is the “object” of evaluation – what was the core question of the change?**

*“How to rear a child without using violent behaviors?”*

- The core question is actually one of the goals that have been agreed upon at the beginning of work
- The parentis reminded of the goal and asked:

- „On a scale of 10 degrees, assess how often you used non-violent parenting methods at the beginning of our work” (1 = you used violent methods often, 10 = you did not use violent methods of parenting)
- How did you behave then?
- What did you feel in those situations?
- Which thoughts were going through your head in those situations?
- Same questions are asked about the current situation and what they want in the future
  - “On the same scale, assess how much you use nonviolent parenting methods”
  - What is different now?
  - How do you behave now?
  - What do you feel in such situations?
  - Which thoughts were going through your head in those situations?

#### Assessment at the start of working on change

<p><b>Session 1</b></p> <p>I yelled regularly, hit him often, and sometimes gave him a serious beating.</p> <p>He is impossible, he wants to drive me crazy.</p> <p>I was upset, angry.</p>	<p><b>Session 5</b></p>	<p><b>Session 10</b></p>
---	-------------------------	--------------------------



## Assessment at the present moment

### Session 1

I yelled regularly, hit him often, and sometimes gave him a serious beating.  
He is impossible, he wants to drive me crazy.  
I was upset, angry.

### Session 5

I still yell at him every day, and I often hit him; afterwards I feel bad and cry.  
What should I do with this child?  
I feel powerless, insecure, sometimes more and sometimes less angry or sad.

### Session 10

### Session 1

I yelled regularly, hit him often, and sometimes gave him a serious beating.  
He is impossible, he wants to drive me crazy.  
I was upset, angry.

### Session 5

I still yell at him every day, and I often hit him; afterwards I feel bad and cry.  
What should I do with this child?  
I feel powerless, insecure, sometimes more and sometimes less angry or sad.  
I remember more often how bad I felt when they beat me.  
You want to help me, and not take my child away. You've given me useful advice.  
The neighbor sometimes invites him to play with her kid.

### Session 10

## Taking a future perspective

### Session 1

I yelled regularly, hit him often, and sometimes gave him a serious beating.  
He is impossible, he wants to drive me crazy.  
I was upset, angry.

### Session 5

I still yell at him every day, and I often hit him; afterwards I feel bad and cry.  
What should I do with this child?  
I feel powerless, insecure, sometimes more and sometimes less angry or sad.  
I remember more often how bad I felt when they beat me.  
You want to help me, and not take my child away. You've given me useful advice.  
The neighbor sometimes invites him to play with her kid.

### Session 10

I would like to never hit my child again.  
  
I would like to be calmer and not get upset about little things.

### Session 1

I yelled regularly, hit him often, and sometimes gave him a serious beating.  
He is impossible, he wants to drive me crazy.  
I was upset, angry.

### Session 5

I still yell at him every day, and I often hit him; afterwards I feel bad and cry.  
What should I do with this child?  
I feel powerless, insecure, sometimes more and sometimes less angry or sad.  
I remember more often how bad I felt when they beat me.  
You want to help me, and not take my child away. You've given me useful advice.  
The neighbor sometimes invites him to play with her kid.

### Session 10

I would like to never hit my child again.  
  
I would like to be calmer and not get upset about little things.  
I should start doing the things you told me to do in situations that make me angry.  
I could enroll him in kindergarden.  
You could help me achieve that.

## Evaluation as intervention

- Questions such as these can be introduced in the conversation:
  - Who helped the change and how?
  - Who else could, and in what way, help the planned changes in the family?
  - Who or what was an obstacle?
  - What was most difficult?

**Evaluation as intervention can:**

- Help the parent not lose hope and see that it is possible to change oneself, and also to gain insight into their situation
- Provide the parent the opportunity to say what they want in the continuation of the work
- Help the helper decide whether they can continue working with the parent and how
- Help the parent see the difference between their perceived and actual reality by talking concretely about their situation in the present moment and in the past and the future

## Lecture

# Motivational interview in promoting change in families

## Behavior change

- Constructive behavior change happens when the person has intrinsic, belief-based motivation
- The person recognizes that they have a problem
- Feeling of discomfort, shame, guilt, loss, threat or humiliation
- Negative consequences / punishment of unwanted behavior

Behavior  
change

### Natural change

self-initiated without  
professional help

### Formal interventions

Counseling,  
psychotherapy, treatment

## Why do people not change?

- They don't recognize they have a problem
- Negative feelings can immobilize a person
- Lack of feeling discomfort or suffering – defense mechanisms to reduce discomfort: negation, rationalization, projection

### Ambivalence:

- The person simultaneously does and does not want change
- A normal aspect of human nature
- A natural phase in the process of change

### Unresolved ambivalence:

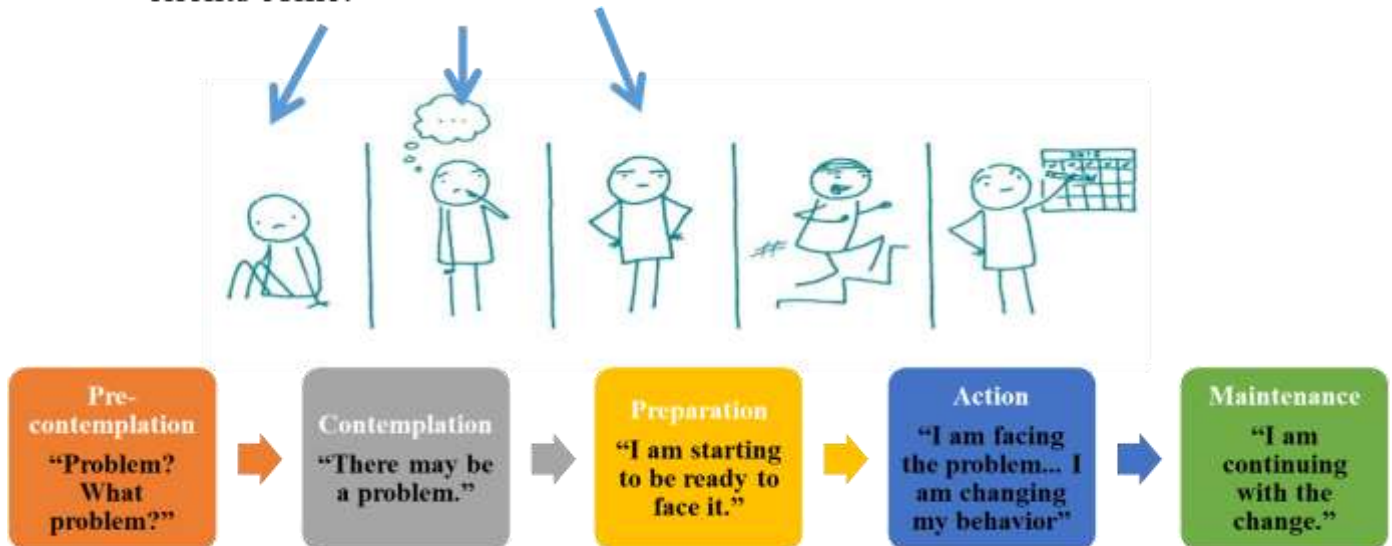
- Problems persist and intensify
- Loss of motivation

### Interventions:

- Help the person resolve ambivalence to be able to make a decision and start the change

### The model of change

Phases in which clients come:



### What is the motivational interview (MI)?

- A technique to increase intrinsic motivation for change by resolving ambivalence
- A way of communicating that encourages a conversation about change
- Focused on the client's current interests and problems
- Does not encourage change that is incongruent with the values and beliefs of the person
- An alternative to directly persuading the person to change their behavior

<http://www.motivationalinterview.org/>

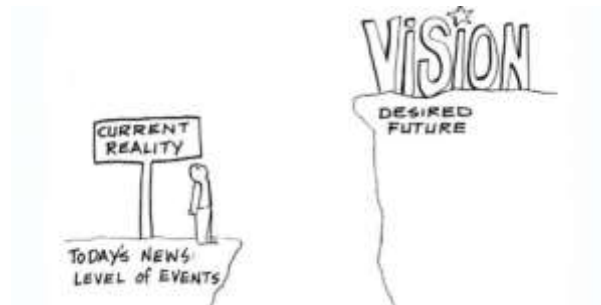
### How is change encouraged with the motivational interview?

Change is encouraged through conversation, so that the person may realize their own reasons for and benefits of change:

1. The drawbacks of the current state
2. The benefits of change
3. Optimism for change
4. Intention for change

### Developing discrepancy:

- Emphasizes internal conflict to increase motivation for change
- Increases awareness of where the person is now and where they want to be
- Highlights contradictions / inconsistencies
- Increases awareness of irrational thoughts / behaviors of the person



THE GOALS OF THE MOTIVATIONAL INTERVIEW	
Help the person feel understood	By intermittently summarizing what the person has said, the helper demonstrates that they are listening, empathizing, and that they understand how the person sees themselves, their world and their future
Help the person become aware of the difference of where they are now and where they wish to be	The helper asks open questions that help the person state their own goals and explore dilemmas The goal is to resolve the dilemmas that are an obstacle to achieving the goal
Affirmation – highlighting and supporting self-efficacy	By pointing out the person's successes so far, the helper supports the person's strong sides

### Principles of achieving change

Resist the reflex for „quick fix“

- Helpers try to "fix" problems in the client's life, and thus reduce the likelihood that he / she will change
- Clients come (sometimes involuntarily) for professional help, but they are still responsible for the change in your life
- Create an atmosphere by showing empathy so that a client can explore own conflicts and face the difficulties

- Use reflective listening, acceptance of feelings and clients' perspective
- Accepting the client as a person does not mean agreement and approval of his/her behavior
- Helpers should disagree with the clients when it is necessary
- Critical element for maintaining relationship is an attempt to understand the perspective of the person
- Acceptance encourages change, while pressure to change provokes resistance
- How will you know if you did it? If you manage to see the world from a position of client and honestly say, "It makes sense, I understand why you see it that way."

### **Motivational questions that lead to constructive change**

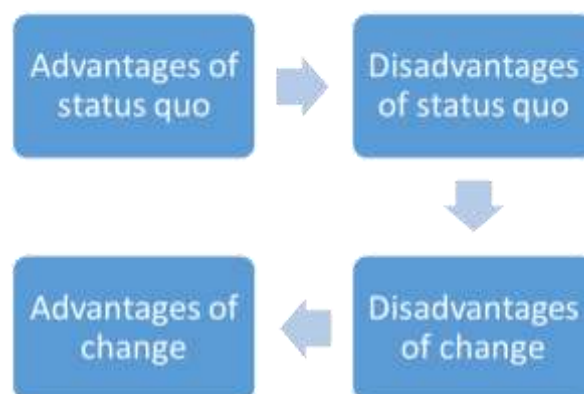
*How to start MI? First learn as much as possible about client's values and worries*

#### **What to ask?**

- What is important to you as a parent/partner...?
- Help me understand why it is important?
- What you as a parent/partner... worry about in this situation?
- Is there something that other people do not understand about your situation?

#### **How to continue MI? Use „Change talk”**

- Encourage talking about change
- Explore imbalance – ask first about the advantages of the status quo and then about the disadvantages
- Encourage elaboration and concretization – after starting talking about change, ask about details – how will that happen? Tell me about it....



## **Examples of open-ended questions that encourage changes**

Disadvantages of the status quo:

- What are your worries you about your current situation?
- What do you think will happen if you do not change?

Benefits of change:

- How would you like things to be different?
- How would you like your life to look like in 5 years?

Intention to change

- It seems to me that you feel blocked at this time. What should change?
- What do you think you could do?
- Who can help you achieve these changes?
- What are you going to do?

## **Obstacles to MI and resistance**

- Defense mechanism that shows that the client and the helper see the situation differently
- Can occur in all phases of change, but most commonly in the contemplation phase
- Can lead to termination of counseling/intervention and to poorer outcomes
- An important sign of dissonance in the helping process
- A normal part of every helping process/counseling
- A sign that the course of conversation and needs to be changed and that different reactions are needed



## How to recognize resistance?

### Quarreling and showing hostility

- Client questions competence or integrity of the helper, questions accuracy of what the helper said, questions the authority and expertise of the helper

### Denial

- Client is not ready to recognize the problems, accept responsibility or expert opinions, blames others, does not agree with the helper's suggestions ("Yes, but ...."), asks for reduction of agreed plan, shows pessimism, apologies

### Interrupting

- Client speaks at the same time as the helper, interrupts the helper (e.g.. "I heard a lot from you")

### Ignoring

- Client ignores what has been agreed, is inattentive (does not listen to what the helper says), does not answer questions or shifts conversation

## How to cope with resistance in MI?

***What NOT to do:*** argue, cajole, persuade, preach, blame, directly confront the client's resistance

### Techniques of coping with resistance:

- Reflecting
- Changing focus – directing attention to the problem the client is ready to talk about
- Reshaping – validating the short-term advantages of a behavior, while pointing out the perspective of long-term disadvantages by providing information
- Emphasizing personal choice and control
- Accepting resistance – “walking with resistance”

## Examples of sentences for coping with resistance

Intervention	Example
<b>Simple reflecting</b>	„I can see you are not glad to be here today“
<b>Emphasized reflecting</b> (emphasizes intensity)	„I can hear you and it is clear to me that this is the last place you want to be today“
<b>Two-sided reflection</b> (emphasizes ambivalence)	„You don't want to be here, but I see you still made the effort to come.“
<b>Changing focus</b>	„It seems that we are going in the wrong direction. It would be good to move on to another topic if that is ok.“
<b>Reshaping</b> (agreeing with the current state + offering new perspective)	„You have told me repeatedly that you can drink more than other people and still be able to function. It is called tolerance. People with a high tolerance do not see the negative consequences, which puts them at higher risk.“
<b>Emphasizing personal choice</b> (returning sense of control)	„It is the job of the professional to direct you toward available services and to offer you professional help. It is up to you to decide whether you are ready to enter treatment. The decision is yours.“
<b>Adjusting to resistance</b> („walking with resistance“)	„We have talked about this quite a lot, you thought about it and you are not willing to enter treatment. Are you quite convinced that it will not help you?“

## How to handle ambivalence? Examples of summing ambivalence

- You said you are not willing to get tested for alcohol, since you do not drink. But you know it will be much more difficult for you to keep your child if you do not go to this test.
- I'd like to understand why it is important to you to persist in decision not to get testing, if your child is as important to you as you say.
- You said that you are not able to separate from husband even though he is very violent, because you are afraid that he will take away the children. You said that you still love him and that he provides money for children. But if children remain in this environment full of violence, social services must take them away. So, you are ready to continue to expose children to violence because you see more advantages than disadvantages to stay in your relationship.
- I see that you are currently in a difficult situation. You love your husband, you do not want to "get him into trouble". On the other hand the violence does not stop. What might help you in this situation not to risk separation of children from you?

## How to make a proposal? "Adoption" of a proposal

- You explained to me ....
- I have the impression that you do not easily find a solution...
- I could suggest .... I can imagine that ....

- How would you feel if you accepted this suggestion?
  - If it's acceptable, formulate it in your own words ....
  - By formulating it, client begins to adopt a proposal and has to adjust it in way to be able to act accordingly
- How do you like now this proposal?
- If you do it in this way, how certain do you feel that you will succeed?

### **MI with persons with mental health difficulties**

Example – depressed person:

*„I don't have a problem, so why should I go to an examination /start treatment? The doctor would only give me drugs, and they don't help, so why should I take them?“*

- Lack of insight into state and difficulties
- Ambivalence regarding starting or continuing treatment

### **Develop relationship with the person**

- Ask for permission

*„Could we talk about your past experiences with medications and why you think they don't help?“*

- The question shows respect for the client, which lessens the pressure to participate in the conversation and take medications

### **Encourage talking about change:**

*„Does not taking medication help you achieve your desired goal?“*

- Allows the client express their motives, why they are behaving the way they are
- Enables the client to explore why behavior change may be good for them
- Empathy – the helper understands the client's perspective
- Reflecting

*„It seems you don't want to take medications because you are worried about having side-effects“*

or

*„I have a feeling you want to change, but that you are worried about the side-effects that can make your condition worse“*

**Normalization** – feeling worried is a common reaction in many people

**Ambivalence** – advantages and disadvantages of taking medications

**Self-efficacy** – affirmation, summarizing, plan of change, support

**Areas:**

- Basic needs – accommodation, income, food
- Health – habits, being in treatment, medication
- Family – relationships, obligations, communication
- Work - employment
- Parenting – child rearing, schooling, child health
- Free time – hobbies, friendships
- Community – support, collaboration
- Personal wellbeing and wellbeing of children/child

**Necessary conditions for participating in MI:**

- Reality-testing is maintained (impaired in psychotic patients, personality disorders – micropsychotic episodes, depression, mania)
- No significant cognitive deficits (do not attempt MI with persons with serious intellectual deficits or psycho-organic syndrome)

**Conducting MI:**

- Number of sessions: 1 to 12 (average about 4)
- Include other family members

**What MI is not...**

- A way of tricking the person to start doing what we want
- A form of cognitive-behavioral therapy – learning new behaviors or restructuring cognitions
- Not directed toward working through past experiences
- Panacea for all clinical problems

**Conclusion – What is motivational interview?**

- Important intervention with individuals and families
- A partnership that respects the client's autonomy
- Encouraging change is a process – the client's decision to change is not momentary
- Recognizing the advantages and disadvantages of the status quo and change through encouraging talking about change
- Resolving ambivalence – the helper assists the client develop a discrepancy between the current situation and his/her desired goals
- Affirming the client's strengths and encouraging self-efficacy – previous successes and achievements, current participation and engagement

- Planning and realizing change – action and maintenance
- MI can be an independent intervention or an introduction into other interventions

### **Small addition....**

Nonverbal communication with a person with mental health difficulties

- Seating so that we look at the client from the side, at an angle
- Open position – arms and legs are not crossed
- Leaning toward the person
- Eyes – support eye contact, but not staring
- Relaxed posture



## Communicating with persons with mental health difficulties

What to do	What not to do
<ul style="list-style-type: none"><li>• Set boundaries – duration and topic of conversation</li><li>• Show respect – when someone feels respected and heard, they are more likely to reciprocate similarly</li><li>• Not lie, be honest – mental disorders do not impair intelligence; persons are often highly intelligent</li><li>• If the person has cognitive deficits, give short and concrete statements and instructions, avoid unclear and ambiguous statements</li><li>• Clear, direct and specific statements regarding the person's behavior, and not their weaknesses and flaws</li><li>• In clients that are hard to understand, give them some time to talk, try to summarize what they said, ask them to add, ask short closed questions that need to be answered with "yes" or "no"</li><li>• Client's anger – "You seem upset/anxious. I would like to understand why you feel that way because I would like to help you feel better and more calm."</li><li>• De-escalating – allow room to move if possible, offer food or drink, as well as choice – is soothing and gives the person a sense of control</li><li>• Sometimes be in silence with the client for a few seconds</li></ul>	<ul style="list-style-type: none"><li>• Do not interrupt</li><li>• Do not stand too close</li><li>• Do not touch the person</li><li>• Do not argue with a client with hallucinations and delusions, rather show empathy for their feeling of fear or threat, point out the fact that they are safe, but also that "I don't see, hear and feel the same as you."</li><li>• Whisper</li><li>• Blame, criticize, threaten</li><li>• Argue – if the client is raising his voice or threatening, ask for a change of behavior: "Please, let us continue in a more calm tone of voice."</li><li>• Offer a lot of answers or information at once</li><li>• Longer periods of silence</li></ul>

<b>If the person with mental health difficulties is/has:</b>	<b>Be:</b>
Problems with reality-testing	Simple and honest
Scared	Supportive, accepting
Has problems concentrating	Repeat question or statement
Agitated	Lower amount of stimuli, including communication
Low insight	Not insist on rational discussion
Withdrawn	Repeatedly encourage communication
Preoccupied with delusions	Do not argue
Low self esteem	Be positive and affirm the person

## **Lecture**

# **Family violence**

### **What is family violence?**

- Family violence is a pattern of behaviors that aim to control family members by force, intimidation, and manipulation
- Family violence is always the abuse of power in relationships that are not based on equality
- Typical forms of violence:

physical violence

psychological / emotional abuse (threat, isolation, humiliation)

sexual violence

control of family resources (finances) or labor exploitation

### **Who are most often victims?**

- Children
  - Women
  - Elderly
  - People with special needs
- An individual can be exposed to family violence during whole life, from childhood to old age

### **Roots of family violence**

Interaction of factors:

- Some individual characteristics of perpetrator and victim (personality, developmental history, values and beliefs)
- Characteristics of the family as a dynamic system, family roles and patterns of behavior family members
- Social and community culture, legislation, practice of law enforcement, tolerance to violence

### **Family violence is a learned behavior**

- Family experiences
- External victimization
- Societal tolerance of family violence



### **Experiences from family of origin**

- Children witness violence and think it is normal
- Abused individuals believe that violence justified if able to effectively use it to gain power and achieve goals
- Different socialization of boys and girls



Transgenerational transmission of family violence

### **External victimization**

- People who have suffered violence may believe that violence is an efficient way of controlling other people and achieving their goals
- People who have used violence in other situations are more likely to use it also in a family → implications for families of conflict veterans??
- There is positive connection between amount of violence in a society and family violence

### **Tolerance of family violence in a society**

- Power and control are been idealized throughout history in all countries
- Children are taught that being powerful and controlling others are admirable traits
- Violence, power and control are shown as acceptable in movies and literature, video games
- Societal values, laws, law enforcement practice reflect level of acceptance of family violence in a given society at a given time
- Violence in the family = violation of fundamental human rights

### **Violence in partner relations**

#### **Partner violence**

- Women are about 10 times more often victims than men
- Men commit more serious violence, more often physical and sexual
- Women more often use psychological abuse, perpetrate less serious physical violence

### **Cycle of violent episode**

#### ***First phase: growing tension***

- The woman is aware that attack is inevitable, perpetrator is increasingly irritated
- Perpetrator behavior:
  - Name-calling, humiliation of the victim

- Verbal threats and demonstration of force
- Victim behavior:
  - Tries to be helpful over own limits
  - Compliant
  - Avoids triggering perpetrator's anger

### ***Second phase: violent event***

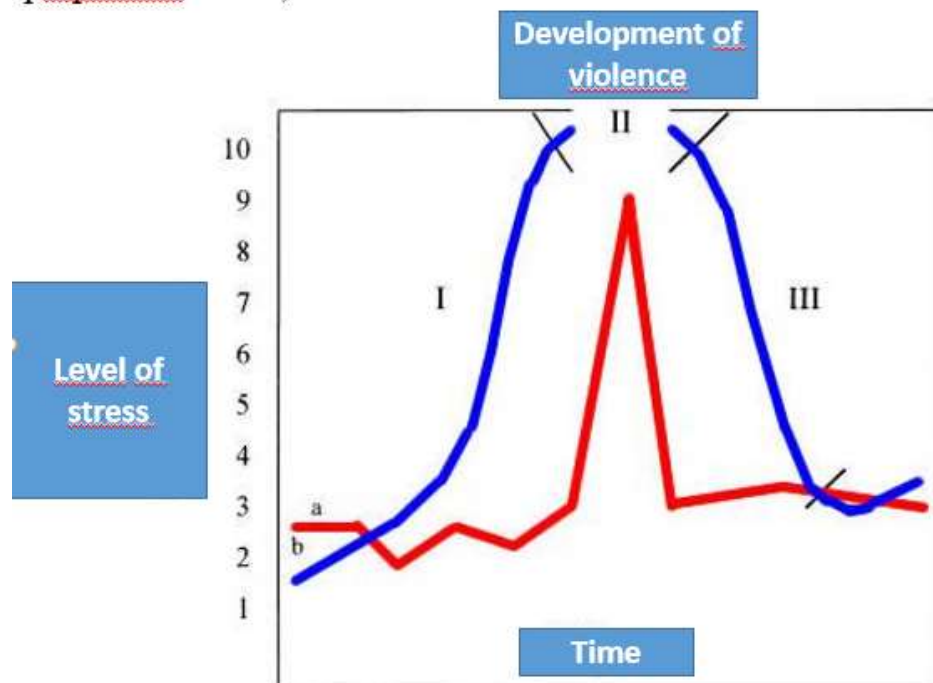
- Duration of violent event can be very different
- Perpetrator: release of tension accumulated in the first phase
- Victim: terrified, shocked, denial and disbelief

May leave home, ask for medical help only if badly injured (not to document the violence!)

Women victims usually return to the partner immediately after received assistance, withdraw testimony to the police

### **Perceptions of stress and tensions in a violent episode**

perpetrator = red; victim = blue

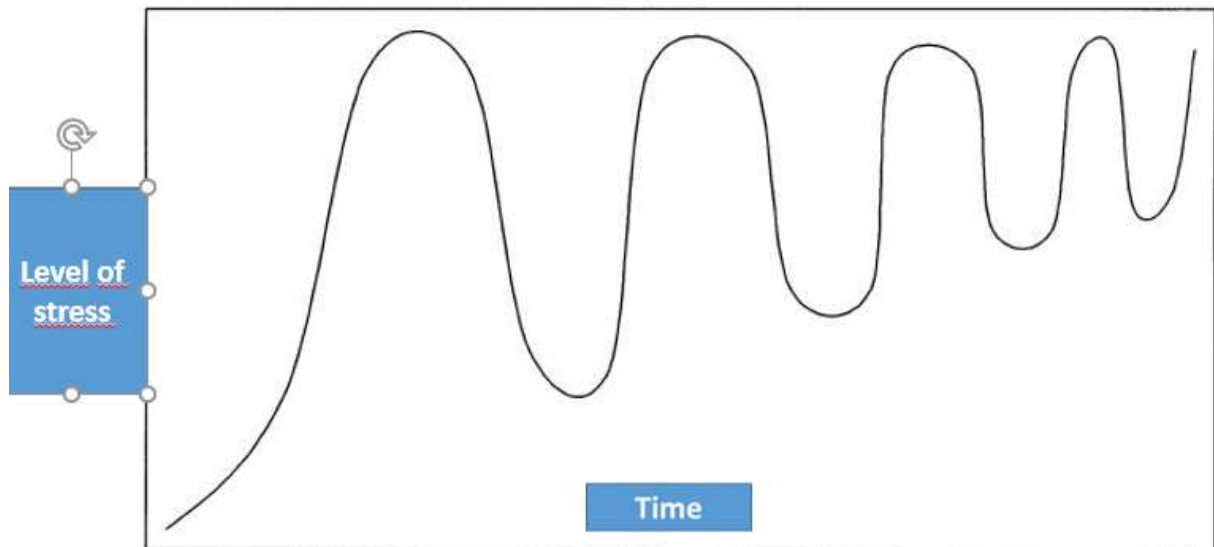


### ***Third phase: regret and apology***

- Some perpetrators show regret for their behavior, justifying own behavior with stress at work, alcohol
- Perpetrators: promise not to repeat the violence, give gifts and behave kindly

- Perpetrators: afraid to lose the relationship with the partner, lose family
- Victims: impressed with apologies and regrets, this phase gives them moral satisfaction and temporary power over the perpetrator
- Experience shows that practically always this is only temporary and that violence is likely to be repeated in shorter periods between two violent events

### Escalation of violence in partnership



### Role of alcohol and drugs in family violence

- Many perpetrators abuse alcohol (over 50%)
- Alcohol increases personal sense of power ("when he drinks he is a brave") - people with poor self-esteem often abuse alcohol and drugs
- Alcohol as self medication to reduce internal tensions which are typical of cyclic perpetrators
- Drinking triggers jealousy → increase in violence, biased interpretation of behavior of the partners
- Perpetrators justify being violent because of being drunk
- BUT: alcohol abuse is not the cause of violence
- Arguments:
  - Violence is learned behavior → can be self-controlled
  - Many perpetrators are violent also when sober
  - Some continue violence after stopping abusing alcohol

- Alcohol reduces behavioral self-control, affects reasoning → increases the likelihood of violence but does not cause it

### **Ways of abusive control of a partner**

- Isolation from primary family and friends (reducing social support!)
- Threats – against children, family members, to expose something embarrassing, hurting, killing
- Humiliation – derogatory names, ridicule appearance and sexuality, mock in public
- Impossible demands – unpredictability of the situation for the victim
- Physical exploitation – excessive work increases victim vulnerability
- Showing occasional affection – increases false hope and increases dependence on the person who has the power

### **Women as perpetrators of family violence**

- Most often women are violent in self-defense or as a consequence of prolonged exposure to partner abuse (80 to 90%)
- Women are also primary perpetrators and active participants in reciprocal partner violence (10 to 20%)

### **Psychological needs of victims of family violence**

- Core of psychological trauma is a sense of helplessness and detachment from the people
- Victims need to establish a sense of security and a feeling of not left alone to the mercy of a perpetrator
- Main principle of helping is to restore a sense of security and control of the victim over own body, thoughts, feelings and relationships with other people

### **What you can do for victim of family violence?**

- Listen with respect to what the victim is saying
- Do not give advice before you hear the whole story
- Take into consideration that what the victim feels is different than what you might feel
- Do not take anger or aggressiveness of the victim personally - it has nothing to do with you, but is a common reaction to traumatic events
- Do not say: „It could be worse”
- Tell that you are sorry for what happened to the victim, that it is not her fault, and that you will figure out how you can help
- Be honest in what you can offer
- Connect and support the victim with other services as she wishes

## **Risk factors for family violence**

### **Perpetrator:**

- Use of alcohol and drugs
- Criminal behavior of
- Family and individual stress (unemployment, poverty)
- Need for power and control
- Beliefs about „masculinity entitlement” in relations to women
- Own history of victim of family / sexual violence
- History of mental health problems
- Borderline personality disorder

### **Family patterns:**

- Big difference in power between spouses (father/mother)
- Family social isolation and lack of social support (migrants, displaced people?)
- Passive, depressive victim (e.g. mother, wife)
- Poor conflict management skills between spouses (shouting, humiliation, intimidation)

### **In relation to children:**

- Poor parenting skills
- Use of harsh physical punishment in disciplining children (often by victimized mother)
- Child neglect
- Lack of supervision over children (parents busy with their own problems)

## **Lecture**

# **Psychological consequences of working with victims and people exposed to trauma and violence**

## **Key concepts in working with victims and people in distress and crisis**

- Indirect or vicarious traumatization
- Counter transference reactions
- Professional stress and job burnout syndrome

## **Why is mental health and wellbeing of helpers at risk?**

- Stress due to disbalance between:
  1. Characteristics of helpers' job and work environment
  2. Expectations from the organization (service), clients, superiors, colleagues, society, oneself
  3. Helper's competencies for the job (knowledge, skills, beliefs) and work motivation
- Professions that include working with people are highly stressful
- Indirect traumatization and counter transference occurs specifically because of working with victims and trauma survivors
- Helpers who work with victims and other people in difficult life situations are at increased risk for their mental health and personal wellbeing
- The risk comes from direct communication with persons who need help which includes a relationship and empathy because of other person's sufferings
- Helpers listen to numerous tragic life stories, descriptions of traumatic experiences and losses
- Helpers may become emotionally overwhelmed by these insights
- At the same time, they are faced with very limited sources and possibilities to help victims and traumatized individuals and families
- Helpers are frequently unaware of the impact of their work upon themselves and tend to avoid seeking help
- Dominant professional framework: survivors and helpers meet as a part of the institutional power structure
  - Victims are weak, helpless, without resources
  - Helpers are strong, powerful and resourceful

- A helper can feel that own need for consultation is a personal weakness and be proud to bear anything to maintain image of self-control and invulnerability
- Helpers typically refuse to admit that they have psychological difficulties because from fear of losing status, respect and the trust of colleagues, superiors

**Indirect traumatization and counter transference refers to thoughts, feelings and behaviors in helpers that are:**

- Parallel to those of victims
- Generated from the experiences (material) of the clients
- Transmitted to the helpers from the clients
- Transmitted trauma material and relationships can be useful or damaging:
  - On one hand it increases empathy that is very important for developing healing relationship
  - On the other hand it makes it more difficult to keep boundaries with clients, but also with co-workers
- If the effects are acknowledged by the helper, they can enhance the recovery process
- If denied, these effects can harm both the helper and the client

**Indirect traumatization**

- Life experiences and situations which the clients describe can have effects on the helpers as if they are reliving them themselves → indirect trauma
- Helpers should know that this can be almost as difficult as direct trauma exposure and can affect them professionally and personally
- The degree to which people will be affected depends on personal and environmental factors, including the type of clients

**Indirect trauma difficulties checklist:**

**Intrusive symptoms among care providers**

- Clients' traumatic experiences become content of helper's' disturbing dreams
- Preoccupation with a client intrudes into helper's thoughts while attempting to concentrate on other things
- Illusion of seeing a client in the street, in a supermarket, on a bus, etc.
- Re-experiencing emotions connected with the case

**Avoidant / numbing symptoms**

- Forgetting appointments with a client, forgetting key information about the case
- Unable to enjoy work, hostility or mistrust of previously enjoyed co-workers
- Loss of interest in usual pleasures and relationships outside the work

- Long-term ambitions and ideals no longer relevant
- Phobic avoidance of a client, supervisor, colleague related to the case (fear of answering telephone or leaving office)

### **Persistent hyper-arousal**

- Restlessness, difficulty concentrating
- Disordered sleep
- Hyper-vigilance for information relating to the case.
- Digestive disorders, difficulty breathing, headaches, backaches, muscle spasms
- Being constantly on edge

### **Personality changes**

- Loss of self-confidence
- Sense of being very different from colleagues not doing similar work
- Lack of personal and professional self-care
- Hopelessness and despair.
- Pervasive expectations of deceit, betrayal, and exploitation
- Lying to colleagues/supervisors

### **Counter transference reactions**

- Re-emergence of emotional reactions of a helper because of working with a specific victim, i.e., the transfer of the helper's emotions to the client
- These strong emotional reactions are a result of the interaction between the experience, which a client in distress is going through, and the unresolved difficulties and previous life experiences of the helper
- Dramatic stories (material) presented by a victim to which a helper listens to, induce his or her feelings, which are difficult to integrate (e.g., the fear of own death, awareness of own vulnerability, fear that something similar could happen to the helper's family and friends, etc.)
- This triggers defense mechanisms such as suppression, denial or projection, which can be manifested in non-functional professional behavior and impaired relations with the client and colleagues
- These strong emotional reactions in the helper can hinder their work, rather than facilitate their understanding of clients and the creative use of professional skills

### **Relations among secondary traumatization, counter transference and job burnout**

- All of these are different negative effects of the helping work with victims



- Situation with counter transference and secondary traumatization is more complicated, but techniques of self-help and organizational support are beneficial for helpers' well being
- These effects of work with victims would not exist if helpers did not have empathy and did not identify with the client's situation, which are important aspects of building a relationship with a person in distress
- The more intensive work with victims, the higher likelihood of secondary traumatization
- The more similarity between the helper and clients, the higher likelihood of counter transference

**Helpers' strategies to work with victims**  
(adapted from A.J. Donk, 1999)

ACTIVE APPROACH		IDENTIFYING WITH	SAVING	Withdrawing	AVOIDING
PASSIVE APPROACH					
Helper takes the role of "all powerful savior":					
- Does things the victim can do herself / himself					
- Takes on full responsibility for the case					
- Overprotects and "guards" the victim					
Sympathizing					
Helper is too emphatic:					
- Identifies so much that feels like a victim					
- Poor boundaries with the victim					
- Overly involved, but the activities are inappropriate and disorganized					
- Feels intense helplessness, can even lead to block in work					
Minimizing and suppressing					
To avoid being emotionally the helper:					
- "Can't see", denies or minimizes problem					
- Displaces the problem					
- Withdraws and distances from the victim					
- Blames the victim					

### What helps to deal with these difficulties

- Knowledge and awareness of specific signs of indirect traumatization and counter transference
- Normalization of secondary traumatic reactions of helpers
- Strengthening inner resources through leisure activities that relax and empower
- Taking care of physical health and wellbeing through exercise and healthy living
- Using imaginative and spiritual activities (i.e. relaxation, visualization)
- Becoming aware of own attitudes towards meaning or work with victims
- Cognitive reframing (i.e. to see work with victims in a more positive light)

- Becoming involved in actions on behalf of helpers' or clients' interests
- Discussing counter transference emotions with a professional
- Ensuring access to consultation and support regarding particular cases

### **What helps in cognitive reframing**

Regarding cognitive reframing / seeing work with victims in a more positive light, helpers find it beneficial:

- Being attentive to clients' improvement and change
- Being part of a healing process
- Learning about humans through client's strength and resilience
- Being aware of own growth and professional change
- Recognizing the importance of own work
- Introducing creativity into own work

In sum: many of the coping strategies reported by helpers are the same ones on which they work with clients

## Lecture

# Prevention of professional stress and job burnout

### Some key questions

- What is stress?
- What is professional stress?
- Is it possible to avoid stress?
- What are the sources and risks for professional stress?
- Can we recognize signs of stress and burnout?
- What are the phases of burnout?
- How can we prevent and mitigate professional stress?

### What is stress?

- Stress is a set of physiological, emotional, cognitive and behavioral reactions to the perceived threats to one's wellbeing and state of good balance (*homeostasis*)
- These perceived threats are stressors or sources of stress
- Stressors activate a process of coping → mental effort or behaviors of a person to overcome, reduce or tolerate internal or external pressures caused by the threatening situation

### Definition of professional stress?

- Professional stress is a disbalance between demands of the work environment and a person's capacities, wishes and expectations to meet these requirements

D. Ajduković & M. Ajduković (1996)

### Can stress be avoided?

- Stress is part of everyday life and work
- Humans have mechanisms for coping with stress:

Proactive behaviors – changing the situation

Avoiding behaviors – ignoring stressor / self-medication / leaving a job

Reinterpreting threatening situation as a challenge

Support seeking – emotional, practical, advice

Increasing capacity to cope – learning new skills

Some mechanisms are more constructive than others

Coping can be changed, learned and practiced

- Prolonged unsuccessfully coping with stress is harmful in many ways → risk for physical and mental health

### **Statistics on consequences of stress at work in EU**

- 50% of all lost working days are related to stress at work
- 5 million accidents at work, which represents an economic loss of at least 20 billion euro per year
- People working long time under high stress productivity decline on the average 7%
- Depression and burnout are becoming major occupational diseases of the 21st century
- More than half of the employees have symptoms of early burnout, 10% experience the ultimate stage of burnout

### **Individual characteristics as risks and resources in coping with professional stress**

- Demographics: gender, age, education, social status
- Self-image, self-confidence, self-perception in the work environment
- Personality traits: e.g. need for high control
- Cognitive characteristics: ability to recognize problems and find solutions, experience with similar situations, mental preparedness for the situation, reframing the stressor

### **Individual characteristics risks and resources in coping with professional stress**

- Motivational: attitudes toward organization, professional value system, level of ambitions, reality of professional expectations, excessive attachment to work
- Work related skills: time management, seeking advice
- Self-care skills: self-encouragement, health monitoring, seeking social support
- Feelings of professional competence

## What are your signs of stress?

Physical	Emotional
<ul style="list-style-type: none"> <li>• Prolonged fatigue</li> <li>• Frequent psychical complaints</li> <li>• Sleep disturbance</li> <li>• Appetite changes</li> </ul>	<ul style="list-style-type: none"> <li>• Anxiety</li> <li>• Feeling alienated</li> <li>• Desire to be alone</li> <li>• Negativism/cynicism</li> <li>• Suspiciousness</li> <li>• Depression/chronic sadness</li> <li>• Feeling pressured/overwhelmed</li> <li>• Diminished pleasure</li> </ul>
Cognitive	Spiritual
<ul style="list-style-type: none"> <li>• Difficulty thinking, concentrating</li> <li>• Increased distractibility/inattention</li> <li>• Problems with decision/priorities</li> <li>• Diminished tolerance for ambiguity</li> <li>• Rigid, inflexible thinking</li> </ul>	<ul style="list-style-type: none"> <li>• Doubt of value system/religious beliefs</li> <li>• Questioning of major life areas (profession, employment, lifestyle)</li> <li>• Feeling threatened and victimised</li> <li>• Disillusionment</li> </ul>
Behavioral	
<ul style="list-style-type: none"> <li>• Anger displacement, blaming others</li> <li>• Reluctance to start/finish work</li> <li>• Social withdrawal</li> <li>• Absenteeism</li> <li>• Unwillingness/refusal to take leave</li> <li>• Substance abuse, self-medication</li> <li>• Disregard for security/risky behaviour</li> </ul>	

### Burnout syndrome

- Consequence of unresolved and prolonged high intensity work stress which is reflected as physical, emotional and mental exhaustion
- Cumulative process that begins with the little warning signs → this is good because it can be stopped and reversed
- One of the most unfavorable consequences of professional stress in health, social and work terms

### Assess your burnout score :

1. Isolated signs of stress (no burnout)	18-24
2. Present some signs of burnout	
2a. mild signs (prolonged exposure to stress)	25-28
2b. serious signs of stress (beginning of burnout and warning due to prolonged exposure to stress)	29-33
3. Advanced burnout (seek help and radical change)	34 →

## **Risk factors for burnout**

- Candidates: perfectionists, idealizing own job, with high expectations, subject to authorities, cannot set own boundaries
- Work conditions: excessive work pressure, poor organization, unclear working roles, lack of knowledge and skills, lack of support

## **Phases of burnout**

First phase: High expectations of oneself

- Work-related enthusiasm, high achievement, working without rest and total commitment to work, work long hours, not taking daily, weekly or annual leave

Second phase: Stagnation

- Dissatisfaction with work, colleagues, clients
- Pessimism, physical and mental fatigue, frustration and loss of ideals, reduced morale, boredom, fatigue, increased criticism, physical signs of stress (various pains)

Third phase: Withdrawal and self-isolation

- Avoiding contact with co-workers, anger and hostility, intolerance, helplessness, loss of hope, difficulties thinking and concentration, high physical and mental fatigue, prone to illnesses, increased use of alcohol, tobacco and drugs, number of physical signs of stress

Fourth phase: Loss of professional interests and/or inability to work

- Low self-esteem, chronic absenteeism, negative feelings about work, intensive cynicism, inability to interact with other people at work, serious emotional problems, serious stress physical, emotional, intellectual and social changes, leaving job

## **Remember!**

- In 1st and 2nd phase of burnout a person can help oneself
- In 3rd and especially in 4th phase of burnout professional help and guidance is necessary
- Symptoms of burnout in 3rd and 4th phase are easily noticed both in professional and private life

## **Self-help of burnout prevention**

- Recognize when the workload exceeds the "normal" limit of tolerance of stress → need to do something to mitigate or stop the burnout while still in time
- Develop self-awareness that *this is burnout!*
- Each person should find what is most appropriate way of coping and develop the skills to enhance it

**Self-monitoring of own stress level**

- In what situations is my job particularly difficult? What is typical for such a situation?
- What are my "warning signs" before such a situation?
- What thoughts, perceptions follow my feeling of being overwhelmed by work?
- In what situations is my work easy? How do I achieve this?
- What happens if I refuse to do a task because of overload? How do people react to this and how does this affect me?

## **MODULE 2 – WORKSHOPS**

### Module 2, Workshop 0

#### **Participant's experiences in practicing skills from the previous module**

(45 minutes)

##### Objectives:

1. To gain overview of the participants' experiences in practicing skills from the previous module.
2. To provide feedback, encouragement and guidance to the participants to implement newly learned skills in their everyday work.

##### Expected outcomes:

1. Participants will gain new insights in obstacles, opportunities and benefits of using the empowerment model of psychosocial work, process of change and collaborative planning of change, different skills of professional dialogue.

##### Materials:

Template for reflecting about integrating into own practice the information and skills learned at the previous module (for each participant)

##### Methods:

Work in two groups (15 - 18 participants).

1. The participants are asked to reflect on how were they able to use in their everyday practice and interactions with clients the insights about the empowerment model of psychosocial work and skills that were exercised during Module 1, and to complete the template for reflecting. (10 minutes)
2. The participants share their experiences in the whole group. (30 minutes)



### **Participant's experiences in practicing skills from the previous module**

Please think about your professional practice during the past month (contacts with individual clients or families), after the previous Module in this program. Identify at least one situation during interaction with a client in which you were able to use knowledge and skills that were taught in Module 1.

Please briefly write down your experiences in interaction with this client:

1. What protective and resilience factors did you recognize in this interaction?

---

---

2. Were you able to use some of the professional dialogue skills: paraphrasing, reflecting emotions, asking open questions, showing empathy? If yes which you used most:

---

3. What were your obstacles to using some of these skills?

---

---

4. Do you think that your use of these skills affected the relationship with the client (trust towards you, belief that you are willing to help)? If yes, please describe how did you recognize this?

---

---

5. Did you succeed in planning one goal of change in client's life together with the client? If yes, how do you know that the client embraced this goal as own?

---

---

## **Family stressors and community relations** (90 minutes)

**Objectives:**

1. To improve the understanding of the person-in-family approach and systemic approach to families
2. To become able to use the eco-map technique as a tool of assessment of family functioning.

**Expected outcomes:**

1. Participants will understand key assumptions about family systems and their utility for practical work with clients.
2. Participants will become able to identify stressors and symptoms in a family system.
3. Participants will become acquainted with eco-map as a specific technique in work with families.

**Materials:**

- Handout *Family stressors and community relations – using eco-map* with the instruction how to create a family eco-map and Appendix with genogram symbols (one per participant)

**Methods:**

Work in groups with 15 members.

1. Participants work in triads which need to be formed so that at least one participant in each triad has experience with working with families, had at least three meetings with the family (i.e. with more than one family member and that enough information are available) and this helper is not sure how to provide support to this family. In each triad they choose one family that will be in focus. (10 minutes)
2. Participants receive the handout and instructions how to make ecomap and are asked to create the eco-map for the family in focus. The family is represented in the central circle using the genogram symbols. After this, they answer the 7 questions about the family. (30 minutes)
3. In the large group the triads share (30 minutes)
  - a. impressions, new insights and questions that arise from the analysis of the family and the eco-map
  - b. how will the helper use this knowledge in future work with this person/family?
4. Discussion in the large group about the differences between individual and family orientated practice. Interpreter will write this on a flip chart. The trainer helps connect the experiences with the theory presented in the lectures and probes about challenges of family orientated practice (opportunities, limitations) at the level of family members, helpers' role, institutions. (20 minutes)

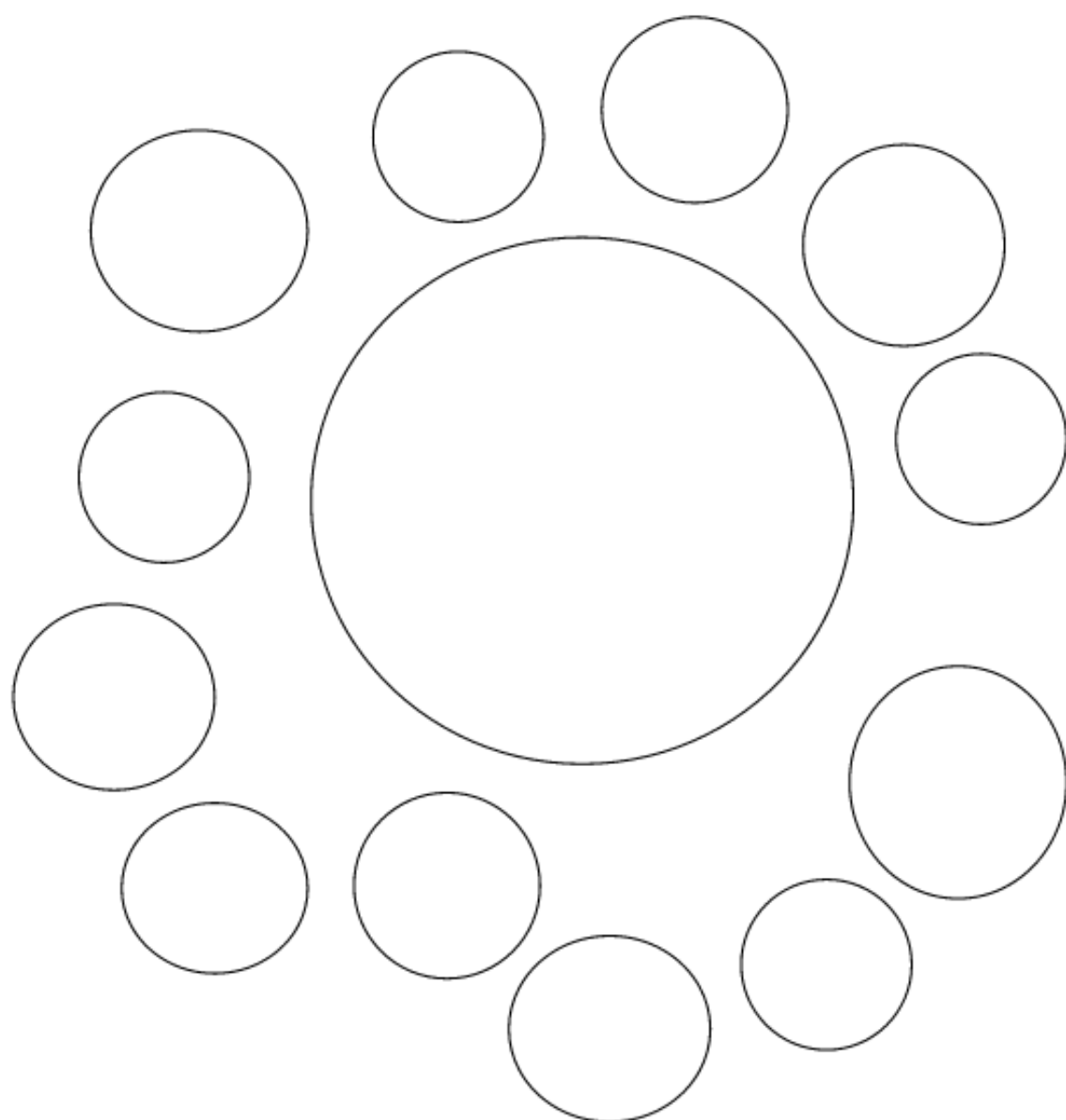
## **Family stressors and community relations – using eco-map**

Mapping techniques (genograms and eco-map) provide a conceptual view of family subsystems and outside systems interacting with the family. These tools help practitioners and families to see various systems and boundaries (family system-family subsystems, parent-child subsystem, and family-community system, etc).

