PSYCHOSOCIAL AND MENTAL HEALTH INTERVENTIONS IN AREAS OF MASS VIOLENCE

A COMMUNITY-BASED APPROACH

GUIDELINE DOCUMENT

SECOND EDITION

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PART III SPECIAL TOPICS

PREFACE

Médecins Sans Frontières (MSF) started mental health and psychosocial interventions in 1990 with a community-based programme in Gaza (Palestine). Since the early 1990s, MSF has implemented psychosocial or mental health interventions in over 40 countries worldwide. The interventions covered various aspects of mental health in different contexts such as acute emergencies, the effects of (acute) trauma, primary healthcare, *adaptation* and chronic *stress*-related complaints, psychosocial support to improve outcomes in nutrition, TB and HIV programmes, and psychiatric care in institutions.

Since MSF is an emergency medical humanitarian organisation, the bulk of our programming is in acute or chronic settings of mass conflict. These are characterised by events that involve thousands of people who have experienced, witnessed or heard of traumatic events. Often there is significant material damage, destruction of the social fabric and community function.

These guidelines focus on manmade rather than natural disasters, but our experiences in India, El Salvador and Pakistan (earthquake interventions), and following the 2004 tsunami, cyclone Nargis in 2008 and the Haiti earthquake in 2010, showed that the principles described also work well in contexts of natural disasters.

We have written these guidelines and contributed substantially to the *Inter Agency* Standing Committee Guidelines, Mental Health: Psychosocial Support in Emergency Settings[1] to share our technical experiences, to help colleagues and other humanitarian workers to avoid repeating the mistakes we have made. We do not claim that our intervention model is the only way to approach psychosocial or mental health problems in areas of conflict. We realise the limitations and opportunities of our organisation's specific medical, humanitarian emergency origin as well as the specificity of our experiences.

The guidelines will help people in coordination positions (medical and programme management) to strategise, plan, supervise, and to coach a psychosocial or mental health programme component.

The guidelines are accessible to lay people and others interested in the theoretical background and workings of conflict-related psychological programme interventions. Mental health professionals and medical staff with less experience in emergency psychosocial programming may also find it useful as part of their preparation for field programmes.

The guidelines are not intended as a handbook for counselling or psychotherapy and do not include detailed treatment protocols and specialised interventions: the mental health specialist will already have been trained in these skills. Furthermore, cultural differences do not favour a standardised approach to protocols.

The guidelines are divided into three parts:

Part I is designed to answer questions regarding mental health and psychosocial programming from a theoretical perspective. General concepts about the exposure to violence, potentially traumatic experiences, and their consequences on various aspects of health from a theoretical perspective are examined. The rationale behind psychosocial and mental health programmes is discussed and a model of intervention introduced.

Part II addresses intervention approaches both for individuals and groups of adults and children.

Mental and physical health are inseparable. How to realise a combined approach is dealt with in the chapter on integration. Examples are given for situations involving malnutrition, sexual violence, chemical and biological warfare. The psychosocial support offered to people suffering from chronic disorders such as HIV/AIDS and TB is also included.

Health workers in settings of conflict witness a great deal of suffering. An essential element of MSF's work is bearing witness to violence and injustice. Opportunities for and limitations on advocacy are discussed in the programming details.

Part III describes specific topics such as assessment, programme planning, monitoring/evaluation as well as training and human resource management.

These guidelines have been uploaded onto the MSF Holland website (http://www.artsenzondergrenzen.nl) and are regularly updated. Comments are welcome and can be sent to: Kaz.de.Jong@amsterdam.msf.org

Italics in the text refer to concepts that are defined in the final chapter. Footnotes are below text on the same page. Literature reference are numbered in the text and listed at the end of book.

Preface to the second edition

The section on psychiatry (patient presentations and treatment, page 38) has been substantially updated in this second edition, and the section on clinical supervision, page 101, has been adapted to an MSF field context.

I should like to thank our national staff all over the world, both counsellors and support staff from our past and present programmes. They have often been traumatised themselves, yet bravely choose to help their own local people deal with similar experiences. They have been the key factor in the success of many of our programmes. Without their patience and persistence, we would never have succeeded.

My thanks also go to all the mental health and other MSF expatriates who left their convenient practices, rewarding salaries and promising job prospects to help others. They have fought the

battle on the frontlines, realising services that enabled local people to help their own communities and change victims into survivors.

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PART I

GENERAL CONCEPTS AND PROGRAMMING PRINCIPLES

A HISTORY AS JUSTIFICATION

Humans have experienced adverse psychological consequences from war throughout history. A systematic study of the psychological effects of war began in the late 19th century. However it was not until 1980 that a specific type of psychological suffering caused by mass violence received official recognition and the internationally recognised *Diagnostic and Statistical Manual of Mental Disorders III* (*DSM* III) ascribed a unique psychiatric diagnostic classification to the phenomenon: Post-Traumatic Stress Disorder (PTSD).[2]

The creation of a new diagnostic classification implied that a generalised pattern of reactions to extreme events had been recognised. Under this new comprehension, psychological suffering following traumatic experiences was no longer ascribed to weakness or malingering,[3] but recognised as a series of predictable and measurable mental health and psychosocial effects.

PTSD has especially interested researchers because it is considered one of the only psychiatric disorders caused uniquely by an external event.[4] In the decade following its 'discovery', research about PTSD contributed significantly to Western researchers' understandings about the relationship between external stimuli and internal psychological processes.[5] However, it also led to an overemphasis on PTSD as the sole reaction to (mass) violence.

It was not until the mid-1990s that research interests surrounding the consequences of (mass) violence broadened to include studies of how social, cultural, moral and spiritual environments influence individual and group responses to trauma.

The following practical guidelines often refer to *traumatic stress* and PTSD. It must be noted, however, that none of the contributors regards *traumatic stress* or PTSD as the sole reaction to (mass) violence. The daily reality in the field of humanitarian assistance confronts us with the pervasive destruction of all aspects of human health (physical