### **Instructions for drawing a family eco-map:**

1. At the center of the eco-map draw a representation of the family consisting of members who live in the same household by using genogram symbols from the Appendix.
2. Draw relations among family members using Relationship Key symbols.
3. Draw relations of the whole family or individual family members with important systems outside the family. If such relations apply for the whole family draw these at the household level and not for each family member.
4. If no relation with important outside system exists for any individual or a family, you should name this system in one of the smaller circles and by not drawing a connection to the family or family members, you will show that no relation exists although you think that this is an important system that should be connected to the family or some family members.
5. Outside systems to consider including in the eco-map may be from different levels of the ecological model of psychosocial work (micro-system, exo-system mezzo-system, macro-system):
  - a) Extended family
  - b) Neighbors
  - c) Different community services (social, educational, medical, mental health, substance abuse, child welfare, legal, courts, police, etc.)
  - d) Employment
  - d) Social groups (church, civil society, sports, spirituality, family, friends)
  - f) Other significant personal relationships
  - i) Other

**Eco-map for family** \_\_\_\_\_



**Relationship Key**

Strong —————

Stressful ~~~~~

Tenuous - - - - -

Broken/ended - - - / - - - / - - - / - - -

After drawing the family eco-map, please answer the following questions and discuss in your small group:

1. What are the current family stressors? List up to five family events that affected this family in the life course (such as death of family member, displacement, illness, loss of home, changing the school, victimization, etc.)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

2. What are evident symptoms of distress of individual family members (children, adults)?

3. How do these symptoms affect their family relations and functioning?

4. Which key systems (community services) are involved with this family and what is the character of such relationship?

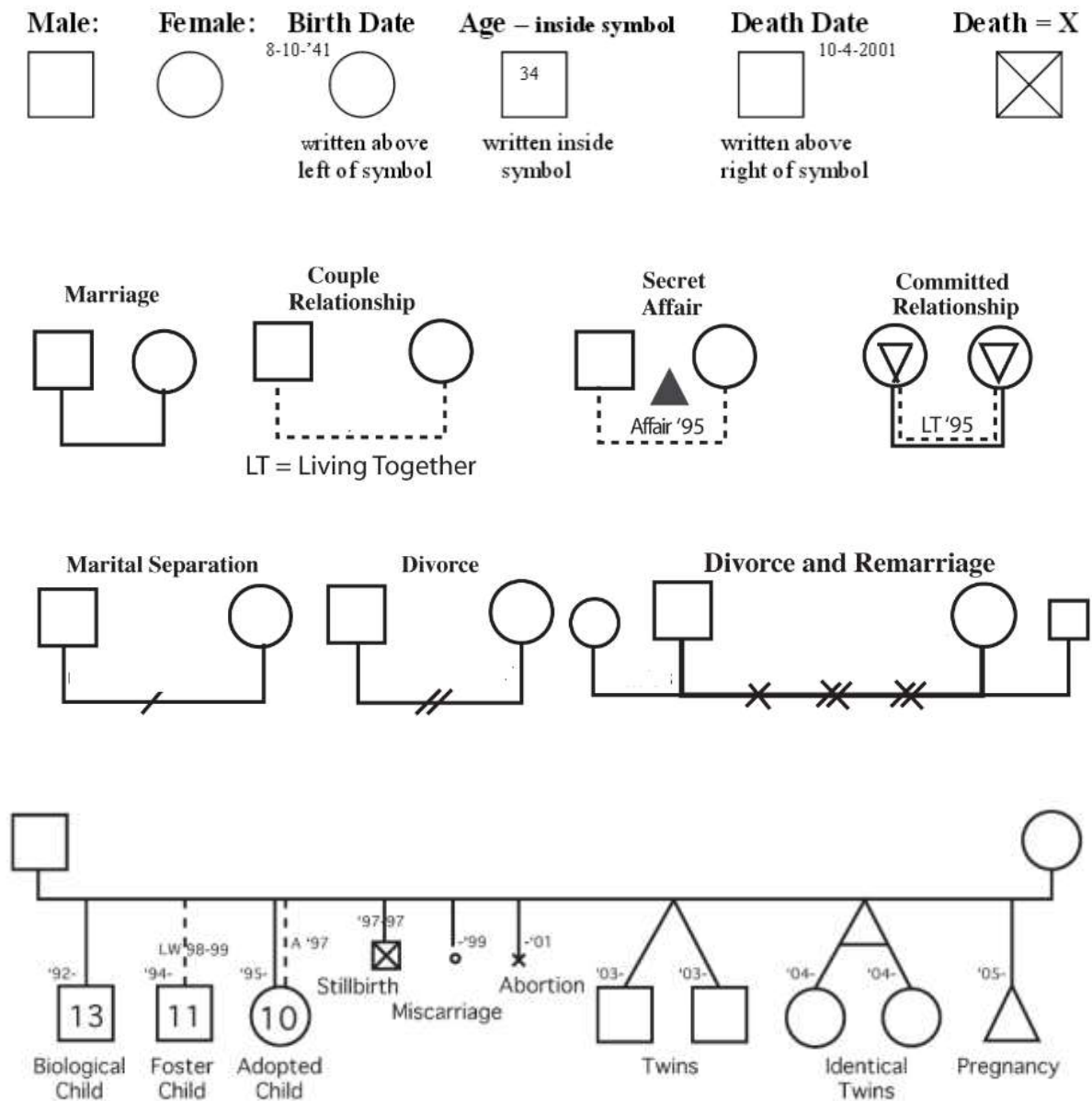
5. How open or close are the family boundaries to other systems?

6. For each family member describe their boundaries to you as a professional. How does that impact your professional relationship?

7. What is the new insight about this family after such assessment of family?

## Appendix: Symbols used in drawing a genogram

Genograms are a graphic representation of the family unit which enable a systematic view of the family and its functioning. The genogram symbols are used to represent each family member, family structure and relations among family members, identify family subsystems, and generation and kin relationships context.



## **Family assessment** (60 minutes)

Objective: To practice assessment of a family.

Expected outcomes:

1. Participants will be able to conduct family assessment
2. Participants will be able to identify and differentiate various within-family subsystems and family boundaries
3. Participants will be able to recognize family strengths and weaknesses.
4. Participants will be able to determine what is the priority intervention for a family from their professional role?

Materials:

- Handout *Assessment of family* (one per triad, total 10 to 14)

Methods:

Work in groups of 15-20 members.

1. Participants work in the same triads from the previous workshop and continue to work on the same family case. They assess the family using the questions in the handout and prepare to present the family to the whole group using these questions. (25 minutes)
2. Discussion in the large group focusing on questions 4 (Summary about family strengths and weaknesses) and 5 (Priority intervention for this family from the helper's professional role). The trainer helps connect experiences with the theory presented in the previous day. (35 minutes)

**Assessment of family (name) \_\_\_\_\_**

1. What was the primary reason for this family to see you?
2. Describe the family structure
3. Describe family functioning:
  - What are the roles of family members
  - Which family subsystems exists and what are the relations among different subsystems
  - What is the pattern of communication within the family
  - How are the problems typically solved in the family
  - What are the core beliefs and values held by the family
  - How much is the family open to receive support from the outside
4. Summarize what are the family strengths and weaknesses.
5. What is the priority intervention for this family from your professional role?



## **Practicing motivational interview** (75 minutes)

**Objective:**

To build skills for motivational interviewing

**Expected outcome:**

Participants will become able plan and lead motivational interview

**Materials:**

- Examples for motivational interview (for each participant)
- Green and red post-it stickers (one of each for for each participant)
- Instructions "*Preparation of motivational interview*" (for each triad)

**Methods:**

Work in groups of 15-20 members.

1. Recognizing the essence of motivational interview technique

Participants work in a large group.

Each participant receives examples of sentences from motivational interviews and will have to decide if the helper's response to the statement of a client reflects principles of motivational interview. The participants will indicate their decision by circling Yes or No after each case and will be ready to provide a short explanation of his/her decision. The trainer will ask some of the participants to share their decision by raising red ("No") or green post-it papers ("Yes") and explain their decision. (15 minutes)

2. Planning the motivational interview

Participants will work in the same triads as in previous workshops and on the same case. They will prepare a short role-play according to instructions "*Preparation of motivational interview*". (15 min)

3. Each group will do a short role play in front of other participants ("fish bowl") lasting up to 5 minutes and trying to make it as realistic as possible (probably 4 cases). Other participants will serve as observes and will provided feedback regarding the principles of motivational interview that were used in each of the presentations. (40 min)

Module 2, Working material 2a

**Decide if the following responses of the helper reflect the principles of motivational interview** (circle Yes or No and explain your decision)

1. Maria: They told me my son has to go to disability assessment in order to get financial support. But I don't trust them, so I haven't scheduled it yet.

Helper: Why take the chance? They're the experts, after all. Let's call from this phone right now - maybe you can arrange the meeting this week.

Yes                  No                  Why?

2. Lucia: I am fed up with my husband Juan constantly blaming me for infidelity. I had a short affair but this was definitely finished long time ago. I would like to work on improving our marriage, but I don't think he is ever going to let this go. Maybe we should just get a divorce.

Helper: Lucia, you are the only one who can decide if you should stay in this marriage or leave it. I wonder what signs you would need to feel more optimistic about working on things with your husband.

Yes                  No                  Why?

3. Natalia: My family and friends prepared a small party when I got a new job. It was a nice atmosphere, but later on several of these people approached me and told me privately how my drinking worries them. They think I'm an alcoholic! I might drink too much from time to time but I'm sure not an alcoholic.

Helper (kindly): Natalia, I think if all those people are telling you you're alcoholic, they're probably right. You might be in denial, don't you think?

Yes                  No                  Why?

4. Enrique: Since my children lost mother, my son Ivan took on too many household responsibilities. A boy his age ought to be playing sports and chasing girls. Instead, he is looking after his younger brother and cleans the house all the time. He even does laundry instead of his sister. But when I try to push him toward more normal thing, like football, he gets angry at me and says I don't understand him. What am I supposed to do?

Helper: In families where an important adult is gone, other family members often take over more responsibilities. What if you supported him to join a chess club or the school newspaper group instead of pushing him toward football? He may be more receptive to that. Perhaps you do not recognize how your son is smart for other things but not for sports. It could be that he will never be all that interested in football.

Yes                  No                  Why?

5. Paola: My son's doctor gave me a long list of all the things I have to do to manage his care. It's overwhelming. I have to give him medication three times a day and to cook for him 5 meals per day. And I have to attend to other kids as well. I just can't do it. But I'm afraid he will die if I don't.

Helper (encouraging): You can do this. You have to.

Yes                  No                  Why?

6. Monica: I need to come up with some sort of plan to help me get back on employment track again, but this family crisis prevents me from thinking about anything else. What do you think I should do?

Helper: Well, I have some ideas about what might help, but first let me hear what you have already considered.

Yes                  No                  Why?

### **Instructions “Preparation of motivational interview”**

1. Identify one family member who is crucial for change of the family system from the family case from the previous workshops.
2. In which stage of readiness for change is this person?
3. Which, if any, signs of resistance to change this person has been showing?
4. Prepare several questions that you will ask this person by applying the principles of motivational interview:
  1. Check the values and concerns/worries of that person (2 to 3 questions).
  2. Prepare 2 to 3 open-ended questions that encourage changes
  3. Give one proposal in the line with the guidelines "How to make a proposal"
4. Prepare a short role-play (about 5 minutes) using these questions with one member of your triad who will get into the role of the family member from the case from the previous workshops.

## **Context of family violence**

(45 minutes)

### **Objective:**

To become aware of own attitudes and relation to perpetrators and victims of family violence.

### **Expected outcomes:**

1. Participants will understand how the culture and societal values are connected to the support and services for victims.
2. Participants will be able to distinguish responsibility of a perpetrator and a victim for own behaviour.

### **Materials:**

- Beliefs about marriage violence (for each participant)
- Who is responsible for violence? (for each participant)
- Flip-chart with markers

### **Methods:**

The whole group (30-40) works together.

1. The “Beliefs about marriage violence scale” is distributed and participants complete it and add their scores. The higher score indicates more justification and acceptance of family violence. The average score is 34 on similar groups (Croatia, Bosnia Herzegovina, Macedonia). First, the range of scores in this group is discussed with the view on implications for a relationship to victims of violence. Next, some of the items where participants show tolerance for violence (by blaming the victim) are discussed and confronted if necessary.

(15 minutes)

2. The “Who is responsible for violence?” material is distributed and the participants asked to assess the degree of responsibility of the man and of the woman for the violent incident described in the vignettes on a scale from 0% to 100%. The trainer invites a few participants to tell their responsibility score for both spouses and shortly explain the reasoning behind it. For each of the 5 situations these scores are written on the flip-chart. For each of them the trainer / interpreter reads the vignette and invites the participants to state their scores and reasoning.

Typically, the participants respond by sharing the degree of responsibility between the spouses so that from first to the fifth situation the responsibility of the woman increases and of the man decreases, although he has committed the same violent attack. This is discussed in the view of 100% of responsibility of each spouse for own behavior and self-control. The message is that violence and abuse is never acceptable and justified. (20 minutes)

The final discussion is about biases in attributing responsibility to family members who suffer from family violence and the implications for providing services to victims.

(10 min)

## Beliefs about violence in marriage

Please express your agreement or disagreement with the statements bellow about violence in a marriage where numbers have the following meanings:

- 1 - strongly disagree
- 2 - partially disagree
- 3 - partially agree
- 4 - I agree

1. Battered women deserve a beating because they provoke a husband. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
2. Women victims of violence enjoy being beaten, otherwise they would have left the husband. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
3. Violence between spouses is their private matter and no one should interfere with this. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
4. If the victim leaves abusive husband, she will be safe from his violence. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
5. Violence in the family occurs only in the lower class of society. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
6. The question of family violence is exaggerated because it is really not such a big problem. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
7. Women are equally violent as men. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
8. Battered women choose violent partners and when they leave one, they find another who will beat them again. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
9. Physical attack is usually an isolated event and it is not likely that it will happen again. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
10. Violence between partners is usually just a little pushing. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
11. If a man beats his wife, he must be mentally ill. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
12. A man who only threatens to hurt his wife is not violent. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
13. A man who is violent towards his wife cannot help it. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
14. A punch or a slap on a face happens in every marriage. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
15. Children need their father even though he is violent towards their mother, so a woman should remain with such a husband. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
16. Violence and love never go together. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4
17. In the period after the war there are many more important issues than marital violence. 1 \_\_\_\_ 2 \_\_\_\_ 3 \_\_\_\_ 4

### Who is responsible for violence?

1. He comes home. He is in very bad mood, because of a conflict with the boss. She asks him what is wrong, whether it was a bad day and offered him a beer. After she brought the beer, he says it is not cold enough and pushed the glass that shatters on the floor. She asks him why he did it, because she has to clean up. He slaps her on the face.

Man is responsible  
100% ----- 0%

Woman is responsible  
100% ----- 0%

2. He comes home. He is in very bad mood. The house is a mess, the child is crying. He asks for a beer. She says: "Can't you see I'm busy with the child. Please take the beer from the fridge yourself." He starts cursing and call her names. He slaps her on the face.

Man is responsible  
100% ----- 0%

Woman is responsible  
100% ----- 0%

3. He comes home. He is in very bad mood. The house is a mess, the child is crying. He asks for a beer. She yells at him: "Get it yourself! I'm not your servant!". He starts yelling at her and calling the names. She yells at him and tells him he's a bad husband. He asks him how he thinks she could manage the home with the little money that he earns. She says: "You never play with the kids and have not cleaned up that garbage from the yard." He slaps her on the face.

Man is responsible  
100% ----- 0%

Woman is responsible  
100% ----- 0%

4. He is comes home. He is in very bad mood. The house is a mess, the child crying. He takes a beer from the fridge and sits down. She approaches him, shouting: "You're a bad husband! You're lazy! You do not earn enough! I am fed up with you!". He slaps her on the face.

Man is responsible  
100% ----- 0%

Woman is responsible  
100% ----- 0%

5. He comes home. He is in very bad mood. The house is a mess, the child is crying. She immediately yells at him and insults him. She has obviously drank. She throws a bottle at his head. He slaps her on the face.

Man is responsible  
100% ----- 0%

Woman is responsible  
100% ----- 0%

## **Risk assessment and safety plan**

(60 minutes)

### Objectives:

1. To learn how to perform a risk assessment and develop safety plan with a victim of family violence and provide support.
2. To become aware of importance of validating the suffering and unacceptability of exposure to family violence.

### Expected outcomes:

1. Participants will understand the importance of providing emotional support to victims of family violence and validating their suffering.
2. Participants will be able to perform a risk assessment and to help a victim of family violence develop her safety plan.

### Materials:

1. Risk assessment protocol (1 for each small group, 10 total)
2. Family violence safety plan (1 for each small group, 10 total)

### Methods:

Work in two groups (15 participants).

1. The participants work in small groups of 3-4 and identify a case of family violence that can provide enough information (at least one of them knows the case in fair amount of details). They complete the risk assessment protocol for this family and conclude about: 1) level of risk – small, medium, high; 2) is the risk increasing. Next, they analyze what they could do to increase the safety of this particular family knowing the level of risk and agree on the two things they would do to help protect the victimized family members. (35 min)
2. Each group presents the level of risk in the case they have analyzed and what they decided to do to help protect the family from further violence. (10 min)
3. In the same small groups the participants go through the safety plan and discuss what they would recommend to the victim from this plan, how feasible is the plan, is something missing or not needed in the plan. They present their conclusions to the whole group. (15 min)

### **Family violence risk assessment protocol**

The presence of these factors can indicate elevated risk of serious injury or death. The absence of these factors is not evidence that there is no such risk.

1. Does the perpetrator have access to **firearm** or is there a firearm in the home?
2. Has the perpetrator ever used or threatened to use a **weapon** against the victim?
3. Has the perpetrator ever attempted to **strangle** or choke the victim?
4. Has the perpetrator ever **threatened to or tried to kill** the victim?
5. Has the **physical violence increased in frequency or severity** over the past year?
6. Has the perpetrator **forced** the victim to have **sex**?
7. Does the perpetrator try to **control** most or all of victim's **daily activities**?
8. Is the perpetrator constantly or violently **jealous**?
9. Has the perpetrator ever threatened or tried to commit **suicide**?
10. Does the **victim believe** that the perpetrator will re-assault or attempt to kill the victim?

*(Adapted from: MN Gender Fairness Implementation Committee)*



## **Family violence safety plan**

These are elements for developing a safety plan to work on with the victim of family violence whose safety is at stake. The purpose is to help the victim have three different scenarios depending on her current or future situation:

A) If she continues to live with the perpetrator but is at risk of physical attack.

B) If she is planning to leave the home for safety reasons.

C) If she has left the home. Abusers try to control their victim's lives. When abusers feel a loss of control - like when victims try to leave them - the abuse often gets worse. The victim should keep being careful even after having left.

### **A) If you continue to live an abusive relationship**

1. Having important phone numbers nearby for you and your children (police, help hotlines, friends).
2. List of friends or neighbours you could tell about the abuse. Ask them to call the police if they hear angry or violent noises. If you have children, teach them how to dial police emergency number. Agree on a code word or sentence that you can use when you need help.
3. Practice how to get out of your home safely in an emergency.
4. Determine which places in your home are safer (there are exits and no potential weapons). If you feel attack is going to happen try to get to one of these safer places.
5. If there are weapons in the house think how you could get them out of the house.

### **B) If you consider leaving your abuser**

1. Identify four places you could go if you leave your home and make sure these people will take you into a home.
2. Think of how you might leave and try this out (such as taking out the trash, walking the pet or going to the store). Put together a bag of things you use every day (see the checklist below). Hide it where it is easy for you to get or find trusted people who will keep it for you.
3. Think about people who might lend you money.
4. Keep a cell phone operational at all times.
5. Consider opening a bank account or getting a credit card in your name.
6. Think how you could take your children with you safely. There are times when taking your children with you may put all of your lives in danger. You need to protect yourself to be able to protect your children.

### **C) If you have left your abuser**

1. Get a protection order from the court or a similar protection measure to prevent your abuser approaching you. Give a copy to the people who take care of your children, their schools and your boss.
2. Change the locks. Consider putting in stronger doors, a security system and outside lights.
3. Tell friends and neighbours that your abuser no longer lives with you. Ask them to call the police if they see your abuser near your home or children.
4. Tell people who take care of your children the names of people who are allowed to pick them up.
5. Tell someone at work about what has happened. Ask that person to screen your calls. Think about and practice a safety plan for your workplace including going to and from work.
6. Do not use the same stores or businesses that you did when you were with your abuser.
7. Find someone that you can call if you feel depressed or afraid.
8. Find a support group.
9. Think of safe way to speak with your abuser if you must.

### **Items to take, if possible**

- Children (if it is safe)
- Money, credit card
- Keys to car, house, work
- Extra clothes
- Medicine
- Important papers for you and your children (birth certificates, health insurance card, school and medical records)
- Driver's license, car registration
- Divorce papers, custody orders
- Address book
- Pictures, jewellery, things that mean a lot to you
- Items for your children (toys, blankets, etc.)

*Adapted after: Domestic violence  
Oakland County Coordinating Council Against Domestic Violence*

## **Identification and classification of professional stressors** (75 minutes)

**Objectives:**

1. To identify current sources of professional stress.
2. To learn how to reappraise stressors.

**Expected outcomes:**

4. Participants will become aware of their professional stressors
5. Participants will be able to distinguish those that are outside of their control, within their control and how to reappraise them and develop a mitigation plan.

**Materials:**

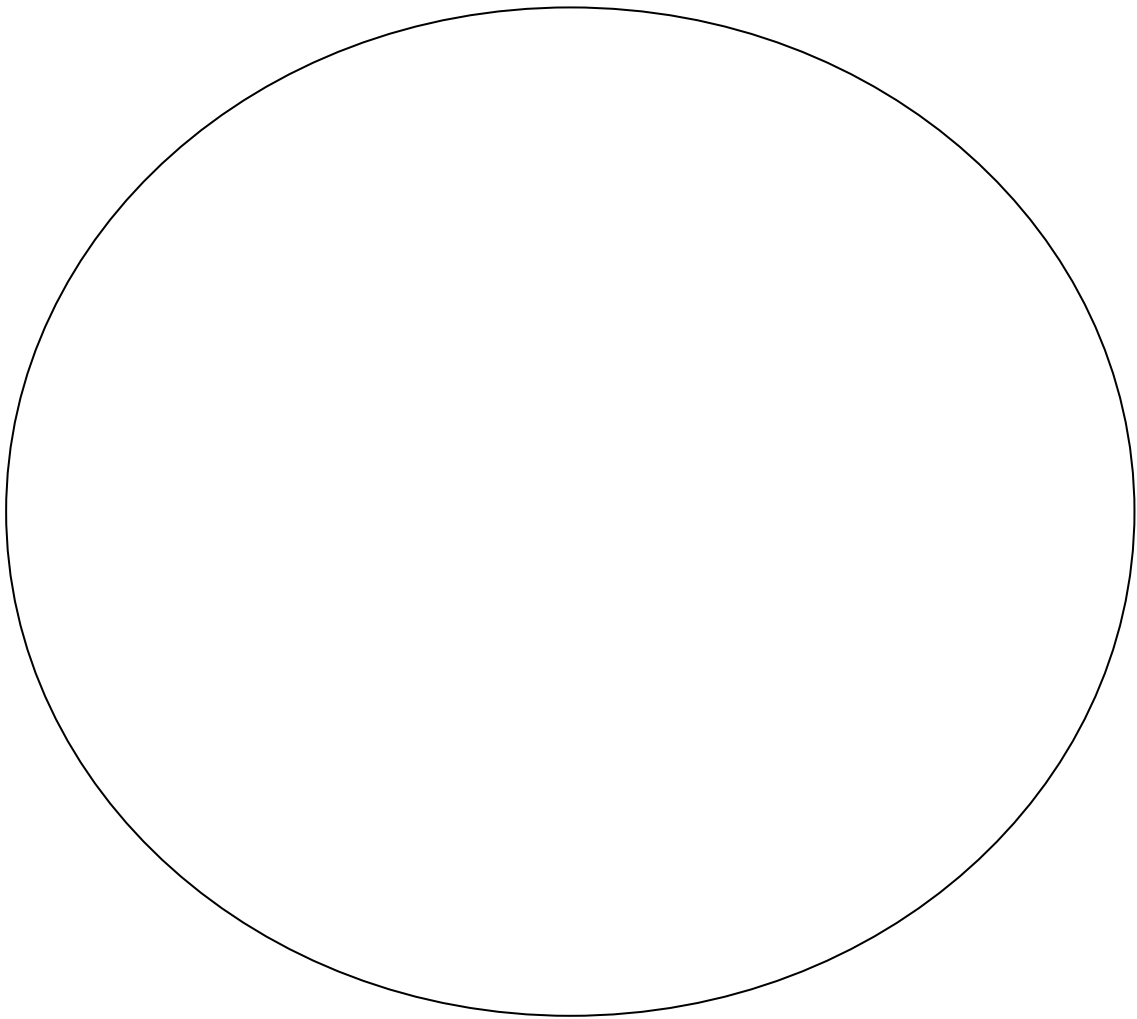
1. Individual forms with a circle (for each participant)
2. Blank piece of paper (for each participant)
3. Flip-chart paper with a big circle, markers for each small group (4-5 groups)

**Methods:**

Two groups with 15 -18 members.

1. Each participant will remember own typical week at work and write on a blank piece of paper all sources of stress during that week. (5 minutes)
2. Next, each participant will classify on a paper with the circle own sources of stress depending if he/she thinks that they could do something about them (write within the circle) or that they cannot do anything about them (write outside of the circle). They will underline sources of stress that are most intensive and disturbing. Each participant will have a clear illustration of sources of stress classified according to their intensity and possible control. (10 minutes)
3. In groups of 4-5 they will make a joint presentation of their sources of stress on the flip-charts with a big circle so that they will write each source of their stress either within or outside of the circle and indicate underline with a marker those that are most intensive. Each group will present their analysis of stressors to other participants with comments by the trainer connecting it with the theory and expected outcomes. (35 minutes)
4. After all the participants list their sources of stress, the following issues are discussed in a large group:
  - Are there some sources of stress that were classified inside or outside of the circle by different participants?
  - Are there some sources that could change their position inside or outside of the circle after the discussion? Under what conditions / prerequisites?
  - How can the participants use this analysis in their stress management?(20 min)

## **Identification and classification of professional stressors**



## **Self-care techniques in preventing professional stress and burnout** (60 minutes)

**Objective:**

To expand the scope of self-care techniques for prevention of job burnout and other mental health consequences of helpers

**Expected outcomes:**

1. Participants will expand the scope of stress mitigation through self-help techniques
2. Participants will be able to use positive thinking to relieve stress

**Materials:**

1. Flip chart with markers
2. Form “Positive thinking about my job”

**Methods:**

Two groups with 15 members.

1. The participants work in groups of 3-4 and share what they do when they feel very stressed because of work and write down these self-care behaviors. (10 min)
2. Each group presents self-care behaviors they have identified. The trainer (with the help of interpreter) classifies these behaviors into groups on a flip-chart (e.g. relaxation; seeking support and sharing; seeking isolation; physical activity; artistic or spiritual activities; destructive coping such as drinking alcohol). (20 min)
3. At the end, each participant comments what is the new technique he/she will use when stressed next time. (5 min)
4. Participants fill out the form “Positive thinking about your job”. The trainer will invite some of the participants to share with the group their answers and the group will comment how can they use this exercise for to mitigate own stress. (20 min)

### **Positive thinking about your job**

1. What you have you recently done well at work?
2. How did it make you feel?
3. Has someone noticed this? Have you mentioned this to someone?
4. Have you rewarded yourself? If yes, how did you reward yourself?
5. What is one positive aspect of your job?

## **MODULE 3 – LECTURES**

### **Lecture**

#### **Mental health, disorders and trauma related mental health**

##### **Mental health is defined as:**

- Level of psychological well-being
- Absence of mental illness
- State of someone who is "functioning at a satisfactory level of emotional and behavioral adjustment"
- Individual's ability to enjoy life
- Ability to create a balance between life activities and efforts to achieve psychological resilience

##### **World Health Organization - mental health includes:**

- „Subjective well-being, perceived self-efficacy, autonomy, competence, inter-generational dependence, and self-actualization of one's intellectual and emotional potential, among others"
- Well-being of an individual encompassed in the realization of their abilities, coping with normal stresses of life, productive work and contribution to their community
- Influence of cultural differences, subjective assessments, and competing professional theories

... the successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and providing the ability to adapt to change and cope with adversity.

##### **So, mental health is:**

- To feel well
- To have no illness
- To experience positive feelings
- To contribute to the community, and own sense of efficacy
- To feel connected with others
- To help and be helped by others
- To be able to do and accomplish matters
- To be able to cope with adversity

## What is mental illness?

- The term mental illness refers to all diagnosable mental disorders
- Mental disorders are health conditions characterized by alterations in thinking, mood, or behavior associated with distress or impaired functioning

## Positive health

Health as the ability to adapt and to self-manage, in the face of social, physical and emotional challenges'

The six main dimensions of health:



## Trauma happens everywhere

- No boundaries to trauma
- Cross-national & cross-cultural perspective
- Traumatic stress research should develop international collaboration

## Post Traumatic Stress Disorder (PTSD) DSM-5

Criterion A: stressor

Criterion B: intrusion symptoms

Criterion C: avoidance

Criterion D: negative alterations in cognitions and mood

Criterion E: alterations in arousal and reactivity

Criterion F: duration more than one month

Criterion G: functional significance



Criterion H: attribution

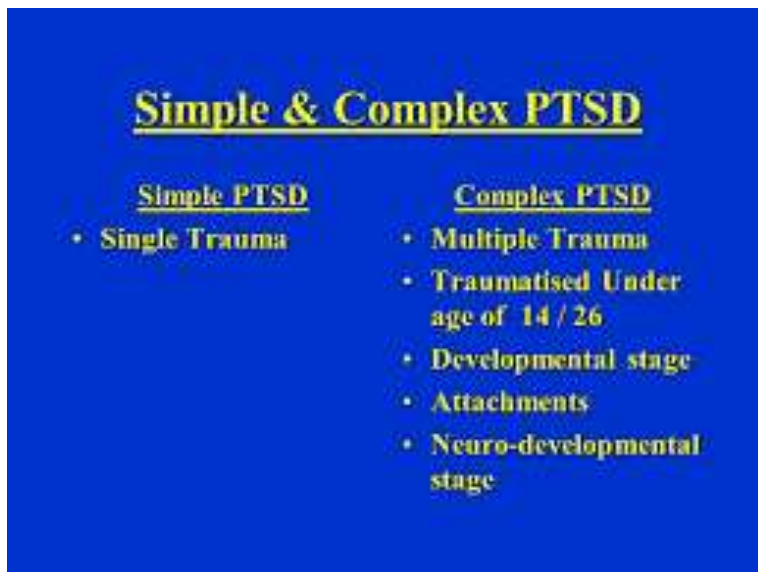
*Specify if:* With dissociative symptoms.

*Specify if:* With delayed expression.

Separate diagnostic criteria included for children ages 6 years or younger (preschool subtype)

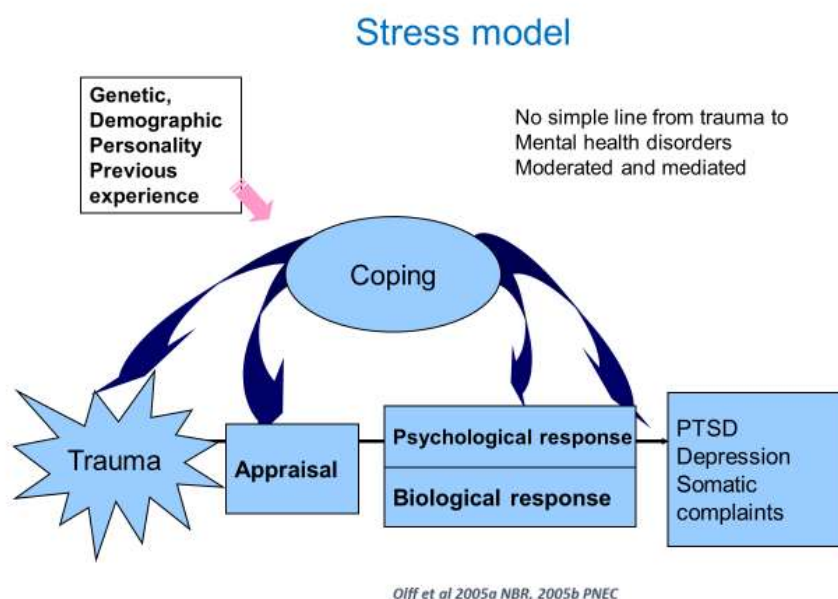
Info: <https://www.ptsd.va.gov/spanish/index.asp>

## Simple and complex PTSD



## Trauma & PTSD prevalence

Traumatic events: 80 %, PTSD 7-8%: women 10-12%, men 4-6%



## **Lecture**

### **Violence and trauma in post-conflict communities**

#### **Consequences of conflict that lead to increased violence:**

- Roles of family members (sometimes drastically) change
- Men returning from traumatic and violent context to the community
- Mothers have assumed the role of both parents
- Parents are less focused on their parental roles
- Lack of usual social support and unavailability of resources
- Increased poverty, unemployment, impoverished living conditions
- Dealing with loss and post-traumatic stress
- Providers in institutions are overwhelmed with providing support to the most vulnerable community members, and affected by the traumatic events at the same time;
- Lack of resources for community development;
- Families expecting fathers to assume the roles they had prior to the conflict.
- Post-traumatic stress, PTSD and a wide range of other mental health issues;
- Health risks related to conflict.

#### **Violence doesn't end with conflict.**

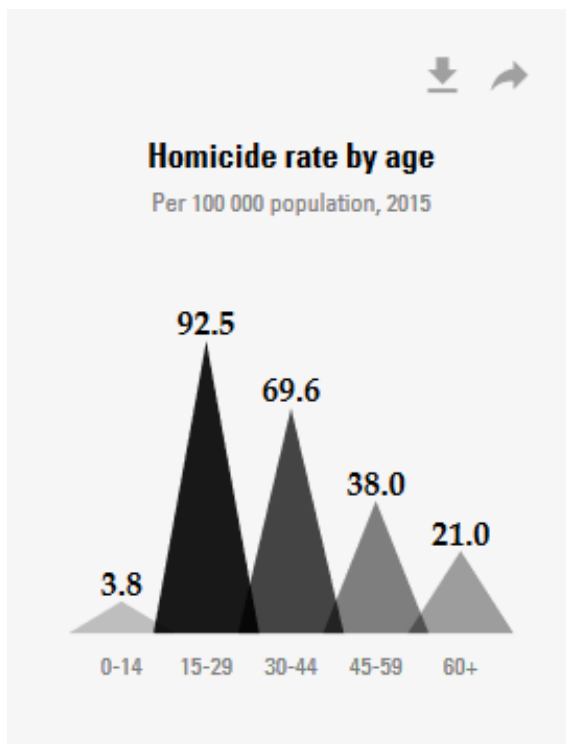
- Domestic, family and gender-based violence
- Intergenerational transmission of trauma
- Community violence, crime, drugs-related violence
- Institutional abuse and sexual violence

#### **Children and youth exposed to violence**

- In post-conflict context –more likely to be exposed to co-occurring violence (more than one type of violence)
- Adoption of violent conflict resolution practices
- Exposure to traumatic events within family, neighborhood, peers
- Anger, helplessness in the face of violence that their family members are exposed to
- Overlap between parent-to-youth aggression and community violence, an association that was exacerbated in families where fathers reported high levels of global distress symptoms

- Although originally viewed primarily as a risk factor for aggression, delinquency, and involvement with the criminal justice system, violence exposure is related to an array of problems:
  - depression, anxiety, post-traumatic stress disorder
  - compromised educational outcomes
  - social relations
  - health status
  - Youth's exposure to violence is linked not only to adjustment problems during childhood but also to later problems during adolescence and adulthood.
- Youth have higher exposure to violence and crime than adults.
- Picture: Colombia, homicide rate by age (WHO, 2015)

*Youth (age 15 to 29) are victims of homicide almost three times more frequent compared to adults over 45 years.*





### Community violence

- Exposure to intentional acts of interpersonal violence in public areas by individuals who are not intimately related to the victim
- Common types of community violence:
  - individual aggression (e.g. bullying, physical fights)
  - group conflicts (e.g. fights among gangs, shootings in public areas such as schools and communities)
  - criminal or terrorist attacks
- Increased rates of crime in the community → ghettoisation → increased poverty

### Institutional traumatization and abuse

- Institutions are overwhelmed with workload in a post-conflict context.
- Service providers have their own traumatic experiences.
- Exposed to secondary traumatization in their workplace.
- Lack of appropriate laws, clear professional standards and guidance in dealing with the conflict and post-conflict psychosocial needs of the community...
- ***Institutional abuse*** - mistreatment of children / adults due to inadequate care or systematic poor practice that affects the whole institution
  - Individual's best interests are sacrificed for the smooth running of a group, service or organization

- Abuse by individuals and groups who hold power over children (children homes, schools), adults (prisons), elderly (in retirement homes)

### **Epidemiological data on exposure to trauma**

- By early adulthood at 25% of the population will have experienced a traumatic event, and by age of 45, most of the population will have experienced such an event
- Significant part of the population will experience multiple traumatic events
- Majority of adults will experience traumatic event that involves intense fear, horror or helplessness at least once during their lives
- Men and women (and girls and boys) do not differ in prevalence of the subjective experience of trauma
- Prevalence rates of trauma exposure dramatically increase in the context of war, political violence or community violence

### **PTSD Prevalence**

- Overall only 10–20% people exposed to trauma develop the full PTSD
- Despite the high likelihood of trauma exposure (50–90%), the prevalence of lifetime PTSD are 8–12%
- Prevalence of current PTSD in civilian population 1-3 %, higher proportions in military
- Much larger proportions develop symptoms below criterion level for PTSD
- Exposure to violence is the type of traumatic event most likely to lead to PTSD
- Women and young adults are at greater risk for PTSD than men and older adults
- Youth and adults from locations with high rate of violence and impoverished areas are at greater risk for PTSD than others
- PTSD is more prevalent in poor or war-torn countries

### ***A tree of factors influencing ability to cope with traumatic experience***

experience of distress before the traumatization

personal and family history of traumatic events

physical health condition before the exposure

nature and intensity of the traumatic event

(perceived) social support

culture and traditions

gender

age

## TYPES OF TRAUMA AND STRESSORS

	TYPE I event (single)	TYPE II event (cumulated)
<b>Violent</b>	Rape/sexual abuse, Assaults Loss	Domestic violence Childhood abuse Hostage-taking Torture War
<b>Non-Violent</b>	Natural disasters Accidents Loss	Accidents following each other Series of natural disasters

### Types of traumatic events and prevalence of PTSD

PTSD after rape – 50%

PTSD after violent assault – 25%

PTSD in war victims – 20%

PTSD after car accident – 15%

### Complex conditions require complex care

PTSD:

Re-experiencing

Avoidance

Sense of threat

COMPLEX PTSD:

Re-experiencing

Avoidance

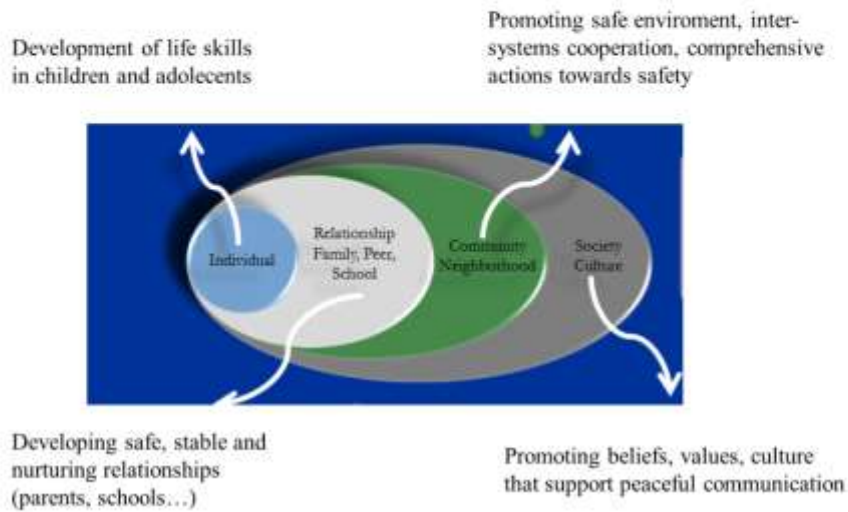
Sense of threat

Affect dysregulation

Negative self-concept

Interpersonal disturbances

## Socioecological model of community violence - solutions



### Phases of intervention

- **Phase one:** improving symptom management, self-soothing and addressing current life stressors to achieve safety and stability in the present (via psychoeducation, stabilization techniques and skills building)
- **Phase two:** trauma-focused work to process traumatic memories (via trauma focused therapies implying exposure);
- **Phase three:** re-establishing social and cultural bonds, and building on treatment gains to enable the client to develop greater personal and interpersonal functioning (via work on meaning making, etc.).

## Lecture

### Screening for trauma and mental health problems

#### Recognizing trauma and mental health needs when resources are very limited

- Terrorist attacks, natural disasters or displacement of many people increase demand for MH services way over the capacity of services
- MH care always starts with identification of people in need
- MH conditions are typically more difficult to identify – especially if internally experienced
- Fear of stigmatisation prevents people with MH needs to request help

#### Assessing mental health problems and needs

- Identification of people with MH needs and problems should be:
  - Systematic, part of health assessment
  - Managable and adaptable
  - Culture-informed
  - Non-stigmatizing

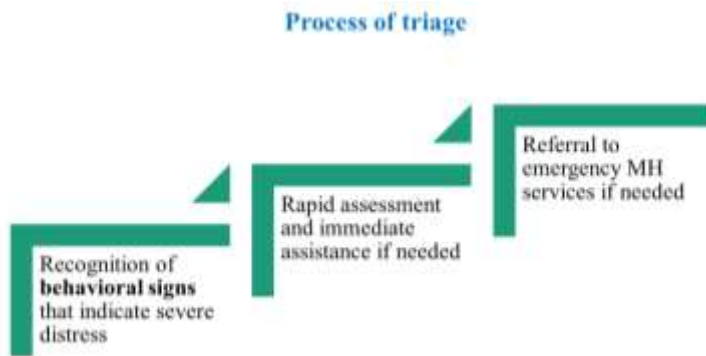
Stepped model of providing MH care when resources are very limited



#### Triage

- Identifying „psychological casualties”
- Prioritizing care for those who need immediate attention
- Identifying persons that are a risk to themselves or other people
- Purpose is not diagnostic





### ***1: Recognizing behavioral signs of severe distress***

- Look for signs of being disoriented or overwhelmed
- Directly approach people who show any of these signs and engage in interaction

#### **Signs of severe distress**

Physical & behavioral	Cognitive & emotional
<ul style="list-style-type: none"> <li>• Glassy-eyed, vacant gaze</li> <li>• Unresponsive to verbal questions or commands</li> <li>• Disorientation or disorganized behavior</li> <li>• Rocking or regressive behaviour</li> <li>• Hyperventilation</li> <li>• Uncontrollable physical reactions (shaking, trembling)</li> <li>• Frantic searching behaviour</li> <li>• Self-destructive or violent behaviour</li> </ul>	<ul style="list-style-type: none"> <li>• Strong emotional responses, uncontrollable crying</li> <li>• Feeling incapacitated by worry</li> <li>• Unable to care for themselves or their children</li> <li>• Unable to make simple decisions</li> <li>• Feeling anxious or fearful, overwhelmed by sadness, confused</li> <li>• Physically/verbally aggressive</li> <li>• Feeling shocked, numb</li> <li>• Guilt, shame</li> </ul>

### ***2. Rapid assessment and immediate assistance***

- Engage the person in visible distress in conversation
- Goals of conversation:
  - Rapid assessment of immediate risk
  - Calm and reassure the person, offer practical assistance

### Three questions for rapid assessment

Distress level	0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10
Personal safety or safety of other people endangered	No Yes
Resources (note up to 3 most important resources)	1. 2. 3.

### Starting the conversation

1. Introduce yourself
2. Ask the person if they need help
3. Provide safe, adequate place to talk
4. Address the signs that you noticed (e.g., „You seemed confused”)

Assessing the distress level - Pay close attention to non-verbal behaviour: tone of voice, body language and behaviour that may indicate high distress

### Assessing danger to safety

- Psychotic symptoms
- Severe affective disturbances
- Disorganized behavior
- Reporting threat of self-harm or harm to others
  - First ask about other aspects of distress
  - Frame questions in a non-stigmatizing way (e.g., „Some people with similar problems have told me that they feel life is not worth living.”)
  - Explore ambiguous responses with specific questions

### Assessing resources

- Aimed at increasing social support – reduce risk of chronic disorder
- Explore how the person perceives the sources of his/her resilience
- „What has helped you survive so far?”

### 3. Referral

- If immediate threat to personal safety or safety of others is probable, the person should immediately be escorted to a specialist
- If threat is improbable, but distress level is high, link the person to additional services

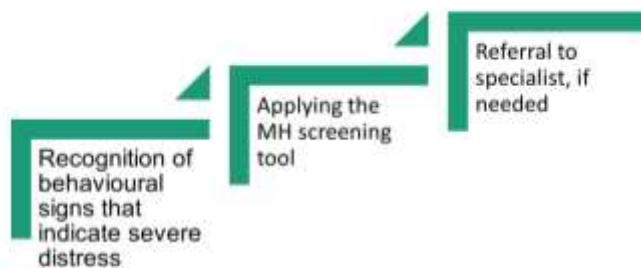
### Stepped model



### Screening

- Identifying individuals who are experiencing heightened distress and who are more likely to develop more serious MH issues.
  - Early identification promotes successful intervention and treatment
- Integrated into comprehensive health screening of persons affected by mass traumatic events, as well as IDPs in general.

### Process of screening



#### 1. Recognition of behavioral signs that indicate severe distress

- If signs of severe distress are visible, start with triage
- If no signs of severe distress, start with overall health screening, including MH

#### 2. Applying the MH screening tool

##### 1. Establish trust before apply MH screener:

- Use it at the end of a comprehensive health assessment
- Explain and normalize the reason for questions
- Emphasize confidentiality

##### 2. Patient typically fills in questionnaire him/herself, with clarifications

##### 3. Evaluate results and provide immediate feedback

### Refugee Health Screener (RHS-13)

1. Muscle, bone, joint pains
2. Feeling down most of the time
3. Too many thoughts
4. Helplessness
5. Scared for no reason
6. Faintness
7. Nervousness
8. Restlessness
9. Crying easily
10. Flashbacks
11. Hyperarousal
12. Emotional numbness
13. Exaggerated startle response

Scoring 0-4 for each item.

***Sum of > 10 points is a positive screen.***

Consider appropriate referral.

### Stepped model



### Referral

- If the screen is positive, refer to specialized MH services
- If the screen is below cut-off, provide information about psychoeducation and available services – if possible, provide written information.

## Lecture

# Neurobiology of psychological trauma

## Stress & memory: why do we remember trauma?

Stressor → stress hormones, neuropeptides & neurotransmitters (eg glucocorticoids/cortisol in humans)

(Evolutionary) useful for:

→ acute response in dangerous situations

→ long term adaptation (memory!)

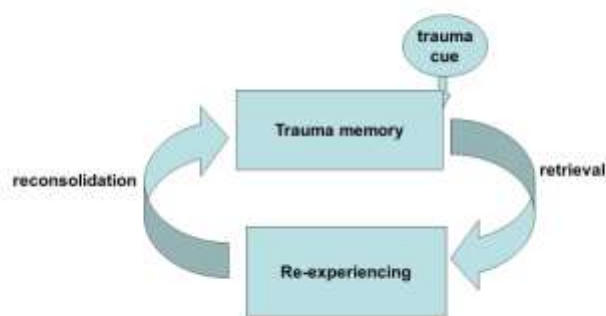
- Stressful experiences are better remembered (consolidated)
- With stress => worse retrieval

## Memory processes

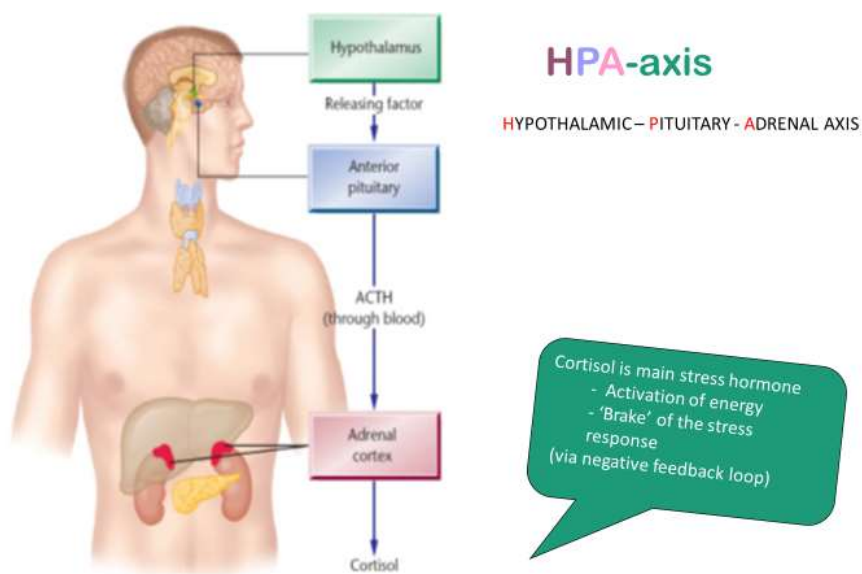
- Consolidation
  - Short term memory → stable long term memory
- Retrieval
  - Retrieval is the process of recollecting previously stored information.
- Extinction
  - Extinction is the process during which conditioned responses to a stimulus that was previously paired with an aversive event **diminish** if the stimulus is presented repeatedly without the aversive event
- Reconsolidation
  - Reconsolidation is the process during which memories that have been rendered labile after memory reactivation are stabilized anew.

Glucocorticoids important in all these processes

## Retrieval & reconsolidation of trauma memory



De Quervain & Margot, 2008



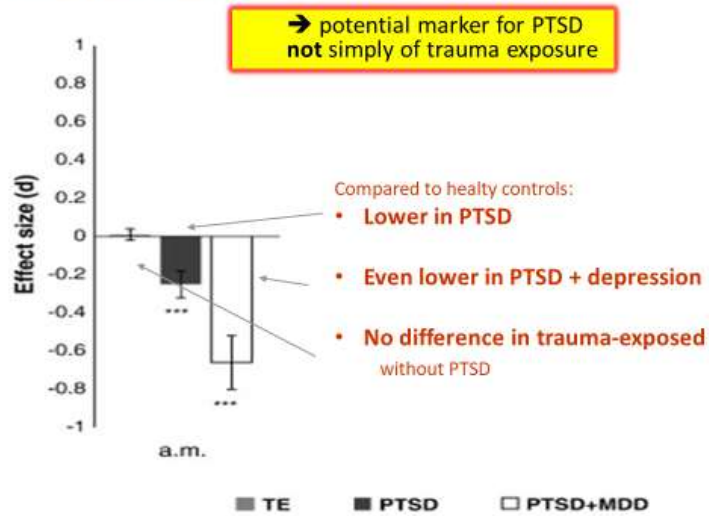
### **Hypothalamic – Pituitary - Adrenal axis**

- There is an enhanced negative feedback in the HPA axis
- There are low cortisol levels in PTSD sufferers
- Corticotrophin Releasing Factor increases locus ceruleus firing and noradrenalin release

### **Some consequences of this facts are:**

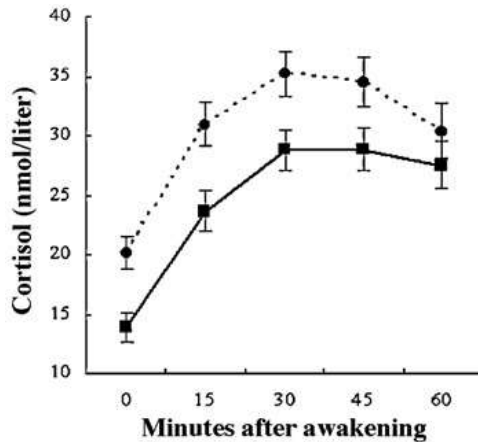
- Initial adrenergic surge may be associated with the consolidation of traumatic memories and
- Low endogenous cortisol levels may:
  - promote development and symptomatology of PTSD by a disinhibition of traumatic memory retrieval and
  - fail to contain the sympathetic stress response

## Meta-analysis morning cortisol



Morris et al., 2012

- Lower cortisol and DHEAS levels
- Consistent with findings in *chronic* sexual abuse



### Cortisol in hair

Can give a long term perspective of cortisol over time, even before trauma

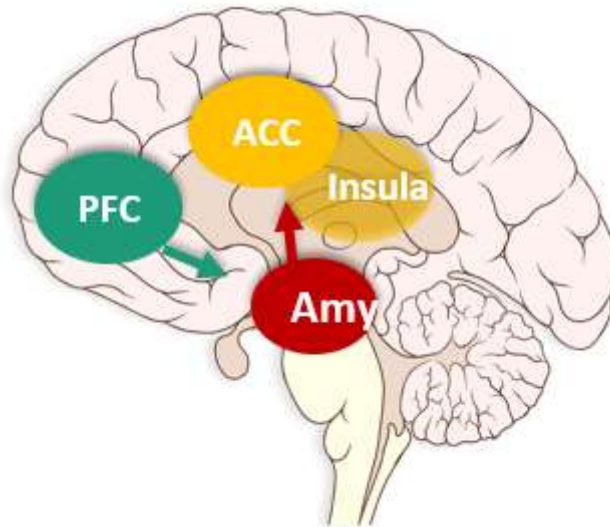
Per cm one month back in time

Very suitable for women!

### PTSD is characterized by:

- Amygdala hyperactivity
- Ventromedial prefrontal cortex (vmPFC) hypoactivity
- Less communication vmPFC – amygdala

- Less prefrontal cortex control over fear response
- May cause excessive fear response in PTSD



## Neurobiology of treatment of PTSD

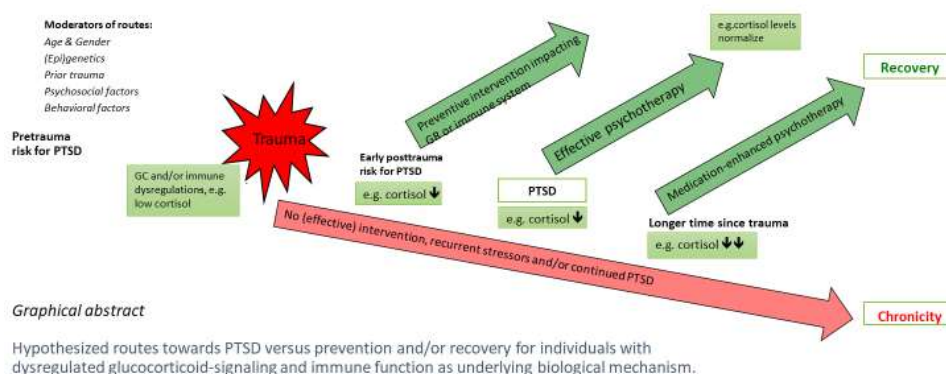
Successful exposure therapy can normalize the neurobiological abnormalities:

- Amygdala ↓
- Ventromedial PFC (vmPFC) ↑

## Neurobiological alterations over time

Without intervention it gets worse

→ Opportunities for interventions



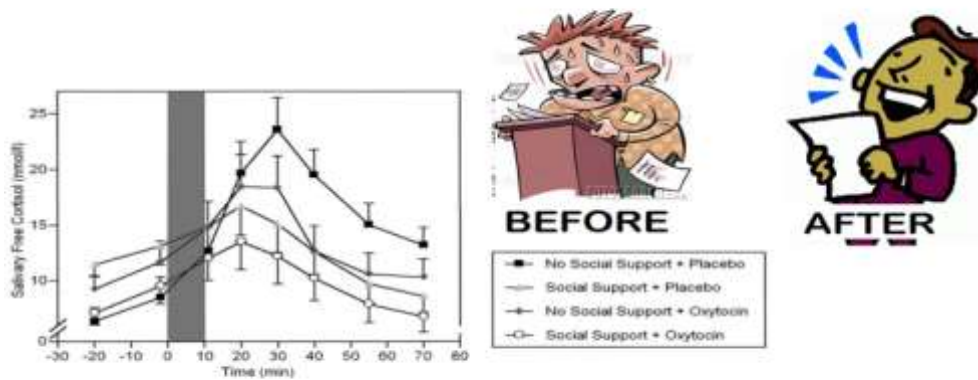
→ No firm evidence was found for the efficacy of all early pharmacotherapies in the prevention of PTSD or ASD, but **hydrocortisone** reduced the risk of developing PTSD.



**Social support** - Lack of support is most important predictor of PTSD!

→ oxytocin: the bonding hormone

## Oxytocin & Cortisol response to public speaking

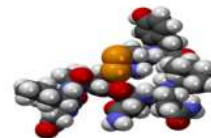


*Oxytocin seems to enhance the buffering effect of social support on stress response*

Heinrichs et al. (2003)



## PTSD (risk) & Oxytocin



PTSD (risk):	Oxytocin:
↑ Amygdala reactivity	↓ Amygdala reactivity
↓ Amygdala-prefrontal cortex (PFC) connectivity	↑ Amygdala-PFC connectivity
↓ Reward processing	↑ Reward processing
↑ HPA-axis sensitivity	↓ HPA-output
↓ Social functioning	↑ Social functioning

## Oxytocin

- Decreased PTSD symptoms up to 6 months after trauma in people with high PTSD symptoms only

## Lecture

### Trauma informed and trauma focused care

#### Trauma-informed care

Shifting the focus from “*What’s wrong with you?*” to “*What happened to you?*”

- Trauma Informed Care involves understanding, recognizing, and responding to the widespread impact of trauma (all types) and understand paths for recovery
- Recognize the signs and symptoms of trauma in patients, families, and staff
- Educate and train helpers in evidenced based trauma informed services
- Emphasize physical, psychological and emotional safety for both users and providers, and helps survivors rebuild a sense of control and empowerment
- Actively avoid re-traumatization
- A trauma-informed approach acknowledges that health care organizations and care teams need to have a complete picture of a patient’s/user’s life situation — past and present — in order to provide effective health care services with a healing orientation.
- Adopting trauma-informed practices can potentially improve patient / users engagement, treatment adherence, and health outcomes, as well as provider and staff wellness
- It can also help reduce avoidable care and excess costs for both the health care and social service sectors

#### The Four "R"s of Trauma-Informed Care

1. Realizing the prevalence of trauma
2. Recognizing how trauma affects individuals
3. Responding by putting this knowledge into practice
4. Resisting retraumatization

##### 1. Realizing the prevalence of trauma

- Many individuals experience trauma during their lifetime (about 80%)
- Although many people exposed to trauma demonstrate few or no lingering symptoms, individuals who experience repeated, chronic, or multiple traumas are more likely to have symptoms and experience negative consequences, including mental illness, substance use disorders, and physical health problems

##### 2. Recognizing how trauma affects individuals

- Trauma can significantly affect how an individual functions.

- Research shows that trauma disrupts the central nervous system and overwhelms a person's ability to cope
- It often results in feeling vulnerable, helpless, and afraid
- It interferes with relationships and fundamental beliefs about oneself, others, and one's place in the world

### 3. Responding by putting this knowledge into practice

- Trauma-informed care is a change of perspective:
  - It's not what's wrong with a person
  - It's what has happened to him to her
- This approach lessens the blame on people who have had adverse experiences in their lives and instead acknowledges it may not be their fault that they are acting badly
- It shows the person that there is an understanding that their past experiences may be affecting their present behavior
- This promotes healing

### 4. Resisting re-traumatization

- Trauma-informed care takes steps to minimize situations that could cause distress or mirror the person's traumatic experiences

Example: Nurse asks child to take off a shirt for a vaccination. Child screams and runs away. Later you find out the child has a history of physical and sexual abuse at home.

## Psychological treatments for PTSD

Trauma-focused psychotherapy: treatment of choice

1. **STAIR Narrative Therapy** (Cloitre)
2. **Cognitive Therapy for PTSD** (Ehlers)
3. **Narrative Exposure Therapy** (Elbert, Schauer, Neuner)
4. **Prolonged Exposure Therapy** (Foa)
5. **Brief Eclectic Psychotherapy for PTSD** (Gersons)
6. **Cognitive Processing Therapy** (Resick)
7. **EMDR Therapy** (Shapiro)

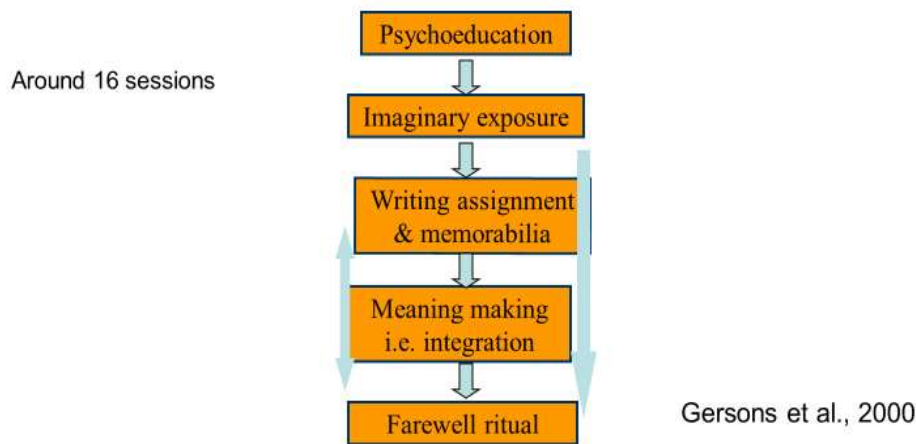


These elements they all have in common:

- Psychoeducation
- Emotion regulation & coping skills
- Imaginal exposure
- Cognitive processing, restructuring, and/or meaning making
- Emotions
- Memory processes

Schnyder et al., 2015, *EJPT*, [www.tandfonline.com/ejpt](http://www.tandfonline.com/ejpt)

## Brief Eclectic Psychotherapy for PTSD (BEPP)



### Stabilization or trauma-focused?

Experts do not agree about whether one should (always/immediately) offer trauma focused treatment

### Early Pharmacological Interventions

- Emerging Intervention
  - *Hydrocortisone*
- Insufficient Evidence
  - *Docosahexaenoic Acid, Escitalopram, Gabapentin, Oxytocin, Propranolol*

### Early Psychosocial Intervention

- Prevention
  - Emerging Evidence - *Group 512 PM, Single-session EMDR, Brief Dyadic Therapy, and Self-guided Internet Based Intervention*
- Early treatment
  - Standard Recommendation - *CBT-T, Cognitive Therapy, EMDR*
  - Low Effect - *Stepped/Collaborative Care*
  - Emerging Evidence – *Internet-based Guided Self-help, Structured Writing*

### Recommended treatments for adults

#### Pharmacological Treatment

- Low Effect - *Fluoxetine, Paroxetine, Sertraline, Venlafaxine*
- Emerging Evidence – *Quetiapine*

- Insufficient Evidence to Recommend – *Thirteen other medications*

### Psychological Treatment (Adults)

- Strong - *Cognitive Processing Therapy, Cognitive Therapy, EMDR, Individual CBT with a Trauma Focus (undifferentiated), Prolonged Exposure*
- Standard - *CBT without a Trauma Focus, Group CBT with a Trauma Focus, Guided Internet-based CBT with a Trauma Focus, Narrative Exposure Therapy, Present Centred Therapy*
- Emerging Evidence - *Couples CBT with a Trauma Focus, Group and Individual CBT with a Trauma Focus, Reconsolidation of Traumatic Memories, Single Session CBT, Written Exposure Therapy, Virtual Reality Therapy*
- Insufficient Evidence - *13 other interventions*

### Non-Psychological and Non-Pharmacological Treatment (Adults)

- Interventions with Emerging Evidence - *Acupuncture, Neurofeedback, Saikokeishikankyoto, Somatic Experiencing, Transcranial Magnetic Stimulation, Yoga*

### Improving interventions for PTSD

Psychotherapy 1st treatment of choice but 1/3 of patients respond poorly or not at all

➔ need for novel interventions

HITT

E-health

Medication Enhanced Psychotherapy (MEP)

### Improving treatment: High Intensive Trauma Therapy (HITT)

Very dense treatments in short period seem promising

#### Innovative e-health interventions



## **SUPPORT Coach**

Adapted (more generic) from PTSD Coach:

- Psycho education, Self assesment (PCL-5), Manage symptoms, Find support, Calender function

Based on Working Memory Theory: EMD app

- Instructs users to focus on a repetitive intrusive image and the associated cognition and emotion
- Instructs to repeatedly perform a task that engages working memory
- Allows for monitoring of the distress (SUD)
- Introduces and reinforces a more positive cognition

## **3MDR**

Multi-modular Motion-assisted Memory

Desensitization and Reconsolidation (3MDR)

## **Augmented reality**

## **Virtual Reality Applications for the Assessment and Treatment of PTSD**

### **SimCoach**

- Not conceived as replacement for clinical helper (providers and experts)
- Engaging the user by providing support and encouragement
- Increasing awareness of situation and treatment options
- Assisting individuals who may otherwise be uncomfortable talking to **a live helper**

### **Last but not least: Self care**

- Taking care of yourself, Taking care of your colleagues, Organisation support, after critical incidents.

## **Lecture**

### **Complex trauma in conflict affected populations, IDPs and combat veterans**

#### **What is complex?**

Beyond 'simple' trauma

- Repeated 'incidence' of violence
- Anticipation of violence
- Chronic duration of unsafety and threat of violence
- In particular at young age
- Significant change of social context (migration, IDP's)
- Realizing the toll of continuous stress is important, in particular in children, including infants
- Stress can be 'toxic'

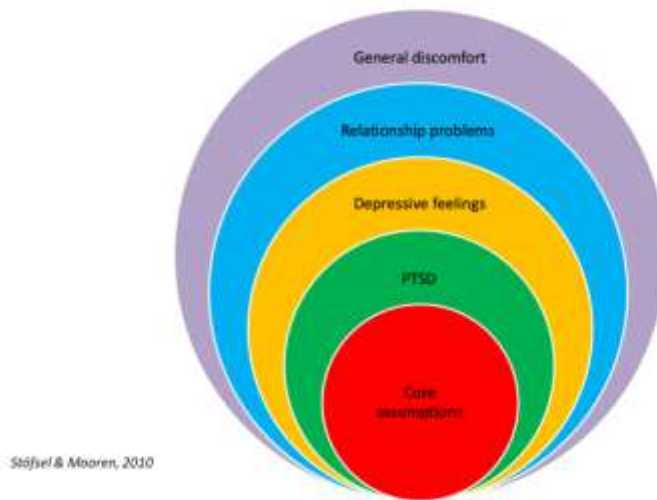
#### **Topics**

- Mental health
- Interpersonal relations
- Personality change
- Individual and
- Group long-term work (with combat veterans)

#### **Mental health and complex trauma**

- Not only a 'memory' problem: more diverse difficulties
- PTSD, next to various problems: anxiety, depression, physical complaints, addiction (alcohol, drugs)
- Thus considered PTSD+
- Problems with regulating emotions: easily in tears, upset, irritated and angry
- Social consequences, isolation, family relationship difficulties

## Model of Complex Trauma



### Interpersonal relationships

- Distrust
- Lack of hope
- Loss of self-efficacy (“Yes, I can”), self-esteem (“I’m at least good enough”), self-confidence (“I know what I want and what I can”)
- Difficulty dealing with emotions
- Decrease of empathy and solidarity (“I know how it feels, how can I help you?”)
- Alienation – larger distance between one person and the other, and the community
- Less use of social support

### Personality change

- What is personality? Personality refers to:
- Rather stable pattern of thinking, feeling and behaving across time, place and context
- Determined by both biology (genes) and environment (experiences)
- Also seen as one’s character: how a person is being described by others (“He is so kind”; “She is short-tempered”)
- „Big five” personality theory → 5 characteristic dimensions:
  1. neuroticism, 2. agreeableness, 3. extraversion, 5. conscientiousness.
- These are observed cross-culturally



- Trauma can cause change of personality
- Due to change of core beliefs related to:
  - Oneself, self-esteem
  - Other persons, trust
  - The world in general, including the future
- Experiences can change a person because painful lessons have been learned that caused different expectations from life
- But: there is life-long learning, new experiences can be beneficial

### **Assessment**

- Instruments for complex trauma are complicated
- Best way to assess is to use questions and screening instruments of general (mental) health, including interviews

### **Individual work with victims of complex trauma**

Several ingredients:

- Attitude: be unprejudiced, give respect, and ask questions (natural ‘curiosity’)
- Trauma: what happened? Have there been significant traumatic incidents and/or losses?
- Core-beliefs: Don’t fight assumptions, try negotiating how ‘true’ they really are – what is available evidence? Are there alternative ideas?;
  - Pizza or pie: what are the ideas and how large are the parts (in %)
  - Thinking of for example, your closest friend, what would he/she think is true?
  - What are advantages or disadvantages of thinking like this?
- Social support: find meaningful connections

### **Group long term work (e.g., with combat veterans)**

- Group work is beneficial because of:
  - Recognition (“We are in the same boat”) and acknowledgement (“I feel respected because you know”)
  - Learning from each other (“I could try that as well”)
  - Less need to tell traumatic experiences (“Don’t want to burden others”; “They will know”)
  - Focus on coping strategies (“How to deal with nightmares, flashbacks, problems at work or in the family”)
  - Social support

- Group work may not be sufficient because:
  - Avoidance: participants feel safe in the group, and create an unsafe outside world together
  - Avoidance: group members are loyal to each other, and no longer provide feedback, criticism and the need to make a change
  - Decrease of sense of responsibility may be the result

## **Lecture**

### **Ambiguous traumatic loss of a family member and complicated grief**

#### **Ambiguous loss in relatives of missing persons**

- Ambiguous loss: "Leaving without goodbye"
- People confronted with ambiguous loss of a loved one are at risk of elevated psychopathology levels
- Symptoms of:
  - Persistent Complex Bereavement Disorder (**PCBD**)/ Prolonged Grief Disorder (**PGD**)
  - Posttraumatic Stress Disorder (**PTSD**)
  - Major Depressive Disorder (**MDD**)

#### **Common symptoms in ambiguous loss**

- Longing and yearning
- Emotional pain
- Preoccupation with the disappeared person or the circumstances of the disappearance
- Confusion
- Inability to problem solve
- Searching behavior
- Sadness, despair, anger
- Physical and emotional exhaustion
- Sense of isolation or aloneness
- Shattered world view

#### **Similar consequences of Ambiguous Loss compared to Traumatic Loss**

- Traumatic loss: death of a loved one due to a violent cause
- Prevalence of PCBD (23%), PTSD (67%), and MDD (69%) among 73 family members of enforced disappeared persons in Colombia similar to prevalence in 222 people whose relative died due to a violent cause (Heeke, Stammel, & Knaevelsrud, 2015)
- Prevalence of PCBD, PTSD, and MDD among 75 family members of enforced disappeared persons in Chile similar to prevalence in 44 people whose loved one died due to violent cause (Pérez-Sales, Durán-Pérez, & Herzfeld, 2000)

### **Common stressors in relatives of missing persons**

- Family relational problems
  - Conflicts between family members who form different beliefs about what has happened
- Legal and financial problems
- Ongoing threat
- Media attention
- Absence of cultural and religious rituals (Hollander, 2016)
- Stigma: a negative and erroneous attitude about a person, which leads to negative action or discrimination (Corrigan & Penn, 2015)
  - Public stigma: stereotypes held by the public about individuals who utilize mental health services (Link, 1987; Skinner, Berry, Griffith, & Byers, 1995)
  - Self stigma: application of these stereotypes to oneself, leading to internalized devaluation and disempowerment (Corrigan, 2002)

### **Dynamics of hope**

- Holding on to hope that the loved one will return may be seen as a strategy to avoid emotions associated with the thought that the separation is permanent
- Holding on to hope is associated with elevated symptoms of PCBD, PTSD, MDD
- Pressure for closure (e.g., to give up searching) paradoxically leads to increased
- Pressure for closure may in the context of enforced disappearance serve politically repressive aims

### **Possible barriers to care in ambiguous loss**

- Lack of perceived need for treatment in relatives of missing persons despite high levels of distress
- Pessimism regarding the effectiveness of treatments
- Distrust in authorities and/ or public mental health care
- Unavailability of treatment
- Financial or transportation barriers
- Stigma

### **Removing barriers to care**

- **Simplify** the messages we use to convey mental health issues, labels contextually appropriate and widely understood
- **UNpack** interventions into components which are easier to deliver and incorporate culturally sensitive strategies

- **Delivered** in people's homes or the nearest primary healthcare center or community facility
- Recruit and train **Available** human resources from the local communities
- **Re-allocate** the scarce and expensive resource of mental health professionals to train, supervise and support community health agents

#### **No evidence based treatment but empirically supported interventions**

- Psycho-education & mobilizing social support
- Exposure
- Behavioral activation

#### **Psycho-education**

- Provide information and emotional support during
  - Contact with the law
  - Searching
  - Return and reconnection or confrontation with the remains (ICRC, 2013)
- Educate about common emotional reactions

#### **Mobilizing social support**

- Important person is invited in the session
- Discuss conflicts/ different coping styles between members of the family
- Externalize the cause to alleviate guilt
- Normalize emotional reactions

#### **Exposure (General)**

- Focused on tolerating the ambiguity surrounding the disappearance
- Aim: to enable the patient to realize that he can stand the painful ambiguity surrounding the disappearance and the feelings and thoughts associated with it
- The therapist asks about the disappeared person and the circumstances surrounding the disappearance
- Then the therapist encourages the patient to get to emotionally charged memories
- The patient is asked
  - To articulate what he misses most, now that his loved one is disappeared
  - To verbalize his thoughts and feelings on the ambiguity surrounding the disappearance
- May include writing assignments

### **Exposure (Imaginal)**

- When a patient avoids particular memories of specific events surrounding the disappearance
- Aim is reduction of emotional responsiveness, through habituation and cognitive change
- Ask the patient to tell the event, at first globally and preferably chronologically
- Ask the patient to close his eyes and focus on the most distressing moments surrounding the traumatic disappearance
- Encourage the patient to tell what he sees, hears, smells, feels, and thinks in the present tense
- Continue until recollections of the events surrounding the disappearance arouse less intense emotions and are no longer avoided

### **Behavioral Activation**

- Explore how the patient tries to find the missing loved one
- Patients may be reluctant to reduce searching behavior because of feelings of guilt or betrayal
- Assist in setting goals and priorities
- Explore what kind of activities the patient undertakes and to what extent these activities are satisfactory. What has changed since the disappearance?
- Important social, recreational, or work-related goals in the near future

### **Conclusion**

- Ambiguous loss in relatives of missing or disappeared persons may bring about mental health problems
- Symptoms of PCBD/PGD, PTSD and depression are common and may be associated with severe distress and functional impairments
- No evidence based treatments available
- Empirically based treatment interventions include psychoeducation, mobilizing social support, exposure, and behavioral activation
- Care providers need to refrain from exerting pressure to move on or achieve closure

## **Lecture**

### **Dealing with trauma and suicidality**

#### **Objectives of dealing with trauma: taking care of others**

- Offer social support, foster support systems
- Avoid intrusive help, keep attentive distance
- Psycho-education, about first responses and process of coping
- Monitoring of process
- Availability of care when needed.
- Most people recover after traumatic incidents. Social support is crucial. People choose their own, often unique, way of coping with trauma. Offering help is helpful, insisting on sharing emotions and stories NOT!

#### **Psycho-education**

- Emphasize: these are normal reactions to abnormal incidents ....
- Use of metaphors:
  - A closet with full drawers are difficult to close
  - A ball under water comes up automatically; needs effort to keep down
- Explaining that responses are normal reactions to abnormal circumstances may take away most risk on adverse mental health problems.
- Explaining about type of responses increases sense of control.
- Suicide occurs throughout the world, affecting individuals of all nations, cultures, religions, genders and classes.

#### **Steps**

1. Recognizing signals and suicidal thoughts of a person
2. Talking about suspicions of suicidality
3. Help, and evaluate
4. Dealing with suicide (-attempt) in the aftermath

#### **1. Signals of suicidality**

- Change in behavior:
  - Avoiding contact
  - Demonstrating reckless behavior
  - Depressed mood or sad

- Verbal signals:
  - “You won’t be bothered by me any longer”
  - “I don’t want it any longer”
  - ”I can better be dead”
- Certain events and circumstances:
  - Earlier suicide attempts
  - Recent loss, e.g., of job or relationship
  - Suicide of someone close
  - Psychological problems

### **Signals: 5 questions**

1. Thoughts of death?
2. Thoughts of suicide?
3. Concrete plan?
4. Today or tomorrow?
5. Situation unsafe?

### **2. Suicide & prevention: Talk about it!**

- Talking may be life-saving; it reduces mental stress, structures thoughts, and helps discovering solutions.
- Attitude: healthy curiosity
- Ask openly: What is going on?
- Mention signals

### **Myths**

- “Talking about suicide will give someone an idea”
- “Suicide occurs suddenly”
- “Talking about suicide will make a person feel even worse”
- “I should be ashamed of wanting to end my life”



## Do's & Dont's

- |   |  |
|---|--|
| <ul style="list-style-type: none"><li>• <b>Mention.</b> Use the word suicide. If you suspect another person thinks of suicide, mention it.</li><li>• <b>Ask further.</b> By asking further you will find out what a person means.</li><li>• <b>Take care of safety.</b> Help the person to create safety and talk about this.</li></ul> | <ul style="list-style-type: none"><li>• <b>Don't go along or agree.</b> Show understanding, but make clear suicide is not a solution.</li><li>• <b>Don't advise.</b> Things that may seem easy, maybe perceived as very difficult.</li><li>• <b>Don't judge.</b> It risks someone refuses to talk further.</li></ul> |
|---|--|

### Understanding suicidal process

- Overwhelming feelings related to vulnerability, powerlessness, helplessness, loneliness, fear and (internally oriented) anger;
- Suicide as an attempt to end problems.
- Mostly, pain is hidden underneath suicidal behavior

### What should family members do?

- Ask the question:
  - Do you sometimes think: for me it has been enough?
  - Do you sometimes think of committing suicide?
  - Do you sometimes think of ending your life?
  - Do you sometimes think: I don't want to live any longer?

### Listen, acknowledge

- When someone says he or she thinks of suicide, ask for feelings, thoughts, and plans. Listen, without judging.
- Examples
  - How bad must that be for you. How come you feel that way?
  - You must feel desperate. Is that right?
  - How often do you think of suicide?
  - Have you thought of how you will do that?

### **Seek help together, think of solution**

- When someone thinks of suicide, it is important this person gets right help.
- Don't think the person will seek help or it will pass automatically.
- Suggest to find support and help together.

### **3. Dealing with suicidality: Preventive interventions**

- Safety plan
- Acknowledgement
- Non-suicidal contract
- Monitoring, keep contact
- Enlarge and involve social support network

#### **Safety plan**

Create a plan on paper to describe safety measures:

1. Warning signals: Things I notice why I'm not okay ....
2. Solving capacities: Things I can do to distract me ....
3. People and/or situations that help me to distract me ....
4. People I can ask for help:
5. Name / place / phone number
6. Things I can do to make my situation safe ...

#### **Non-suicidal contract**

Agreement on paper, signed:

- Not to end one's life;
- Get in touch whenever someone is feeling in distress (provide phone number, names contact persons).

#### **Monitoring, increase social support**

- Make agreements about future contact;
- Connect with other, close, persons

### **4. In the aftermath of suicide**

- Offer opportunity to share emotions and sorrow
- Take suicide (attempt) very seriously
- Discuss impact of suicide (attempt)

- Give perspective on future contact, if needed

### **Self-care, more self-care ...**

- It can require much emotionally from family members or friends when you know someone close is thinking of suicide.

### **Take care by:**

- Talk to own friends
- Don't promise to keep the story secret
- Take care of relaxation and distraction
- Build-in your own, daily check

### **Suicide & prevention: Public health actions**

- Flyer
- Hot, or chatline
- App
- Cards, to be used in case of emergency, with phonenumbers
- Directions for media
- Applications for schoolchildren and students with suicidal thoughts
- Signal mapping tool for education
- ... for other professionals, such as general practitioners.

## **Do's**

### **Mention:**

- "You are saying you don't want to live any longer, are you saying that you think of suicide?"
- "If I understand correctly, you think of suicide, is that right?"

## **Don'ts**

### **Act right away:**

- "mmm, let's think how to take away your negative thoughts"

### **Panic:**

- "Stay right here, I'll NOW call crisis service"
- "Gee, how awful, this is truly too bad?"

## Do's

### Concretise:

- "You are saying: I won't be here later on – what do you mean with later?"
- "You are saying it is all miserable for you. What exactly is so miserable for you?"

## Don'ts

### Agree:

- "Well, I get it whay you don't want to live any longer...."
- "Well, if I were in your shoes, I would give up as well...."

### Judge:

- "How selfish!, think of your children."

## MODULE 3 - WORKSHOPS

### Module 3, Workshop 1

#### **Trauma around us: Learning from experience of trauma and losses**

(75 minutes)

##### Objective:

To increase awareness of people's reactions to traumatic experiences and losses (cognitive, emotional, behavioral, relational), coping strategies and their resilience.

##### Expected outcomes:

1. Participant will connect the content of the training with personal and other people's experiences of surviving trauma and loss.
2. Participants will become aware of own and other people's resilience and strength in coping with trauma and loss.

##### Materials:

1. Template with a table below for each participant
2. Flipchart with the table with 6 column headings and 4-5 rows
3. Markers

Event related to trauma and loss	Emotions	Thoughts	Behaviors	What helped to overcome (coping)	What changed as a result of coping

##### Methods:

Work in small groups of 3 participants, reflect on own experiences, share in a small group, and present to the whole group, summarize commonalities in reactions to trauma and loss.

1. Trainer explains that this exercise will help the participants connect the emotions, thoughts and behaviors they and other people have when a traumatic event happens or people suffer a material, symbolic or person loss. But that it will also show how people cope in such situations and what the outcomes of coping can be.

This may be personally emotional exercise so if someone feels that this is too demanding or intimate, they should think of the case of someone they know well.

Each participant receives the template with a table.

Participants are asked to remember an event that was traumatic or included a material, symbolic or person loss for them, and then write in the table the feelings, thoughts and behaviors at that time. They should also write what helped them overcome the situation (coping) and what changed as a result of such coping.

(10 min)

2. Participants share and compare their experiences and insights in trios, with focus on coping and outcomes. If these outcomes are positive, this is a demonstration of resilience.

(25 min)

3. The trainer asks several volunteers to present the contents of their individual table and share it with the whole group. The interpreter (trainer) writes this in the table on the flipchart.

(25 min)

4. The trainer uses the contents of the table to emphasize similarities in reactions to experiences of trauma and loss, how people cope, and that trauma and loss trigger manifestations of resilience.

(10 min)

### **Trauma around us: Learning from experience of trauma and losses**

Event related to trauma and loss	Emotions	Thoughts	Behaviors	What helped to overcome (coping)	What changed as a result of coping

## **Exercise screening for trauma and referral**

(75 minutes)

### **Objective:**

To present different screening instruments for trauma exposure, posttraumatic stress reactions, and other mental health problems

### **Expected outcomes:**

3. Participant will understand the use of screeners and will be able to decide which may be most appropriate for their professional situation.
4. Participants will be able to administer a screener.

### **Materials:**

Screening instruments one of each participant

- RHS-15
- ACE
- PHQ 9
- THQ
- GPS

Two scenarios for role play: 1) Describing exposure to traumatic experiences and 2) describing posttraumatic and other health symptoms a person has.

### **Methods:**

Work in one group. Presentation of screeners for trauma exposure and posttraumatic stress reactions, other mental health screeners available in Spanish.

Trainers will present 5 screeners and explain how they are used.

(30 min)

The participants will work in pairs. First one of the members of the pair will administer a screener for exposure to traumatic events to the other person in the pair. This person will have the role of a user/client and will respond based on the scenario for traumatic exposure.

(10 min)

Members of the pairs will switch roles and will use the second scenario.

(10 min)

Discussion summarizing experiences in the large audience and questions.

(25 min)



## REFUGEE HEALTH SCREENER-15 (RHS-15)

# Pathways to Wellness

## Integrating Refugee Health and Well-being

*Creating pathways for refugee survivors to heal*



**ENGLISH VERSION**

### DEMOGRAPHIC INFORMATION

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADMINISTERED BY: \_\_\_\_\_ DATE OF SCREEN: \_\_\_\_\_

DATE OF ARRIVAL: \_\_\_\_\_ GENDER: \_\_\_\_\_ HEALTH ID #: \_\_\_\_\_

**Developed by the *Pathways to Wellness* project and generously supported by the Robert Wood Johnson Foundation, The Bill and Melinda Gates Foundation, United Way of King County, The Medina Foundation, Seattle Foundation, and the Boeing Employees Community Fund.**

*Pathways to Wellness: Integrating Community Health and Well-being* is a project of Lutheran Community Services Northwest, Asian Counseling and Referral Services, Public Health Seattle & King County, and Dr. Michael Hollifield. For more information, please contact Beth Farmer at 206-816-3252 or [bfarmer@lcsnw.org](mailto:bfarmer@lcsnw.org).

## REFUGEE HEALTH SCREENER (RHS-15)

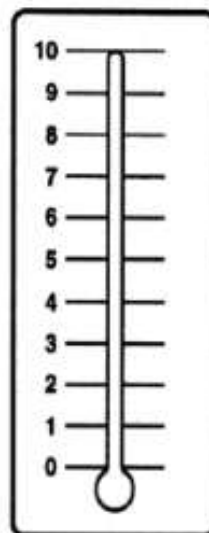
14. Generally over your life, do you feel that you are:

- Able to handle (cope with) anything that comes your way .....0  
 Able to handle (cope with) most things that come your way .....1  
 Able to handle (cope with) some things, but not able to cope with other things.....2  
 Unable to cope with most things.....3  
 Unable to cope with anything .....4

15.

### Distress Thermometer

**FIRST:** Please circle the number (0-10) that best describes how much distress you have been experiencing in the past week including today.



Extreme distress

"I feel as bad as I ever have"



"Things are good"

No distress

ADD TOTAL SCORE OF ITEMS 1-14: \_\_\_\_

#### SCORING

Screening is **POSITIVE**

1. If Items 1-14 is  $\geq 12$  OR
2. Distress Thermometer is  $\geq 5$

Self administered: \_\_\_\_

Not self administered: \_\_\_\_

**CIRCLE ONE:**

**SCREEN NEGATIVE**

**SCREEN POSITIVE  
REFER FOR SERVICES**

## PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name \_\_\_\_\_ Age \_\_\_\_\_ Sex: ☐ Female ☐ Male Today's Date \_\_\_\_\_

1. During the <b>last 4 weeks</b> , how much have you been bothered by any of the following problems?	Not bothered	Bothered a little	Bothered a lot
a. Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Pain in your arms, legs, or joints (knees, hips, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Menstrual cramps or other problems with your periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Pain or problems during sexual intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Feeling your heart pound or race	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Constipation, loose bowels, or diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Nausea, gas, or indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Over the <b>last 2 weeks</b> , how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
a. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.

Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).

Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).



<b>3. Questions about anxiety.</b>			
a. In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>	
<b>If you checked "NO", go to question #5.</b>			
b. Has this ever happened before?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Do these attacks bother you a lot or are you worried about having another attack?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>4. Think about your last bad anxiety attack.</b>			
	<b>NO</b>	<b>YES</b>	
a. Were you short of breath?	<input type="checkbox"/>	<input type="checkbox"/>	
b. Did your heart race, pound, or skip?	<input type="checkbox"/>	<input type="checkbox"/>	
c. Did you have chest pain or pressure?	<input type="checkbox"/>	<input type="checkbox"/>	
d. Did you sweat?	<input type="checkbox"/>	<input type="checkbox"/>	
e. Did you feel as if you were choking?	<input type="checkbox"/>	<input type="checkbox"/>	
f. Did you have hot flashes or chills?	<input type="checkbox"/>	<input type="checkbox"/>	
g. Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>	
h. Did you feel dizzy, unsteady, or faint?	<input type="checkbox"/>	<input type="checkbox"/>	
i. Did you have tingling or numbness in parts of your body?...	<input type="checkbox"/>	<input type="checkbox"/>	
j. Did you tremble or shake?	<input type="checkbox"/>	<input type="checkbox"/>	
k. Were you afraid you were dying?	<input type="checkbox"/>	<input type="checkbox"/>	
<b>5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?</b>			
	<b>Not at all</b>	<b>Several days</b>	<b>More than half the days</b>
a. Feeling nervous, anxious, on edge, or worrying a lot about different things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>If you checked "Not at all", go to question #6.</b>			
b. Feeling restless so that it is hard to sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Getting tired very easily.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Muscle tension, aches, or soreness.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Trouble falling asleep or staying asleep.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Trouble concentrating on things, such as reading a book or watching TV.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Becoming easily annoyed or irritable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING: Pan Syn if all of #3a-d are "YES" and four or more of #4a-k are "YES". Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

<b>6. Questions about eating.</b>			
a.	Do you often feel that you can't control <u>what</u> or <u>how much</u> you eat?	<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
b.	Do you often eat, <u>within any 2-hour period</u> , what most people would regard as an unusually <u>large</u> amount of food?	<input type="checkbox"/>	<input type="checkbox"/>
<b>If you checked "NO" to either #a or #b, go to question #9.</b>			
c.	Has this been as often, on average, as twice a week for the last 3 months?	<input type="checkbox"/>	<input type="checkbox"/>
<b>7. In the last 3 months have you <u>often</u> done any of the following in order to avoid gaining weight?</b>			
a.	Made yourself vomit?	<input type="checkbox"/>	<input type="checkbox"/>
b.	Took more than twice the recommended dose of laxatives?	<input type="checkbox"/>	<input type="checkbox"/>
c.	Fasted — not eaten anything at all for at least 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>
d.	Exercised for more than an hour specifically to avoid gaining weight after binge eating?	<input type="checkbox"/>	<input type="checkbox"/>
<b>8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?</b>		<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>9. Do you ever drink alcohol (including beer or wine)?</b>		<b>NO</b> <input type="checkbox"/>	<b>YES</b> <input type="checkbox"/>
<b>If you checked "NO" go to question #11.</b>			
<b>10. Have any of the following happened to you <u>more than once in the last 6 months</u>?</b>		<b>NO</b>	<b>YES</b>
a.	You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	<input type="checkbox"/>	<input type="checkbox"/>
b.	You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	<input type="checkbox"/>	<input type="checkbox"/>
c.	You missed or were late for work, school, or other activities because you were drinking or hung over.	<input type="checkbox"/>	<input type="checkbox"/>
d.	You had a problem getting along with other people while you were drinking.	<input type="checkbox"/>	<input type="checkbox"/>
e.	You drove a car after having several drinks or after drinking too much.	<input type="checkbox"/>	<input type="checkbox"/>
<b>11. If you checked off <u>any</u> problems on this questionnaire, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?</b>			
<b>Not difficult at all</b>	<b>Somewhat difficult</b>	<b>Very difficult</b>	<b>Extremely difficult</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.  
Alc Abu if any of #10a-e is 'YES'.

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

## TRAUMA HISTORY QUESTIONNAIRE

The following is a series of questions about serious or traumatic life events. These types of events actually occur with some regularity, although we would like to believe they are rare, and they affect how people feel about, react to, and/or think about things subsequently. Knowing about the occurrence of such events, and reactions to them, will help us to develop programs for prevention, education, and other services. The questionnaire is divided into questions covering crime experiences, general disaster and trauma questions, and questions about physical and sexual experiences.

For each event, please indicate (circle) whether it happened and, if it did, the number of times and your approximate age when it happened (give your best guess if you are not sure). Also note the nature of your relationship to the person involved and the specific nature of the event, if appropriate.

<b>Crime-Related Events</b>		<b>Circle one</b>		<i>If you circled yes, please indicate</i>	
				Number of times	Approximate age(s)
1	Has anyone ever tried to take something directly from you by using force or the threat of force, such as a stick-up or mugging?	No	Yes		
2	Has anyone ever attempted to rob you or actually robbed you (i.e., stolen your personal belongings)?	No	Yes		
3	Has anyone ever attempted to or succeeded in breaking into your home when you were <u>not</u> there?	No	Yes		
4	Has anyone ever attempted to or succeed in breaking into your home while you <u>were</u> there?	No	Yes		
<b>General Disaster and Trauma</b>		<b>Circle one</b>		<i>If you circled yes, please indicate</i>	
				Number of times	Approximate age(s)
5	Have you ever had a serious accident at work, in a car, or somewhere else? ( <b>If yes</b> , please specify below) _____	No	Yes		
6	Have you ever experienced a natural disaster such as a tornado, hurricane, flood or major earthquake, etc., where you felt you or your loved ones were in danger of death or injury? ( <b>If yes</b> , please specify below) _____	No	Yes		

7	Have you ever experienced a “man-made” disaster such as a train crash, building collapse, bank robbery, fire, etc., where you felt you or your loved ones were in danger of death or injury? ( <b>If yes</b> , please specify below) _____	No	Yes		
8	Have you ever been exposed to dangerous chemicals or radioactivity that might threaten your health?	No	Yes		
9	Have you ever been in any other situation in which you were seriously injured? ( <b>If yes</b> , please specify below) _____	No	Yes		
10	Have you ever been in any other situation in which you feared you <u>might</u> be killed or seriously injured? ( <b>If yes</b> , please specify below) _____	No	Yes		
11	Have you ever seen someone seriously injured or killed? ( <b>If yes</b> , please specify who below) _____	No	Yes		
12	Have you ever seen dead bodies (other than at a funeral) or had to handle dead bodies for any reason? ( <b>If yes</b> , please specify below) _____	No	Yes		
13	Have you ever had a close friend or family member murdered, or killed by a drunk driver? ( <b>If yes</b> , please specify relationship [e.g., mother, grandson, etc.] below) _____	No	Yes		
14	Have you ever had a spouse, romantic partner, or child die? ( <b>If yes</b> , please specify relationship below) _____	No	Yes		
15	Have you ever had a serious or life-threatening illness? ( <b>If yes</b> , please specify below) _____	No	Yes		
16	Have you ever received news of a serious injury, life-threatening illness, or unexpected death of someone close to you? ( <b>If yes</b> , please indicate below) _____	No	Yes		
17	Have you ever had to engage in combat while in military service in an official or unofficial war zone? ( <b>If yes</b> , please indicate where below) _____	No	Yes		

<b>Physical and Sexual Experiences</b>		<b>Circle one</b>		<b>If you circled yes, please indicate</b>	
				<b>Repeated?</b>	<b>Approximate age(s) and frequency</b>
18	Has anyone ever made you have intercourse or oral or anal sex against your will? ( <b>If yes</b> , please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below)	No	Yes		
19	Has anyone ever touched private parts of your body, or made you touch theirs, under force or threat? ( <b>If yes</b> , please indicate nature of relationship with person [e.g., stranger, friend, relative, parent, sibling] below) _____	No	Yes		
20	Other than incidents mentioned in Questions 18 and 19, have there been any other situations in which another person tried to force you to have an unwanted sexual contact?	No	Yes		
21	Has anyone, including family members or friends, ever attacked you with a gun, knife, or some other weapon?	No	Yes		
22	Has anyone, including family members or friends, ever attacked you <u>without</u> a weapon and seriously injured you?	No	Yes		
23	Has anyone in your family ever beaten, spanked, or pushed you hard enough to cause injury?	No	Yes		
24	Have you experienced any other extraordinarily stressful situation or event that is not covered above? ( <b>If yes</b> , please specify below) _____	No	Yes		

**Citation:**

Hooper, L. M., Stockton, P., Krupnick, J., & Green, B. L. (2011). The development, use, and psychometric properties of the Trauma History Questionnaire. *Journal of Loss and Trauma*, 16, 258-283.



## Adverse Childhood Experience (ACE) Questionnaire

### Finding your ACE Score

**While you were growing up, during your first 18 years of life:**

1. Did a parent or other adult in the household **often** ...

Swear at you, insult you, put you down, or humiliate you?

**or**

Act in a way that made you afraid that you might be physically hurt?

Yes    No

If yes enter 1 \_\_\_\_\_

2. Did a parent or other adult in the household **often** ...

Push, grab, slap, or throw something at you?

**or**

**Ever** hit you so hard that you had marks or were injured?

Yes    No

If yes enter 1 \_\_\_\_\_

3. Did an adult or person at least 5 years older than you **ever**...

Touch or fondle you or have you touch their body in a sexual way?

**or**

Try to or actually have oral, anal, or vaginal sex with you?

Yes    No

If yes enter 1 \_\_\_\_\_

4. Did you **often** feel that ...

No one in your family loved you or thought you were important or special?

**or**

Your family didn't look out for each other, feel close to each other, or support each other?

Yes    No

If yes enter 1 \_\_\_\_\_

5. Did you **often** feel that ...

You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

**or**

Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

Yes    No

If yes enter 1 \_\_\_\_\_

6. Were your parents **ever** separated or divorced?

Yes    No

If yes enter 1 \_\_\_\_\_

7. Was your mother or stepmother:

**Often** pushed, grabbed, slapped, or had something thrown at her?

**or**

**Sometimes or often** kicked, bitten, hit with a fist, or hit with something hard?

**or**

**Ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?

Yes    No

If yes enter 1 \_\_\_\_\_

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

Yes    No

If yes enter 1 \_\_\_\_\_

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

Yes    No

If yes enter 1 \_\_\_\_\_

10. Did a household member go to prison?

Yes    No

If yes enter 1 \_\_\_\_\_

**Now add up your "Yes" answers: \_\_\_\_\_ This is your ACE Score**

## Module 3, Working material 2.5.

Global Psychotrauma Screen (GPS)		Participant Identification Number	
Gender		<input type="checkbox"/> Female	<input type="checkbox"/> Male
Age (years)		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
<b>Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic.</b> <b>In the past month, have you....</b>			
1.	had nightmares about the past traumatic life event(s) you have experienced or thought about the event(s) when you did not want to?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
2.	tried hard not to think about past traumatic life event(s) or went out of your way to avoid situations that reminded you of the event(s)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
3.	been constantly on guard, watchful, or easily startled?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
4.	felt numb or detached from people, activities, or your surroundings?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
5.	felt guilty or unable to stop blaming yourself or others for past traumatic life event(s) or any problems the event(s) caused?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
6.	tended to feel worthless?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
7.	experienced angry outbursts that you could not control?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
8.	been feeling nervous, anxious, or on edge?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
9.	been unable to stop or control worrying?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
10.	been feeling down, depressed, or hopeless?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
11.	been experiencing little interest or pleasure in doing things?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
12.	had any problems falling or staying asleep?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
13.	tried to intentionally hurt yourself?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
14.	perceived or experienced the world or other people differently, so that things seem dreamlike, strange or unreal?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
15.	felt detached or separated from your body (for example, feeling like you are looking down on yourself from above, or like you are an outside observer of your own body)?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
16.	had any other physical, emotional or social problems that bothered you?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
17.	experienced other stressful events? (such as financial problems, changing jobs, moving to another house, relational crisis in work or private life)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
18.	tried to reduce tensions by using alcohol, tobacco, drugs or medication?	<input type="checkbox"/> No	<input type="checkbox"/> Yes
19.	missed supportive people near you that you could readily count on for help in times of difficulty? (such as emotional support, watch over children or pets, give rides to hospital or store, help when you are sick?)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
20.	During <b><u>your childhood</u></b> (0-18 years), did you experience any traumatic life events? (e.g., a serious accident or fire, physical or sexual assault or abuse, a disaster, seeing someone be killed or seriously injured, or having a loved one die)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
21.	Have you <b><u>ever</u></b> received a psychiatric diagnosis or have you ever been treated for psychological problems? (for instance depression, anxiety or a personality disorder?)	<input type="checkbox"/> No	<input type="checkbox"/> Yes
22.	Do you <b><u>generally</u></b> consider yourself to be a resilient person?	<input type="checkbox"/> No	<input type="checkbox"/> Yes

**Scoring instructions**

- For items 1 through 22: No=0; Yes=1.
- A total score for psychotrauma related symptoms can be derived by summing up the items 1 through 16 and 18 (possible scores range from 0 to 17).
- Items 1 through 5 may be summed up to derive a total PC-PTSD-5 score (possible scores range from 0 to 5). A score of 3 or higher indicates possible PTSD.

## **INTERVENTIONS FOR TRAUMA CASES BY MENTAL HEALTH NON-PROFESSIONALS**

(75 minutes)

### **Objective:**

Experience of application of stabilizing interventions with traumatized individuals.

### **Expected outcomes:**

1. Participants will be able to choose appropriate stabilizing interventions for each case.
2. Participants will implement some of the interventions and reflect on their experience.

### **Methods:**

Work in two groups. Analysis of cases and selecting appropriate interventions, work in triads, trying out interventions; feedback and discussion

1. Analyzing the cases and description of appropriate interventions under the guidance of the trainer. The interpreter reads the three cases one by one and the participants follow in their text. The trainer discusses with the group which of the interventions would be appropriate.

(30 min)

2. Implementing interventions in triads: The participants work in triads, where one member role plays the person/user, one the helper who provides one appropriate intervention, the third member is an observer.

(20 min)

3. Feedback and discussion: The persons/users are asked if the intervention was appropriate, would they do something differently. They describe how it was to follow the instructions and exercise the technique. The “helper” shares own experience from own perspective, the observer comments on the process and what skills the “helper” used in interaction with the person/user apart from the stabilization interventions (i.e. skills of the helping dialogue)

(25 min)

## **INTERVENTIONS FOR TRAUMA CASES BY MENTAL HEALTH NON-PROFESSIONALS**

(60 minutes)

### Case descriptions

A woman, 32 years, has been a victim of sexual abuse by her father for many years. Now, she is living by herself, having occasional contact with her family. The abuse has stopped. She is having trouble finding employment and comes to the center for social welfare for support. When she starts talking about herself, one of the first things that she says is that she thinks her father had abused her, and that she has never told this to anybody, and starts to get very upset, sobbing, crying and shaking, remembering what had happened to her and how her mother knew about the abuse and didn't do anything about it. What intervention would you use?

A woman, 32 years, has been a victim of sexual abuse by her father for many years. Now, she is living by herself, having occasional contact with her family. The abuse has stopped. She is having trouble with her reproductive health and comes to the doctor for advice. When the gynecologist suggests that she lies down in order to be able to do the exam, she cries and says that she feels very uncomfortable. She describes feeling a huge amount of stress and tension when she goes for this kind of an exam or before having sexual relations. Both are very painful for her. She thinks this is a direct consequence of her being abused by her father. What intervention would you use?

A woman, 32 years, has been a victim of sexual abuse by her father for many years. Now, she is living by herself, having occasional contact with her family. The abuse has stopped. She is having trouble finding employment and comes to the center for social welfare for support. When she starts talking about herself, one of the first things that she says is that she thinks her father had abused her. In the middle of the story, she stops talking about what happened, and says she feels stuck, doesn't know how to tell her story, like her brain is suddenly in a fog, she can't remember what she wanted to say or even what happened. What intervention would you use?

## **Trauma interventions - examples**

### **1. Grounding the body. (10-15 minutes.)**

This exercise can help a survivor to come down from hyperarousal and find a more balanced emotional state. It can also be used to focus survivors who are in 'freeze-mode'. Sit on your chair. Feel your feet touching the ground. Stamp your left foot into the ground, then your right. Do it slowly: left, right, left. Do this several times. Feel your thighs and buttocks in contact with the seat of your chair (5 seconds). Notice if your legs and buttocks now feel more present or less present than when you started focusing on your legs. Now move your focus to your spine. Feel your spine as your midline. Slowly lengthen your spine and notice if it affects your breath (10 seconds). Move your focus toward your hands and arms. Put your hands together. Do it in a way that feels comfortable for you. Push your hands together and feel your strength and temperature. Release and pause, then push your hands together again. Release and rest your arms. Now move your focus to your eyes. Look around the room. Find something that tells you that you are here. Remind yourself that you are here, now, and that you are safe. Notice how this exercise affects your breathing, your presence, your mood, and your strength.

### **2. Progressive release of muscular tension. (15 minutes)**

This exercise calms a survivor who is agitated. Whenever you become anxious, your body tenses. This can generate symptoms of pain in the shoulders, neck or back, or tension in the jaw, arms or legs. To train yourself to progressively release this tension, start by intentionally tensing specific groups of muscles, and relaxing them. Focus on the difference of feeling between the tense and relaxed state of the muscles. Practice on different parts of the body: the head, face, neck, shoulder, back, stomach, buttocks, arms, hands, legs or feet. Increase tension and hold it for 5 seconds; then release and hold for 10 seconds. Find the tempo that suits you. Increase the tension and release the tension ten times in each muscle group, with a short pause in between.

- Start by focusing on your hands. Make a fist, hold it for 5 seconds, release for 10. Notice the difference between the tense and released states. Do it once more.
- Move the focus to your arms. Pull your forearms towards your shoulder. Feel the tension in your upper arms. Hold for 5 seconds, release for 10. Notice the difference. Do it once more.
- Stretch your arm out and lock the elbow. Feel the tension in the triceps. Hold for 5 seconds, release for 10. Notice the difference. Repeat. When your arms are relaxed, let them rest in your lap.
- Focus on your face. Increase the tension in your forehead, lift your eyebrows. Notice the tension. Hold for 5 seconds, release for 10. Notice the difference. Repeat.
- Increase the tension in your jaw. Hold. Release. Repeat.
- Focus on the muscles in your neck. Bend your neck so that your chin touches your chest, turn your head slowly to the left, bring it back to the centre, bend it back, bring it back to the centre, turn it to the right, bring it back to the centre. Repeat slowly since there is often a lot of tension in this area.

- Focus on your shoulders. Lift them. Hold and notice the tension. Release. Notice the difference. Repeat.
- Focus on the shoulder blades. Pull them back. Increase the tension. Relax. Notice the difference and repeat.
- Stretch your back by sitting in a very upright position. Hold the tension and relax, notice the difference and repeat.
- Increase the tension in your buttocks. Hold for 5 seconds and release, notice the difference, repeat.
- Hold your breath. Pull your stomach in, tighten it, and relax. Notice the difference, repeat.
- Focus on your legs. Stretch them out, feel the tension in your thighs, hold and relax.
- Straighten your legs again; this time make your toes point towards you. Notice the tension in the back of your legs, and the feeling of relaxation when you release. Repeat.
- Focus on your toes, make them point downwards as far as you can. Feel the tension and release.
- Scan your whole body. Does any part still feel tense? Repeat the exercise for this part.
- Imagine that a relaxed feeling is spreading through your whole body. Your body feels warm, perhaps a little heavier, relaxed.

### **3. Creating a safe place. (10-12 minutes.)**

This exercise helps survivors who are in “freeze-mode”, feeling numbed and frozen. Make yourself comfortable, with your feet on the ground. Feel and relax your body, your head, your face, your arms, spine, stomach, buttocks, thighs, legs. Choose whether you want to close your eyes or keep them open during this exercise. Listen carefully to the Trainer’s voice. • Think of a place in which in the past you were calm and confident and safe. It may be outdoors, at home, or somewhere else. It can be a place to which you have been once or many times, which you saw in a film or heard about, or imagine. You can be there by yourself or with someone you know. It can be private, unknown to others, somewhere that no one can find without your permission. Or you can decide to share it with others. This place must suit you and meet your needs. You can constantly recreate or adapt it. It is comfortable and richly equipped for all your wants. Everything you need to be comfortable is present. It is somewhere that fits you. It shuts out every stimulus that might be overwhelming.

- Imagine this place. Imagine you are there. Take time to absorb it in detail: its colors, shapes, smells and sound. Imagine sunshine, feel the wind and the temperature. Notice how it feels to stand, sit or lie there, how your skin and your body feel in contact with it.
- How does your body feel when everyone is safe, and everything is fine? In your safe place you can see, hear, smell and feel exactly what you need to feel safe. Perhaps you take off your shoes and feel what it is like to walk barefoot in the grass or in the sand.
- You can go to this place whenever you want and as often as you want. Just thinking about it will cause you to feel calmer and more confident.
- Remain there for five more seconds. Then prepare to return to this room, open your eyes, stretch yourself, do what you need to return to the present.



#### **4. Re-orienting to the present. (10 minutes.)**

This exercise is of help to survivors in ‘freeze-mode’, who feel numbed and frozen. Form pairs and sit together. One of the pair should play a helper and the other a survivor. The Helper should assist the Survivor to use her senses to put herself fully in the present and feel safe. Take turns. Look round you and name 3 things you see.

- Look at something (an object, a color, etc.)
- Tell yourself what you are seeing. Name 3 things you hear.
- Listen to a sound (music, voices, other sounds).
- Tell yourself what you are hearing. Name 3 things you touch.
- Touch something (different textures, different objects).
- Tell yourself what you are touching. Now, notice your state of mind.
- Do you feel that you are more present in the room or less present after doing the exercise?
- Do you feel calmer or more energized?

**Source: Mental health and gender-based violence. Helping survivors of sexual violence in conflict – a training manual; 2014 Health and Human Rights Info, revised 2016**  
([https://www.hhri.org/wp-content/uploads/2019/01/HHRI\\_EN\\_GBV.pdf](https://www.hhri.org/wp-content/uploads/2019/01/HHRI_EN_GBV.pdf); 9.5.2019.)

## **MENTAL HEALTH CONSEQUENCES OF AMBIGUOUS LOSS AND GRIEF**

(75 minutes)

### **Objectives:**

1. To facilitate participants' understanding of normal grief, Complicated Grief Disorder (CG) and Ambiguous Loss (AL)
2. To facilitate participant's understanding of clients suffering from CG and AL

### **Expected outcomes:**

1. Participants will be able to distinguish between normal grief, CG and AL
2. Participants will demonstrate their understanding of grief, CG and AL
3. Participants will be able to discuss the rationale of corresponding interventions.

### **Materials:**

1. Flipcharts
2. Markers
3. Case descriptions

### **Methods:**

Work in two groups.

The group is divided into small subgroups of four participants (4-5 small groups). Each group receives one case which it analyzes and answers the questions formulated at the end of the case. (25 min)

One group member will present their outcomes to the whole group. Each group presents and if more than one small group worked on the same case, they will present one after other, followed by a discussion. (45 min)

### **Case of Anna**

Anna is 30 years old, IDP woman who fled from her village to the regional city together with her family (9 year old son, 1 year old daughter and husband).

Her sister's family has also moved to the same location.

Anna's husband got a job and they managed quite well. A year after displacement, Anna was able to visit her relatives in the village and took her small daughter with her. Over the next few days the daughter became ill but it did not look very serious. However, when her condition worsened, they could not bring in a doctor. The little girl suddenly died. Anna was devastated, she could not comprehend what has happened, she was constantly crying, blaming herself, felt guilty. She could hardly think about anything else. She felt intense feelings of yearning and longing, and had trouble concentrating on other things. She felt her mind was in a fog and she had little control over her emotions and/or thoughts.

The next several months she remembers as a nightmare, her world crushed, she was not able to take care of her son, in fact she started to be angry at him. She refused to sleep with her husband and starting blaming him for having an affair with a young female co-worker. Anna did not want to see her parents and was angry on them for being alive whilst her young daughter passed away. At the same time she was grateful that they were taking care of her son. She had thoughts that she does not deserve to live and enjoy life. At times she would say that her little baby needs her mother 'there' and wanted to die. Her condition lasted a year before she decided to talk to a nurse she knew.

Questions the group:

- How would you define the condition of Anna?
- How can you explain that Anna was angry at her son?
- What would you do if a person like Anna came to you, i.e. if you were that nurse?

## **Case of Maria**

Maria is a 43 year old woman whose husband was killed in the conflict a year ago.

Maria was close to her husband, but they didn't have children, and her family lives in another town, quite far. Maria works as a salesperson in a local grocery store. In order to survive she kept a few chicken to sell eggs and poultry.

Maria was devastated by her husband's death. She has strong feelings of protest and despair. She experienced deep yearning and longing for her husband, and had waves of anxiety about how she will go on living without him. She felt completely empty inside herself. She felt disconnected from her family, colleagues and friends and was constantly thinking about the unfairness of her husband's premature death.

She started quite often not to go to work calling in sick because seeing her neighbors walking with their spouses or buying groceries would remind her of her enormous loss. She started to sleep much more than before, because then she had the feeling that her husband is close to her. She also stopped taking care of the chickens.

Maria had intense feelings of guilt, thinking she could have been a better wife to her husband. She started to think that her life is not worth living anymore. Her religious beliefs and fear of pain protected her from realizing such thoughts.

The next-door neighbor, a social worker, who noticed the changes in her appearance, initiated conversation with her, gave contacts of the psychiatrist and convinced her to approach him. Psychiatrist prescribed her medication and in parallel started therapy. She was invited to participate in the bereavement peer-support group.

Gradually, her condition started to improve. She was very grateful not only to the psychiatrist and peers, but also to the social worker, her neighbor and often said that she saved her.

Questions for the group:

- How would you define the condition of Maria?
- What are the risk factors that influenced Maria's condition?
- What would you do if a person like Maria came to you for support, i.e. if you were that social worker?

### **Case of Juan:**

Juan is a 45 years old man, living in the village. His wife left him and his son when the son was three years old. He is a farmer, and has brought up his son on his own.

Two years ago, his 20 years old son disappeared in one of the military actions. Since then there were no news about him, although Juan tried everything to find out what happened to his son over the past two years. Juan believes that his son is alive and still waits for his return home. He keeps his room intact and in order, hoping he will come back. Juan does not take care of the farm and house any more, except taking care of his son's room.

Before the son disappeared Juan was in close relationship with a woman from his village. His son liked her, and Juan was about to invite her to live with him and his son. But after the son disappeared, he did not do it, because he did not want the son to come back home and find that this woman lives in the house. He sees her much less often than before.

When Juan visits the local government office to enquire about news about his son, they behave as if the son is dead, and that makes Juan very angry. So he has stopped all contact with anybody who believes that his son is dead.

Most often, Juan feels exhausted, has barely the energy to take care of himself, and has started to drink alcohol more because it helps him get through the day. Juan has felt very proud when his son volunteered to defend their town, but now blames himself for not stopping when he left to fight.

Questions for the group:

- How would you define the condition of Juan?
- What are the possible resilience factors that Juan has?
- What would you do if a person like Juan came to you for support.

## **Recognizing risk of suicide and basic interventions** (75 minutes)

### Objective:

1. To facilitate talking about suicide
2. To increase competencies with suicide prevention interventions

### Expected outcomes:

1. Participants will be able to talk about the risk of suicide
2. Participants will have ideas for suicide prevention to implement

### Materials:

- Instructions “Basic interventions for suicide prevention”
- Cases of risk of suicide (4)

### Methods:

Work in 2 groups (15-20 members) on: 1) Exercising interventions in triads and 2) discussing prevention in the community in a fishbowl

1. Exercise interventions (35 min)

Split the group in triads: helper, client/user, observer. Each triad will use one prepared case of risk of suicide. In each triad they will do a role-play (20 min) the following elements of interventions:

- a. talking about signals
- b. safety plan
- c. suicide contract
- d. involving a family member or friend
- e. evaluation of intervention.

The trainer will facilitate a reflection of how was it to talk about suicide (10 min).

2. Discussing prevention in the community in a fishbowl (35 min)

Split the group into two by assigning numbers (1-2). The participants will sit in an inner and an outer circle. There will be two rounds of discussion in a fish bowl, with 1/2 of the participants in turn forming a circle inside while other participants sit outside the circle. The inner circle will discuss and the outer circle will observe and listen. After 10 minutes they switch places: the inner circle goes outside, the half of the outer circle takes the inner seats. During every switch there will be new questions to the inner group participants.

Fishbowl Round 1 (10’)

Discuss own experiences with suicide and trauma in your community:

- a. Have you known of suicide cases in your community? What have been your responses; how were the responses in the community?
- b. Are there obstacles for suicide prevention in your community? What are they?

Fishbowl Round 2 (10’)

- c. What are the possibilities to prevent suicide in your community? What are resources? Who should do what?
- d. What is needed to implement and use these interventions?

Summary in the whole group: recollection and sharing of ideas and conclusions (10 min).

### **Case examples for exercise of suicide prevention**

1. Maria is 12 years old and the teachers are worried about her behaviour. She withdraws, hardly talks to peers, her grades drop down and she is quiet. They don't know her like this. Do her parents share these observations? School is aware that her brother had been killed in a traffic accident last year. She was called to a meeting by the school headmaster/social worker/psychologist.

2. Lucia (55) has lost her job three months ago. She is really worried about not having enough money to buy food for her family. She tried to find a new job, but jobs are scarce. She had no success yet. Her husband is also without job, they are now both at home all day. They feel so frustrated and worried about the future that they are emotional, they have fights all the time. She secretly wishes her life was over. She was called to a meeting by the social worker to the family centre.

3. Natalia is a teenager of 17 years old. She is the middle child in a family of father, mother, and 3 kids. They migrated from elsewhere, and all family members need to adapt to the new situation. They don't talk about the past. Natalia fantasizes about death. To her it is an attractive escape from life. She says she doesn't fear ending her life. She has a rope in her room and she secretly collects medication pills. Her family members are not aware of her suicidality. She was called to a meeting by the social worker to the family centre.

4. Enrique (25) is involved in a conflict within his family. He has made mistakes in the past. Due to his gambling debts, his brothers and parents are in financial problems. They have paid large sums of money so he will be safe. But now they want their money back, and Enrique doesn't have a job. He doesn't know how to pay back. Increasingly, he is thinking it would be better to just die. His wife thinks he changed lately, but she doesn't know about his feelings and thoughts. He was called to a meeting by the social worker to the family centre.



### **Safety plan for persons with suicidal thoughts**

**Name:**

**Step 1** Warning signals – Things I notice when I am not feeling well:

How do I notice I'm getting upset?

**Step 2** Resources – Things I can do myself to distract me:

Which things can you do to not act according to your suicidal thoughts?

Which things can you do to shift your thoughts and forget your problems for a while?

**Step 3** People and/or social situations that help me to find distraction:

With whom do you feel okay?

With whom can you shift your thoughts, even for a short moment?

Is there a place where you are among people and are safe?

Is there a place where you are distracted from your thoughts and worries?

Is there an activity that leads to some distraction?

**Step 4** People I can ask for help:

Name	Place	Phone
------	-------	-------

Who of your family or friends could you talk to in case of a suicidal crisis? Who would be helpful?

To whom could you talk when you experience much stress?

**Step 5** Helpers or organisations that I can call during a crisis:

Name	Phone	Emergency phone
------	-------	-----------------

Name	Phone	Emergency phone
------	-------	-----------------

General practitioner: Which helpers can you write down on your safety plan? Are there any other helpers?

**Step 6** Things I can do to make my situation safe:

How can you take care you are safe and remain safe during a crisis?

How can you take that you don't get access easily to means that you can use to commit suicide?

## **Countertransference in work with trauma victims** (60 minutes)

**Objective:** Rise awareness on own psychological reactions in work with trauma victims

**Expected outcomes:** Participants will learn to be aware of own reactions in work with trauma victims

**Materials:** flipchart, markers

**Methods:** The workshop is done in two groups, participants work in triads, listening to the story of the person (20 min); writing down the reactions they had (10 min), reflection and discussion (30 min)

1. Listening to the story of the person (30 min): The group is divided into triads. One of the members will role play as the person/user, one will role play a helper, and the third member observes and later describes what they saw. “The helper” uses active listening for 20 minutes to better understand the story of the traumatic event of the person. The “user” is supposed to choose one of the cases they know of a person who experienced a traumatic event, role play that person for 20 minutes and tell the story to “the helper”. Participants are instructed to observe how they feel during the conversation, what physical reactions they had during the conversation, what thoughts went through their head. They keep in mind how they react to what the person is saying, to the way they are saying it, to their appearance as well.

After the role play (20 min), all three members of the triad write down the reactions they had during the conversation (10 min) and share what they noticed.

2. Feedback and discussion (30 minutes):

Each triad shares what they had noticed during the conversation, and the trainers connect reactions of the “helpers” and observers to countertransference to trauma, and the reactions of the “user” to transference. The trainers can also ask, in order to get better insight into countertransference: Were there some questions participants wanted to ask, but refrained from asking?

Trainers will, based on the reflections that the participants provide, emphasize the difference between countertransference (emotions of the helper transferred/projected to the client), confluence (feeling emotions that the client is feeling, like the client's story is happening to the helper) and empathy (feeling for the client, helper imagines how they would feel if the same thing was happening to him/her).

## **Disseminating knowledge about trauma and loss in traumatised communities**

(75 minutes)

### **Objective:**

To exercise how to disseminate knowledge about consequences of trauma and loss in communities affected by violence.

### **Expected outcome:**

Participants will be able to design information about consequences of trauma and loss for specific target groups in traumatised communities using formal communication channels and structures (TV, government, school, police,)

### **Materials:**

Flipchart, markers

### **Methods:**

Work in two groups. In each group 4 small subgroups discuss contents and modes of dissemination through different formal channels, and role play in front of the whole group.

Group preparation: 15 minutes.

Group presentations: One representative from Groups A-D give a 5-minute presentation and then reporter / head of health and social protection / school teacher / police officer ask appropriate questions (3 minutes) → presentation of 4 groups: 40 minutes

Trainer's comments and group discussion: 15 minutes

### Module 3, Working material 7

A. Group: You have been invited by the local TV in a community which has been affected by conflict to explain about consequences of exposure to traumatic events and loss of family members. The group should prepare what to say in a five minute show and how to answer the reporter's questions which will be also prepared by the group. One group member will present the topic in 5 minutes, another group member will afterwards ask 2 questions as a reporter.

B. Group: You have been invited by the head of regional sector for health and social protections to give them advice how to work with huge number of traumatised people who have recently moved into the major cities in the region from areas affected by violence. The group should prepare a five minute presentation to the municipal leadership of health and social protection and how to answer politicians' questions which will be also prepared by the group. One group member will present the topic in 5 minutes, another group member will afterwards ask 2 questions as a health and social protection head.

C. Group: You have been invited by the local school to give a five minute talk about effects of trauma on family for teachers and school staff. The group should prepare a five minute presentation and how to answer questions from the audience which will be also prepared by the group. One group member will present the topic in 5 minutes, another group member will afterwards ask 2 questions as a school teacher.

D. Group: You have been asked by the local police to give a five minute talk about consequences of trauma due to violence and what to expect when interviewing a witness of neighbour's domestic violence who herself has been traumatised by previous violence. The group should prepare a five minute presentation and how to address police officers' questions which will be also prepared by the group. One group member will present the topic in 5 minutes, another group member will afterwards ask 2 questions as a police officer.

## MODULE 4 - LECTURES

### Lecture

## Groups in psychosocial work

### Defining group work

Different clients engage in group work to obtain professional assistance and support in resolving certain personal and social problems, to cope more effectively with life's difficulties and to develop knowledge and skills important for a better understanding of themselves, other people and the community they live in. The process that takes place in such groups is known as group work, group treatment or the group approach in psychosocial work. **Group work** is determined by a prudent use of group processes and interventions to achieve the common and individual goals that are consistent with the values and ethical principles of the helping professions.

**The basic principle of group work** is that group members can help each other by sharing feelings, information, giving suggestions, ideas and solutions to problems, and supporting each other, with the assumption that the group process is the main source of change and development of individual group members.

### Advantages of group work:

- Allows members to realize that they are not the only ones who have a specific problem
- Allows members to provide support, understanding, ideas and feedback to each other
- Facilitates learning through imitation and the exchange of knowledge and experience
- Group decision making: the knowledge and skills of several members complement and interact with each other
- Increases **motivation** of individuals for solving problems
- Indispensable when the central problem are relationships with other people: **the group is a “mirror”** of each member, they learn about themselves through the interaction with others
- Especially suitable for **socially withdrawn individuals** because it allows them to test reality (the group is a “small universe” where members present their problems in a safe environment, and develop new behaviours by role playing, modelling and testing of new skills)
- Greater time efficiency and economy resulting from the simultaneous work with a number of clients

### Classification of groups in psychosocial work

Group work, as a supporting and helping process, refers to many different kinds of groups with an even greater range of specific objectives. The classification which will be shown below describes the three major types of groups: groups for personal change of clients, groups for solving problems important to the clients, and groups for professional help for helpers. Although “pure” types of groups rarely exist in practice, this classification was selected so as to show their diversity in psychosocial work.

- I. Treatment groups or groups for personal change of clients
- II. Groups for solving problems important to the clients
- III. Groups for professional help for helpers

## **I. Treatment groups or groups for personal change of clients**

- 1. Groups with professional leadership
  - a. Educational groups
  - b. Groups for personal growth and development
  - c. Groups for personal change
  - d. Socialization groups
    - Groups for learning social skills
    - Groups for participation in the management of institutions
    - Groups for leisure and recreation
  - e. Support groups
- 2. Self-directed groups
- 3. Self-help groups

### **1.a.Educational groups**

#### Purpose:

- Facilitating learning about the social environment and the wider community
- Acquiring new knowledge and skills

#### Characteristics:

- The content is more important than the emotional needs of members
- The professional presents theoretical knowledge, and discussion is used to encourage learning
- The leader should take into account each member's knowledge, degree of skill, and experience with the content that is being taught in the group
- Members have a shared interest in the content, as well as some other characteristics (age, current difficulties, ...)

#### Examples:

- *a group of future foster parents who are getting acquainted with the concept of foster care*
- *a group of homeless people, with the purpose of getting them acquainted with their rights and the ways of leaving the homeless status*
- *a group of students who learn about the creative approach in working with different groups of clients*

## **1.b. Groups for personal growth and development**

### Purpose:

- Expanding self-awareness
- Changing attitudes and beliefs
- Improving ways of expressing emotion
- Changing behaviour

### Characteristics:

- Emphasizes the development of potential members
- Support and feedback from other members are important
- The group is a means for developing the members' skills, and not for solving their socioemotional problems
- Members differ in their experiences and skills

### Examples:

- *a group for training parental competence, improving parental skills*
- *a preventive group for children of divorced parents*
- *a reminiscence group for the elderly*

## **1.c. Groups for personal change**

### Purpose:

- Changing members' dysfunctional behaviours, which are called asocial, deviant and/or undesirable in their surroundings

### Characteristics:

- Members are together to solve a problem they have
- Members are often involuntary clients
- Problems are systematically assessed before the beginning of group work, and that is the starting point for forming individual treatment goals
- The leader often focuses on individual members and their specific needs
- In working with the group, openness of members, disclosure of feelings and mutual assistance in finding solutions are encouraged

### Examples:

- *a group of perpetrators of domestic violence*
- *a group of adolescents for the treatment of drug addiction*
- *a group of juvenile offenders placed in a correctional facility*

### **1.d. Socialization groups**

#### Purpose:

- Acquiring social skills and patterns of social behaviour that will facilitate establishing successful relationships in the community where they live

#### Characteristics:

- Members improve interpersonal skills through participation in structured and pre-planned activities
- Creative techniques (games, music, acting, dancing, drawing) are commonly used
- Types of socialization groups:
  - for learning social skills
  - for participation in the management of institutions
  - for leisure and recreation

#### Examples:

- *a group for learning non-violent conflict resolution in childhood*
- *a group of older children in a children's home who help the new children in their adjustment to the home*
- *a group for leisure and socializing of retirees (dance, drama, journalism...)*

### **1.e. Support groups**

#### Purpose:

- Providing support in times of crisis and difficult periods of life
- Developing successful coping with life's stresses and significant transitional periods in life that involve a change in behavior and coping

#### Characteristics:

- Organized for unexpected or rare events, or when social support or coping are poor
- Members have experienced similar hardships and share them
- Members are simultaneously those who provide assistance and those who receive it – reciprocity
- Characteristics like gender, period of life and socio-cultural context of members are taken into account
- In these groups the focus is not on a problem that needs a solution, but on the difficulty that we cannot change and that requires adjustment

#### Examples:

- *a support group for young people who have left the children's home*
- *a support group for people who have lost their jobs*
- *a support group for former addicts*



## **2. Self-directed groups**

### Purpose:

- Empowering members to independently solve their problems and take control of their lives

### Characteristics:

- The leader is a professional, but his/her role is merely to encourage the members to express their opinions and ideas; he/she only gives a broad framework within which the members determine what they need and how they want to achieve it
- Members have a central role in planning and structuring the work
- Open-ended membership (up to 20, 40 members)
- Members were not chosen by the leaders

### Examples:

- *a journalism group of Roma children*
- *a drama group in a correctional facility for youth*
- *a group of refugee knitters*

## **3. Self-help groups**

### Purpose:

- Providing support in difficult and transitional periods of life
- Empowering members
- Developing self-esteem by helping others
- Expanding social networks, a possibility for social learning, cognitive changes
- Social action (improving professional services of a certain group of people, a change in the health/welfare system/law; aimed at the general public in order to reduce prejudice and stigmatization)

### Characteristics:

- No professional leader
- The possibility to tell “the whole story” in an accepting environment
- Established way of giving support between meetings
- Among the members are also those who serve as models
- Members have had a similar life event, direct experience

### Examples:

- *a self-help group for single parents*
- *a self-help group for the elderly without family*
- *a self-help group for people with disabilities*

## **II. Groups for solving problems important to the clients**

1. Groups for meeting the needs of an organization that provides psychosocial assistance
  - a. Management boards
  - b. Councils
  - c. Work groups
2. Groups for meeting the needs of clients
  - a. Professional team
  - b. Treatment conference
  - c. Groups for social action
  - d. Various consultative groups

## **III. Groups for professional help to helpers**

1. Educational groups, including psychotherapy training
2. Supervision groups
3. Debriefing groups for integration of traumatic experiences

## Lecture

### Planning of group work

The planning of group work is a process that takes place before the commencement of the group. This involves all activities of the future leader that are focused on designing and initiating the group. The process of planning usually involves the following steps:

1. Needs assessment
2. Defining the purpose and general objectives of the group
3. Choosing the setting
4. Selecting a group approach and modes of work
5. Identifying potential group members
6. Approaching and recruiting members
7. Group composition
8. Motivating members and initial agreement
9. Preparing the group environment
10. Defining evaluation procedures

#### 1. Needs assessment

The beginning of planning group work involves identifying certain common needs of a group of people and assessing the possibility to meet these needs through group work. Identifying the needs of potential members as the starting point of planning is important because people participate in groups exactly for that reason, to satisfy their various needs. The needs of members in a group are not necessarily identical, nor do they have the same intensity.

#### 2. Defining the purpose and general objectives of the group

Groups are formed for some identifiable purpose and with the assumption that the members who gather in it have at least one common goal.

**The purpose of the group** refers to **what is planned to be achieved** by group work (e.g. improvement of communication skills). It is usually reflected in the group's name.

**Group objectives** refer to **how** the purpose of the group can be achieved. Objectives should be specific, clear, and measurable. In other words, objectives show what the expected knowledge/abilities/achievements of members at the end of the group work are, that is, what needs will be met. A clear definition of objectives is a necessary precondition for planning the evaluation of the effects of group work.

### **3. Choosing the setting**

The purpose and general objectives of the group will influence the selection of the service, organization or institution where the group will be established. Its objectives, resources, and clients will influence the decision on where a particular group should gather and with whose financial support.

This includes: negotiating financial resources, ways of supervision, providing facilities and equipment, securing adequate resources to operate until the termination of the group.

### **4. Selecting a group approach and modes of work**

This includes the decision of the leader on the mode and methods of work that would suit the members best: group discussion, interactive activities, cognitive approach, behaviour modification, creative expression, a combination of approaches, etc.

In this step, some basic characteristics of the group are defined: size, open-ended/close-ended membership, voluntariness, duration, type of leadership and so on.

**Size of the group** – depends on the objectives, characteristics of members, type of leadership. For example:

- Groups for problem solving: 4-6 members
- Treatment groups: 6-10 (or 4-15) members
- Educational groups: 6-20 (or more as long as gaining social experience is ensured)

The group should be small enough to ensure that its purpose is fully achieved, but large enough to provide the members with a satisfactory exchange of experiences.

**Open-ended or closed-ended membership** – the decision depends on the purpose of the group and the setting of the group.

- Closed-ended groups (the group begins and ends its work with the same members) are the most common treatment groups and groups for problem solving
- Open-ended groups (the members enter the group and leave it depending on the speed with which they meet their needs)

### **5. Identifying potential group members**

At this stage of planning, the leader should consider who the possible members are, with regard to the group's purpose and objectives. It is important to assess whether potential members share his opinion on the need to establish the group.

In-depth knowledge about the population to which the group will be offered is needed: review of the existing documentation of services, data collection in a particular community, talking with colleagues, and personal contact with potential clients.

### **6. Approaching and recruiting members**

Having established who the potential members of the group are, the leader has to decide how to approach and recruit them. This can be done in several ways, depending on the clients and objectives:

- Personal contact with potential members
- Written invitation addressed to a potential member

- Notice in the form of posters at a meeting place of potential members or on particular web sites
- Leaflet that is distributed to potential members or left at their frequent meeting place
- The media (newspaper or internet ads, television or radio announcements)

Regardless of the way, it is important to specify the:

- Purpose of the group
- Anticipated duration and frequency of group meetings
- Time and venue of the first meeting
- Other services (e.g. transportation, child care, etc.)
- Method of applying for the group, payment etc.

## 7. Group composition

The principles in composing a group:

1. Homogeneity – with respect to the goal of participation and specific descriptive characteristics of members (similar or the same problem or needs in order to facilitate understanding)
2. Heterogeneity – with respect to life experiences of members and skills to cope with problems (differences that contribute to seeing a problem from different perspectives)

The aim is to achieve balance between homogeneity and heterogeneity of members' characteristics.

Characteristics that members bring to the group:

- Descriptive characteristics – e.g. age, gender, marital status, number of children, occupation...
- Characteristics of behaviour – the way an individual reacts in certain situations, for example, aggressive, withdrawn, talkative, quiet, sensitive...

It is desirable for members to be similar in their descriptive characteristics (identification is important for building trust), and to differ in the characteristics of their behaviour (addressing specific problems in different ways) – especially in groups for problem solving and treatment groups. A group with the same descriptive characteristics and characteristics of behaviour makes little progress.

Especially important selection criteria:

- **Age** – the main criterion for groups of elderly, children and adolescents; in other groups, e.g. teachers, having members of different ages is desirable
- **Gender** – depends on the purpose and the members. Gender homogeneity is better for support groups, while gender heterogeneity is better for e.g. assertiveness training groups. Preferably, one gender should make up 1/2 to 1/3 of the group (the minority gender must not become the scapegoat)
- **Sociocultural origin** – large differences lead to difficulties in communication, division into subgroups, or isolation of members

## 8. Motivating members and initial agreement

The motivating phase is a very challenging period that entails explaining to the members what they can achieve and which goals they can accomplish in the group. A potential member should get information and support, without feeling pressured to participate in the work. Motivating should provide the members with all the information and full freedom to decide whether to participate in the group. In this way we may lose some potential members, but this will have a positive effect on those who are in doubt.

The initial contact between the group leader and a potential member is of utmost importance for further work: the leader should be clear about the content and methods of work, and accept the opinion, reluctance and possible distrust of the member. Linking the group objectives with individual goals will help the member become aware which of his/her goals can be achieved in the group.

**The initial agreement** should include the rights and obligations of members and leaders, as well as their objectives and assignments at the level of specific behaviours. Based on this agreement, members decide whether to participate in the group work or not. Further defining (detailed decisions on the objectives) continues in the initial stage of group work.

With involuntary members (groups in penal institutions, groups for perpetrators of domestic violence, groups of young offenders, etc.), the task of the leader is to motivate them to **actively participate in the group**.

## 9. Preparing the group environment

There are three groups of factors that the leader should keep in mind when preparing the environment for the group work:

- social environment
- physical environment
- specific services

### Social environment

The effectiveness of group work often depends on the attitudes and cooperation with people who are not members of a group (e.g. family, friends, teachers). In other words, the work of the group depends both on the attitudes and cooperation of important persons, but also of service providers and institutions. It is necessary to investigate:

- whether any other service provider is planning a similar group
- the attitudes of important people towards the group
- the family – needs to be actively involved and informed

### Physical environment

Size of the room:

- smaller room – closer contact (for adults)
- smaller room – harder to work (with children)

It is good to work in the same room all the time, so the members can experience that space as “belonging” to them. It is good to allow time between the meetings of two different groups.

## **Specific services**

Identify which specific services should be provided for members so that they can freely attend the group meetings (e.g. transport for the elderly or child care for single mothers).

## **10. Defining evaluation procedures**

An integral part of planning group work is a decision on the methods and criteria for evaluating the effects of group work. Evaluation is not an activity that takes place only after the termination of the group; rather, the monitoring of the effects is planned in advance and carried out throughout the group process. Evaluation is not only a “before – after” process, but a continuous process that provides feedback to the members and the leader about the effectiveness of the group.

Evaluation of group work includes:

1. **Monitoring implementation of group work:** evaluation of group meetings, evaluation of the leader’s performance, satisfaction of members with the relations within the group etc.
2. **Evaluation of the outcomes of group work on members:** how members and the group as a whole achieved individual and group goals

Sources of information for evaluation of the effects of group work include:

- Self-assessment questionnaires
- Interviews
- Assessments by other people (using questionnaires, interviews...)
- Official records
- Observations

## Lecture

### Structuring group meetings

Structuring the work of the group refers to predetermining the activities that will take place in the group. The leader's activities focus on:

- Determining the work program, i.e. **what** is done in the group
- Determining the work methods, i.e. **how** it is done
- Developing appropriate communication patterns

An integral part of structuring the group work is creating a provisional work program. The program is initially prepared in the planning phase, and the leader checks it further in the initial phase of the group. The activities and contents of work that need to be implemented to achieve individual and group goals are specified in the program. The more time constrained the group is (the less time it has for achieving the objectives), the more detailed the program of the planned meetings should be.

The term “**time-limited groups**” usually refers to groups that have between 6 and 14 planned meetings. Given the time constraint, goals should be especially clearly defined and formulated. This is typical for groups for learning social skills. In these groups, all meetings have a pre-scheduled content that is typically a mixture of:

- Educational content
- Various interactive content and exercises that help members successfully acquire specific knowledge and skills
- Discussions on experiences in the group and the difficulties that can be expected in the application of new skills outside of the group
- Brief overview of members' tasks between the two meetings
- Evaluation of the meeting

During the central phase of group work, the needs of the members and of the group should be assessed, and the content of the next meeting should be adjusted accordingly. At the same time, the overall work program should follow the natural steps of the process (e.g. learning social skills, improving knowledge, mourning...). The content of the meeting should also be adjusted to the phase of group work, its characteristics and specific objectives (such as the introduction of members, achieving group cohesion, preparing for the ending of group work...).

Each meeting focuses on a specific objective/objectives that contribute to achieving the group objectives. When structuring a meeting, the objectives of the meeting and of each activity (its purpose in the overall structure of the meeting) should be clearly stated. The overview of the meeting structure should also include a detailed description of the activities (what each leader says/does, what members say/do, what are their expected reactions...), their duration, and the materials needed for their implementation.

#### Structure of a group meeting

1. Introductory activity / activities



- Stating the context (the purpose and objectives of the meeting); members are introduced into the meeting
  - Interactive activities, “warm up activities”; updates about the members’ lives...
2. Central activity /activities:
    - Achieving the objectives through various activities
  3. Final activity /activities:
    - Reflecting on acquired knowledge; relaxation; interactive games; rounding up the meeting; setting homework/assignments until the next meeting...
  4. Evaluation of the meeting

*Example of the overall group structure of a time-limited group*

Group about sexuality and responsible sexual behaviour for adolescents is a time-limited group with 12 planned meetings, each lasting 120 minutes. The plan of the overall structure of meetings is:

1. Introductory meeting (getting to know each other, purpose and objectives, fears and expectations)
2. Gender and sex roles
3. Biological basis of sexuality
4. Sexually transmitted diseases
5. Contraception
6. Self-image and own sexuality
7. Influence of social environment on sexuality (media, peers, parents)
8. Communication skills (talking about sex with parents)
9. Romantic relationships in adolescence
10. Communication skills (talking about relationships and sex with your partner)
11. Sexual intercourse (fears, expectations, norms)
12. Final meeting (evaluation, saying goodbye)

*Example of the structure of a group meeting*

Second meeting: Gender and sex roles

Objectives:

1. To learn the difference between gender and biological sex
2. To raise awareness of gender stereotypes and how they affect us

Materials:

- Large (A3) paper divided into 4 squares with writings: TV, book, newspaper and Internet

- Gender-sex quiz for each member
- Unfinished sentences related to gender roles for each member
- Pens for each member
- Current newspapers, journals and magazines
- Scissors
- Glue
- 2 flip-chart papers
- Papers in different colors for the evaluation

### Activities:

- Introducing yourself through presenting your interests in different types of media (15 minutes)

The co-leaders should prepare in advance a large (A3) paper divided into 4 squares and write one type of media in each of them (TV, book, newspaper and Internet). After the greetings co-leaders explain to members that each of them should think about their favourite movie or TV series; book; newspaper, journal or magazine; and web page. Then each member explains why he/she chose that particular answer, that is, what he/she likes best about that choice. Co-leaders can also participate in this activity. The purpose of the activity is for members to get to know each other and to increase group cohesion.

- Introducing the terminology (gender and biological sex) (5 minutes)

One of the co-leaders introduces the topic of the meeting and shortly explains the difference between gender and biological sex.

- Gender-sex quiz (20 minutes)

Members individually fill out a gender-sex quiz where they have to mark whether a certain belief, behavior, norm etc. (e.g. A guy should always pay for the girl's drink) is based on one's gender role or biological sex. After that members read their answers and co-leaders facilitate a discussion about rules and norms for men and women in the society, differences between societies, changes through history, etc. Besides learning the difference between gender and biological sex, the purpose is to raise awareness on the role of society in the evolution of gender differences and how they can affect everyday life of individuals.

- Unfinished sentences (20 minutes)

Members individually fill out forms with unfinished sentences related to gender roles (e.g. Men like most...). They read their sentence endings and co-leaders facilitate a discussion on the reasons for finishing a certain sentence in that way, pointing out the similarities and differences in their answers and encouraging members to think about examples from their own lives that fit their descriptions and those that contradict them. The purpose is to introduce the topic of stereotypes and encourage members to think about their own attitudes about this topic.

- Collage (35 minutes)

Co-leaders divide members into two groups. This can be done either by using some creative method or purposefully. Since one group makes a collage about the presentation of women

in the media and the other about the presentation of men, groups can be gender homogenous so that, for example, boys make a collage about women and vice versa. Co-leaders give the members a large number of current newspapers, journals and magazines and each group makes their collage on a flip-chart paper. Co-leaders facilitate discussions in two smaller groups and follow their progress. After finishing both groups present their collages to the others and explain their conclusions about the media presentation of men and women.

- Final discussion (20 minutes)

Co-leaders encouraging members to think about possible consequences of such generalizations and facilitate a discussion on stereotypes and how they affect us, our expectations, behaviors, relations with people of different gender, and what we can do about it in our everyday lives (treat people equally regardless of gender and approach them as individuals, not men or women).

- Meeting evaluation (5 minutes)

Co-leaders put lots of papers in different colors in the middle of the circle and ask the participant to each choose one or more colors that reflect their opinion of the meeting (how they felt, what they achieved, their overall impressions) and shortly explain their choice. Co-leaders also participate in the evaluation.

## **Group rules**

### **Establishing group rules**

The agreement on the mode of group work is usually formulated as group rules. These are established in the initial phase of group work. However, these rules can be changed throughout the duration of the group if it becomes apparent that some changes are necessary. For example, when the members avoid or break some rules, this might indicate the need to discuss them openly and maybe change them.

When establishing the rules, the leader has to ask the members for their suggestions (what rules would make them feel comfortable and safe during the group work). These suggestions are discussed, and the leader can propose additional rules if the members have not mentioned something important. These rules have to be written down where everyone can see them. They are used as a reminder throughout the entire duration of the group work, whenever it is needed.

### **Principles of establishing group rules:**

- They have to be worded in a positive way
- They have to refer to specific behaviours
- They have to be worded as full sentences, not just highlights
- All members have to participate in creating the rules
- The rules have to be clear and acceptable for everyone
- There have to be consequences for breaking rules – consequences for breaking certain rules may not be appropriate for breaking others (e.g. buying coffee/chocolate for everyone, singing a song in front of the group etc., are not appropriate consequences for breaking confidentiality)

**Some important group rules:**

- *Everything that we say in the group, stays within the group*
- *When one person talks, others listen*
- *We treat each other with respect*
- *We have a right to different opinions*
- *We say only as much as we want to say*
- *We arrive on time*

**Structure of group relations and roles****Behaviors important for maintaining the group – functional for the group:**

- Encouraging and noticing efforts made by other members
- Releasing tension – humor
- Protecting members and maintaining group norms
- Endeavours to reconcile and harmonize different ideas and views
- Negotiating and finding solutions that will suit everyone involved
- Promoting actions and giving ideas to achieve the group objectives

**Behaviors focused on individual needs, that don't match the objectives of the group – non-functional behaviors:**

- Blocking – disagreeing and opposing to everything that happens in the group
- Dominating – attracting attention to oneself
- Withdrawing – reluctance and refusal to actively participate in the group
- "Teasing" – interrupting the work with inappropriate jokes
- Competing – striving to always be right and the best in everything
- Advocating special interests – efforts to achieve their personal, specific goals that do not match those of the group

Members bring a certain role with them to the group. Individuals who have a “positive” role are a source of support and they contribute to achieving the group’s and individual goals. Individuals whose roles are “negative” are a potential source of difficulty for the leader, a source of destructive processes and dissatisfaction among members of the group. However, these roles also have certain functions in the group. Each role has two sides.

How can the leader deal with individuals who are “stuck” in one of these roles?

On the one hand, it is important that the leader gets to know and understand the meaning of that particular role for the member in the group or in his life. It is also necessary to examine the meaning and the function of this role for the group as a whole.

**Roles that appear in groups most often:**

- Scapegoat
- Maladapted
- Dominant
- Informal leader
- Silent member
- Saboteur
- Entertainer
- Helper

**Scapegoat**

- The group projects the feelings or attitudes that are considered unacceptable on that member
- This is the person who is “to blame” for everything bad that happens in the group
- He gets isolated, rejected, mocked, belittled...
- This is the member who has not progressed as much as the others or whose behaviour or being somehow different from the others creates antipathy or tension within the group
- This role does not appear in the initial phase of work
- The leader sometimes participates in the process of creating a scapegoat if the members do not act in accordance with his/her expectations – authoritarian leadership

**Why does such a member remain in the group?**

- Benefits more by participating than by leaving the group
- Negative attention is better than none at all

**What should the leader do?**

- Try to understand why this role is necessary for the group
- Not ignore it
- Takes a direct action that protects the scapegoat – establishes control of verbal and physical violence
- Sometimes it is enough to support the member indirectly
- Scapegoats are not only individuals, but also a minority subgroup that is different from the majority

**Maladapted**

- Brings various norms and standards into question
- Encourages people to reflect on their conformity to the group
- Can contribute to the group work when conformity becomes too pronounced

- The maladapted member who later conforms becomes a popular member of the group
- This encourages a feeling of satisfaction due to the return of the maladapted member to the group and pride in belonging to a group that can respect and encourage different ideas
- If the maladapted behaviour is directed at the leader, he/she can feel angry, helpless, and incompetent

Working with a maladapted member includes:

- Tolerance of maladapted behaviour – he/she is not an enemy; if the leader behaves friendly, he “gives permission” to other members of the group to speak openly about their feelings and attitudes related to the group work
- Exploring messages and feelings that are the basis of such behaviour
- Recognizing the meaning of such behaviour for the group – the behaviour of the maladapted member is doing something for the group

**Dominant**

- Competition with the others or with the leader
- “Who is better in the task performance, who is better informed, who is more self-sacrificing...?”
- “Know-it-all”, “perfect”...
- The leader has to discover the meaning that lies behind domination, talk about it
- Reasons may include fear of close relationships, fear that they will not be noticed...
- The question is, what needs does the individual meet through this role? Can he be helped to meet these needs in another way?

**Informal leader**

- Meets the needs that the formal leader is satisfying less well or insufficiently
- Individuals who have a high status in the eyes of other members who follow him
- The leader can perceive him as a threat to his authority
- He can be a support for the leader
- The leader has to think about the personal goals of the informal leader

**Silent member**

- Can cause problems and tensions because the others don't know what he is thinking and feeling
- Sits and assesses others
- Does not share his/her own problems
- The leader can perceive him as uninterested

It is important to understand the meaning of this behaviour, it can mean different things:

- Silent member feels uncomfortable to talk
- The group works too fast for him
- He doesn't have the same problem as the rest of the members

#### What can the leader do?

- Be straightforward
- Not impose participation
- Know that people differ in how much they talk
- Be aware that one can actively participate just by listening
- Establish an appropriate relationship between the silent member and the others

#### **Saboteur**

- Finds faults in everything
- Avoids doing his part
- May present a negative model

#### What can the leader do?

- React speaking from the "I position"
- Invite members of the group to share their experience of this member's behaviour
- Investigate the cause of such behaviour with the saboteur
- It is important not to ignore such behaviour, but to provide enough freedom for the member and the group to express their reactions to such behaviour

#### **Entertainer**

- Eases group tension
- Can lead to shifting focus of the group away from the real problems
- Sometimes this behaviour may represent his defence against anxiety or developing close relationships, his concealment of insecurity and incompetence

#### **Helper**

- Tries to understand and support everyone in the group
- Helps selflessly
- Eases tension
- Sometimes doesn't work on his problems, because he is focused on others

## Lecture

### Working with adolescents

Adolescence is an important transitional period of human development between childhood and adulthood. This is a time when young people begin to explore their individuality and independence, and starting to think critically about themselves and the world around them. They begin to integrate and adjust the biological, psychological and social changes and challenges that accompany adolescence. It is often claimed that the phenomenon of adolescence is a relative novelty in the history of Western civilization, i.e. that it was first mentioned only with the emergence of the industrial society. In addition to changes in economic relations, Western societies began to experience radical changes of their educational systems, as well as changes in the family structure, family relationships and in the philosophy of child rearing. Because of all this, the position of children and young people began to change as well. All these changes can contribute to problems in adolescents' adaptation to new life roles, which sometimes leads to various externalizing and internalizing problems in their development.

#### Externalizing and internalizing problems of youth

Based on the ecological models of human development and behaviour, it is believed that risk behaviours of children and adolescents develop as a result of a complex interaction of personal dispositions of the child with various risks from different social environments: family, peers, school and local community.

These interactions can lead to two types of problems:

- Externalizing problem behaviors – behaviors directed towards the outside world. The characteristic of these behaviors is that the child/adolescent reacts in ways that cause problems for other people in his/her surroundings. These are insufficiently controlled behaviors.
- Internalizing problem behaviors and experiences – behaviors directed towards oneself. Such behaviors are usually not a problem for people from the child's environment, so they often go unnoticed until the problems become very serious. These are overly controlled behaviors.

Results from research consistently show that internalizing and externalizing problems are associated with negative aspects of the interaction between the parent and the child. The literature on gender differences indicates a higher incidence of externalizing problems among boys, and of internalizing problems among girls, although more recent studies show that these differences are diminishing. Internalization – externalization is a dimension of behavior, not a typology, so a combination of both elements can be found in most children.

The terms *internalizing and externalizing problems* of youth typically refer to low-intensity problems, and they comprise of a number of different behaviors. If there is a greater intensity of problems and if the symptoms meet the criteria for a psychiatric diagnosis, the term *disorder* is used. Co-morbidity is extremely common in the psychopathology of childhood and adolescence, which makes diagnosing difficult (e.g. mood disorders are often associated with other psychiatric disorders that may aggravate or mask depressive symptoms).

Externalizing problem behaviors are, for example, bullying, hyperactivity, aggression, theft, delinquency, etc. Violent and/or delinquent behavior are the most common externalizing problems in children and young people. Underlying such behaviors are often internalizing problems (e.g. a boy who is depressed perpetrates bullying) and/or experiencing domestic



violence (young people learn violent patterns of behavior and of problem solving). From the psychiatric perspective, these diagnoses are usually various conduct disorders.

**Treatment programs** in the framework of cognitive-behavioral approach have been proven effective for violent behavior of young people. Group work is often used, mainly focusing on three key aspects of behavior:

- interpersonal, communication and social skills
- regulation of anger and self-control
- development of moral values, beliefs and attitudes

Internalizing problem behaviors and experiences are, for example, anxiety, depression, loneliness, social withdrawal, tics, enuresis, eating disorders, etc. Specifically, suicidality of youth is a problem from the spectrum of internalizing problems that attracts a lot of public attention. Internalizing disorders that are commonly found in children and adolescents are anxiety and depression, with psychiatric diagnoses that generally correspond to those in adults, but the clinical presentation is different.

### **Anxiety**

- Predominance of worry, apprehension and tension
- Fear of people, going out, going to school and other social situations
- Physical manifestations of fear are common
- Symptoms related to particular diagnoses:
  - **Separation anxiety** – panic resulting from the separation from the parents
  - **Obsessive-compulsive disorder (OCD)** – obsessions (imposing and recurring thoughts) and compulsions (patterns of behaviour which the child repeats in order to avoid a negative outcome and stop the obsessions)
  - **Generalized anxiety disorder (GAD)** – anxiety and worry about future events
  - **Phobias** – social (school) and specific phobias

### **Depression**

- The main symptoms of depression are low mood, irritability and lack of interest
  - **early childhood** – intrusive behaviour, avoiding going to school, anxiety, physical symptoms (abdominal pain, headache)
  - **adolescence** – withdrawal, loss of energy, feelings of worthlessness and guilt, fluctuations in body weight, suicidal thoughts
- Children and adolescents are not always able to explain to adults how they feel
- Adults who care for the child are not always able to recognize depression based on the behaviour of the child or adolescent
- Symptoms of depression have different manifestations in children than in adults

### **Suicidality – warning signs:**

- Changes in sleeping and eating habits

- Withdrawal from friends, family, and from usual activities
- Violent behaviour, running away from home
- Drug and alcohol abuse
- Unusual neglect of physical appearance
- Pronounced personality changes (e.g. mood swings, sudden withdrawal or irritability)
- Difficulty concentrating, constant feeling of boredom or a sudden drop in school achievement
- Frequent complaints of physical problems such as headache, abdominal pain, fatigue, etc.
- Loss of interest in activities that were previously enjoyable
- Irritability when they are commended or rewarded

**Adolescents who plan committing suicide may also:**

- Say that they are a bad person
- Make statements such as: “very soon I won't be a problem to anyone anymore“, “everything is meaningless” or “I wish I was dead”
- Give away all of their favourite things or destroy them
- Become euphoric after a long period of depression
- Show psychotic signs – hallucinate or have bizarre thoughts
- Write poems or essays about death
- Start saying goodbye to the loved ones (e.g. on social networks)

**Characteristics of children/adolescents with behavioral problems**

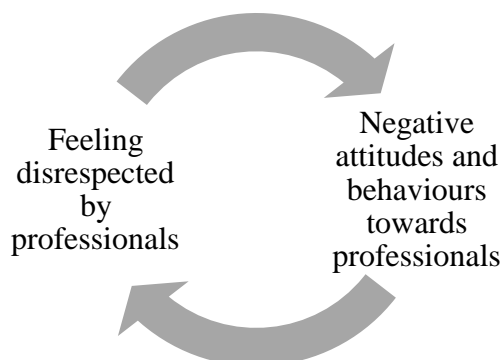
- Often both internalizing and externalizing problems are present
- Experience of numerous difficult life events (adverse childhood experiences - ACE), such as violence and/or neglect in the family, presence of mental problems or drug abuse in the family, parents’ divorce, incarceration of a family member, etc. When four or more such experiences are present, the risk for behavioral problems is 10 times higher
- Low empathy
- Low tolerance for frustration
- Poor self-control
- Poorly developed academic, social and other competences
- Propensity for risky behaviors
- Unwillingness to change
- Resistance and oppositional behaviors

Resistance is a common reaction of adolescents with behavioral problems and therefore the professional's first task is to understand its sources and reduce it, so that cooperation could be achieved.

**Some of the most common factors that can hinder cooperation are:**

- Fear or contempt for authority
- Mistrust to adults
- Unpleasant or bad previous experience with professionals/helpers
- Unknown person or situation
- Fear of possible consequences and outcomes
- Refusing to accept that they have a problem
- Feeling of coercion (involuntariness)
- Feeling that they have nothing to lose
- Feeling that they are not respected
- Cultural differences
- Professional's inadequate actions
- Mental health problems

Since these young people often express an unwillingness to change their behaviors, changes in motivation have to be achieved before starting to work on other issues. The most important thing in dealing with a young person's resistance is establishing a relationship with them. A trusting and respectful relationship is a basis for setting and achieving objectives that are focused on changes in their behavior. On the other hand, feeling disrespected by professional helpers leads to negative attitudes and behaviors of youth toward them, which can cause further inappropriate reactions of professionals and, in turn, more adolescent's negative reactions.



## **Factors that strengthen the relationship with adolescents**

### **Authenticity (credibility)**

- Ability to acquire knowledge and information, and motivation to apply that in working with children and young people. Determined by:
  - Competence (knowledge, skills ... ..)
  - Reliability (predictability, consistency)
  - Motivation to work in the interests of the adolescent
  - Dynamics (activity, energy, self-confidence)

### **Empathy**

- Intensive focus on verbal and nonverbal communication
- User-friendly language
- Showing a lot of understanding
- Similar emotional tone as the adolescent

### **Warmth**

- Commitment (clearly demonstrating the desire to help the adolescent)
- Trying to understand the adolescent
- Spontaneity (the helper also gives something of his own, does not mask emotions)

### **Specificities of talking with children**

- The younger the children are, the weaker is their understanding of verbal messages and questions. When talking to them, it is necessary to adapt the vocabulary to their age and ability to understand, to clarify words and terms that are unfamiliar to them, and check their understanding of what has been said.
- Children also have difficulties in recognizing, understanding and expressing their own thoughts, feelings, and behaviours. Since they have a weaker ability of verbal expression, drawing, games and stories can be used to facilitate their expression of thoughts and feelings.
- Emotional instability (excitement, variability, impulsivity, short term thinking)
- Mistrust to adults / strangers – patience is needed
- Problem of motivation to talk

When talking to adolescents and establishing a relationship with them, certain behaviors can facilitate that and other can make it harder or even prevent it. Therefore, it is advisable to **avoid the following behaviors that usually put off adolescents:**

- Excessive curiosity
- Adjusting, pretending
- Ordering, commanding

- Warning, threatening
- Moralizing, lecturing
- Comforting, minimizing
- Distracting, joking, changing the topic
- Do not condemn, criticize, blame or shame them

**When working with adolescents, use the following:**

- Treat them as equals (although professional distance always exists)
- Be tolerant
- Use clear communication
- Show interest
- Give a lot of information and give the opportunity to ask questions
- Clarify the situation and purpose (explain the reasons why the adolescent had to come and talk to you, if that is the case, what it is that you do and what the objectives of your work are)
- Clarify the roles (especially your role as a helper / professional)
- Clarify expectations/alternatives
- Give the time to adjust
- Emphasize the importance of participation/activity
- Be open and honest, explain (what I want to know, why, they don't have to say something they don't want to...)

**Dealing with resistance**

Resistance to authority is common in adolescence. Sometimes adolescents intentionally contradict adults who are in a position of authority, so it is important that the professional is someone outside of their usual routines. Resistance, the same as change, is interpersonal, so helper's reactions can increase or reduce it.

In dealing with resistance, you should use a lot of active and reflective listening because it shows the adolescents that you have really heard and understood them. Also, in facilitating communication and encouraging them to start a conversation with you, use open questions and show interest in what they are saying. Confrontation can be very useful, although it is recommended in the very beginning, when the relationship has not been established yet. When the adolescent lies or tries to manipulate you or the situation, these behaviors should be openly discussed. That kind of confrontation builds respect towards the helper and strengthens the relationship.

**The helper should be proactive in building the relationship by:**

- Openness/honesty (e.g. *"I often find it difficult to establish a relationship with you"*)
- Expressing emotions / behaviors we noticed (e.g. *"I'm worried because I feel I can't connect with you in a way that would suit you. I'm wondering if you feel that way too?"*)

- Checking with the adolescent (e.g. *“It seems to me that we fail to provide what you need in this relationship, I wonder if we can do something different to make you feel more comfortable and open to conversation. What would you find most useful?”*)
- Offering alternatives (e.g. *“Do you want to continue with this topic or to move to... / leave it for next week and then continue?”*)

### **Motivating for change**

When it comes to willingness to change, children and adolescents most often either:

- Do not perceive the existence of the problem
- Perceive the problem, but aren't ready to do something about it, or
- Are motivated for change, but doubt they can achieve it

#### **If they don't perceive the existence of the problem:**

- Establish a relationship
- Make an arrangement about the direction of your joint work and get the permission to start a conversation about behavioral change
- Obtain an insight into the adolescent's perception of the problem, and personal importance of the problem behavior
- Question the belief that current problem behavior has no consequences
- Increase awareness that problem behavior affects the life of the adolescent and his/her environment
- Build a belief that such behavior could have harmful consequences in the long run
- Identify objective and emotional barriers to changing problem behaviors
- Talk about the social environment: how close people can support change, empowering positive comments from close people

#### **If they perceive the problem, but are not ready to do something about it:**

- Create ambivalence towards current behavior through recognizing more gains than loss in changing it
- Work on internalizing adolescent's extrinsic motivation (identify extrinsic motivators for staying in the treatment and identify intrinsic motivators)
- Provide feedback after behavior assessment
- Create self-motivating statements
- Ask questions about the importance of the objective (e.g. from 0 to 10), about the advantages of change

#### **If they are motivated for change, but doubt they can achieve it:**

- Reduce ambivalence
- Empower self-efficacy and self-confidence – remind of earlier achievements
- Identify barriers to change and analyze potential ways of overcoming them

- Encourage optimism related to change (e.g. “*Why do you think you can achieve that change? What personal strengths do you have?*”)
- Strengthen the intent to change (e.g. “*What part do you think you could change? Can others help you?*”)
- Notice and praise each small sign that the adolescent is moving in the desired direction.

### **Planning the change**

When the adolescent expresses or shows a certain motivation for change, further steps should be planned. Planning the change in adolescent’s behaviour should be a joint task of the helper and the adolescent. The plan should be very structured, divided into smaller steps and all the steps have to be clearly defined and explained to the adolescent. In addition, the plan should be put in writing and revised when needed.

#### **In planning the change, use the following steps:**

1. Define clear short-term objective(s)
2. Identify solutions that worked well before

*What have you tried already? What helped you to deal with a problem, even though if it didn’t last long?*

3. Identify the first step towards achieving the objective

*What little part of the problem can you begin to address first? What could be a step in the right direction for you, even if it means a very small change? What would be a step after that?*

Or scaling steps: *If goal completion is step 10, what are the key steps before that (e.g. 3, 5, 7, 9)*

4. Identify strengths: what can help in achieving the objective

*What can help you achieve your goal? What are your strengths, abilities? Can you count on someone’s help?*

5. Make a specific plan – tasks

*What will we do over the next month or \_\_\_ days? What will we do next week?*

### **The Six-Part Story Method**

This method can be used with both smaller children and adolescents. Also, it is useful in different situations and can be modified for different purposes. Its primary purpose is therapeutic work with children when dealing with stressful and traumatic events. In such situations projective techniques can help in establishing a relationship and talking about topics that are difficult for the child / adolescent.

For using the Six-Part Story Method only a paper and crayons are needed. The helper instructs the child to divide the paper into six equal parts (using a pencil or a crayon, not by cutting it). He/she explains to the child that they will be telling a story without words, by drawing it. Each part of the paper will contain a different drawing:

1. The main character: This can be an imaginary person or someone from a book or a movie; it can be a human being, an animal, or an object, whatever the child wants. The first element of the story should show the main character and the setting around him/her.
2. Objective (main task of the character): In every story, the main character has some kind of a task, mission, some reason for being in the story and this is drawn in the second part of the paper.
3. Helpful factors (Who or what can help him?)
4. Obstructing factors (barriers of completing the task)
5. How does the character face these barriers (what does he/she do)?
6. What happens after the character's action? Does the story have an ending or it goes on after the last drawing?

After drawing these six pictures, the child tells the story to the helper, who focuses on the tone in which the story was told, the context of the story and its topics, the moral of the story (lessons), and strategies for coping with stress. Each picture gives additional information about coping strategies (e.g., does the child show imagination in choosing the character, what kind of beliefs and values are in the core of the character's objective, what kind of help is available to the character, etc.). This method can also help in identifying a current problem that the child may not be completely aware of. Based on his/her analysis of the drawings and the story, the helper can identify child's strengths and coping strategies, and plan further interventions and activities.

### **Group work with adolescents**

Although children and adolescents mostly enjoy working in a group, their participation is often not completely voluntary. This is because parents bring them to the professional because of a problem that they have perceived, but the adolescents do not see the situation as a problematic one or do not think that they are the ones who have to change or do something about it. Furthermore, this kind of group work is often a new experience for them so they do not know what to expect and have different fears and worries about it. That is why the leader should consider giving them "permission" not to be in the group, but also address their expectations and fears regarding group work.

All of the principles of working with adolescents individually also apply to group work. Relationship should be established with all members and with the group as a whole. "Ice-breaking" and "getting to know each other" exercises can also be very useful in this phase. The leader's honesty is very important and adolescents will recognize someone who is pretending and not genuine very quickly. This is another important reason for discussing fears and expectations in the very beginning, so that the members can know what to expect. Group rules should be established and discussed together with all members, which will also reduce some of their fears (e.g. that they will have to talk about something they don't want to in front of the group).

Whenever possible, it is good to include members in planning and creating group activities. The group leader can give them suggestions and direct them, but their ideas should be taken into account. The leader can also bring different guests to the group, especially other older adolescents who have participated in similar groups or have some other experience that is relevant for the members. Peer education and peer-led groups are very effective with adolescent members.



**Topics that may be in focus of group work with adolescents are:**

- Identity (Who am I?)
- Relationship with parents
- Friendship – the importance of belonging to a group
- Peer pressure
- Sexuality
- Life values
- Smoking, alcohol, drugs, risk behaviours
- Planning the future

## **Lecture**

### **Psychoeducational workshops**

#### **Psychoeducational workshops during the war in Croatia**

The purpose of the workshops was:

- Strengthening the resilience of children growing up in difficult and risky circumstances
- Improving mental health of children who were exposed to war events
- Cooperation between the school and NGO

During the war in Croatia there were a lot of communities where children were growing up in difficult conditions that presented a risk for their development. Specifically, in one of the communities the circumstances were: unresolved basic existential needs, separation of families, unemployment and poor living conditions, which further enabled the development of problems such as alcoholism, violence and a rising number of divorces. Furthermore, the resources within the community were scarce and there were no psychologists or other mental health professionals. Teachers and other significant adults were traumatized during the war and exposed to the cumulative effect of stressors when returning to their community.

Therefore, a project focused on that particular community was developed. It was led by a team of two psychologists and one social worker who came to the local community 1-2 times a week and worked directly with children, parents and teachers. During the first phase, all teachers and a part of Centre for social care staff attended multi-day seminars on the needs of children and the possibilities of individual and group work. That was a part of activities focused on establishing good cooperation with local community services, primarily the elementary school and the local Centre for social care, which is crucial for achieving the objectives of the project and its long-term effects.

In working with children, the first task was to assess their needs and mental health so that further interventions could be planned. Three instruments were used for that purpose: Children's Depression Inventory (CDI), Posttraumatic Stress Reactions Scale and a Questionnaire on child characteristics. The assessment was conducted with pupils from 8 to 14 years of age. The results showed that there was a lot of children under heightened risk for developmental problems, specifically 18% of them had pronounced depressive reactions, 17.5% had pronounced post-traumatic stress reactions and almost 6% of children had both severe depressive and post-traumatic stress responses. Based on these mental health indicators, 26% of children were highly at risk. Traumatic events that were most frequently mentioned were related equally to war and refuge, but also to domestic violence.

In planning further interventions, we asked the following questions:

- What are the most vulnerable groups of children? Why is that so? What are the most prominent needs of these children? What are their strengths and resiliencies?
- What can be done when such a large group is at risk? Which approach to use in working with them?
- Who are the stakeholders that should be involved in planning and implementing the program?

Based on the answers to those questions socialization groups for children were planned in cooperation with the teachers, who later continued to lead those groups. High-risk children were identified based on their earlier assessment and both group and individual work were used to answer their needs.

### **Evaluation of the outcomes of psychoeducational workshops for children**

Evaluation model before – after with a control group was used, where children who were not participating in the workshops were the control group. Results showed that depressive and post-traumatic stress responses of children who attended the workshops (treatment group) stayed the same, but those responses increased significantly in the control group. Although the treatment group showed no clear changes in a short period, it was concluded that the intervention was effective because it could be expected that their symptoms would worsen over time, as was observed in the control group. It should be noted that long-term evaluations should be performed to have a clear picture of the effectiveness of such interventions, but this is sometimes very hard to achieve in certain circumstances, such as the state of war.

### **Dealing with a crisis situation**

In such circumstances it is not rare that a crisis situation emerges. For example, during the period of planning this intervention, a 13-year-old pupil, who had been identified as having elevated depressive responses, committed suicide. His friends, who also belonged to the risk group, were present at the scene. One of those friends was previously identified as having the highest score on depressive reactions. Because of such an event, additional interventions had to be planned and executed immediately.

### **What actions were taken?**

- A crisis intervention at the school
- Further education of teachers
- Establishing cooperation with the school medical doctor
- Psychoeducational workshops for children
- Socialization groups for children
- Individual treatment for children who needed it

### **Psychoeducational workshops**

Workshops are a form of group work where participants actively learn and participate in the process of achieving the objectives of the group work. The emphasis is on experiential learning of any topic and with all clients, as well as with other participants, depending on the needs.

This kind of work implies a clear overall structure within which various techniques can be implemented, depending on the topic and the specific characteristics of workshop participants.

### **Psychoeducational approach**

Psychoeducation is a structured interventions that provides:

- Information on the nature, signs, manifestations and consequences of certain psychological states (worries, depression, PTSD, anger, aggressiveness, etc.).
- Information about the strategies that can alleviate a certain psychological state

Purpose of psychoeducation:

- Normalizing the feelings and reactions of individuals and groups by providing information on the expected reactions and feelings in certain adverse situations
- Adopting new strategies of dealing with certain problems and difficulties
- Encouraging further and more intensive treatment if necessary

### **Theoretical basis for psychoeducational workshops**

Psychoeducational approach is based on:

- Cognitive approach
- Contemporary understanding of mental health, which is closely linked to the concept of resilience
- Focused not only on maintaining good mental health, but also on the development of skills and resources that are needed to deal with and survive various life events

### **Psychoeducation and other interventions**

Psychoeducation is:

- More time-limited
- More structured
- More focused on and adjusted to the needs of the group than the individual
- Less interactive
- Assumes less self-disclosure (less “threatening” for the individual)
- Does not include assessment and development of an individual plan for change

### **Steps of planning a psychoeducative workshop**

Generally correspond to the steps of planning group work in general:

1. Needs assessment
2. Defining the purpose
3. Defining the objectives
4. Selecting the approach and methods of work
5. Identifying clients
6. Selecting the mode of work
7. Motivating
8. Preparing the environment
9. Defining evaluation procedures

### **Formats**

It can be implemented in different ways:

- Public lectures
- Educational workshops
- Media program

#### Workshops for children

- Facilitates interaction between children and care-providers
- Allows a large group of children to receive new insights into the sources and signs of their difficulties and to expand their strategies of coping with difficult life situations
- The content needs to be appropriate to the age of the participants
- Adjust the mode of work (subgroups, couples)
- Working in co-leadership is important

#### **Structure of psychoeducational workshops**

Every psychoeducational workshop has the same internal structure:

1. Introduction
2. Introducing the members
3. Warm-up exercise
4. Central activity:
  - a. cognitive
  - b. phase of working through emotions
  - c. return to cognitive
5. Closing activity (good atmosphere and mutual support)
6. Short evaluation of the session

#### **Characteristics of parts of a workshop**

1. Introduction
  - An extremely important part of the session. It comprises:
    - a. Introducing the leaders
    - b. Explaining how the members of the workshop were selected
    - c. The purpose and objective of the meeting, mode of work
    - d. Rules
  - Although this section is short (about 10 minutes), the motivation of members to participate in the workshop depends on its clarity, particularly on explaining the purpose and objectives
  - Introducing the leaders and explaining how the members were selected will affect their readiness to participate, and whether they feel stigmatized

- Information on the mode of work, methods and rules contribute to a feeling of safety in the group
2. Introducing the members
    - There are a number of ways to introduce members to each other, e.g. presenting one's name in a creative way, presenting one's interests and characteristics through interactive games, identifying similarities between members through games, etc.; they contribute to a supportive and fun atmosphere, as well as enable relaxation after initial tension
  3. Warm-up exercises
    - If the leader deems it necessary (releasing tension through a game)
    - Raising the level of energy and focusing on group work
  4. Central activity
    - Members/children follow the leaders' instructions (templates or handouts can be used)
    - It is desirable that the children take home a written record of the content of the workshop, so they can recall and use new knowledge, strategies and skills
    - This stage accomplishes one of the main goals of psychoeducation: normalization by providing information about the most common reactions and feelings in difficult situations
    - The leader encourages the members to share their experiences, and build on that using pre-prepared examples, which facilitates adopting new strategies and skills
    - This phase ends with the return to the cognitive content: summarizing and emphasizing the important points
  5. Closing activity
    - Supportive atmosphere (an activity that supports a sense of belonging to the group)
  6. Evaluation – of the process, after every session
    - It should be short, as a guideline for the leaders for the future (“smiley faces”, a short conversation)

**The psychoeducational approach allows participants to:**

- Develop social skills
- Develop the skills of effective coping with stress
- Expand their network of support
- Give a different meaning to some life situations

All of this contributes to the development of resilience in an appropriate and interesting way for the participants, while also being time effective.

## **Example: PSYCHOEDUCATIONAL WORKSHOP “What do I do when I feel bad”**

**Needs assessment:** improving the mental health of children and developing resilience

**Purpose:** informing, normalizing feelings and reactions, adopting new coping strategies, encouraging further intensive treatment if necessary

**Objectives:**

1. Expanding strategies for coping with difficult life situations
2. Adopting constructive ways of communication
3. Creating a positive self-image
4. Preventing suicide among children and youth

**Approach:** Psychoeducational workshop

**Identifying clients:** through school personnel (psychologists)

**Clients:** 10 to 15 children aged 8-14 years with high levels of post-traumatic stress reactions and depressive symptoms

**Duration:** 180 min (150 min + 2 breaks, 15 min each)

**Location:** the school that the children attend

**Type of leadership:** co-leadership

**Materials:** flipcharts, templates “What I do when I feel bad”, leaflets with coping strategies (leaflet 1 or 2, depending on the age of the participants), templates with circles of social support, A4 envelopes, a ball of wool, crayons

**Motivating:** school personnel (psychologists) motivate the children to participate

**Preparing the environment:** at the teachers’ meeting, the teachers are informed about the workshop, the signs of post-traumatic stress reactions and depressive symptoms, and the appropriate ways to respond

**Evaluation:** oral evaluation of the process at the end of the workshop and outcome evaluation by applying psychological instruments for mental health assessment before and after conducting the workshop (before-after method)

## **Workshop description**

### **1. Introduction**

One of the co-leaders explains to the children why they were invited to the workshop. He/she says that we can all find ourselves in difficult situations in life, in situations when we are sad, worried and anxious. It is a common experience for all children and adults. But we differ in how we deal with such events. Therefore, the aim of this workshop is to learn some behaviours that can help us deal more easily with such situations and express our feelings to others so that they can support us, instead of distancing ourselves further. So, we'll talk about what we can do to feel better when we feel bad.

Duration: 15 minutes

### **2. Introducing the members and defining the rules**

Every child introduces him/herself by saying their names and something they like doing, they enjoy. Along with their name, they can name a characteristic of theirs that they are proud of.

This introduction is important because it points to the strengths of the child and his/her possible mechanisms of coping with difficult situations.

Rules are set in accordance with the principles of forming rules in group work.

Duration: 20 minutes

### **3. Template “What do I do when I feel bad”**

#### **Question 1**

Children are given the template and asked to answer the first question. When the children write their responses, each of them reads what they wrote, and the leader writes down on the flipchart what children do to feel better when they are sad.

Duration: 20 minutes

#### **Question 2**

A group conversation follows, about which ways that help us are “good ways”, and which ways are not so good for dealing with pain. The good ways listed on the flipchart are circled. These ways or strategies are also discussed. For example, if a child mentions that he/she leaves and shuts him/herself in his/her room, we talk about what would happen if this took a long time, if this would be a good or a bad way. The purpose is for the children to learn that there are a variety of good strategies and that it is important to change them, i.e. use diverse strategies depending on the situation.

The children choose and write down some good and bad ways of dealing with pain on the template “What do I do when I feel bad” (question 2).

Duration: 20 minutes



## Leaflet

Children are given an appropriate leaflet (leaflet 1 for younger children, leaflet 2 for older ones). One child reads it out loud (or several children, with each reading a part) and the group comments on some of these strategies. A particular focus is on some of the strategies such as shouting or breaking things. It is explained that we do these not to jeopardize ourselves or our relationships with others further. We suggest some other techniques to them (e.g. drawing their anger and writing down all the feelings and ugly words that come to mind and then tearing up that paper). Some of the techniques can be demonstrated if necessary.

Duration: 20 minutes

## Question 4

A conversation about which of the good ways of coping can help them. The children are asked to write down some of the good ways that they have not yet used, but they think that they might use them in the future (question 4).

Duration: 10 minutes

## Circles of social support

Children are given templates with the circles of social support. They are instructed to write down the people who surround them in the appropriate circles. They write their own name in the circle that says “ME”. Then, in the circle that says “THE PEOPLE CLOSEST TO ME” they write down their favourite people, with whom they like spending time (e.g. mother, father, friend, educator/teacher, cousin, etc.). In the circle that says “PEOPLE WHO ARE QUITE CLOSE TO ME” they write down people who are also dear to them, but are somewhat less close to them than the previous ones. In the circle that says “PEOPLE WHO I HAVE SUPERFICIAL RELATIONSHIPS WITH, ACQUAINTANCES”, they write down people who they don’t know well, but they like them and would like to be closer to them.

Then they are asked to circle the people whom they can turn to for help when they feel bad or when they need support.

Duration: 10 minutes

## Question 6

Children should choose one person from whom they would like to get support in the next week and write down their name (question 6). Encourage them to choose someone among the participants.

Duration: 5 minutes

#### Question 7

Children choose one of the good ways to cope that they will apply in the next week and write it down (question 7).

Duration: 5 minutes

#### **4. Closing activity**

Every child is given an envelope (A4 size). Ask them to draw on it something that represents a symbol of safety for them. Then they put all their papers into the envelope with instructions that, whenever they feel sad, they can open the envelope and remember all the different things they can do in this situation and all the people they can turn to, who can provide them with support.

Children stand up and put their envelopes on the floor in front of them. The leader takes a ball of wool and hands it to someone with the instruction to wrap the thread around their wrist, and throw the rest of the wool to the child whose symbol they like. This child also wraps the thread around his/her wrist and throws the ball of wool to the next one and this process is repeated; the children first have to be instructed not to throw the ball to someone who already received it. This continues until all children have a part of the thread wrapped around their wrists. A net that reflects the importance of connectedness and support is created. This is emphasized to the children, noting that it is important to remember this support network when they're sad and alone. Then they can each tear off the piece of the thread wrapped around their wrists and tie it as a bracelet that they can keep as a memory of that day's meeting.

Duration: 20 minutes

#### **5. Evaluation**

A brief conversation about how they liked the workshop and whether it was useful for them.

Duration: 5 minutes

### Template „What do I do when I feel bad“

1. What do you do when you feel bad? What do you need in order not to feel better?

--

2. What do people do to reduce pain? Write good and bad ways of dealing with pain.

GOOD	BAD

3. Leaflet

4. Which of these good ways of coping can help you? Write some down. Add some that you haven't used yet, but you think you could.

--

5. Write down the people who surround you in these circles. Among them, circle those people whom you can turn to when you need support or when you feel bad.
6. Choose one person who you would want to turn to for a conversation or support in the following week. Write down the name of that person:

\_\_\_\_\_

7. Choose and write down one of the good ways of coping that you will apply in the next week:


## **Leaflet 1**

### **What do you do when you feel bad?**

1. I hug one of my toys or other things
2. I think about what I'm going to do
3. I cry to feel better
4. If I think I did something wrong, I try to fix it
5. I eat or drink
6. I pray
7. I draw something, write or read
8. I look for someone's help to solve this problem
9. I fight with someone
10. I try to think about something nice
11. I hit, throw or break things
12. I tease someone
13. I play
14. I yell or scream
15. I run or walk away
16. I try to solve this problem in different ways
17. I talk to someone about how I feel
18. I walk, run or ride a bike
19. I try to forget about it
20. I try to relax, stay calm
21. I console myself that things are not as bad as they seem
22. I watch TV or listen to music

## Leaflet 2

You have experienced an event that causes intense feelings or physical reactions in most people, which can interfere with your daily life and cause much suffering, sadness, anxiety. Maybe you feel like this right now or you may have such feeling later. **It is perfectly normal and common for most people to have such a reaction.** Sometimes such reactions occur immediately after a difficult event, sometimes after a few hours or days. In some cases, it may even take weeks or months.

These are some common signs and consequences that may occur after a difficult event:

**PHYSICAL** signs: fatigue, nausea, vomiting, weakness, headache, difficulty breathing, shortness of breath, heart pounding, sweating, difficulties with sleeping, increase in blood pressure (each of these signs requires a consultation with a doctor)

**THOUGHTS:** difficulties to concentrate, poor memory, “dark” thoughts, frequent returning of some images and thoughts about the event, nightmares, distrust toward others, blaming someone

**EMOTIONAL:** anxiety, resentment, anger, depression, sadness, apathy, feeling helpless, loneliness, discouragement, feeling of emptiness

**BEHAVIOURAL:** withdrawal from others, inability to rest, changes in relations to friends or family, increased aggressiveness (desire to hurt someone), hypersensitivity in relation to the people who surround you, crying, shouting, fist clenching, jaw clenching, changes in the manner of talking, change in appetite, loss of interest in usual activities

Signs such as these listed above can last several days, weeks or a few months. With the understanding and support of close people in the family, school or anywhere else where you live, these consequences can disappear faster.

It may be that this difficult event and your reactions to it become so painful that it may be necessary to see a psychologist or a doctor. This does not mean that you are weak or crazy. It simply means that whatever you experienced was too strong and difficult and that you need support to cope with it easier and faster.

Here are some things you can do for yourself:

- **CARE ABOUT YOUR FEELINGS**  
Maybe you can help others by checking how they are, sharing with them what you are feeling
- **SPEND TIME WITH PEOPLE WHOSE COMPANY YOU ENJOY**  
Spend free time with friends and those with whom you like to be, **DON'T ISOLATE YOURSELF**
- **STAY IN TOUCH WITH THE PEOPLE WHO ARE IMPORTANT TO YOU**
- **RE-READ FAVOURITE BOOKS AND WATCH FAVOURITE MOVIES**
- **ALLOW YOURSELF TO BE ACTIVE, DO THINGS, MEET PEOPLE, GO TO PLACES YOU LIKE**
- **ALLOW YOURSELF TO CRY**
- **FIND THINGS THAT CAN MAKE YOU LAUGH**
- **EXPRESS YOURSELF BY PARTICIPATING IN A GROUP**
- **ARRANGE EVENTS IN THE PLACE WHERE YOU LIVE, GIVE SUGGESTIONS TO THE SCHOOL AND TEACHERS**

This difficult period of your life will not be made easier by taking tranquilizers or alcohol – they will only aggravate the problem

**PLAY** with those younger than yourself...

**PLAY** with peers...

**PLAY** with pets...

**PLAY** with parents...

**PLAY**...

**Sometimes it is enough to choose only one option that you didn't use before to make you feel better.**

These things will make you feel better:

#### PHYSICAL CARE

Eat regularly and diversely, even if you don't care about food

- Go to the doctor regularly when you need to, when you're sick
- Go for regular check-ups, for example, at the dentist's
- Do sports or other physical activities that are fun: exercise, swim, dance, walk, run
- Get enough sleep
- Go out with friends or relatives on an outing
- Rest enough
- Wear clothes that you like

#### PSYCHOLOGICAL CARE

- Take time for thinking about yourself
- Keep to your normal lifestyle as much as possible
- Talk to the person you trust when you feel bad - talking to people you trust is good
- Keep a journal, write poems and stories, anything you can think of
- Do something that you are not very good at, but it makes you happy
- Let others see different sides of you
- Go to an exhibition, theatre, sporting event, movies
- Let others give you small gifts (e.g., a drawing, a flower)
- Be curious
- Sometimes say no to some obligations
- Spend time in nature
- Nurture and share your optimism and hope

- Accept that you don't have to be perfect at everything
- Discover what is important to you and what place this has in your life
- Sing
- Have a role model (favourite singer, actor)
- Read and listen to what inspires you (books, favourite music, comic books, fairy tales, poems, novels...)

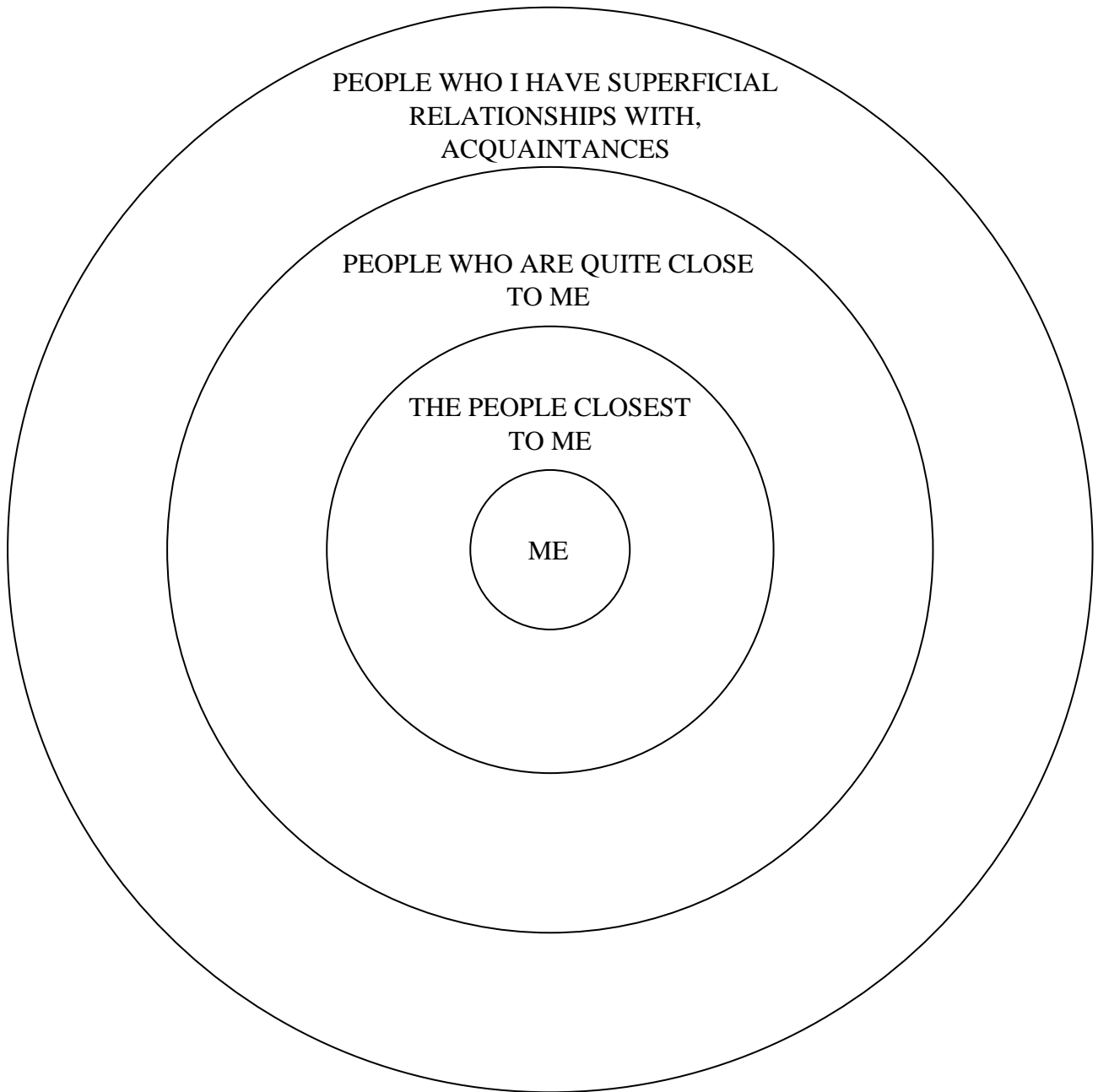
#### SPIRITUAL CARE

- Take time for reflection
- Pray

#### SCHOOL AND OBLIGATIONS

- USE school BREAKS - don't study during the breaks, socialize with others
- Organise your time - be busy with different jobs and activities
- "Chat" (talk casually) with friends
- Discover which obligations you find exciting and interesting
- Create a comfortable working place for yourself
- Ask if you don't know something
- Try to make decisions every day, no matter how small, to keep a sense of control over your life (for example, if people ask you what you would like to eat, answer them, even if you don't feel like eating anything or you're not sure what you'd like)
- Negotiate for your needs
- Talk to your peers about difficult assignments, ask them for help

Thoughts and dreams in which you relive an event, as well as occasional flashes of memories, are normal - they will eventually become less frequent and less painful. You're normal and **you're having a normal reaction to a difficult event. These reactions, although painful, show that you are a normal human being.**



## Lecture

# Planning and leading educational (training) workshops for helpers

## Planning educational workshops for helpers

In order to successfully carry out the workshop for helpers, it is necessary to take into account certain steps for planning group work, which can also be applied to other time-limited workshops. Principles of structuring group meetings should also be followed in structuring workshops. In other words, all previously addressed principles also apply here.

The following steps for planning group work are particularly important and have certain specificities that have to be taken into account:

### Needs assessment

- It is first necessary to assess and/or find out which topic (of all topics covered by different modules) is the most relevant for the participants (helpers) who will be targeted
- It is very important to have an insight into what is relevant to their professional work, so that the topic wouldn't be something that is not useful for the participants or something they are already experts in
- The topics shouldn't be chosen simply because they are interesting to the trainer, but based on the participants' needs
- Assessment of needs could be very useful in identifying the best topic for your participants

### Defining the purpose and general objectives of the group

- Clearly define the purpose and goal of the workshop, i.e. exactly what it is that you want to achieve (goals related to topics such as family violence, professional stress, work with adolescents, group work...)
- Given the time constraint of each workshop, objectives should be especially clearly defined and formulated
- They should be relevant for potential participants and their needs

*Example of workshop purpose:* To expand the professionals' scope of techniques for prevention of professional stress and job burnout (Module 2)

*Example of workshop objectives:*

1. To introduce to the helpers how to identify and classify professional stressors
2. To introduce to the helpers techniques of self-help and prevention of professional stress

### Selecting a group approach and modes of work

The leader must decide in advance which method would be the most appropriate for the achievement of workshop objectives, e.g. group discussion, interactive activities, cognitive approach, creative techniques, a combination of different approaches, etc. For work with helpers it is recommended to use a combination of interactive lectures and interactive activities.

If it is possible, co-leadership should be used because of its advantages in the early stages of planning and leading workshops. Group size depends on the chosen group objectives, but since it is an educational workshop for helpers, it is possible to include up to 20 participants.



### Identifying potential group members and group composition

Potential participants can be “identified” in their own professional environment or through other organizations that deal with the chosen topic. Various methods can be used, such as personal communication, discussion with organizational leaders, etc.

Workshop participants should be chosen based on their needs and the purpose and objectives of the workshop:

- If, for example, the chosen topic relates to professional stress and job burnout, professionals of different profiles and professions can be included
- If, on the other hand, the topic of working with trauma is concerned, it is important to take into account what prior knowledge and experience in this field the helpers have

Homogeneity / heterogeneity criteria:

- Participants will be heterogeneous in terms of age, sex, occupation, and homogeneous in belonging to a helping profession (e.g. psychologists, social workers, medical workers, activists or volunteers working with people who are victims of violence, war conflicts, etc.)
- The level of prior knowledge and/or experience with the topic should be determined in advance, so that all participants could benefit from their participation – challenges of working with individuals with various levels of knowledge and experience should be identified in advance and minimized as much as possible (e.g. through choosing appropriate content of the workshop, and also work methods and activities)
- Potential challenges of working with participants who have different work roles or are at a different level in the hierarchy within the organization (e.g. if a superior and a subordinate both participate in the workshop) should also be identified and planned for in advance

### Preparing the group environment

Social environment

- Participants’ absence from their work assignments during the workshop should be discussed in advance with their superiors (including the explanation of the benefits of their participation)
- It is important for the management of the participants’ organizations to clearly communicate the criteria of inclusion in the workshops with all employees, so that everyone understand why some employees were chosen to participate and others have not

Physical environment

- Determine where the workshop will take place
- It would be good to conduct it in an environment where you won’t be disturbed, for example, not in the participants’ workplace, because they will not be focused on the workshop due to everyday job demands as distractors
- It is important that the space is comfortable for the anticipated number of participants and that peaceful and uninterrupted work is enabled

### Defining evaluation procedures

Create a short and simple evaluation of the workshop that will include the assessment of:

- Usefulness of the workshop
- Acquisition of new knowledge and skills
- Possibility of applying new knowledge and skills in own professional context
- Your leading of the workshop
- Group atmosphere
- Improvement suggestions

### **Structuring the workshop**

The rules for structuring a workshop are the same as when structuring individual group meetings. The difference is that a workshop is a shorter type of work and therefore extremely structured. Nevertheless, no matter whether the work lasts for 4 hours, one day or two days, the rules on structuring group work are universal. The planning, initial, central and final phase of group work always exist (regardless whether the group lasts over several weeks, months or years) and workshops, which last considerably shorter, also need to go through all of these phases – initial, central and final phase can all take place in 4 hours of a workshop.

As always in structuring group meetings and group work in general, the leader's activities focus on:

- Determining the work program, i.e. what is done in the group
- Determining the work methods, i.e. how it is done
- Developing appropriate communication patterns

Rules of structuring group meetings also apply on structuring educational workshops:

- Work program should follow the natural steps of the process (e.g. learning skills, improving knowledge)
- The content of the workshop should also be adjusted to the phase of work, its characteristics and specific objectives (such as the introduction of members, achieving workshop objectives, preparing for the ending of the workshop...)
- The overview of the workshop should include a detailed description of the activities (what each leader says/does, what participants say/do, what are their expected reactions...), their duration, and the materials needed for their implementation

Like all meetings in “time-limited groups”, an educational workshop usually includes:

- Educational content
- Various interactive content and exercises that help members successfully acquire specific knowledge and skills
- Discussions on experiences in the group and the difficulties that can be expected in the application of new skills outside of the group
- Brief overview of newly acquired knowledge and skills (summing up)
- Evaluation of the workshop

*Example:* Structure of a 4-hour workshop

#### **1. Introductory activity / activities (30 – 45 minutes)**

- Stating the context (the purpose and objectives of the workshop) and group rules

- Introduction of participants
  - Participants' expectations
  - Interactive activities, "warm up activities"
2. Central activities (2,5 – 3 hours)
    - Achieving the objectives through various activities (lectures and interactive exercises)
  3. Final activity / activities (15 – 30 minutes)
    - Reflecting on acquired knowledge and skills; relaxation; interactive games; rounding up the workshop
  4. Evaluation of the workshop (15 minutes)
    - Written evaluation; participants' and leader's final observations

## MODULE 4 – WORKSHOPS

### Module 4, Workshop 1

#### **Phases of group work** (60 minutes)

##### Objectives:

3. To understand the specifics of different phases of group work.
4. To be able to adapt the structure of group meetings to the specifics of a particular group work phase.

##### Expected outcomes:

6. Participants will recognize the phases of group work
7. Participants will understand the processes that are specific for different phases of group work
8. Participants will understand the specific tasks of group leaders in different phases of group work

##### Materials:

- 6 flip charts with a drawn table: *Specifics of phases of group work* containing names of the phases of group work and aspects for each phase
- 6 sets of cut paper slips with specifics of different phases of group work
- 6 glues/scotch tapes
- Handout 1 - *Description of process in phases of group work* (for each participant)
- Handout 2 - *Correct classification of specifics of phases of group work* (for each participant)

##### Methods:

Two groups with 15 participants.

1. The trainer explains that there are 3 phases of group work: initial, central and final phase. Each of those phases has its own specifics when it comes to the thoughts, emotions and behaviours of members and leaders. There are also specific characteristics of the group processes that occur. These phases are universal for all groups, regardless of the type of group or group members. The leader of the group has to understand them in order to react accordingly to certain behaviours of group members and to guide the group processes in an appropriate manner. The aims of each phase are shortly explained by the trainer. (10 min)
2. The participants are divided into 3 groups of 5.
  - a. Each group is given slips of paper with specifics of phases of group work. They are also given a flipchart (prepared beforehand) with names of the phases of group work and 3 aspects for each phase (characteristics of group process, behaviour and experiences of members and the role of the leader).
  - b. The task is to assign different characteristics of the process, members and group leader to a specific phase of group work. The participants discuss and glue slips of paper to the appropriate positions in the table on the flipchart. (15 min)
  - c. Each group presents their answers for one of the phases of group work and other groups comment whether they have chosen some different answers. The trainer discusses their answers with the participants and explains. (35 min)
3. Participants receive handouts with the specifics of phases of group work.

**Handout 1: Correct classification of different phases of group work**

	<b>Characteristics of group process</b>	<b>Behavior and experiences of group members</b>	<b>Role of the group leader</b>
<b>Initial phase</b>	<ul style="list-style-type: none"> <li>- The aim of the group is clearly set; it is being discussed</li> <li>- Neither structure nor norms of behavior are developed – modes of work are determined</li> <li>- All that is in common for the members is observed and pointed out – the foundation of group cohesion</li> <li>- Members are oriented towards each other, the group, the leaders and the mode of group work</li> </ul>	<ul style="list-style-type: none"> <li>- Members are careful; they participate and avoid</li> <li>- Anxiety (unknown)</li> <li>- Mutual distrust – distance</li> <li>- No personal expressions</li> <li>- Members retain possibility of withdrawing from the group</li> <li>- Members are unsure how to find their way around and cope with the demands</li> <li>- Members don't see the mutual similarity and connection yet</li> </ul>	<ul style="list-style-type: none"> <li>- The leader helps in explaining and considering goals</li> <li>- Directs the enactment of the group "contract"</li> <li>- Encourages connection between members</li> <li>- Helps in identifying what members have in common</li> <li>- Helps include members in the group</li> <li>- Alleviates anxiety</li> <li>- Facilitates communication</li> <li>- Helps establish rules</li> <li>- Identifies individual members' needs</li> </ul>
<b>Central phase</b>	<ul style="list-style-type: none"> <li>- Adoption of group norms and modes of group work</li> <li>- Development of norms: how to communicate, resolve conflicts and disputes, mutually encourage, support each other etc.</li> <li>- Structure of mutual relations is created – roles and status</li> <li>- Development of the sense of community and mutuality</li> <li>- The group becomes a place where members can work on their problems, share experiences and opinions, discuss, be involved in conflicts, try out new skills, to share...</li> </ul>	<ul style="list-style-type: none"> <li>- Members test and review the situation in the group</li> <li>- Members are looking for where they can fit in, find their role and define their status</li> <li>- Assessing each other, fighting for power, competing</li> <li>- By the end of this phase members find place in the group</li> <li>- Members feel more accepted and they more readily accept others</li> <li>- More willing to risk exposing themselves and their ideas</li> <li>- Members explain their goals and what they want to achieve by participating in the group</li> </ul>	<ul style="list-style-type: none"> <li>- Encourages development of positive group norms</li> <li>- Helps members get to know each other better, identify common needs, interests, concerns, feelings, ways in which they can help each other</li> <li>- Improves communication within the group</li> <li>- Encourages members to share their problems in the group, to support and give each other feedback</li> <li>- Encourages constructive conflict resolution</li> <li>- Encourages members to try out different skills</li> </ul>

		<ul style="list-style-type: none"> <li>- Members recognize that the goals can be achieved – they are more motivated</li> <li>- Members understand and accept the role of the leader</li> <li>- Members are less dependent on the leader</li> <li>- Members rely more on each other</li> <li>- Members perceive the group experience as unique</li> </ul>	
<b>Final phase</b>	<ul style="list-style-type: none"> <li>- Talking about ending group work</li> <li>- Consolidating positive changes</li> <li>- Members are distancing from each other and from the leader</li> </ul>	<ul style="list-style-type: none"> <li>- Members talk increasingly about changing their behavior patterns outside of the group</li> <li>- Members critically review their experiences, share feelings, evaluate</li> <li>- Members begin to find satisfaction outside of the group, find new activities</li> <li>- Ambivalent feelings of the majority of members: pride in the progress made, fear of loss of support both from the group and the leader</li> <li>- Many members want to continue the group work</li> <li>- Possible reactions: denial of the end or of positive significance of the group; regress to earlier behaviour patterns, premature abandonment of the group, going to a new group (so-called constructive escape)</li> </ul>	<ul style="list-style-type: none"> <li>- Assesses members' progress, helps them to stabilize it</li> <li>- Prepares members for ending of the group</li> <li>- Helps members express ambivalence towards the end of group work</li> <li>- Sets goals for the period remaining until the end of the group</li> <li>- Assists in evaluation of the group experience</li> <li>- Shares observations on the progress and expresses confidence in members' ability to continue without the group and the leader</li> <li>- Supports members' efforts to leave the group and develop new relationships</li> <li>- May have mixed feelings: satisfaction with the progress of the group, but also sorrow for the termination of the group</li> </ul>

## Handout 2 *Description of process in phases of group work*

### INITIAL PHASE

Members' position	Required processes	Role of the leader
<p>Uncertainty about the unknown Trust versus distrust Approaching versus avoidance</p> <p>Approaching behaviors:</p> <ul style="list-style-type: none"> <li>- want a relationship with the leader and other members</li> <li>- want to achieve the purpose</li> <li>- want to open up</li> <li>- want closeness</li> <li>- want to be accepted</li> </ul> <p>Avoidance emotions:</p> <ul style="list-style-type: none"> <li>- fear of the unknown</li> <li>- fear of not being accepted by others</li> <li>- fear of failure</li> <li>- fear of being hurt</li> <li>- fear of vulnerability</li> <li>- fear of involvement</li> <li>- fear of distrust</li> </ul> <p>Exploration Not committing Allowing oneself the opportunity to withdraw from the group Maintaining distance</p>	<p>Focus of:</p> <ul style="list-style-type: none"> <li>- leader on the group</li> <li>- members on the situation</li> <li>- members on the leader</li> <li>- members on the other members</li> <li>- members on the group plans</li> <li>- members on the time, place, frequency, content of the meetings</li> </ul> <p>Defining modes of group work and forming of group:</p> <ul style="list-style-type: none"> <li>- rules</li> <li>- values</li> <li>- models of communication</li> </ul> <p>The purpose of the group must be clearly defined through discussion, agreement and acceptance. Although the purpose was individually discussed with each member, the same must be done with group together to establish a reference point (which is important later).</p> <p>Identify and establish common interests to develop cohesion.</p>	<p>Facilitates group forming processes.</p> <p>Responds to members' expectations for direction, structure, approval and assistance.</p> <p>Active – at the beginning, members are more dependent on the leader.</p> <p>Helps every member join the group, reduce uncertainty, communicate and explore, and yet to keep a certain distance.</p> <p>Acknowledges everyone's feelings of insecurity, expresses his/her confidence in the potential of the group to achieve its purpose.</p> <p>Helps members explore and discuss the purpose, reach an agreement.</p> <p>Facilitates connections between members, helping them to see what they have in common.</p> <p>Helps establish group norms – mostly achieved through actions of the leader, verbal and non-verbal.</p>

## CENTRAL PHASE

Members' position	Required processes	The role of the leader
<p>At the beginning of central phase members are still:</p> <ul style="list-style-type: none"> <li>- exploring and testing the situation</li> <li>- discovering where they belong</li> <li>- comparing each other</li> <li>- struggling for power</li> <li>- competing for leadership</li> <li>- searching for their roles</li> <li>- negotiating their status</li> </ul> <p>At the end of central phase members:</p> <ul style="list-style-type: none"> <li>- found their place in the group</li> <li>- found other people that they like (possible formation of sub-groups)</li> <li>- feel better understood and accepted by the others</li> <li>- more accepting and understanding of other members</li> <li>- recognize similarities and differences, and realize how useful they are</li> <li>- recognize everyone's uniqueness</li> <li>- see own contribution</li> <li>- feel the attraction and the desire to share with other members</li> <li>- try to understand how the leader and other members perceive the group</li> <li>- understand the meaning of the group for them</li> <li>- clarify their personal goals</li> </ul>	<p>Group culture, modes of action, and norms of behavior need to be developed, recognized, understood and accepted. The same is needed for norms how to express, manage and resolve conflicts and differences.</p> <p>Norms that help experimentation, flexibility and responsibility for supporting and encouraging each other need to be established.</p> <p>Models of social interaction and communication need to be developed.</p> <p>Structure of interpersonal relations, status determination, order, leadership and roles appears.</p> <p>Realistic group goals need to be clarified and defined. The needs and goals of individual members with regard to the group goals and the needs of other members should be understood.</p> <p>Perception of the group by the members and the leader needs to become compatible.</p> <p>Members need to test the leader and other members, and become confident that they can express their feelings and bring their problems to the group without being dismissed or punished.</p> <p>Members need to respect their similarities and differences.</p>	<p>Facilitates group processes.</p> <p>Supports normative behavioral patterns, has significantly less central role, maximizes the leadership of the group and its functioning.</p> <p>Assesses the group development:</p> <ul style="list-style-type: none"> <li>- what phase the group is in</li> <li>- how it is progressing</li> <li>- what the stresses and strains are</li> </ul> <p>Assesses each member: attitudes, relations, behavior, motivation, goals, integration in the group.</p> <p>Helps the group clarify the goals, encourages discussion among members, includes members in the decision-making processes.</p> <p>Continues to encourage development of group norms.</p> <p>Recognizes similarities between:</p> <ul style="list-style-type: none"> <li>- members' goals</li> <li>- ways of harmonizing goals</li> <li>- members' interdependent concerns</li> </ul> <p>Recognizes differences between the members, between the leader and members.</p> <p>Helps members get to know each other, realizes how they can help each other; helps</p>



<ul style="list-style-type: none"> <li>- recognize that their goals can be fulfilled within the group</li> </ul> <p>Members test whether the leader cares about them and accepts them, how the leader will use his/her authority, will he/she protect them.</p> <p>Members understand and accept the leader's role, become less dependent on the leader, trust each other more.</p> <p>As the members feel more confident and comfortable:</p> <ul style="list-style-type: none"> <li>- stand out more</li> <li>- share more about their experiences, feelings, opinions,</li> <li>- willing to risk exposing themselves and presenting own ideas</li> </ul> <p>Focus on group goals: Discussions become more focused. Members are more committed to working on problems and helping each other. Having been successful, they become more involved with the problems, and see how they concern them. They support other members in opening up and support their efforts to solve problems. Observe more similarities/differences. As the group becomes more important in their lives, members perceive the group experience as unique.</p>	<p>Membership needs to become stable.</p> <p>Individuals should be engaged, committed to the group, its goals, other members and the leader.</p> <p>Group cohesion needs to be developed.</p> <p>Group should be seen as a setting where members can actually work on their problems – exchange, discuss, confront, try out, really share.</p>	<p>identify common interests, concerns and feelings.</p> <p>Allows members to test the leader and group rules, but also sets boundaries; does not let people hurt each other.</p> <p>Promotes flexibility among the roles so that members can try out and modify the ways in which they will contribute to the group and the relationships with others. The leader may need to directly confront members if they to treat others based on stereotypes.</p> <p>Works to improve group communication. Points out when people do not listen to each other, or that it is okay to be angry. Encourages members to support or explore comments and behaviour of others, and bring their own examples to the group.</p> <p>Intervenes and manages conflicts if they become too threatening. (At this stage, the conflicts and disagreements are expected.)</p> <p>Confronts members with their irrational opinions, undesirable behaviors.</p> <p>When necessary, works with members individually – to encourage them to express themselves in the group, to help them better understand what was going on in the group, or, after much conflict, to help them understand their tendency to leave the group (to escape, avoid a difficult situation).</p>
--	--	---

## FINAL PHASE

Members' position	Required processes	The role of the leader
<p>Members talk more about their successful efforts to try new things and change their existing patterns of behaviour outside of the group. Communication is free and simple.</p> <p>Members are starting to move away – they find satisfaction in relationships outside of the group (they can terminate the relationship with the other members, causing a weakening of group cohesion) and/or in new activities.</p> <p>Members talk about the changes that have occurred in themselves and in the group. They look back on past experiences, mourn them, evaluate them, and show a desire to relive earlier experiences (to show that they know better now).</p> <p>Many members think about the end with ambivalence and uncertainty – they realize that they have made progress, but they are afraid that they will lose the support of the leader and the group.</p> <p>Group experience may have been so positive and pleasant that the members may wish to continue working in a group.</p> <p>Different possible reactions:</p> <ul style="list-style-type: none"> <li>- Denial – of the end and of the possible meaning of the group experience.</li> </ul>	<p>Necessary to talk about the ending.</p> <p>Necessary to stabilize the benefits that were achieved.</p> <p>Necessary to help members leave the relationship with the leader, group and their mutual relationships.</p> <p>If this group experience had a significant impact on the members, it must become a reference point for members when they enter new groups and situations.</p> <p>Termination of satisfying the group's needs.</p>	<p>Facilitates group processes.</p> <p>Prepares members for the group ending.</p> <p>Estimated their readiness and desire to terminate the group. Can the members continue to improve outside of the group?</p> <p>Assesses progress towards achievement of goals.</p> <p>Helps members stabilize their improvements.</p> <p>Opens up the topic of ending of the group (talks early enough about the need for finishing the group).</p> <p>Anticipates reactions of members to the ending.</p> <p>Sets goals to be met within the scheduled time, before the end of the group.</p> <p>Plans time and content in order to gain the maximum out of the remaining meetings.</p> <p>Helps members express their ambivalent feelings to the group ending.</p> <p>Helps evaluate group experiences.</p> <p>Supports members who have not made as much of a progress as they had hoped for, or as other members did.</p>

<ul style="list-style-type: none"> <li>- Regression – they return to earlier forms of behaviour, feel unable to cope with relationships and tasks that were previously mastered; act as in the earlier stages of the group; negative symptoms may occur so as to show: “We are not better; we still need the leader and the group”.</li> <li>- Escape – they don't come to meetings, quit before the official end; show hostility toward the leader and other members (message: “I'll leave you before you leave me”).</li> <li>- Constructive escape –they start attending a new group, start other relationships</li> </ul>		<p>Shares his/her view on the progress and his/her confidence in the ability of members to carry on without the leader and the group.</p> <p>Supports the efforts of members to move away from the group, to develop new relationships outside of the group.</p> <p>Clarifies the nature of any continued relations with the group or individuals. If necessary, the leader is available to an individual to help him/her.</p> <p>Contacts others who need to be included (staff, family members).</p> <p>Helps members link their group experience with future life experiences as directly as possible.</p> <p>Is aware of own ambivalent feelings related to the group ending. The leader may be satisfied with the progress, but feels the loss and regrets not having helped members more</p>
---	--	--

Drawing for the flip chart *Specifics of phases of group work*

	Characteristics of group process	Behavior and experiences of group members	Role of the group leader
Initial phase			
Central phase			
Final phase			

Sentences of specifics of different phases of group work to be cut into paper slips

THE AIM OF THE GROUP IS CLEARLY SET; IT IS DISCUSSED
NEITHER THE STRUCTURE NOR THE NORMS OF BEHAVIOUR ARE DEVELOPED – MODES OF WORK ARE DETERMINED
ALL THAT IS IN COMMON FOR THE MEMBERS IS OBSERVED AND POINTED OUT – THE FOUNDATION OF GROUP COHESION
MEMBERS ARE ORIENTED TOWARDS EACH OTHER, THE GROUP, THE LEADERS AND THE MODE OF GROUP WORK
MEMBERS ARE CAREFUL; THEY PARTICIPATE AND AVOID
ANXIETY (UNKNOWN)
MUTUAL DISTRUST – DISTANCE
NO PERSONAL EXPRESSIONS
MEMBERS RETAIN THE POSSIBILITY OF WITHDRAWING FROM THE GROUP
MEMBERS UNSURE HOW TO FIND THEIR WAY AROUND AND COPE WITH THE DEMANDS
MEMBERS DON'T SEE MUTUAL SIMILARITY AND CONNECTION YET
THE LEADER HELPS IN EXPLAINING AND CONSIDERING GOALS
THE LEADER FACILITATES AGREEING ON THE GROUP "CONTRACT"
ENCOURAGES CONNECTION BETWEEN MEMBERS
HELPS IDENTIFY WHAT MEMBERS THEY HAVE IN COMMON
HELPS MEMBERS' INCLUSION IN THE GROUP
ALLEVIATES ANXIETY

FACILITATES COMMUNICATION
HELPS ESTABLISH RULES
IDENTIFIES INDIVIDUAL MEMBERS' NEEDS
ADOPTION OF GROUP NORMS AND MODES OF GROUP WORK
DEVELOPMENT OF NORMS: HOW TO COMMUNICATE, RESOLVE CONFLICTS AND DISPUTES, MUTUALLY ENCOURAGE, SUPPORT EACH OTHER ETC.
STRUCTURE OF MUTUAL RELATIONS IS CREATED – ROLES AND STATUS
DEVELOPMENT OF SENSE OF COMMUNITY AND MUTUALITY
GROUP BECOMES A PLACE WHERE MEMBERS CAN WORK ON THEIR PROBLEMS, SHARE EXPERIENCES AND OPINIONS, DISCUSS, BE INVOLVED IN CONFLICTS, TRY OUT NEW SKILLS, SHARE...
MEMBERS TEST AND REVIEW THE SITUATION IN THE GROUP
MEMBERS LOOKING FOR WHERE THEY CAN FIT IN, FIND THEIR ROLE AND DEFINE THEIR STATUS
ASSESSING EACH OTHER, FIGHTING FOR POWER, COMPETING
BY THE END OF THIS PHASE THEY HAVE FOUND THEIR PLACE IN THE GROUP
MEMBERS FEEL MORE ACCEPTED AND MORE READILY ACCEPT OTHERS
MEMBERS MORE WILLING TO RISK EXPOSING THEMSELVES AND THEIR IDEAS
MEMBERS EXPLAIN THEIR GOALS AND WHAT THEY WANT TO ACHIEVE BY PARTICIPATING IN THE GROUP
MEMBERS RECOGNIZE THAT THE GOALS CAN BE ACHIEVED – THEY ARE MORE MOTIVATED
MEMBERS UNDERSTAND AND ACCEPT THE ROLE OF THE LEADER

MEMBERS ARE LESS DEPENDENT ON THE LEADER
MEMBERS RELY MORE ON EACH OTHER
MEMBERS PERCEIVE THE GROUP EXPERIENCE AS UNIQUE
ENCOURAGES THE DEVELOPMENT OF POSITIVE GROUP NORMS
HELPS MEMBERS GET TO KNOW EACH OTHER BETTER, IDENTIFYES COMMON NEEDS, INTERESTS, CONCERNS, FEELINGS, WAYS IN WHICH THEY CAN HELP EACH OTHER
IMPROVES COMMUNICATION WITHIN THE GROUP
ENCOURAGES MEMBERS TO SHARE THEIR PROBLEMS IN THE GROUP, TO SUPPORT AND GIVE EACH OTHER FEEDBACK
ENCOURAGES CONSTRUCTIVE CONFLICT RESOLUTION
ENCOURAGES MEMBERS TO TRY OUT DIFFERENT SKILLS
TALKING ABOUT THE END OF GROUP WORK
CONSOLIDATING POSITIVE CHANGES
MEMBERS ARE DISTANCING FROM EACH OTHER AND FROM THE LEADER
MEMBERS INCREASINGLY TALK ABOUT CHANGING THEIR BEHAVIOUR PATTERNS OUTSIDE THE GROUP
MEMBERS CRITICALLY REVIEW THEIR EXPERIENCES, SHARE FEELINGS, EVALUATE
MEMBERS BEGIN TO FIND SATISFACTION OUTSIDE OF THE GROUP, FIND NEW ACTIVITIES
AMBIVALENT FEELINGS OF THE MAJORITY OF MEMBERS: PRIDE IN THE PROGRESS MADE, FEAR OF LOSS OF SUPPORT BOTH FROM THE GROUP AND THE LEADER
MANY MEMBERS WANT TO CONTINUE THE GROUP WORK

POSSIBLE REACTIONS: DENIAL OF THE END OR OF THE POSITIVE SIGNIFICANCE OF THE GROUP; REGRESS TO EARLIER BEHAVIOUR PATTERNS, PREMATURE ABANDONMENT OF THE GROUP, GOING TO A NEW GROUP (SO-CALLED CONSTRUCTIVE ESCAPE)
ASSESSES THE MEMBERS' PROGRESS, HELPS THEM TO STABILIZE IT
PREPARES MEMBERS FOR THE ENDING OF THE GROUP
HELPS MEMBERS EXPRESS AMBIVALENCE TOWARDS THE END OF THE GROUP WORK
SETS GOALS FOR THE PERIOD REMAINING UNTIL THE END OF THE GROUP
ASSISTS IN EVALUATION OF THE GROUP EXPERIENCE
SHARES OBSERVATIONS ON THE PROGRESS AND EXPRESSES CONFIDENCE IN THE MEMBERS' ABILITY TO CONTINUE WITHOUT THE GROUP AND THE LEADER
SUPPORTS THE MEMBERS' EFFORTS TO LEAVE THE GROUP AND DEVELOP NEW RELATIONSHIPS
MAY HAVE MIXED FEELINGS: SATISFACTION WITH THE PROGRESS OF THE GROUP, BUT ALSO SORROW FOR THE TERMINATION OF THE GROUP



## **Planning of group work**

(60 minutes + 90 minutes)

### Objectives:

1. To practice and develop competences for planning of group work

### Expected outcomes:

1. Participants will learn the steps of planning a group
2. Participants will understand the specifics of planning different types of groups for different members
3. Participants will be able to plan a group

### Materials:

- Forms for planning of group work for each participant + 10 for the workshop

### Methods:

Two groups with 15 participants. Participants are divided into 3 subgroups.

1. The trainer asks the participants to think about themselves as potential group leaders. Each group gets a form for planning of group work. Their assignment is to plan their group, following all the steps explained in the previous lecture. The trainer answers their questions and follows their progress. Each group chooses a presenter of their work. (60 min)
2. Group representatives present their plans and after each of them, the trainer gives feedback and suggestions for improvement. Special attention will be given to the adaptation of general principles for planning to the specifics of particular groups and to the applicability of the plan. (90 min, 30 min for each group)

### Form for planning group work

Group: \_\_\_\_\_

#### 1. NEEDS

What are the common needs of potential group members? Who identified those needs?  
In what way?

---

---

What are the needs of the service or organization that is planning this group? What do they get by starting this group?

---

---

#### 2. PURPOSE/AIM

Specify the purpose/aim of this group in one sentence.

---

---

#### 3. OBJECTIVES

Specify 5 objectives that you want to achieve through group work.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

4. EFFECTS

What is expected to be different in the lives of group members after participating in this group? Who expects those changes?

---

---

5. TYPE OF GROUP

Name the type of this group.

---

---

6. WORK METHODS

What will be done in the group in order to achieve the expected aim and goals (e.g. group discussions, role playing, using didactic materials, debates, games etc.)?

---

---

7. MODE OF GROUP WORK

Describe the specifics of mode of group work. Decide on the duration and the frequency of group meetings, the duration of group work (number of meetings), time of the meetings, necessary resources, etc.

Time and duration of a group meeting: \_\_\_\_\_

Duration of group work (number of meetings): \_\_\_\_\_

Planned number of members: \_\_\_\_\_

Open/closed group: \_\_\_\_\_

Necessary funds (for what): \_\_\_\_\_

Type of leadership (number of leaders): \_\_\_\_\_

8. ASSEMBLING THE GROUP AND CRITERIA FOR THE SELECTION OF MEMBERS

Specify the characteristics that will make the group homogeneous or heterogeneous regarding:

**Descriptive characteristics of members** (e.g. gender, age, educational level, parental status, socioeconomic status, number of children, etc.)

Homogeneous: \_\_\_\_\_

Heterogeneous: \_\_\_\_\_

**Characteristics of members' behaviour and experiences** (e.g. previous life experiences, emotional state, motivation, interests, communicational patterns, control of aggressive impulses etc.)

Homogeneous: \_\_\_\_\_

Heterogeneous: \_\_\_\_\_

9. EXPECTED CHALLENGES OR SPECIAL NEEDS OF THE MEMBERS

What are the expected challenges in working with a group like this? What are special needs or characteristics of members that you have to take into account?

---

---

10. RECRUITMENT OF POTENTIAL MEMBERS

Describe how are you going to approach and motivate members to participate in this group.

---

---

### 11. AGREEMENT (“Contract”)

Specify what will be involved in the process of agreeing on mutual rights and obligations of the members and you as the leader.

---

---

### 12. PREPARING THE GROUP ENVIRONMENT

What is the social context in which this group will take place? Is it necessary to make certain preparations in the environment that are important for achieving the purpose and goals of this group? If it is, specify these interventions.

---

---

### 13. EVALUATION

Describe the ways of monitoring and evaluating the effects of group work.

---

---

---

---

---

---

---

---

---

---

## **Structuring group meetings**

(75 minutes)

### Objectives:

1. To practice planning specific group meetings

### Expected outcomes:

1. Participants will understand which activities are appropriate for different parts of a group meeting
2. Participants will be able to plan a group meeting

### Materials:

- Forms for structuring group meetings for each participant + 10 for the workshop

### Methods:

Two groups with 15 participants.

1. Participants are divided into 3 subgroups (the same as in the previous workshop on planning of group work). Each group chooses one objective from their *Form for planning of group work*. Their task is to structure a group meeting that would *be focused on that objective, using the* Form for structuring group meetings. This group meeting has to be planned within the central phase of group work. (30 min)
2. Group representatives present their planned group meetings and after each of them, the trainer gives feedback and suggestions for improvement. The focus will be on how the planned activities correspond to the chosen objective and to the part of the meeting. (45 min, 15 min for each group)

## Form for structuring group meetings

Group: \_\_\_\_\_

Number of the meeting: \_\_\_\_\_

### Aim(s) of the meeting:

1. \_\_\_\_\_
2. \_\_\_\_\_

### Activities:

#### Introductory activity (activities):

1. Title of activity: \_\_\_\_\_

Aim: \_\_\_\_\_

Duration: \_\_\_\_ minutes

Materials: \_\_\_\_\_

Description (what does each of the leaders say/do, what the members' tasks and expected reactions are etc.):

---

---

---

#### Central activity (activities):

1. Title of activity: \_\_\_\_\_

Aim: \_\_\_\_\_

Duration: \_\_\_\_ minutes

Materials: \_\_\_\_\_

Description (what does each of the leaders say/do, what the members' tasks and expected reactions are etc.):

---

---

---

2. Title of activity: \_\_\_\_\_

Aim: \_\_\_\_\_

Duration: \_\_\_\_ minutes

Materials: \_\_\_\_\_

Description (what does each of the leaders say/do, what the members' tasks and expected reactions are etc.):

---

---

---

### **Closing activity (activities):**

1. Title of activity: \_\_\_\_\_

Aim: \_\_\_\_\_

Duration: \_\_\_\_ minutes

Materials: \_\_\_\_\_

Description (what does each of the leaders say/do, what the members' tasks and expected reactions are etc.):

---

---

---

### **Evaluation of the meeting:**

---

---

---



## **Co-leadership**

(120 minutes)

### Objectives:

1. To understand the benefits and challenges of co-leadership
2. To recognize own characteristics important for co-leadership
3. To learn how to prepare for co-leadership

### Expected outcomes:

1. Participants will become aware of their interactions with a co-leader
2. Participants will become aware of own characteristics and expectation which are important for co-leadership
3. Participants will improve their skills of preparing for leadership

### Materials:

- Crayons (2 for each participant)
- Blank A4 paper for each participant
- Papers with questions (4 of each)
- Forms for the preparation for co-leadership for each participant
- Handout *Co-leadership* for each participant

### Methods:

Two groups, with even numbers of participants in each.

1. The participants form pairs and take one blank A4 paper and 2 crayons each. They sit back-to-back. The participants have to draw something abstract using crayons without their partner seeing what they draw. The drawing should not be very complex or complicated. After they are done, they turn the paper over, exchange the crayons with their partner. Persons A and B are chosen in each pair. Person A (still sitting back-to-back with person B) looks at own drawing and explains to person B how to draw exactly the same drawing (like a copy). Person A can give any kind of instructions, being as precise as he/she can. Person B draws according to the instruction he/she hears, but is not allowed to ask any questions or talk to person A. When person A has finished, they switch roles. After both “copies” are finished, partners sit next to each other and look at each other’s drawings. (15 min)
2. The trainer asks the participants to comment on their experience (what was easier/harder for them – giving instructions or following them, what made it easy/hard, what is the point of this exercise). (15 min)
3. Participants are divided in 4 groups. Each group gets a paper with different questions regarding co-leadership, discusses the questions and writes down group conclusions. (10 min)
4. Each group presents their answers to the questions and the trainer explains further when necessary. (25 min)

5. Participants are divided into pairs and each of them fills out their own Form for co-leadership. After completing it, participants analyse and discuss in pairs. (20 min)
6. Group discussion about the necessity of preparation for co-leadership in order to prevent events that could have a negative impact on the group members and the relationship of co-leaders. Discussion about fears regarding the co-leadership and leading a group in general. (25 min)
7. The trainer explains other different techniques for preparing for co-leadership. (10 min)

## CO-LEADERSHIP

Two helpers sometimes share the role and functions of the leader. Co-leadership is not in itself effective, necessary nor mandatory. When choosing leadership, it is necessary to consider the characteristics of the group and the characteristics of the members.

### Group size

- In larger groups, co-leadership is more necessary
- In a small group – if a problem is such that it may overwhelm or overload the leader (e.g. a group for working through a trauma experience)

**Purpose** – if the purpose and objectives of the group include:

- Working in subgroups (the co-leader can assist in connecting the subgroups, provide a better insight into their similarities and differences)
- Modelling of social and communication skills: members see the relationship based on cooperation, trust, clear communication and resolution of disagreements between the co-leaders
- If the members are of different genders: a model of cooperation between the genders

**Continuity** – if it is important not to interrupt the group work, one co-leader can continue when the other is absent.

### Group members

- If it is sometimes necessary to provide individual attention to members (due to specific characteristics)
- If expressing strong emotions by the members is expected

**Setting** – sometimes this decision is conditioned by the rules of the organization or the availability of funding

## BENEFITS OF CO-LEADERSHIP

- Provides a source of support, encouragement and feedback
- Helps overcome fears of incompetence
- Increases the freedom of choice of techniques and styles – the group learns from different styles and experiences of each co-leader
- Enables the co-leaders to learn about themselves, their style and interaction
- Facilitates the development of cooperation and communication by modelling – the co-leaders are a model for members of how two different people can work together, support each other, respect their differences, disagree and resolve disputes

## WHEN AND HOW TO CHOOSE THE CO-LEADER?

**When:** At the very beginning of the group planning, when the purpose and objectives of the group are defined, which is followed by joint work on establishing the group.

**How:** The co-leaders are more successful if they have similar attitudes toward group work as a supporting process and toward the purpose and objectives of a particular group, but different professional skills, knowledge and personal characteristics of the leaders.

## GENDER OF CO-LEADERS

Some questions should be answered first:

1. What gender of the leader is right for the group?
  - two male co-leaders in a group for abused women will be a disadvantage for the group
  - in groups where the topic is partner relations, male-female pairs of co-leaders are a better choice
2. What is the personal preference of the co-leaders? Are the co-leaders in resistance about working with the opposite gender or do they prefer it?
3. What are the necessary preparations to ensure good partnership between the co-leaders depending on their gender?

Objective opportunity to choose a co-leader – women are in the majority in the helping professions – sometimes it is impossible to provide a pair of co-leaders of different gender.

## EQUALITY IN THE CO-LEADERSHIP RELATIONSHIP

### The principle of complementarity

Co-leaders are not equal always and in every situation, and absolute equality is not decisive. It is important to accept the uniqueness of the co-leaders and their specific knowledge and skills.

It is important to have **a clear agreement** on how to work in all combinations:

- When the co-leaders are of different professions
- When they have different experiences
- One is a novice, the other is his/her teacher
- When they have a similar or the same experience

An agreement is needed to avoid traps: one is always passive, not developing their skills, fighting for their turn to speak, not complementing each other, interfering etc.

### The importance of mutual trust

They need to devote a lot of time to developing the partnership – even if they know each other from before!

Stress can be an accompanying experience of co-leadership.

## PREPARATION FOR CO-LEADERSHIP

Preparation for co-leadership is extremely important and can be carried out in various ways. For example, you can use:

- Questionnaires in which the co-leaders respond to a series of questions about themselves concerning their experiences in group work, leadership styles, professional interests and values, fears, etc.
- Unfinished sentences on the topic “My co-leader and I...”
- Guided fantasies
- Exercises, games and other creative activities...

An open and frank conversation with the co-leader is a necessary part of the preparation!

## Module 4, Working material 4

Is there an ideal combination of co-leaders when it comes to their gender?

Can the gender of the leader facilitate or make it harder to lead a certain group and why?

In which kind of groups should the co-leaders be a man and a woman and why?

What are the benefits of co-leadership?

What are the characteristics of the group or its members that are important for deciding to work in a co-leadership?

What are the important requirements that should be fulfilled in order to ensure a good fit of the co-leaders, their good functioning and mutual understanding?



### Form for the preparation for co-leadership

1. What is my experience in working with a group, as a leader or co-leader?
2. What style of work/leadership do I particularly like?
3. What is my educational or theoretical orientation (medical, cognitive-behavioural, psychoanalytical, psycho-educational approach, etc.)?

4. Where am I on the following dimensions of group leadership?

**active**

**passive**

3-----2-----1-----0-----1-----2-----3

**focused on  
the process**

**focussed on  
the task**

3-----2-----1-----0-----1-----2-----3

**I take  
control**

**I surrender  
control**

3-----2-----1-----0-----1-----2-----3

**democratic**

**authoritarian**

3-----2-----1-----0-----1-----2-----3

5. Please complete the following sentences.
  - a. My expectations from my co-leader are....
  - b. My co-leader should know about me that....
  - c. It is important for me to know about my co-leader....
  - d. The skills I have as a group leader are.....
  - e. The skills I would like to develop as a group leader are...
6. Fears: What would be the worst things that could happen to you as a group leader? Name three fears.
  1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_

What do you expect from your co-leader in such situations?

## **Working with children and adolescents**

(105 minutes)

### Objectives:

1. To familiarize with the possibilities of application of interactive games for children and youth in order to achieve certain individual or group goals
2. To experience the effect of the application of interactive games with the aim of better understanding the purpose of these activities

### Expected outcomes:

1. Participants will understand the purpose of the application of interactive games with children and adolescents
2. Participants will be able to apply the demonstrated activities in their own work
3. The level of group cohesion among the participants will increase

### Materials:

- toys and other items (brought from Zagreb)
- 6 sets of You and I cards
- A4 blank papers for each participant
- 4 scotch tapes
- pens

### Method:

Two groups with 15 participants.

1. As adolescence brings many changes in the life of a young person, so do some other periods in life too, where the period of middle childhood should also be mentioned. This is the period (7-13 years) that begins with a big change in the child's life – starting school, including preschool that children start as early as 5-year-olds. This is exactly the period suitable for joint organized activities for the children to practice those social skills that will enable them for better social adjustment in their surroundings (e.g. open communication, non-violent conflict resolution, tolerance of diversity, etc.).

Therefore, we will present several interactive games that can be implemented in a group context, that are appropriate for elementary school aged children (but also for adolescents), and which promote connectedness and group cohesion among children, non-violent conflict resolution, positive self-image, etc.

The following activities are primarily intended for children, but they will be presented to members of the group in a way that they will actively participate in them. Thus, the participants are explained that these are exercises that are often used with children and adolescents, but they are applicable in all groups, and they will now have the opportunity to experience them for themselves. This means that they will not play the roles of children or adolescents, but they themselves will have the experience of going through the activities. The trainer will give them instructions and facilitate discussions. (5 min)

2. Activity 1: Little things that mean a lot (25 min)

Objective: introduction, creating group cohesion, making it easier to open up

The trainer puts a large number of small objects (small toys and other items) that can have some importance for the participants in the middle of the circle. Everyone looks at these items and then chooses one of them, examines it, feel its warmth and structure, shows it to others and talks about that object: Why did I chose it? What does it remind me of? Why do

I like this object? What does it mean for me? In the end the trainer explains that this activity is applicable with any clients in a group. Its objectives are multiple: getting to know each other, creating group cohesion, making it easier for members to open up, empowerment.

3. Activity 2: Mirror, mirror on the wall (15 min)

Objective: To recognize their own and other people's feelings and ways of expression

Everyone stands in a circle. The trainer instructs one participant to stand in the middle and show how he/she behaves when he's angry using movements and/or facial expressions. Everyone else repeats the gesture or the expression so that this member could see themselves „in the mirror“. The aim of this game is to observe their own behaviour when experiencing different emotions. The trainer then chooses another participant and specifies another emotion that should be shown using gestures and facial expressions. It can be boredom, being offended, joy, love, exhilaration, rage, jealousy... This is followed by a conversation with participants about how they felt when others reflected their behaviour.

4. Activity 3: You and I cards (40 min)

Objective: Active listening, empathy, distinguishing speech of acceptance and speech of rejection (accusation, assault, aggression)

Participants are divided into pairs. One participant gets the role of the observer, and the trainer explains that his/her task is to carefully observe all situations and try to summarize the conclusions at the end.

You and I cards are set in the middle of the circle. The cards differ according to colour, some are blue, the others yellow. It should be mentioned here that some cards/situations are better adjusted to children/adolescents and others to adults. The point is to show them the possibility of applying this kind of activity with different populations. In the first pair one member takes a blue card and reads the text on it. His/her pair must say something to that, react to that text. So, the couple should engage in a conversation that starts from the participant who has a You-card, and the trainer and other members observe how the conversation develops. Then the second member of the pair reads the yellow card (I-card) and his/her pair should react to what they heard, that is, a new conversation begins between the two of them.

Then the next couple draws another pair of cards, and so on until all the cards have been used. All other participants listen to the situations and the reactions to them. The participant who was the observer present their observations, summarizes what he/she saw. This is followed by a discussion, where the participants comment on the differences between the way of speech on blue cards and the yellow ones, on whether the text on the cards allowed the continuation of the conversation or caused a breakdown in communication.

5. Activity 4: How do others see me (20 min)

Objective: raising self-esteem, strengthening group cohesiveness and rounding up the group work

Participants tape a blank sheet of paper of to each other's back. They all have pens and move around, writing down each other's positive qualities on other person's backs. The trainer can stop this activity when everyone has at least 6-7 written traits on their backs. Everyone returns to the circle and looks at the messages they received. They comment on them if they want. The trainer explains the purpose of this activity: raising self-esteem, strengthening group cohesiveness and rounding up the group work. It can be used with individuals on whose self-esteem we want to work on, but also in other groups, wherein this activity is particularly appropriate for the final phase of group work.

**You and I cards**

<p><b>GIRLFRIEND</b></p> <p>You let me waiting for three hours!</p>	<p><b>GIRLFRIEND</b></p> <p>I am angry because I've been waiting here for quite a long time. I'd like you to respect our plans.</p>
<p><b>TEACHER</b></p> <p>This is not the first time that you came without your homework.</p>	<p><b>TEACHER</b></p> <p>I wish you advanced more in mathematics, so I am not happy that you're not doing your homework regularly.</p>
<p><b>BUS CONDUCTOR</b></p> <p>Get those legs off the seat. Do you put your feet on the table at home too?</p>	<p><b>BUS CONDUCTOR</b></p> <p>Please don't put your feet on the seat. I would like it if other passengers could have a clean seat.</p>
<p><b>DRIVER</b></p> <p>Why do you drive a car when you can't park?</p>	<p><b>DRIVER</b></p> <p>Please move your car a little, because it's closing the exit of my parking lot. I'm angry when I see that I can't leave, and I'm in a hurry.</p>
<p><b>PARENT</b></p> <p>You're a bum. You come home very late every day, but now you've gone too far! It's two o'clock in the morning!</p>	<p><b>PARENT</b></p> <p>I feel worried when you come home this late. I would like if you were at home more, if we saw each other a little more often, spent some time together. And when you stay out for so long, I'm afraid that someone might do something bad to you.</p>
<p><b>SCHOOL PRINCIPAL</b></p> <p>You are constantly late for work.</p>	<p><b>SCHOOL PRINCIPAL</b></p> <p>I noticed that you were a little late today. I would like for the classes at school to go regularly, so please do your best to be on time.</p>
<p><b>SALESPERSON</b></p> <p>Why are you looking around the shelves so much? The merchandise shouldn't be touched.</p>	<p><b>SALESPERSON</b></p> <p>Sorry, but customers next to you would like to take something off the shelf. Can I help you find what you need?</p>

## **Psychoeducative approach in group work**

(165 minutes, 135 min + 30 min break)

### Objectives:

1. To understand the specifics of the psychoeducative approach in group work
2. To learn how to implement a psychoeducative workshop

### Expected outcomes:

1. Participants will have the experience of participating in a psychoeducative workshop
2. Participants will be able to plan and implement a psychoeducative workshop “What do I do when I feel bad”
3. Participants will be able to apply their knowledge about the planning and implementing of the psychoeducative workshop “What do I do when I feel bad” to planning workshops on other topics or with other members

### Materials:

- 2 flipcharts and markers
- Templates “What do you do when you feel bad” for each participant
- Leaflets with coping strategies for each participant
- Templates with circles of social support for each participant
- Envelopes for each participant
- 2 balls of wool

### Methods:

Two groups with 15 participants.

1. In each group the trainers will demonstrate the psychoeducative workshop for children and youth “What do I do when I feel bad”, that the SPA (Society for Psychological Assistance) implemented with children affected by the war, who had high levels of post-traumatic stress reactions and depressive symptoms. Participants will get into the roles of adolescents (12-14 years old), preferably refugees with whom they have had experience, and will go through the whole process of the workshop. (75 min)
2. Break (30 min)
3. The participants give feedback on their experience of participating in the workshop, and then the trainer gives feedback. (20 min)
4. The trainer first explains what would have been done differently if the participants really were children (more attention to the flyer and a detailed discussion about its contents, longer and more detailed discussions regarding each of the tasks, using colourful crayons, flyers printed on colored paper with pictures/drawings, etc.). Then the trainer leads a discussion about the ways in which this and similar workshops could be useful in working with children and youth. The discussion is focused on the possibilities of applying this and similar workshops in the contexts of participants’ workplaces. In what way could this workshop be adapted to other clients? What are other possible topics of such workshops? How can they be developed? Who are potential clients? What adjustments are needed for different groups of clients? In what contexts would these workshops take place? What adaptations in the environment would be necessary for their successful implementation? (40 min)

## **Workshop description**

### **Introductory part of the workshop**

1. The trainer explains to the participants (in the roles of adolescents) why they were invited to the workshop (because they had more severe experiences than others or the same experiences made them feel worse than others). The trainer explains to them that the aim of the workshop is to learn some behaviours that can help us in facing and dealing with difficult situations. The goal is also to learn to express feelings so that others can provide support for us.  
This is followed by introducing and getting to know each other. Everyone state their names and something they love to do, something they enjoy or some characteristic of theirs which they are proud of.  
This is followed by defining rules of group work, which need to be selected and formulated in accordance with the instructions for defining rules of group work. (20 min)

### **Central part of the workshop**

2. The templates “What do I do when I feel bad” are used. Participants first write down on their templates (question 1) what they do when they feel bad, and then the trainer asks each of them to say one of the things that they wrote down, preferably something that hasn’t already been mentioned. The coach writes down their answers on a flipchart. (10 min)
3. Then the trainer shortly comments on which are “good” and which are “bad” ways of coping and tells the participants to write down an example of each on their templates (question 2). (5 min)
4. Participants are given the flyer with coping strategies that contains information on difficulties and signs that happen as a result of events that are difficult for us, and strategies to cope with them. The trainer asks them to read about the coping strategies and then to comment on that. If necessary, he/she explains additional strategies or explains/demonstrates some strategies that were not clear to the participants. Participants are then told to write down (question 4 on the template) some good coping strategies that they haven’t used yet and think that they could be useful. The trainer asks the participants to read the flyer in detail at home. (15 min)
5. Templates with circles of social support are used in the following activity. Participants have to list the people around them, with regard to how close these people are to them. Then, they circle people who they think they could turn to for help and support.  
They choose one person to turn to in the next week for support and write the name of that person on the template “What do I do when I feel bad” under question 6.  
Participants also choose and write down (question 7) one good way of coping that they will use in the next week. (10 min)

### **Final part of the workshop**

6. Each participant receives an envelope and draws on it something that is a symbol of safety for him/her. Participants put all the papers from the workshop in their envelopes. The trainer tells them to open that envelope whenever they are sad or feel that they need support and use it to remember what they can do in this situation and to whom they can turn.  
Participants stand up and put their envelopes on the floor in front of them. One of the participants receives the ball of wool and has to wrap the thread around his/her wrist and then throw the rest of the ball to a participant whose symbol on the envelope he/she likes. All other participants also have to wrap the thread around their wrists and then throw the rest of the ball to someone who hadn’t gotten it yet, until all participants have a thread of wool wrapped around their hand. Then the trainer explains that these intertwined threads of

wool between them represent a network of connectedness and support. Then he/she tells the participants to tear off the part of the thread that they have wrapped around their hand and tie it as a bracelet, which they can keep as a memory of today's meeting, and of the fact that they have others who they can turn to for support.

This is followed by the evaluation of the process, that is, a short talk about whether they liked the workshop and did they find it useful. (15 min)

**„What do I do when I feel bad“**

8. What do you do when you feel bad? What do you need to feel better?

--

9. What people do to reduce the pain? Write a good and a bad way of dealing with pain.

GOOD	BAD

10. Leaflet

11. Which of these good ways of coping can help you? Write some. Add some if you haven't used them yet, and you think you could.

--

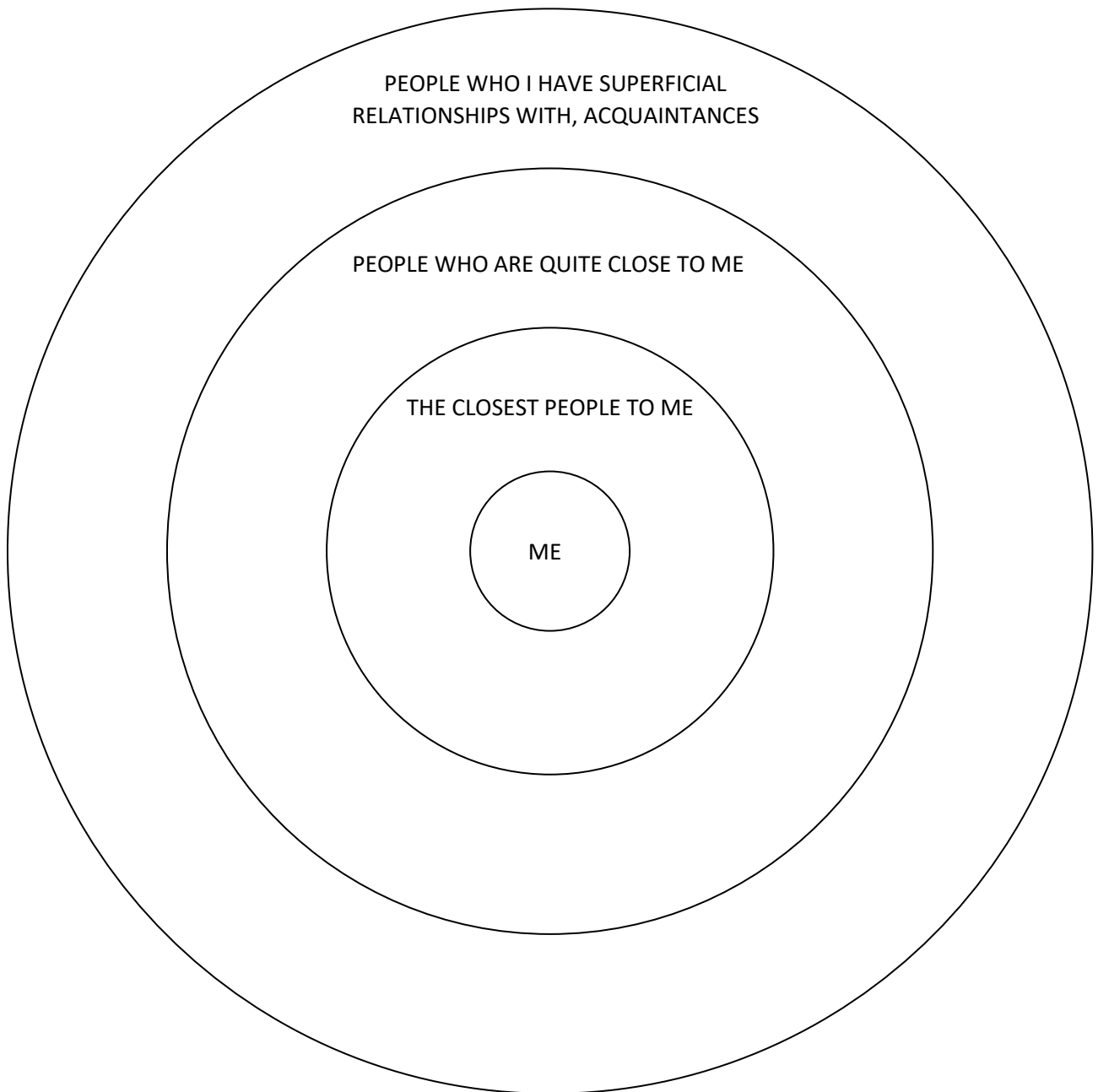
12. Name the people who surround you in these circles. Of those you named, circle those people whom you can turn to when you need support or when you feel bad.

13. Choose one person who you would want to turn to for a conversation or support in the next week. Write the name of that person:

\_\_\_\_\_

14. Choose and specify one of the good ways of coping that you will apply in the next week.



*You have experienced an event that causes intense feelings or physical reactions in most people, which can interfere with your daily life and cause much suffering, sadness, anxiety. Maybe you feel those right now or you will feel them later. **It is perfectly normal and common for most people to have such a reaction.** Sometimes such reactions occur immediately after a difficult event, sometimes after a few hours or days. In some cases, it may even take weeks or months.*

These are some common signs, i.e. consequences that may occur after a difficult event:

PHYSICAL signs: fatigue, nausea, vomiting, weakness, headache, difficulty breathing, shortness of breath, palpitations, sweating, insomnia, increase in blood pressure (each of these signs requires a consultation with the doctor)

THOUGHT signs: inability to concentrate, poor memory, thought numbness, torn thoughts, "dark" thoughts, stiffness of thoughts, incoherence in speech, constant returning of some images and thoughts, nightmares, distrust toward others, blaming someone

EMOTIONAL signs: anxiety, resentment, anger, depression, sadness, apathy, gloom, helplessness, loneliness, discouragement, panic, a feeling of emptiness

BEHAVIOURAL signs: withdrawal from others, inability to rest, changes in behaviour to friends, family, increased aggressiveness (the desire to hit someone), hypersensitivity in relation to the people who surround you, crying, shouting, fist clenching, jaw clenching, changes in the manner of talking, very strong or very weak need for food, loss of interest in usual activities

*Signs that occur after an event that has been disturbing and difficult for us can last several days, weeks or a few months. With the understanding and support of close people in the family, school or anywhere else where you live, these effects can pass faster. It may happen that this difficult event and your reaction to it become so painful that it is necessary to seek the help of a psychologist or a doctor. This does not mean that you are weak or crazy. It simply means that whatever you*

*experienced was too strong and difficult and that you need support to cope with it easier and faster.*

- CARE ABOUT YOUR FEELINGS

Help others as much as you can by checking how they were, sharing with them what you are feeling

SPEND TIME WITH PEOPLE WHOSE COMPANY YOU ENJOY

Spend free time with friends and those with whom you like to be, DON'T ISOLATE

STAY IN TOUCH WITH THE IMPORTANT PEOPLE IN YOUR LIFE

LOVE YOURSELF

RE-READ FAVOURITE BOOKS AND WATCH FAVOURITE MOVIES

ALLOW YOURSELF ACTIVITIES YOU LIKE, THINGS, PEOPLE, PLACES

ALLOW YOURSELF TO CRY

FIND THINGS THAT CAN MAKE YOU LAUGH

EXPRESS YOURSELF BY FOUNDING AND PARTICIPATING IN A GROUP,

ARRANGE EVENTS IN THE PLACE WHERE YOU LIVE, GIVE SUGGESTIONS TO THE SCHOOL AND TEACHERS

This difficult period of your life will not be made easier by taking tranquillizers or alcohol - they will only aggravate the problem

PLAY with those younger than yourself...

PLAY with peers...

PLAY with pets...

PLAY with parents...

PLAY...

**Sometimes it is enough to choose only one option that you didn't use before to make you feel better.**

TRY DOING THIS TO MAKE YOU FEEL BETTER:

- PHYSICAL CARE

Eat regularly and diversely, even if you don't care about food

GO TO THE DOCTOR REGULARLY WHEN YOU NEED TO, WHEN YOU'RE SICK

Go for regular checkups, for example, control at the dentist's

Do whatever is good for you

Do sports or other physical activities that are fun: EXERCISE, SWIM, DANCE, WALK, RUN

GET ENOUGH SLEEP

Go out with friends or relatives on an outing

Rest enough

WEAR CLOTHES THAT YOU LIKE

- PSYCHOLOGICAL CARE

TAKE TIME FOR THINKING ABOUT YOURSELF

Keep to your normal lifestyle as much as possible

TALK TO THE PERSON YOU TRUST WHEN YOU FEEL BAD, talk to others - talking is the best medicine

KEEP A JOURNAL, lexicon, write poems and stories, anything you can think of

READ BOOKS THAT HAVE NOTHING TO DO WITH SCHOOL

DO SOMETHING THAT YOU ARE NOT VERY GOOD AT, BUT IT MAKES YOU HAPPY

Pay attention to your experiences - listen to your thoughts, beliefs, feelings

LET OTHERS MEET DIFFERENT SIDES OF YOU

Go to an exhibition, to the theatre, a sporting event, the movies

LET OTHERS GIVE YOU GIFTS (ATTENTION, SMALL GIFTS, e.g., a drawing, a flower)

BE CURIOUS

Sometimes say NO to some obligations

- SPIRITUAL CARE

TAKE TIME FOR REFLECTION

SPEND TIME IN THE NATURE

NURTURE AND SHARE YOUR OPTIMISM AND HOPE

ACCEPT THAT YOU DON'T HAVE TO BE PERFECT AT EVERYTHING

DISCOVER WHAT IS IMPORTANT FOR YOU AND WHAT PLACE THIS HAS IN YOUR LIFE

PRAY

SING

HAVE A ROLE MODEL (FAVOURITE SINGER, ACTOR)

READ AND LISTEN WHAT INSPIRES YOU (books, favourite music, comic books, fairy tales, poems, novels...)

- SCHOOL AND OBLIGATIONS

USE school BREAKS - don't study during the breaks, socialize with others

Organise your time - be busy with different jobs and activities

"CHAT" (talk casually) with friends

DISCOVER WHICH OBLIGATIONS YOU FIND EXCITING AND INTERESTING

Create a comfortable working place for yourself

ASK IF YOU DON'T KNOW SOMETHING

Try to make as much decisions as possible every day, no matter how small, to keep a sense of control over your life (for example, if they ask you what you would like to eat, answer them, even if you don't feel like eating anything or you're not sure what you'd like)

NEGOTIATE FOR YOUR NEEDS

TALK TO FRIENDS ABOUT THE DIFFICULT ASSIGNMENTS, ASK THEM HOW THEY FIXED IT

Thoughts and dreams in which you relive an event, as well as the occasional flashes of memories, are normal - they will eventually become less frequent and less painful. You're a normal and **you're having a normal reaction to a difficult event. These reactions, although painful, show that you are a normal human being.**

## **MODULE 5 - LECTURES**

### **Lecture**

#### **Psychological crisis at individual and community level**

##### **What is a crisis?**

- Word „crisis” in everyday communication is used to emphasize that the situation is threatening and urgent; a turning point, a period of making difficult decisions
- The root of the word is in Greek *krisis* = a decision
- This is the situation that requires making a difficult choice, selecting a possible solution towards which there is ambivalence because of a problem affecting individuals, families or communities

##### **Duration of a crisis**

- Crises are time limited – they are resolved (successfully or not successfully) within 4 to 6 weeks
- Since it is impossible to function in a prolonged disbalanced state of crisis, new balance is established
- During a crisis, a person is open for psychological interventions because usual defense mechanisms are weakened, and typical behavioral patterns are not functional

##### **Psychological status of people in crisis**

- Feelings of threat and fear because of realistic or potential loss of important individuals (family members, friends ...), goods or important symbolic issues (house, land)
- Feelings of loss of control, feeling very vulnerable and in a need of help from other people or institutions
- Strong feelings of helplessness, anxiety, cognitive disorganization → mistakes in perception, conclusions, difficult decision making, poor concentration, forgetfulness
- Ineffective behaviors, senseless movements, abrupt changing of decisions, blocked behaviors

##### **Community crisis and individual psychological crisis**

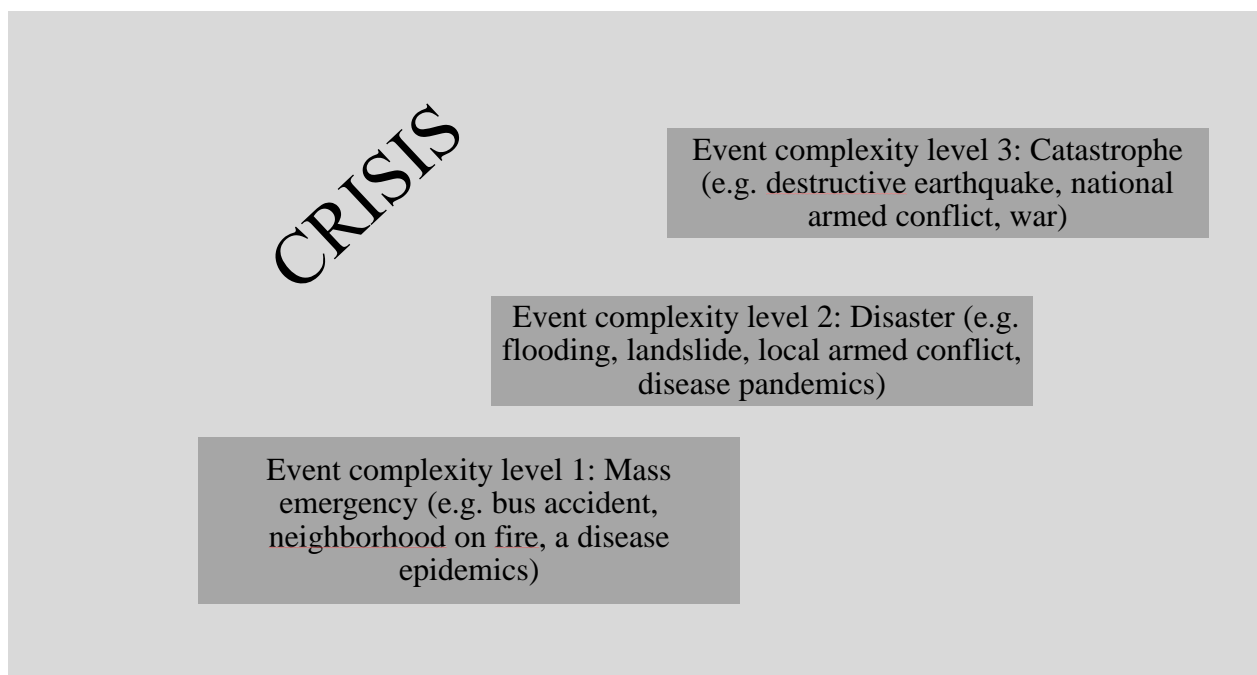
- Sudden or rare events that affect large number of people in a particular community
- Events that cause large human suffering, personal and material losses of many people and disturb normal functioning of a community

- The community structures are disabled and cannot provide help to individuals and families who are affected by the event
- Community crisis is characterized by psychological and interpersonal reactions that can be visible immediately after the event or have later onset or have prolonged duration → potential for individual psychological crisis

### **Effects of community crisis on affected populations**

- Persisting and disturbing images (smell, sounds, visuals) of the critical event
- Basic life beliefs about the world are questioned
- Grieving for multiple losses – people, home, safety, livelihood, neighbors, symbolic memorabilia (e.g. photographs)
- Possible survivor guilt, blaming oneself for not foreseeing the event
- Within several weeks most affected people go through wide range of very strong emotions

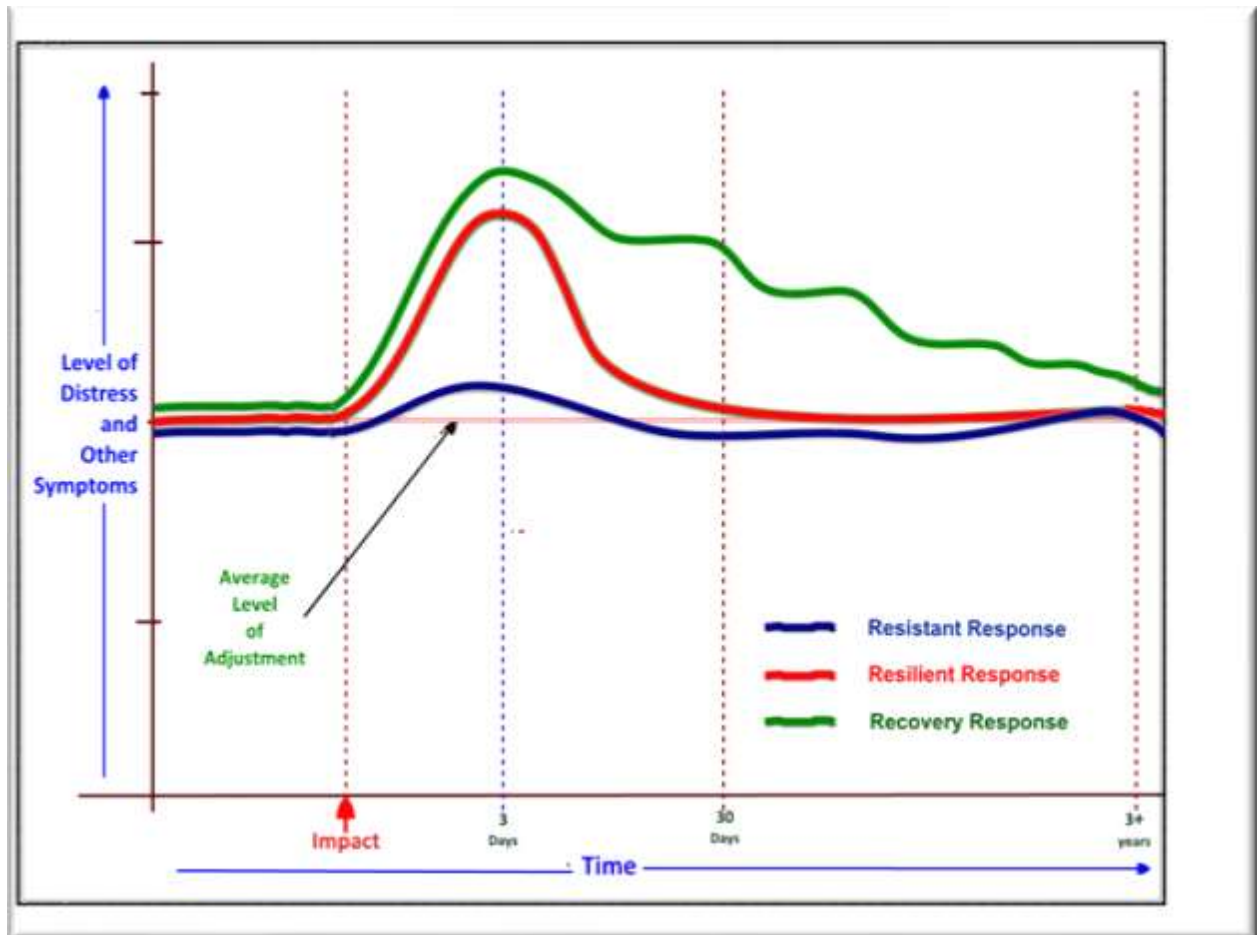
### **Types of events leading to different levels of community crisis**



### **Priorities which people have in a community crisis**

- Destruction and shattered community due to non-functioning or displacement make the survivors feel unprotected and vulnerable → priority is establishing safety
- The priority of affected people → bringing family members together

- Huge need for social support when natural social support network is damaged → organized psychological first aid (PFA)
- High level of uncertainty → fast and reliable information
- Disorganized social, health and school systems → establishing functional institutions contributes to the feelings of safety, normalization



### **Sense of Coherence as internal protective factor in crisis and trauma (Antonovsky, 1996)**

Individual's life orientation that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected



### **Factors that decrease psychosocial resilience to crisis**

- Serious threat to life
- Exposure to dead bodies, destruction
- Facing circumstances which are difficult to control and anticipate
- Experiences of great losses and physical harm
- Threat that the event can be repeated
- Family members with mental disorders

### **Factors that increase psychosocial resistance to crisis**

- Social support
- Accepting reality
- Belief in own strengths and strong value system
- Capacity to improvise
- Receiving psychological first aid (PFA)

**Five essential principles of mitigating crisis („Hobfoll principles”) (Hobfoll et al, 2007)**



1. Promoting a sense of safety



2. Promoting calming



3. Promoting sense of self-  
and collective efficacy



4. Promoting connectedness



5. Promoting hope

**Practical recommendations for people in crisis**

- Connect with other people
- Be active
- Pay attention to what is going on around you, observe
- Learn from own experience
- Help other people



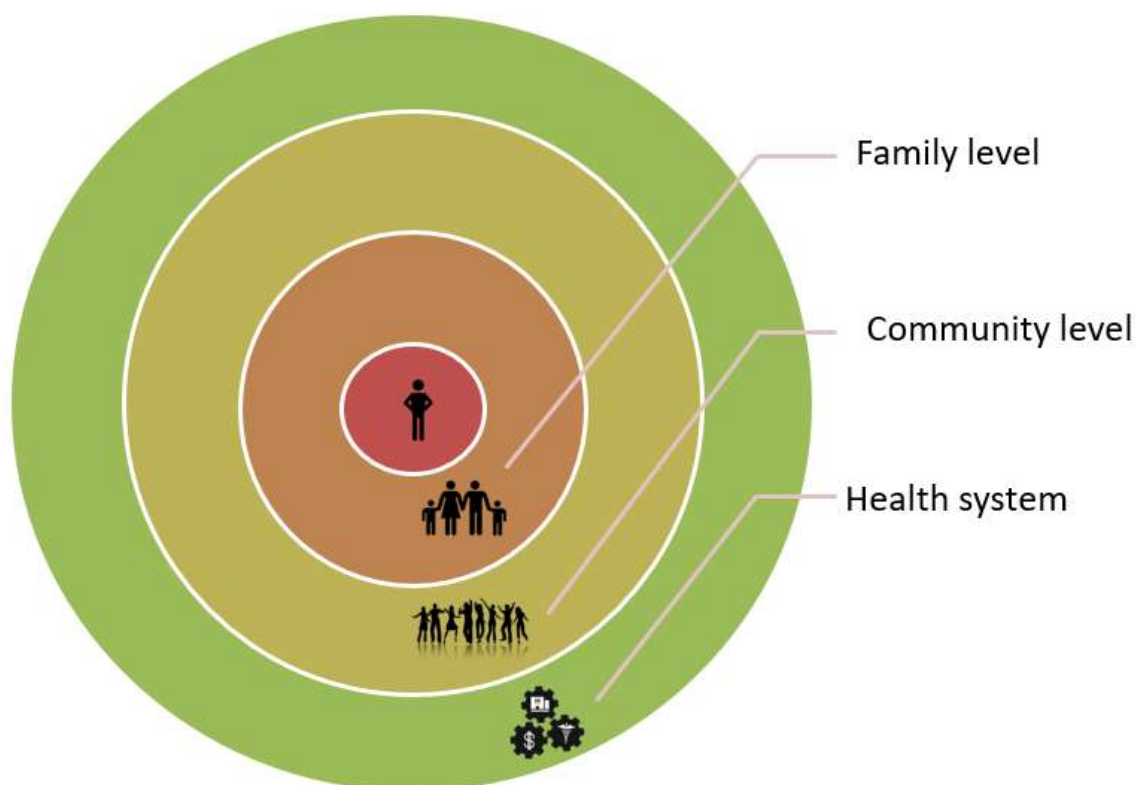
## Lecture

### Psychological First Aid (PFA) in communities affected by conflict and other harmful events

#### Goals of providing psychosocial care in affected communities

- Alleviate feelings of distress, uncertainty, and non-functional behaviors
- Normalize the life of individual, family, and community as quickly as possible
- Reduce long-term adverse consequences and costs for community and society

#### Different levels of affected community



#### Phases of community psychosocial care

1. Preparing before the crisis event (if possible)
2. Actions immediately after the crisis event
3. Alleviating the consequences of the event
4. Recovery of community and individuals

## **Definition of psychological first aid (PFA)**

Psychological first aid is a flexible and individualized form of psychosocial support that emphasizes psychoeducation, social support and encouragement, avoiding talking about the details of the event, while ensuring the delivery of highly specialized interventions only to those who show serious symptoms.

(NATO-TENTS Guidelines, 2008)

## **Psychological First Aid**

- A preventive procedure whose purpose is to avert long-term harmful consequences
- Goals:

Needs assessment of individuals and community

Establishing emotional equilibrium of affected persons

Help in understanding own current difficulties

Reestablishing the feeling of control and preserving hope

Increasing the feeling of efficacy

Connectedness with other people

## **Assumptions of psychological first aid**

- A relatively small number of affected persons will develop mental health problems → people retain their psychosocial resilience even in the worst situations
- Specialized mental health interventions should be limited only to those individuals who demonstrate severe mental health problems (after positive screening)
- The situation is changeable, so the services of psychological first aid should be adjusted accordingly

## Stepped model of providing psychosocial care in affected communities



### Needs of affected people

- Safety
- Correct information about the event and its causes
- Correct information about rights (legal, financial support, establishment of institutions...)
- Health – especially vulnerable groups
- Information about access to resources
- Understanding distressing posttraumatic reactions
- Support in grieving process and impaired beliefs about the self and the world

### First phase

- *Safety*
- Correct information about the event and its causes
- *Correct information about rights (legal, financial support, establishment of institutions...)*

- *Health – especially vulnerable groups*
- Information about access to resources
- Understanding distressing posttraumatic reactions
- Support in grieving process and impaired beliefs about the self and the world

### **Second phase**

- Safety
- Correct information about the event and its causes
- Correct information about rights (legal, financial support, establishment of institutions...)
- *Health – especially vulnerable groups*
- *Information about access to resources*
- *Understanding distressing posttraumatic reactions*
- Support in grieving process and impaired beliefs about the self and the world

### **Third phase**

- Safety
- Correct information about the event and its causes
- *Correct information about rights (legal, financial support, establishment of institutions...)*
- *Health – especially vulnerable groups*
- *Information about access to resources*
- *Understanding distressing posttraumatic reactions*
- *Support in grieving process and impaired beliefs about the self and the world*

### **Priorities for PFA**

- Individuals and especially vulnerable groups

Children and adolescents, elderly, pregnant women, single parents

People with chronic illness, people in difficult living conditions, poor and isolated people

People with multiple exposure to traumatic events, or prior mental health problems

People with special needs (language, legal status, no social network, ethnic minorities, migrants...)

### **Activities of PFA**

- Providing practical help in a compassionate way
- Increasing the feeling of safety: help with accommodation and food, health care, reconnecting with family members
- Recognizing and registering persons who are especially strongly distressed and their referral to higher level of professional help
- Informing (leaflets, Internet, local media) → correct, timely, concrete, useful
- Consulting and training helpers to increase the capacities of organizations to offer what is needed for reestablishment of community and family networks
- Establishing centers where people can access help (one-stop center)

### **Sequence of PFA**

0. Preparing
1. Making contact
2. Providing feeling of safety and comfort
3. Emotional stabilization
4. Providing practical help
5. Social support
6. Psychoeducation about ways of coping
7. Referring to relevant institutions

### **Preparing**

Collecting important information about:

- The nature of the crisis event, number of affected people, likelihood of the danger repeating...
- Current situation of the people
- Support services and organizations that are present on the ground
- Particularly sensitive groups and individuals
- Cultural specificities of subgroups

## **1. Making contact**

- Make contact in a non-threatening, compassionate and helping way
- Create a basis for establishing a trusting relationship and increase the likelihood that the person will accept help
- Pay attention to your:
  - Non-verbal communication
  - Tone of voice
  - Positive speech
  - Open body posture
  - Interested facial expression

## **2. Providing feeling of safety and comfort**

1. Ensure immediate physical safety
2. Provide information about available services
3. Encourage social inclusion
4. Protect from exposure to additional traumatic experiences and reminders of trauma

## **3. Stabilizing**

- Persons who have strong stress reactions need:
  - Guidance how to calm down (breathing exercises, stretching, walking, muscle relaxation, grounding)
  - Help in focusing attention on concrete feelings and solvable problems
  - Directing attention to their surroundings
  - Normalizing emotional reactions to traumatic events

## **4. Assessment of current needs and worries**

- Focus on:
  - Immediate situation after the event
  - Separation from close persons or worry about their safety
  - Coping with death / injury of close persons
  - Coping with losing a house, property...

Availability of social support (family, friends, community members)

Negative emotions (e.g. guilt, shame)

### 5. Providing practical help

- Affected persons have a whole range of needs and worries → help them to prioritize and solve problems one by one
- Help them take concrete action in solving problems (e.g. assistance in submitting applications for receiving help, access rights)

### 6. Social support

Social support is extremely important in the recovery process:

- Informational: enables participating in various activities (exchange of information, experiences, participating in communal activities)
- Instrumental: access to practical and material help
- Emotional: gives feeling of belonging, compassion, being needed by others

### 7. Educating about ways of coping (psychoeducation)

Positive coping	Negative coping
<ul style="list-style-type: none"><li>• Adequate rest and diet</li><li>• Keeping a daily routine</li><li>• Participating in positive activities</li><li>• Adjusting one's expectations</li><li>• Setting reachable goals</li><li>• Using methods of calming down</li><li>• Seeking counseling</li><li>• Seeking and providing support from and to others</li><li>• Using humor</li></ul>	<ul style="list-style-type: none"><li>• Abuse of alcohol and medication</li><li>• Passivity</li><li>• Social isolation, withdrawal</li><li>• Aggressiveness</li><li>• Lack of self-care</li><li>• Engaging in risky behaviors</li><li>• Blaming self or others</li></ul>

### 8. Referral to relevant institutions

- Depending on needs, access to services should be made available:

Primary and specialized health care

Social services

Legal assistance

Education and employment

Help in getting accommodation

**Time matters!**

- Psychosocial care needs time to show results
- The affected population is typically impatient to see improvements in reestablishing the community, in their mental health and well-being
- Everyone involved in providing community interventions must deal with two opposing qualities: working quickly and being patient



## **Lecture**

### **Psychological crisis interventions for helpers**

#### **Helper stress**

- Consequence of high work load and responsibility, unfavorable working conditions, exposure to a large number of distressed people and personal coping with human suffering
- Events connected with own helping role in life-threatening situations provoke very strong emotions and reactions that can immediately or later affect professional behavior
- It is necessary to plan for and establish procedures that help prevent professional burnout and vicarious traumatization of helpers

#### **Helpers can effectively help people in crisis if:**

1. They understand the meaning of crisis as a psychological process
2. Know the principles of crisis interventions → in the first phase of a crisis people depend on receiving help, but they need to be encouraged to develop and use own resources
3. They recognize crisis situations in their work, their own crises, and their effect on their work
4. They support other helpers when they are faced with crisis events

#### **The specificities of crisis events in the helping professions**

- Can be a shocking event, whose effect is very personal and strong, and sets in motion a „shock” crisis in which the usual ways of thinking, feeling and acting are not adequate
- An event that has a symbolic meaning, a personal meaning for the individual → crisis

#### **What affects the helper's reactions to crisis events? (Snelgrove, 1994.)**

1. Severity of the event or accident → larger scope and more serious consequences endanger the mental health of helpers more strongly
2. Type of event → if identifying with the victims is easier, the consequences are bigger
3. Level of responsibility related to the event → greater responsibility → greater risk of stress and feeling of guilt
4. Physical and psychological closeness of the event → if colleagues or friends are involved, greater risk for stronger reactions

5. Prior experience with crises → the way they were resolved will affect the reactions in the current situation
6. The helper's personal situation (divorce, death of close family member, pressures at work) → reduced coping capacities
7. Others' behavior during the crisis → other helpers acting rationally or they have lost control of behavior
8. Availability of professional support (defusing, debriefing, counselling) → reactions can be less strong
9. Support or condemnation of colleagues, family and public opinion → if condemning, there is a greater risk of stronger and longer reaction
10. Involvement of media → looking for the culprit; judging or emphasizing the difficulties of the profession and of the context where the crisis event happened can affect the resolving of the crisis
11. Superiors' attitudes about the helper → can affect the helper's reaction

#### **What to do when helpers are exposed to crisis events?**

- A crisis event that has the characteristics of a stress event requires normalization of reactions
- Normalization: teaching individual helper or a group of helpers that stress reactions are common in such situations
- Formats:
  - Group discussion, brochures
  - Consultations with superiors or colleagues
- A crisis event that has the characteristics of a traumatic event requires venting
- Venting: Telling about the event and emotional defusing
- New, uncomfortable experiences are integrated more easily if they are talked about → individuals can accept the truth about what happened and reappraise themselves and life
- If it is done individually, it is important to find a supportive person for the conversation (so called *crisis counselor*)
- Format: *defusing* and *psychological debriefing*
- A crisis event that has the characteristics of a loss requires support in grieving

- If the event includes the death of someone personally known, it is important to make time for the grieving process
- Format: psychological debriefing, support in grieving, counselling

### **What are psychological crisis interventions for helpers?**

- Procedures that help helpers normalize their functioning and feelings after crisis events
- Procedures to prevent serious and long-term mental health consequences

### **Components of psychological crisis interventions**

1. Establishing trust with the affected person
2. Exploring the dimensions of the problem (reactions, emotions, functioning)
3. Teaching the person about crisis reactions
4. Exploring possible solutions that are acceptable to the person
5. Providing support in taking concrete actions
6. Follow up of changes

### **Specifics of psychological crisis interventions**

1. Brief and time-limited
2. Limited goals – preventing adverse consequences (establishing emotional balance, understanding own current difficulties, regaining feeling of control)
3. Timing – as soon after the crisis event as possible
4. Proactivity and adaptability to the specific circumstances

### **Information to assess the need for psychological crisis intervention**

1. What happened?
2. Who was involved (directly or indirectly)?
3. Where did the event happen?
4. When did the event happen?
5. What are the reactions of those affected?

### **Specific crisis procedures for helpers**

1. Demobilization
2. Defusing

### 3. Psychological debriefing

#### **Demobilization**

- Brief exchange after a large-scale crisis event
- Helpers + group leader meet immediately after the event, at the scene of the event, at the end of a shift
- Group leader teaches for 10 minutes about the symptoms they may have in the following days and ways of self-help (until debriefing is organized)
- After the meeting, the participants go home or to their usual work assignments
- Rest-information-time out sequence

#### **Defusing (emotional unloading)**

- Meeting of a small group of helpers that work together + group leader
- Immediately after the work, before leaving the scene of the event
- Duration 20 - 60 minutes
- Phases:
  1. Explanation of the purpose of the meeting
  2. Exploring the event – in free-flowing conversation, perceptions and experiences of the crisis event are exchanged → normalization
  3. Psychoeducation about stress reactions, posttraumatic reactions and ways of coping

#### **Psychological debriefing**

- Most complex procedure among crisis interventions
- Group meeting is led by professional trained for this procedure
- Necessary skills:
  - professional dialogue skills and group processes
  - work with grieving and traumatized people
  - work with emotions of fear and anxiety
- The group leader must be outside of the circle of those affected by the event

#### **Conducting debriefing**

- Detailed review of the crisis situation focused on:

- thoughts
- sensory experiences
- emotional and behavioral reactions
- psychoeducation about stress and trauma
- Only those affected by the event attend the session
- Purpose: Integrating experiences of working with victims of the event into helpers' overall life experience

### **Preparing debriefing**

1. Participants:
  - No subordinates and superiors together
  - Similar level of involvement with the event
2. When to do the debriefing:
  - **Not** earlier than 24 hours after the event
  - **Ideal:** 1-3 days after the event because defense mechanisms are weaker
  - **Good:** within several weeks – repression of psychological effects of the event is still weak, psychoeducation is useful
  - **Not recommended:** after 3 or more months – only psychoeducation about the symptoms of stress
3. Where:
  - Neutral environment (not on the scene of the event)
  - Ensure the participants feel safe
  - 5 to 10 group members, sitting in a circle
4. Duration depends on:
  - Severity of event
  - Group size
  - Openness of the group

### **Phases of debriefing: from cognitive to emotional, and back to cognitive**

1. Introduction of participants, defining purpose and rules regarding the session

2. Review of facts about the event, clearing misconceptions, rumors
3. Sharing thoughts about event
4. Review of individual reactions about event
5. Review of psychological and physical effects of witnessing event
6. Teaching about stress and trauma and coping
7. Concluding phase – address issues that require elaboration and information about referral paths

## **Lecture**

### **Community and social capital in time of distress**

#### **What is community?**

- A group of people who share:
  - Territory of geographical location
  - Are linked by social ties
  - Have common interest
  - Are willing to participate and engage in joint action
- Local communities (e. g. neighborhoods, towns) we come from are a good example

#### **How community members are linked?**

- Common history of living together
- Interpersonal and intergroup relations that have immediate influence on life of individuals, families and groups
- Common goals and interest
- Social norms and related expectations that members will follow them
- Interdependence of individual and groups in accomplishing common goals
- Perception of similarities with others
- Sense of „weness” that differs „us” from other communities

#### **Functional (effective) community**

- People feel safe and accepted, can rely on each other, are ready to help each other, have a sense of shared identity
- Most important: members are ready to work together in order to accomplish common goals
- Idea and value of common good can mobilize members to make joint efforts in order to improve their life conditions

#### **Psychological sense of community**

- One feels that s/he belongs in and contributes to a larger collective due to:
  - Shared membership

- Influence
- Integration and fulfillment of needs
- Shared emotional connections

### **Social capital**

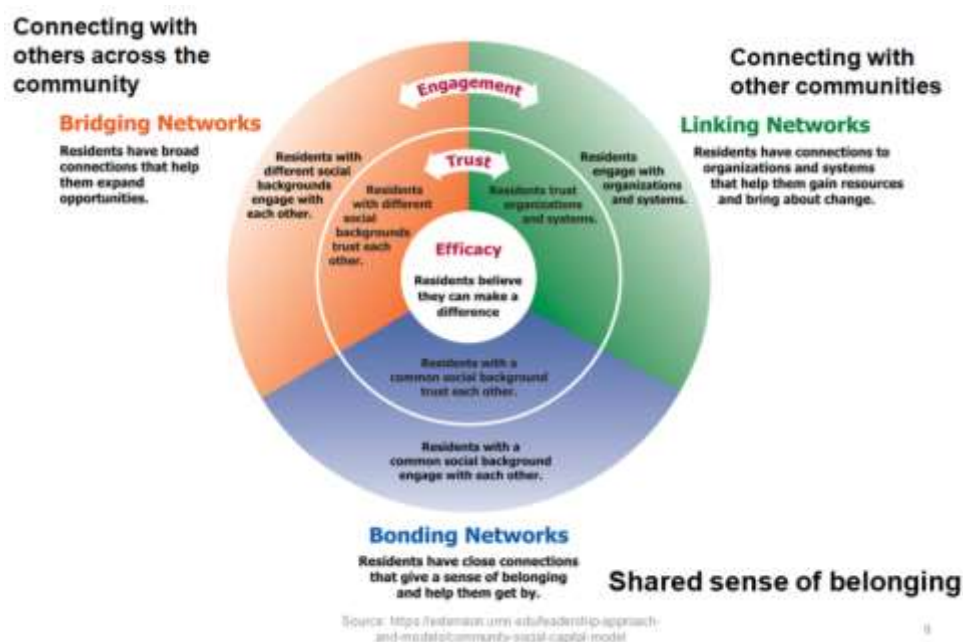


### **Functional (effective) community**

- Social capital is a „glue” of a society
- Three components of social relations in highly functional communities
  1. Social trust: people are willing and ready to cooperate with other community members; not only with their family members and relatives.
  2. Norm compliance: norms are respected and followed and members comply with them even in the absence of control. Community imposes sanctions on those who do not behave according to the prescribed norms.
  3. Network and reciprocity: members believe they can rely on other members, feel they have duty to each other and are willing to participate in a balanced exchange (e. g. returning favors). Members are aware their needs and goals are better satisfied if they work together with other community members.



## Community Social Capital Model (BLB)



## Evidence of importance of social capital

- General finding: communities with more social capital have less social problems (e. g. lower violence)
- Social trust among individuals and groups is related to improved mental health
- Colombia findings: national representative sample (N=3025) (Hurtado, Kawachi & Sudarsky, 2011)
  - Cognitive dimensions of social capital (perception of trust and reciprocity) were related to better self-rated health
  - Importance of education: self-rated health was better in those who completed high school (unlike the less educated) and perceived reciprocity in interpersonal relations.
  - Role of interpersonal trust: it provided a sense of security and safety and was linked with behaviors related to community belonging, including civic actions.
- Social trust (Caribbean coast sample) was positively related to greater engagement in civic life (Taylor, 2015)

## Community functioning in time of distress

- Everyday functioning in normal circumstances is assured by functional general community support – a well-development network of individuals, groups and institutions

- In time of distress community may experience serious breakdown of its vitality depending on intensity of stroke and injury it suffered
- In time of crisis, especially prolonged one, community social tissue may be seriously damaged and cause community malfunctioning
- Lack or decline in social support and social embeddedness help in explaining much of the mental health consequences of calamities - need to move beyond the “dose-response” paradigm into studying family and community processes that foster resilience or obstruct recovery

### **Impact of political violence and prolonged conflict on communities**

- Violence has strong effects on individuals and communities.
  - People who experience violence are at risk of (prolonged) mental health problems
  - Exposure to political violence is a risk factor for an individual well-being
  - (Good) mental health is related to civic participation
- Consequences on mental health in Colombia:
  - 10% of adults and 12% of adolescents have mental disorders (Ministry of health, 2015 cited in The Lancet, 2018 (5)).
  - Prevalence of anxiety, depression and PTSD is highest in conflict-affected zones.
- Strong impact on whole communities and society at large
- The social systems are contexts for two contradictory processes: people experience injuries and suffering and they are expected to recover and function again in the very same social context
- Key challenge: how violent communities can be transformed into peaceful and functional communities
  - (Lasting) peace is a process, conflict does not end when arms have been laid down
  - Formal peace agreements usually fail to establish peaceful (let alone amicable) relations among formerly conflicting groups
    - E. g. almost 25 years after Erdut agreement (Croatia) or Dayton agreement (B&H) there are still (ethnic) tensions and social distancing
    - Challenges of Colombia Peace Agreement in 2016?

## Mass violence has detrimental effects on social tissue of communities

- The casualties and victims are manifold
- Violence is intentional and directed to specific groups (e. g. ethnic groups)
- Violence is directed primarily to destroy, exterminate and prevent the unwanted group to come back to their community and recuperate
- Violence is total: it is not directed only to destroy individual human lives, but also group symbols (e. g. flags, monuments, churches, cemeteries) and culture
- Social networks and other normally available support mechanisms are shattered
- Communities are left fragmented, and often divided along the lines critical for the conflict (e. g. ethnicity, race, ideology, class)

## Social characteristics of communities distressed by (mass) violence

- Distressed communities are disconnected communities (EIG, 2017)
1. Questionable safety – is the violence really over; how safe am I, my family and my community?
    - Not only a matter of physical safety and fulfillment of basic human needs
    - Due to prolonged exposure to violence people are extremely alert to incidence of discrimination, particularly group based
    - Formerly conflicting groups (and other groups living in the community) may feel continuously threatened by each other.
      - Resources are scarce, so **realistic threat** may be perceived as high, i. e. people may feel their economic well-being is threatened (e. g. lack of job opportunities, land distribution is unjust, unequal access to health-care and social-care system etc.).
      - **Symbolic threat** is even more common in post-conflict settings. People feel threat to their attitudes, values, norms, beliefs and other components at the core of their group identity. E. g. majority may feel threat to their dominant social status, minority may feel threat of being discriminated.
    - People experience gross violation of human rights and seek justice, expecting those who are guilty of committing violence, criminal acts or atrocities to be brought to justice and punished
    - Feeling of safety, psychological health of victims, and community reintegration may be seriously endangered by the presence of those involved in violence but have gone unpunished

- Necessity to remove conflict-related emotional barriers in order to achieve peace
- Different needs of victims and perpetrators
- Needs-based model (Nadler & Shnabel, 2008)
  - Victims feel threat to their identity as powerful actor
  - Perpetrators feel threat to their identity as moral actors
- Key issue: how to (re)integrate people with different conflict experiences
- Community empowerment approach seeks to satisfy needs of both sides:
  - Victims seek to be empowered by acknowledging their suffering and injustice done to them
  - Perpetrators seek acceptance from others, bringing them back to a moral community.

## 2. Normative structure has been shattered

- Functional society is based on *social norms* - the accepted and expected behaviors in certain situations
- The norms are reflected in society's values - people know what is right, good and desirable
- Social values are important part of a culture and provide behavioral guidance
- Large-scale violence changes a normative system of the society: people see others achieving their goals by breaching the norms and formal institutions do not respond adequately.
  - People start questioning their values and beliefs and many adjust their behavior accordingly (e. g. use violence for accomplishing their goals, participate in drug trafficking, smuggling etc.)
- Lack of trust between individuals and groups is a direct consequence of a normative collapse because common norms do not navigate anymore who can be trusted and who cannot.
- People have no firm guidance about what to expect from others in the community and (benevolent) expectations about future behaviors of others is at the core of trust
- Lack of trust seriously hinders social recovery

## 3. Worldview of affected people has been shattered

- People generally believe that the world is a reasonably safe, predictable, benevolent, and meaningful place. This set of beliefs is at the core of our fundamental assumptions about who we are, what is the world around us and how we make sense about those two.
- When things are normal, our assumptive world helps us to perceive a balance between what we do and what we get as an outcome.
- When this routine is severely disturbed by e. g. experiencing trauma, this may have a devastating impact on this balance and cause our fundamental assumptions to be ‘shattered’.
- Our recent study has shown that worldview changes did not only impair mental health outcomes of individuals, but also were related to impaired social outcomes.
- More severe war-related trauma symptoms were linked to a more profound worldview change, which was in turn associated with people being less ready to become closer with the members of the formerly conflicting group, less engaging in trustful relations and more demanding of an apology from the ‘other side.’
- It seems that intergroup trust is most seriously violated by trauma inflicted during inter-group violence.

## Lecture

# Community recovery and community resilience

## Community recovery

- Communities torn apart by violence require a community approach

## Tasks of effective community-based intervention

- Help facilitate psychosocial reconstruction of communities
- Decrease social tensions among groups that have been involved in a conflict
- Provide treatment for the traumatized individuals
- Work towards re-connecting community members
- Help create the environment perceived as safe enough to facilitate recovery

## Community recovery as social reconstruction process

- Possibly the key process conducive to recovery from individual and collective traumatization and losses at the community level
- It implies *re-construction* instead of *resumption*, relationship renewal and repair in deeply changed circumstances instead of starting the relationships all over again, as if nothing has happened
- These processes are group oriented and determined by what happened between the groups in conflict, not only among individuals
- Although individuals interact, it is the in-group and inter-group dynamics within a social context that determines pace, intensity and nature of such interactions (limited and superficial vs. open and cordial)

## Social reconstruction

- Process within a community which brings the community's damaged social functioning to a normal level of interpersonal and groups relations and renews the social fabric of the affected community

**Connections among four levels of social reconstruction after conflict** (Corkalo Biruski & Ajdukovic, 2009)



**Individual and community resilience**

**Resilience**

- Process contrast to psychopathology or breakdown
- Resilience focuses on strengths rather than on vulnerabilities, on capabilities rather than deficits, on resources rather than losses, on transformation rather than status quo
- Individual and community resilience
- Key issue: what are crucial predictors (individual, social and societal) of healthy adjustment
- Resilience describes ability („adaptive capacities”) of individuals, groups, communities and societies to „bounce back” after experiencing adversary conditions.

**Post-traumatic growth (PTG)**

- Process of a positive psychological change after experiencing severe adversity and/or traumatic experience
- Recent meta-analysis:
  - The prevalence of moderate-to-high PTG among trauma victims was 52.58 %.
  - Higher rate of moderate-to-high PTG among younger than 60, those who had shorter time since trauma, had specific professional exposure and suffered from direct trauma.
- No evidence on PTG at the community level.

## What is community resilience?

- Capacity of a community to take a positive trajectory of adaptation after distress or adversity
- Includes number of elements that help communities to resist and to recover when facing natural and/or man-made disasters, including political violence, intergroup conflicts and war
- Most of the models are developed outside the context of political violence. However, core elements of community resilience are universally relevant and applicable.

## Community resilience - components



Source: Adapted from Norris et al., 2008

## What are community resilience components?

1. Local knowledge: how community understands its own vulnerabilities. Three sub-components:
  - Factual knowledge (e. g. what institutions are available for providing help)
  - Training and education (professionals and general public)
  - Collective efficacy and empowerment (shared belief about community's ability to overcome disruptions and consequences of a disaster)
2. Community networks and relationships: strength of community ties enhanced by trust and shared values
3. (Effective) communication: Common understandings and opportunities for members to articulate needs, views and attitudes
4. Health: level of health care before and after a calamity community understands its own vulnerabilities. Two sub-components:
  - Health services including infrastructure and general public health



- Care for both physical and mental health (e. g. psychological first aid)
5. Governance/leadership: responsible for how communities handle crisis. Two sub-components:
    - How effective, efficient and capable in responding are infrastructure and services
    - Public support and involvement
  6. Resources: most important aspects – fairness in resource allocation
  7. Economic investment
  8. Preparedness: e. g. building and developing culture of peace and reconciliation in order to ensure non-repetition of conflict
  9. Mental outlook: cognitive, affective and behavioral habits when facing the uncertainty. Two features are of special importance:
    - Hope – beliefs that things will improve
    - Adaptability – capability and willingness to change while accepting that community will be different. Especially important after prolonged intergroup conflict when communities have changed substantially due to human losses and breakdown of social capital.

#### **Community resilience in Colombia: some evidence**

- Past exposure to political violence, current experience with community antisocial behavior, and perceived social trust were positively related to civic participation (Taylor, 2015)
- It is possible that those who feel unsafe in the community due to community antisocial behavior establish bonds with other victims.
- As the result of being exposed to political and community violence, individuals may be motivated to act prosocially and help others through community engagement (Taylor et al., 2014).

## Lecture

# Empowerment of Local Communities and Social Action

## Community empowerment

- Communities that have gone through crises (conflict, natural disaster, etc.) go through the process of social reconstruction
- **Empowerment** = developing the capabilities of members and the group as a whole to change the factors that determine their living environment
  - seek to instill in community members the belief that they can affect change and can improve their own lives
  - community-based projects provide organizational tools and resources to carry out such changes and improvements
  - promoted through inclusive participation and decision-making, capacity building and the means to implement decisions

## Empowerment in the Colombian context

- Empowerment always occurs in the context of the local social system and implies an increase in the relative power and ability of disadvantaged groups in their specific socio-political environment (Haider, 2009)
- Empowerment strategies need to address the needs of both the individuals and the communities, as well as the larger society
- Effective empowerment of vulnerable disadvantaged groups = the capacity building of the disadvantaged + the reform of oppressive rules and practices

## Social action in the community

- Social action model is a community oriented program
  - Useful because it:
    - Responds to authentic and specific needs
    - Fastest way to answer those needs
    - Assumes involvement of community members
- = Rapid, efficient and cost-effective fulfilment of community needs
- Goal of social action: social change in a community by mobilizing members of the community to work together for the common good

- Goals can be accomplished by empowering community to gain more control over the process of decision-making and access to resources
- A social action group is key to implementing social change
- They coordinate efforts aimed at changing some aspects of the social or physical environment
- A mechanism for the common achievement of objectives for the common good
- Important role of group leader / coordinator:
  - Plans group activities
  - Raises awareness of various competencies and strengths that group members have
  - Needs to be familiar with principles of group work as well as to have knowledge of community

### **Planning a social action**

- Important to plan social action
- Intertwined steps
- Starts with an individual or a smaller group which systematically enlarges to increase its capacity to reach the goal

### **Steps in planning social action**

1. Needs assessment
2. Defining the purpose and objectives of the social action
3. Defining group composition and group size
4. Motivating potential members of the social action group
5. Selecting a mode of work
6. Ensuring needed resources/ tools

### **Needs assessment**

- Identify certain common needs in a community
- Assess the possibility to meet these needs through social action
- SWOT analysis of the community to gain better perspective



### Purpose and objectives of the social action

- **What** is planned to be achieved by social action
  - e.g. improve the quality of life of older people, reduce social isolation of victims of armed conflict, increase resources for young single mothers
  - must be considered important by local community
- **How** it can be achieved
  - a) organize food delivery to those less mobile; support groups for victims or single mothers
  - b) excursions for elderly, victims, single mothers
  - c) collecting cultural heritage in which elderly could take part and contribute to the community; providing information of victims about accessing their rights; guidance on upbringing of children for single mothers

### Composition and size of the social action group

- **Composition:**
  - Ensure that members represent all relevant services, institutions and individuals important to achieve the goal
  - Involve people from the community - opinion makers and prominent community members (sportsmen, celebrities, etc.) to promote the idea of the program
- **Size:**
  - Depends on the goal
  - If the group is too big to coordinate efficiently, divide it into subgroups/teams for specific activities (4-6 team members)
  - The bigger the group, the more important the role of the coordinator

## **Motivating potential members**

- Who are the key figures in the community? (teachers, medical doctors, nurses, priests, media people, local politicians?)
- Importance of personal contact with potential members, whether eye-to-eye or by phone
- Role of a social mobilizer (either an activist or a selected community representative), who acts as a facilitator and stimulates group formation for social action
- A potential member should be informed about the goals of the social action and the role they would have in reaching the goal. It is especially important to show them how important their support is for the success of the social action
  - The message is: *We need you and we expect your support.*
- Initial meeting with group members is needed to define goals and tasks together. Working together on what should be achieved and how by the social action is strong motivating factor.
  - The question for the group in this phase is: *What will be different in our community when we succeed?*

## **Selecting a mode of work**

- Selection of methods of work depends on several elements:
  - Duration, time limitations
  - Type of coordination needed
  - Division of roles and tasks, i.e. existence of subgroups
  - Modes of cooperation between subgroups, as well as between the group for social action and the community
  - Assessment of barriers to achieving the goal of social action
  - Assessment of support
  - Evaluation

## **Selecting a mode of work**

- Principle of empowerment should be present at all levels
  - Ownership
  - Real power
  - Creating possibilities

- Satisfying expectations
- Accepting differences
- Respect
- Support
- Openness and communication

### **Needed resources/ tools**

- Resources include work, knowledge and competencies of the group members.
- However, financial resources are also very important and should be planned from the start:
  - The minimal funds needed to achieve the goal
  - Potential sources of funding (local government, private sponsors, small donators, state budget, etc.)
- It is recommended to include community, i.e. local sources of funding as it empowers people and their feeling of belonging to a community. Also, it makes them less dependent and passive

### **Advantages and disadvantages of social action groups**

#### **ADVANTAGES**

- Work in group is more creative and energetic
- People enjoy more when they work in groups
- Satisfies the need for social contact (need to belong)
- Results in better efficacy and faster goal achieving
- Often it is the only way to accomplish the goals of a social action

#### **DISADVANTAGES**

- Much time and energy invested in organizing activities and interaction between members
- Some group members can be marginalized as working in groups is incompatible with their nature
- Different social action groups can become competitive and hence be detrimental to positive changes in a community

## Challenges of social action groups

Special attention should be paid to the most common challenges of conducting a social action

- Non-productive group meetings
- Failure to execute agreements and decisions
- Competing among different groups in the same community
- Conflicts and personal disagreements among members
- Hidden personal goals of individual group members
- Destructive patterns of communication
- Group conformity

## How to respond to challenges of social action groups

- Aside from following the basic principles of group work, there are several techniques that generally contribute to the efficacy and successfulness of social action groups:
  - *Brainstorming* has two principles:
    - There are no bad ideas; every idea is worthy
    - No evaluation of different ideas at first
  - *Structured conflict resolution* includes 6 steps:
    1. Defining the problem
    2. Analyzing the problem
    3. Devising possible solutions
    4. Evaluating potential solutions and choosing the best one
    5. Delegating responsibilities
    6. Evaluating outcome

## Examples of social action

For children

- **Context:** Croatia, small town heavily destroyed during the war
- **Goal:** To take children from this community to a summer camp
- **Why it needed social action group:** No money for such activity; poor community; local institutions could not provide funding

- **How it was accomplished:** Funding was ensured by reaching out to ex-members of that community who left the community and became successful, and who donated the money

For youth

- **Goal:** Establishing a youth club in a community destroyed by the war (to empower youth and to encourage their active involvement in the community)
- **Why it needed social action group:** No space, no access to local institution nor knowledge how to raise funding, and the adults in the community showed no interest
- **How it was accomplished:** Working with youth (communication and negotiating skills); arranging meetings with local institutions; organizing public forums; arranging for experts on mental health to give public lectures; very important – a local politician willing to invest time and energy in coordinating this action



## **MODULE 5 WORKSHOPS**

### **Module 5, Workshop 1**

#### **Experiences with community crisis events (60 minutes)**

**Objective:**

To become aware of own experience with community crisis

**Expected outcomes:**

9. Participants will be able to analyze elements of community crisis and affected people's behaviors
10. Participants will compare own experiences and behaviors in a community crisis

**Materials:**

- Template for analyzing an event that resulted in a community crisis and people's needs and behaviors in these circumstances for each participant

**Methods:**

Two groups with 15 participants.

Participants are reminded of the characteristics of events presented in the lecture and asked to tell if they have witnessed such events or have been exposed to any of them. At this stage they should only name the event because in the further steps they will analyze events in subgroups of threes. (10 minutes)

Participants work in subgroups of three using the template and analyze the critical events that affected their community and perhaps also themselves. First, each participant will complete the template for themselves, and then discuss with others. They should try to find similarities and differences between their examples. This should be noted at the end of the template for presentation to the whole group. (25 minutes)

Each subgroup presents their findings about commonalities and specifics of the community crisis they have witnessed, i.e. primarily the last section of the template. (20 minutes)

Trainers concludes with highlighting the wealth of experiences with crisis in the group and coping mechanisms that communities have displayed as well as those of participants (5 minutes)

## **Elements of community crisis events**

What was the event that affected the community and created a crisis:

What was your role and experiences related to this event:

Which elements of the event made it cause the community crisis:

Was there disruption of functioning of community services, destruction, and if so, how:

How did the people behave: during the event, immediately after the event, months later

Did you recognize what were the priorities of people affected by the community crisis

How long did the crisis last (days, weeks, months):

What resources people used to overcome the crisis:

Is there something you would do differently now that you know about the community crises than at the time you were describing:

.....

In your small group what are the:

1) Similarities among community crises you presented:

2) Difference between these community crises:

## **Planning PFA in a community crisis** (75 minutes)

### Objectives:

To exercise planning Psychological First Aid (PFA)

### Expected outcomes:

Participants will be able to plan PFA in phases from the crisis event to end of first month post-event

### Materials:

- Description of the event (terrorist attack) in three similar variants which refer to providing PFA either: (1) during first two days, (2) from second day to end of first week, (3) from second week to end of the month post-event. (12 copies of each variant)

### Methods:

Two groups with 15-17 participants.

Participants work in subgroups of 5. They are reminded about key issues of PFA as presented in the lecture. Each subgroup receives one variant of the description of the event (one for each participant in a respective subgroup). (10 minutes)

The participants in each subgroup develop a plan of providing PFA in the respective period after the event based on the information in the description of the event and provided during the lecture. They should take into account goals of PFA, needs of affected people, priority groups of victims, activities provided within PFA, sequence of PFA, resources that need to be mobilized, relations with other services. (30 minutes)

Two groups that work on the plan for the second and third period should assume that PFA has been already provided in the previous period(s), so that they continue with planning appropriate PFA activities for “their” period.

Each group presents the plan for providing PFA in the respective period which is commented by other participants and the trainer. (30 minutes)

## **PFA after a terrorist attack (first two days)**

At the bus stop in the city center, on October 23, at 7.30 am a very strong explosion occurred, leaving 25 people injured. By 8 am the victims were transported to several hospitals.

There were a lot of onlookers at the scene who watched the ambulance, police and firefighters work. At 8.30 am another bomb exploded in a garbage bin behind the back of the onlookers. It killed 3 people and seriously injured 15 people, including one police officer and two firefighters. About 35 people farther from the site of the blast sustained minor injuries. They were provided with first aid by the already present ambulance staff.

The ambulance transported the seriously injured and killed to hospitals by 9 a.m., and additional fire and police forces were engaged.

Among the witnesses of two event there were 5 children aged 6 who were with their parents and 10 children aged around 14 years. Among the citizens who witnessed the explosions were 8 elderly people between the ages of 70 and 80. There were 6 foreigners among the witnesses of the blast.

At 10 o'clock you were notified of the incident and the location of the injured and their family members, and that there were still a significant number of witnesses at the scene who were very upset.

### **What should be done within PFA during first two days for adults?**

Describe as specifically as possible how to provide PFA regarding adults during the first two days after the event taking into account PFA goals, needs of affected people, priority groups of victims, activities provided within PFA, sequence of PFA, resources that need to be mobilized, relations with other services.

## **PFA after a terrorist attack**

### **(from second day to end of first week)**

At the bus stop in the city center, on October 23, at 7.30 am a very strong explosion occurred, leaving 25 people injured. By 8 am the victims were transported to several hospitals.

There were a lot of onlookers at the scene who watched the ambulance, police and firefighters work. At 8.30 am another bomb exploded in a garbage bin behind the back of the onlookers. It killed 3 people and seriously injured 15 people, including one police officer and two firefighters. About 35 people farther from the site of the blast sustained minor injuries. They were provided with first aid by the already present ambulance staff.

The ambulance transported the seriously injured and killed to hospitals by 9 a.m., and additional fire and police forces were engaged.

Among the witnesses of two event there were 5 children aged 6 who were with their parents and 10 children aged around 14 years. Among the citizens who witnessed the explosions were 8 elderly people between the ages of 70 and 80. There were 6 foreigners among the witnesses of the blast.

Some injured people were still in the hospital, but the majority have been released to home care. The list of the injured, of families who have lost a member and most of the onlookers were available with their addresses and telephones.

During the first two days 15 helpers were engaged in providing PFA. Most of them worked more than 10 hours each day with the victims.

### **What should be done within PFA from second day to end of the week for adults?**

Describe as specifically as possible how to provide PFA regarding the adults from the second day to the end of the first week after the event taking into account PFA goals, needs of affected people, priority groups of victims, activities already provided within the PFA (during the first two days), PFA sequence, resources that need to be mobilized, relationships with other services.

Take into account that other helpers have already been providing PFA to victims for two days.

## **PFA after a terrorist attack**

(from second week to end of first month)

At the bus stop in the city center, on October 23, at 7.30 am a very strong explosion occurred, leaving 25 people injured. By 8 am the victims were transported to several hospitals.

There were a lot of onlookers at the scene who watched the ambulance, police and firefighters work. At 8.30 am another bomb exploded in a garbage bin behind the back of the onlookers. It killed 3 people and seriously injured 15 people, including one police officer and two firefighters. About 35 people farther from the site of the blast sustained minor injuries. They were provided with first aid by the already present ambulance staff.

The ambulance transported the seriously injured and killed to hospitals by 9 a.m., and additional fire and police forces were engaged.

Among the witnesses of two event there were 5 children aged 6 who were with their parents and 10 children aged around 14 years. Among the citizens who witnessed the explosions were 8 elderly people between the ages of 70 and 80. There were 6 foreigners among the witnesses of the blast.

Only a few injured people were still in the hospital, but the majority have been released to home care. Many of them have returned to work and other regular activities. The list of the injured, of families who have lost a member and most of the onlookers were available with their addresses and telephones.

During the first two weeks 15 helpers were engaged in providing PFA. Most of them worked more than 10 hours each day with the victims.

### **What should be done within PFA from second week to end of the month for adults?**

Describe as specifically as possible how to provide PFA regarding the adults from the second week to the end of the month after the event taking into account PFA goals, needs of affected people, priority groups of victims, activities already provided within the PFA (during the first two weeks), PFA sequence, resources that need to be mobilized, relationships with other services.

Take into account that other helpers have already been providing PFA to victims for two weeks.

## Module 5, Workshop 3

### **Planning PFA for children and adolescents in a community crisis (60 minutes)**

#### Objectives:

To exercise planning Psychological First Aid (PFA) specifically for vulnerable groups, in this case children and adolescents

#### Expected outcomes:

Participants will be able to plan PFA for vulnerable groups who have been exposed to a critical event

#### Materials:

Description of the event (terrorist attack) in three variants already used in Workshop 2 (no need for these materials in this workshop)

Psychological First Aid for children - Do's and Do not's (for each participant)

#### Methods:

Two groups with 15-17 participants.

Participants work in same subgroups of 5 as in the previous workshop. They first share their views on the specific needs of children and adolescents in community crisis situations. They are reminded to refer to the topics regarding working with children and adolescents that have been addressed in the previous modules of this training. (15 minutes)

The participants in each subgroup develop a plan of providing PFA specifically for children, and adolescents in the respective period after the event, based on the information in the description of the event and provided during the lecture. They should take into account goals of PFA, specific needs of these groups of victims, activities that respond to these needs and capacities, resources that need to be mobilized, relations with other services. (20 minutes)

Two groups that work on the plan for the second and third period should assume that PFA has been already provided in the previous period(s) to these vulnerable groups and plan appropriate PFA activities for "their" period.

Each group presents the plan for providing PFA for the vulnerable groups in the respective period which is commented by other participants and the trainer. (20 minutes)

## Psychological First Aid for children

<b>Listen to the child speaking to you.</b>	Do not force child to socialize with you; the child has the right to choose what he or she wants to do.
<b>Be patient and calm.</b>	Do not yell at the child or shame in any way.
<b>Talk with respect for the child.</b>	Do not urge child to tell his or her story, to engage in activities, to make new friends.
<b>Use kind tones and simple language, be empathic and open.</b>	Follow the pace of the child.
<b>Honestly say when you don't know something. Make sure to find out if it is possible.</b>	Do not hug the child unless you are absolutely sure that it is acceptable for the child.
<b>Adjust to the child's short attention span.</b>	Do not cry in front of children. You can say that it is difficult and briefly get out of the situation.
<b>Be creative and open to the child's needs.</b>	Do not make fun of the child when he or she is expressing feelings, even for the purpose of trying to make him laugh. It shows disrespect.
<b>Be playful and encourage the child to learn through play.</b>	Do not question child's lifestyle, religion or customs.
<b>Emphasize stories of friendship, loyalty and caring.</b>	Don't make up answers to child's questions just because you are uncomfortable or want to comfort the child.
<b>Tell stories with children in the lead roles.</b>	Do not pity the child or underestimate his or her capacity to cope with difficulties.
<b>Use acting, plush toys and dolls.</b>	Do not take child's aggressive outbursts or withdrawals personally.
<b>Encourage singing, clapping, dancing, movement.</b>	Give up the expectation that all children will love you and that everything will be easy for you to do. This leads to frustration and self-blame.
<b>Let the child know that he or she has the right to refuse to participate in the activity and talk.</b>	Don't expect children to be thrilled with every activity you design. Invite them to create activities together with you.



## **Demonstrating interventions for helpers after a crisis event**

(75 minutes)

### Objectives:

To exercise interventions to support helpers who have been professionally involved in a crisis event

### Expected outcomes:

11. Participants will be able to provide simple interventions for supporting helpers who have been involved in a crisis event (demobilization, defusing)
12. Participants will understand the process of psychological debriefing

### Materials:

- Description of a community crisis event in which a group of helpers have been intensively involved – this is the same event (terrorist attack) from previous two workshops (no specific material is needed)

### Methods:

One group with 30 to 35 participants (demonstration in a fish bowl). Trainer and 8 participants sit in an inner circle and other participants (observers) sit in the outer circle, allowing them to observe the process in the inner circle.

Trainer will demonstrate demobilization, defusing and psychological debriefing with helpers who have been involved in intensive provision of PFA after the terrorist attack. The event had characteristics of a traumatizing event. The participants get into the role of helpers who were on the scene of the event on first day and were providing PFA for 8 hours. (10 minutes to get organized)

### Demonstrating demobilization (10 minutes):

Assumptions: End of the shift for the group of helpers who have been helping distressed witnesses of the event, but who have not been injured.

Trainer will teach for 5 minutes about the symptoms that people in distress may have and about simple coping techniques (e.g. relaxation, breathing). Recommend the helpers to go home, eat and rest.

Participants from the inner circle move to the outer circle, and new group of 8 participants take the place in the inner circle.

### Demonstrating defusing (15 minutes):

Assumptions: End of the shift for the group of helpers who have been helping highly distressed family members of the injured and who have witnessed dead bodies.

Trainer will explain the purpose of the meeting (to emotionally unload before leaving the scene of the event). In a free-flowing conversation the trainer will encourage talk about perceptions and experiences of the crisis event. Short psychoeducation about stress reactions, symptoms

that people in distress may have (5 minutes) and about simple coping techniques (e.g. relaxation, breathing). Recommend the participants to go home, who eat and rest.

Participants from the inner circle change seats with observers.

Demonstrating psychological debriefing (30 minutes):

Assumptions: Three days after the event the session is held with the group of helpers who have been involved with the injured victims, their families, children, elderly, foreigners who have witnessed the terrorist attack.

1. Introduction of participants, defining purpose and rules regarding the session
2. Review of facts about the event, clearing misconceptions, rumors
3. Sharing thoughts about event
4. Review of individual reactions about event
5. Review of psychological and physical effects of witnessing event
6. Teaching about stress and trauma and coping
7. Concluding phase – address issues that require elaboration and information about referral paths

Feedback from the participants on demonstration (10 minutes)

## **Effects of armed conflict on my community** (60 minutes)

**Objective:**

5. To analyse impact of the armed conflict on individuals and communities

**Expected outcomes:**

13. Participants will recognize and understand how the armed conflict affected their communities and influenced their individual and group lives
14. Participants will exchange their experiences; they will be able to recognize similarities and differences in how they and their communities experienced the conflict

**Materials:**

- Template *Effects of armed conflict on my community* (for each participant)

**Method:**

Work in two groups.

Participants are divided in small groups of five.

Participants are reminded that exposure to community violence has impact on each and every individual in the community. However, each individual processes community events specifically and sees the impact on community in a particular way.

Participants individually fill the templates. It is important to emphasize that they are asked to look into their very intimate experiences and thoughts related to the conflict. These elaborations may be difficult and emotionally challenging; however, they are hard to be put aside; this is why is important to recognize, acknowledge and analyse them in order to be able to confront them, to manage them and to integrate them productively as an important part of our life experience. (15 minutes)

Experiences are shared in groups of five and are summarized based on the small group discussion. It is suggested that shared experiences are outlined in two major points: 1. how your community has generally changed by the conflict; 2. what is the major “life lesson” you have learned because of the conflict. (25-30 minutes)

(Please note that personal changes are not suggested to be shared in the large group, because these issues may be too sensitive; nevertheless, in small groups each participant has control to share as much as s/he is willing to).

The insights and summaries of small group conversations are discussed in light of community social reconstruction, i. e. how personal lessons and community changes are relevant for the future of the community. (15 minutes)

## Effects of armed conflict on my community

1. How has the conflict changed my worldview and my beliefs?
2. How has the conflict changed the people around you, in your community?
3. When you think about your community what is generally different which you think can be related to the conflict?
4. What is the life lesson you have learned because of the conflict? If there have been any changes in your “life lesson” over time, please describe them.

## **How functional is my community?**

(90 min)

### Objective:

1. To identify and discuss characteristics of own community from the perspective of a functional community

### Materials:

1. Flip-charts and markers (8 – one for each small group)
2. Scotch tape
3. Templates *How functional is my community?* (8 – one for each small group)

Methods: Work in two groups of 15 participants.

Participants introduce the communities in which they work in their own words. They should say the name of the community (in very large cities this could be e. g. a neighborhood of a large city), how large it is, what is the social composition of the community, and mention one problem in the community they are concerned with. (15 minutes)

The participants form 4 small groups of 4 members, based on the similarity among the communities they work in. In the small group they should use the template *How functional is my community?* to discuss how relevant is the following for their communities (30 minutes):

1. Is there a psychological sense of belonging to the community? How do you know this?
2. Which elements of social capital are present in the community (mutual trust, complying with norms, social network, support and reciprocity)?
3. Which elements of poor functioning of the community they recognize (questionable safety, shattered normative structure, shattered worldview)?
4. How are these elements of poor community functioning related to the problems which the group members mentioned at the beginning of the session?
5. For each community mention one resource (e. g. institution, group of people, informal organization) which is important for making a change in this community.

Each small group will draw a table on a flip-chart (drawing attached) to summarize characteristics of their communities and present this to the whole group. They will write the names of these communities above the table (30 min). The trainer will facilitate a discussion among the participants to find similarities and differences among the communities. (20 min)

Note: The last question will serve as a bridge to Workshop 7 (assessment of resources) and to end the day in an optimistic mode.

### **How functional is my community?**

Please think of the communities in which you work and answer the following:

1. Is there a psychological sense of belonging to the community? How do you know this?
  
2. Are elements of social capital present in your communities (mutual trust, complying with norms, social network, support and reciprocity)? Can you illustrate this?
  
3. Which elements of poor functioning of your communities do you recognize (questionable safety, shattered normative structure, shattered worldview)?
  
4. How are these elements of poor community functioning related to the problems which you mentioned at the beginning of the session?
  
5. For each community mention one resource (e. g. institution, group of people, informal organization) which is important for making a change in this community.

Table to summarize characteristics of communities

Name of communities: \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

Illustrations of sense of belonging	Elements of social capital	Elements of poor community functioning	Problems in the community	Resources

## **Assessment of community needs and resources and social action plan** (75 minutes)

Objective: To identify strengths, weaknesses, opportunities and threats of their local communities.

Expected outcomes:

- Participants will be able to recognize different aspects of their respective local community.
- Participants will be able to identify (and agree upon) social actions that could answer to some of the needs of their communities
- Participant will be able to implement SWOT planning technique to identify major helpful and harmful factors to achieving specific goals of their community
- Participants will be able to recognize the needs in their local community.
- Participants will exchange ideas on initiatives that could strengthen resources in their respective communities.

Materials:

- Template for individual *SWOT analysis* for each participant
- Flipcharts with drawn SWOT template, markers (10 flip charts and markers)
- Working material *Planning social action in a community*

Methods:

Participants remain in the same groups according to communities they come (same or similar). If more than 5 come from the same large city, they will form groups based on other similarities, e.g. the same sector of services or neighborhoods (4-5 small groups).

Description:

Participants work individually to analyze characteristics of their communities in order to identify needs to be satisfied via social action of their communities that could be answered via social action. Each person will get a template for *SWOT analysis* and will complete it. (15 minutes)

Members of the small group will briefly compare their responses in the template. Based on shared experiences, the small group will write on a poster (flipchart) their answers for each area of the template, which will be used in the next workshop to present the social action that they could initiate at the local community level or in their work environment. They should focus on goals that could be accomplished via social action in a shorter time (30 minutes)

After finishing this task, each small group will get working material *Planning social action in a community*. The task is to create a social action plan that could be implemented and that would empower people in the community, including social action group members. Remind participants that social action should be lead with a moto that *things can be better than they are* and that *it is possible to make them better*, that through such work they will feel that they can change the factors that influence their life, and that they will feel empowered because of it. But it is important to choose a goal that is important to them and others in the community and to plan the action so that it is likely to succeed. Each group should start from the



identified community characteristics (SWOT analysis) and write their responses into the working material. (30 min)

### **SWOT ANALYSIS of the community**

Thinking about your local community please: 1) briefly describe strengths of your community; 2) weaknesses of your community; 3) opportunities; 4) threats

<b>STRENGTHS</b>	<b>WEAKNESSES</b>
<b>OPPORTUNITIES</b>	<b>THREATS</b>

Based on the SWOT analysis, list at least one social action that you could initiate at the local community or in your work environment to empower it:

---

---

---

## Planning social action in a community

**Name of the social action:** \_\_\_\_\_

**1. Assessing the need for concrete social action**

*What needs could be met through social action in your community?*

**2. Expected outcomes of social action**

*What will be different?*

*How will he know that the action has produced results?*

**3. Composition of the social action group**

*Who needs to be involved in a social action to be effective?*

*Who will be the startup group?*

*Who will coordinate the work of this group?*

**4. Motivate potential members of the social action group**

*What needs to be done to include those we want to join in social action?*

*How will they be informed and informed about the planned action?*

**5. Mode of operation**

*Where will the group meet?*

*What roles and tasks will each member of the startup group have?*

*How will they work with and coordinate with other community groups or initiatives?*

**6. Assessment of possible obstacles**

*What could make it difficult to achieve your goals?*

*Who can make social action difficult?*

**7. Assessment of additional sources of support**

*Who might be allies in the implementation of the action in the community?*

**8. Funds required**

*What are the minimum resources needed to achieve the goals and for what?*

*Who is the potential source of funding?*

*What should be done to secure these funds?*

## **What can I do for my community?**

(60 minutes)

Objective: To make social action plan for specific communities

Expected outcomes:

- Participants will be able to identify social actions based on the empowerment approach that could answer to some of the needs of their communities
- Participants will commit to implementation of their social action plans in their respective communities

Methods: Participants continue working in the same groups as in the previous session.

Description:

Representatives from each small group (representing one community) will briefly present their SWOT analysis that served as the basis for the social action plan and present the social action plan to other groups. During the presentation of each plan, participants verbalize their decision to implement the action. After each presentation, participants from other communities and leaders will make constructive remarks to help make each plan concrete. (60 min)

While giving constructive remarks, leaders should focus on:

- Feasibility of action goals
- Anticipating the difficulties and obstacles in carrying out the action
- Mutually motivating group members to persevere and getting others to take action
- What new skill, knowledge or capacity will *they* gain while implementing this social action plan
- The role of the interests of different social groups in the community in the implementation of the action
- Fostering enthusiastic atmosphere for the group
- By verbalizing their decision to implement the action, members accept a psychological obligation to carry out the action
- That each group leave with the feeling that there is really something they can and will do

## **FOLLOW UP**

### **Lecture**

## **Helping Skills in a Multicultural Context**

### **Opening statement**

- Helpers are likely to be in contact with culturally different populations.
- Differences in culture and life experiences can affect the point of view, interpretation and understanding of problems as well as choice of interventions.

### **Example of “triggers” to learn more about multicultural aspects of helping:**

- Trainee: *“I think I can not work with clients of different ethnical background.”*
- Members of HIV-counseling team: *“We do not want group supervision any more. We want individual supervision with different supervisors who have same professional background as each of us has”.*
- Member of my current supervision group: *“You all can not understand how is to be a counselor in Catholic counseling centre”.*
- Member of my current training group *“I was afraid how group will accept me since my professional background is theology.”*
- My thoughts: *“How should I approach medical doctors as trainees?”*
- My thoughts while working in Albania: *“Why they are nodding their heads but saying that they do not agree?”*

### **Key concepts**

- Culture
- Multiculturalism (multicultural issues or/perspectives, diversities, differences)
- Multicultural helping context
- Multicultural competencies
- Multicultural helper in a social context

### **Culture**

- Way of living
- Script for life led by believes, values, norms, symbols and different understanding of existence

- System of cognitions, emotions, assumptions, beliefs, expectations from others
- Affects individual's perceptions of the world, communication styles, interpretations of experiences, selection of goals, and ways of working toward our chosen goals

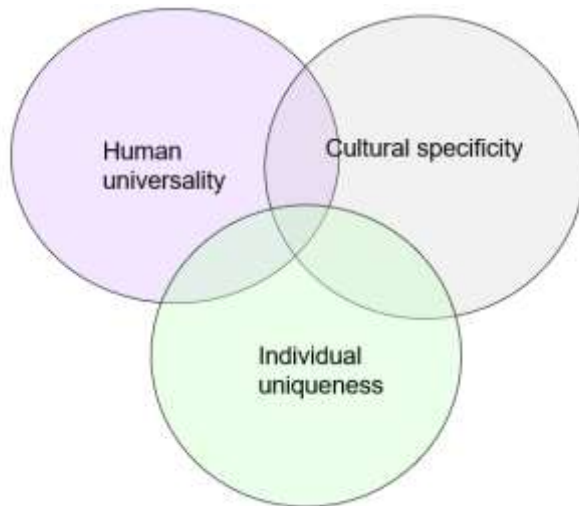
### **Multiculturalism**

- *Multiculturalism* indicates some relationship between two or more diverse cultural groups.
- *Multicultural perspective* recognizes the complexity of a pluralistic society in which cultural factors influence understanding regarding helpers' work:
  - psychological health and illness
  - behavior and relational norms
  - attitudes toward receiving help and how to provide help
- Refers not only to minority and ethnic groups, but also to gender, age, religion, socio-economic status, sexual orientation, disabilities, area of residence, language ... → individual and collective identity factors.
- For any cultural identity factor (gender, age, ethnicity, disability, socio-economic status, sexual orientation ...) people belong to either a socially disadvantaged or socially privileged group.
- Any individual can belong to both socially disadvantaged and socially privileged groups when more than one demographic factor is considered.
- Cultural identity factors are more than helper's simple knowledge of socio-demographic factors → important for understanding individual and interpersonal psychological processes of individuals.

### **Multicultural helping context**

- Two questions for the helper regarding multicultural differences:
  - How cultural differences affect the helping relationship and how should helper respond to these differences?
  - Do the same multicultural issues affect a client, and if they do, how should helper respond?
- It is a risk to overestimate or underestimate the role of culture in a helping process.
- How can a helper balance these risks?

In some ways every person is like ALL persons, like SOME persons, and like NO other persons



- It is not enough for helpers to be aware of how beliefs and attitudes about differences in people might affect their relationship with clients.
- Good helper must be able to respond to these differences □ multicultural helping competencies.

### **Multicultural competency**

- Multicultural competency is a process in which individuals and systems relate with respect and fairness to people from all cultures, languages, class, race, ethnicity, religion and other differences in a way that recognizes, acknowledges and appreciates values of an individual, family and communities, and protects dignity of each of them.

### **General and specific multicultural competencies**

- General multicultural competency: understanding different forms of disadvantages (discrimination based on gender, ethnicity, religion ...)
- Specific multicultural competencies:
  - Clients with different sexual orientations
  - Clients and families with specific needs
  - Clients of different age
  - .....

### **Three elements of multicultural competencies**

1. Awareness about own worldview
2. Knowledge

- About own cultural heritage and of cultural heritage of our clients

- Understanding different forms of disadvantages on personal and professional level

### 3. Skills

- To formulate goals and lead helping process
- To discuss cultural differences in helping process
- To recognize transference and counter-transference related to cultural differences

### **Transference and counter-transference related to cultural differences**

- How counter-transference reactions to the client can be based in helper's understanding of internalized social class?
- A helper who is typically a member of middle / educated class can still maintain the identity of own origins as a member of lower class.
- A helper might react to the affluent client with envy or resentment or may have doubts about self-achievement or with despise to the client from the lower class.
- Because subjective experience of social class is invisible, it is easy to overlook in discussion of difference.

### **How to improve own multicultural competencies**

#### ***1. Becoming aware of own worldview:***

- Learn about your own culture
- Understand your personal worldview
- Appreciate your own multiple identities

*Key question: Who am I?*

Exercise 1: Awareness of own worldview

Exercise 2: Cultural influences during my educational for a helper

- Remember your own education for a helper
- Make a list of your three most important teachers
- Next to each teacher's name write how each of them was different from you in age, gender, religion, ethnicity, social class, profession and in any other way important for you
- Did any of these differences influence your experience with them as teachers? Like: level of trust, expectations, emotional distance or closeness, conflicts, feeling of being (un)fairly treated ...



- Concerning these differences, is there anything you wish you had done differently or your teacher had done differently?

## **2. Understanding the client's worldview:**

- Learn about the historical context of the client's culture
- Be curious about the client's worldview

*Key questions:*

- *What do I want to know about the client's culture?*
- *How can I learn that?*
- *What is the cultural context of the client's problem?*

## **3. Creating a culturally-sensitive relationship:**

- View helping process as a “cultural encounter” of two individuals who respect each other
- Create culturally appropriate collaborative alliance with the client

*Key questions:*

- *How multicultural differences influence the helping relationship and how should I react to these differences*
- *How will I create a trustful relation addressing multicultural differences in a helping process?*

Exercise 3: Understanding worldview of a client

Exercise 4: Preparing for a multicultural encounter

- Imagine that you are going to meet in a week with the family from a minority culture from a distant part of Colombia who have been victimized during the armed conflict:

How you are going to present yourself to be culturally sensitive?

What will you do to facilitate culturally appropriate collaborative alliance?

- If you compare your answers with your „usual” activities in preparation for the first meeting with a family that comes to see you because of their problems:

What is different?

What is the same?

## **Multicultural helper in a social context**

Important questions:

- How much diversity is tolerable for your society?
- Which differences are acceptable for the society? Which are not?
- How are these differences socially constructed?
- How did they become a criterion of inclusion or exclusion, stigmatization, discrimination, marginalization, domination?

### **Avoiding heterogeneity as a way of reducing complexity**

- Systems (individuals, organizations, society) tend to reduce complexity in order to reduce tensions and ambivalence in social relations
- Systems prefer homogeneity when they are in crisis and have a clear need for safety, certainty and clarity

### **How the helpers behave in such situation?**

- Helpers perceive social practices and cope with complexity instead of reducing it
- They follow the perspective that homogeneity and heterogeneity are interdependent in ensuring stability and fostering social change
- Helpers:
  - Need specific knowledge about cultural patterns of constructing diversity and their effect on everyday life of their clients
  - Should know how to recognize and respond to problems of coping with similarities and differences in the personal and social system of clients

## **Lecture**

### **Strengthening helping work through supervision**

#### **Why is mental health and wellbeing of helpers at risk?**

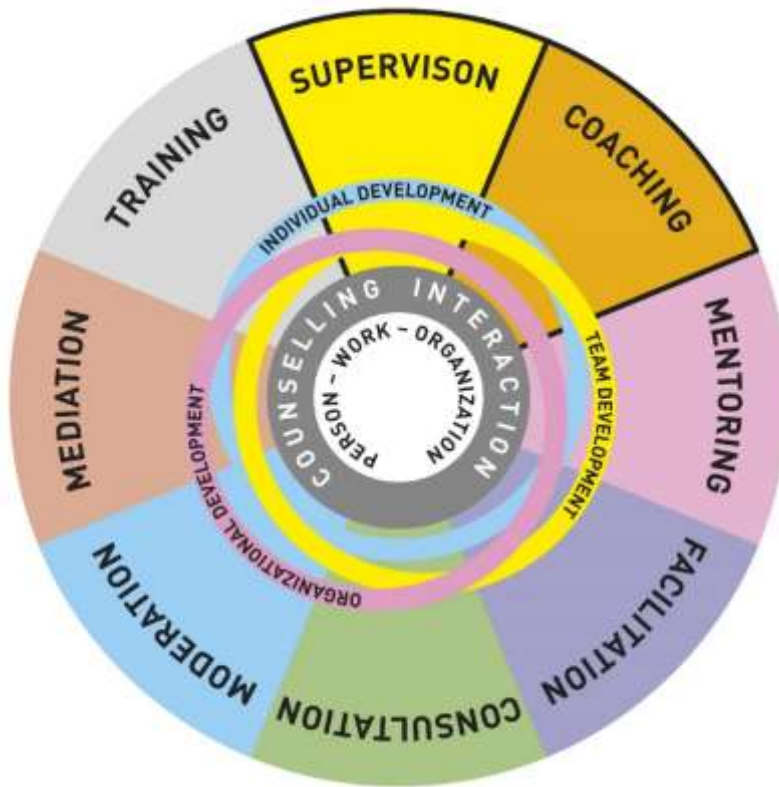
- Stress due to disbalance between:
  1. Characteristics of helpers' job and work environment
  2. Expectations from the organization (service), clients, superiors, colleagues, society, oneself
  3. Helper's competencies for the job (knowledge, skills, beliefs) and work motivation
- Professions that include working with people are highly stressful
- Indirect traumatization and counter transference occurs because of working with victims and trauma survivors
- Helpers who work with victims and other people in difficult life situations are at increased risk for their mental health and personal wellbeing

#### **What helps do to deal with these difficulties?**

- Increased knowledge
- Consultation and asking for support regarding particular cases
- Use of different strategies of self-help to prevention burnout
- Use supervision

#### **Key questions**

- What is supervision? And what is not?
- Who needs supervision?
- Who are the supervisors?
- What are the outcomes of supervision?
- What is supervision?
- Who are the supervisors?
- Supervision as professional dialogue in the bigger picture of counseling for professionals



### **Supervision – scope of concept**

1. Supervision as a counseling profession focuses on the interaction of persons, professional tasks and organizations

1.1. Supervision for work with clients

1.2. Educational supervision for professionals in training courses

1.3. Supervision as improvement of professional functioning

1.4. Organization supervision

2. Supervision as a managerial function

### **1. Supervision as a counseling profession focuses on the interaction of persons, professional tasks and organizations**

- Primarily serves the development of individuals, teams and organizations, and improves the professional lives with regard to roles in an institutional context
- Focuses on ensuring and developing the quality of communication among staff members and methods of cooperation in various working contexts.
- Offers support in decision making processes and in challenging and demanding professional situations and conflicts.

- Assists in finding innovative solutions for new challenges and measures to combat mobbing and burnout.

### **1.1. Supervision for work with clients**

- Supervision provides a reflective space to helpers who work with clients in psychosocial work (e.g. social workers, psychologists, nurses, therapists) to develop quality of their professional attitudes and performance
- When helpers receive supervision they are called „supervisees”
- The focus is on the supervisees’ clients and on how the supervisees work with their clients.
- This approach often means that the supervisor is an experienced practitioner in the work field s/he supervises

### **1.2. Educational supervision**

- This kind of supervision is part of the development of helping competences in specific training programs
- It serves to integrate knowledge, skills and values / attitudes the trainees have acquired during their professional training
- It focuses on learning to master specific methods, skills or approaches to the expected level of competences in a particular method or approach
- The supervisor should be an experienced practitioner of that same method or approach

### **1.3 Supervision as improvement of professional functioning**

- Supervision focuses on the improvement of individuals, teams and organizations in all work fields
- The main aims include higher quality, more effectiveness and work efficiency in professional contexts
- According to this approach, the supervisor is an expert for counseling the interaction of persons, professional tasks and organizations, but not a practitioner of a specific work field

### **1.4. Organization supervision**

- This approach focuses on the effective functioning of an organization and improvement of organizational culture
- The emphasis is on reflecting about relationship between the team and the wider organizational environment

- It clarifies power positions and institutional and subjective understanding of roles and tasks
- The supervisor is an expert for counseling but is not the part of the organizational structure

## **2. Supervision as a managerial function**

- It takes place in an organization at an operative level
- It includes the managing and controlling of defined and communicated tasks
- The supervisor is part of the organizational hierarchy
- This understanding of supervision has its origins in Anglo-Saxon countries

### **What is NOT supervision**

- Counseling and personal therapy for the helper, although during supervision the helper will grow personally and the process will have many therapeutic effects
- Education, although helper will learn a lot about themselves and their profession
- Consultation, although the helper will change a lot in his/her work during supervision
- Grading, although the helper will get a lot of feedback from the supervisor about their work
- Control and monitoring

### **What IS supervision? What supervision offers?**

- The ability to look at the work process with other eyes and rethink it in a new way
- Experience of learning, growth and change
- Process during which the competence and independence of helpers grows
- Process in which we are guided by the values and ethics of the helping professions
- A process based on the partnership of the supervisor and the supervisee

### **Who are the supervisors? The role of the supervisor is to:**

- formulate a working alliance / agreement with a supervisee in a transparent and participatory manner
- work "thematically open - but personally confidential"
- create a stimulating learning environment

- guide the process through clear work steps
- take into account different perspectives
- be flexible
- be independent (come "from the outside", is not a part of the organization in which the helpers work)

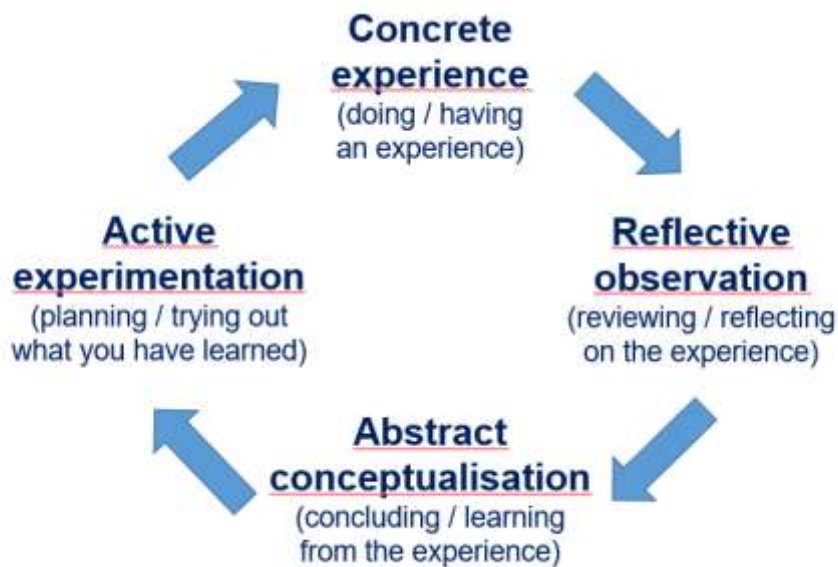
### **Is supervision a professional counseling for helpers ?!**

	<b>Supervision</b>	<b>Client counseling</b>
<b>Focus</b>	Professional situation	Life situation
<b>Goal</b>	Better understanding of the professional situation through the reflection process	Better understanding of the life situation
<b>Outcome</b>	Professional and personal growth Quality assurance	Personal growth Improving the quality of life

### **What is common to supervision and client counseling?**

- Climate of trust
- Helping relationship
- Self-disclosure
- It can be painful and difficult
- The same communication skills are used
- Session structure
- The importance of the process

### **Experiential learning cycle in supervision (Kolb, 1974)**



### **Experiential learning cycle in supervision**

1. Concrete experience - a new experience or situation is encountered, or a reinterpretation of existing experience.
2. Reflective observation of the New Experience - of particular importance are any inconsistencies between experience and understanding.
3. Abstract conceptualization reflection gives rise to a new idea, or a modification of an existing abstract concept (the person has learned from their experience).
4. Active experimentation - the helper applies their idea(s) to the world around them to see what happens.

### **Supervision effectiveness: What does the research show?**

Supervision is most effective when it focuses on:

- Helping better performing of professional tasks
  - Supervision aimed at improving the practical work is associated with greater work satisfaction
- Social and emotional support
  - Developing a positive supervisor-helper relationship
- Helpers show greater personal and professional well-being
  - The quality of the supervisor relationship and the level of participation in group supervision is associated with an increase in the level of helpers critical thinking

### **Outcomes of participating in supervision**



1. Better professional performance
2. Clarification of roles and functions in organizations
3. Effective handling of conflicts and contradictions
4. Learning
5. New insights
6. Prevention and reduction of stress and burnout
7. Professional development
8. Quality management
9. Self-awareness
10. Wellbeing/ Health

**Supervision in the context of „New professional accountability”**



### How can this be addressed?



### Supervision – luxury or necessity?

- Supervision is a process which can help professionals to stop and reflect even when they feel that their job is like Sisyphus'
- Rather than hastily taking on a new "burden", professionals in supervision can take their time to look around and inside themselves
- This is in a line with one of the key features of supervision in which the final goal is not simply to reach a peak but the process itself
- Such supervision is not a luxury but necessity

## **FOLLOW UP - WORKSHOPS**

### Follow-up, Exercise 1

#### **Awareness of own worldview**

1. I am \_\_\_\_\_ (sex/gender) and this influences my helping in the following way:  
\_\_\_\_\_.
2. I am \_\_\_\_\_ (age) and this influences my helping in the following way:  
\_\_\_\_\_.
3. I am \_\_\_\_\_ (religion) and this influences my helping in the following way:  
\_\_\_\_\_.
4. My social background / class is \_\_\_\_\_ and this influences my helping in the following way:  
\_\_\_\_\_.
5. My profession is \_\_\_\_\_ and this influences my helping in the following way: \_\_\_\_\_.
6. My sexual orientation is \_\_\_\_\_ and this influences my helping in the following way: \_\_\_\_\_.
7. I am \_\_\_\_\_ (married / in a steady relationship / divorced / single) and this influences my helping in the following way:  
\_\_\_\_\_.

#### **Discuss in small groups:**

1. It was difficult for me to complete these statements: \_\_\_\_\_

2. It was easy for me to complete these statements: \_\_\_\_\_
3. Until now I did not think about the contents of these statements: \_\_\_\_\_
4. I am uncomfortable to talk with other people about the following aspects of my identity:  
\_\_\_\_\_, because I think this may provoke the  
following reactions \_\_\_\_\_.

### **Understanding worldview of a client**

1. Please think about your typical clients and list multicultural differences that exist between your and them. What does this mean for you? What does this mean for the helping process?
2. What do you wish to know about the culture of these clients if you want to be effective in your helping work? How can you learn this?
3. What do you think (your hypotheses of phantasies) that your clients think or feel about you with regards to your sex / gender, ethnicity, religion, profession and social background? What did they do or say to make you think this way?
4. In working with clients who belong to certain cultural groups could you feel some uneasiness? Which?
5. What could you do to present yourself to be culturally sensitive? What could you do to facilitate culturally appropriate collaborative alliance?
6. How would other, ordinary people describe these clients?
7. Based on your experience, what is the best way to ensure that you are not missing something culturally important when working with these clients?

### **Understanding worldview of a client**

8. Please think about your typical clients and list multicultural differences that exist between your and them. What does this mean for you? What does this mean for the helping process?
9. What do you wish to know about the culture of these clients if you want to be effective in your helping work? How can you learn this?
10. What do you think (your hypotheses of phantasies) that your clients think or feel about you with regards to your sex / gender, ethnicity, religion, profession and social background? What did they do or say to make you think this way?
11. In working with clients who belong to certain cultural groups could you feel some uneasiness? Which?
12. What could you do to present yourself to be culturally sensitive? What could you do to facilitate culturally appropriate collaborative alliance?
13. How would other, ordinary people describe these clients?
14. Based on your experience, what is the best way to ensure that you are not missing something culturally important when working with these clients?

## Literature

- Hohman, M. (2016) Motivational interviewing in social work practice. New York/London: The Guilford Press.
- Miller, W.R., Rollnick, S. (2002) Motivational Interviewing. Helping People Change. Second edition. New York: The Giliford Press.
- Rosengren, D.B. (2009) Building motivational interviewing skills. New York/London: The Guilford Press.
- Schumacher, J.A., Madson, M.B. (2015) Fundamentals of motivational interviewing. Oxford: Oxford University Press
- Dwivedi, K.N. (1993). *Group work with children and adolescents*. London: Jessica Kingsley Publishers Ltd.
- Gordon, T. (2000). *Parent effectiveness training: The proven program for raising responsible children*. Random House Inc.
- Kurland, R. & Salmon, R. (1999). *Teaching a methods course in social work with groups*. Alexandria, VA: Council of Social Work Education.
- Malekoff, A. (1997). *Group work with adolescents: Principles and practice*. New York, London: The Guilford Press.
- Margolis, D., Dacey, J. & Kenny, M. (2006). *Adolescent development*. Boston: Cengage Learning.
- Zastrow, C.H. (2009). *Social work with groups: A comprehensive workbook*. Belmont, CA: Brooks/Cole.
- Mollica RF, Cardozo BL, Osofsky HJ, Raphael B, Ager A, Salama P. Mental health in complex emergencies. *The Lancet*. 2004;364(9450):2058-2067. doi:10.1016/S0140-6736(04)17519-3.
- Litz BT, Gray MJ, Bryant RA, Adler AB. Early intervention for trauma: Current status and future directions. *Clinical Psychology: Science and Practice*. 2002;9(2):112-134. doi:10.1093/clipsy.9.2.112.
- Broadbent M, Moxham L, Dwyer T. The development and use of mental health triage scales in Australia. *Int J Ment Health Nurs*. 2007;16(6):413-421. doi:10.1111/j.1447-0349.2007.00496.x.
- Lutheran Community Services Northwest. *Walking Together: A mental health therapist's guide to working with refugees*; 2015.
- Burkle F. Acute-phase mental health consequences of disasters: Implications for triage and emergency medical services. *Annals of Emergency Medicine*. 1996;28(2):119-128. doi:10.1016/S0196-0644(96)70051-3.

Pathways to Wellness: Integrating Refugee Health and Wellbeing. *Refugee Health Screener-15 (RHS-15). Replication packet*; 2013.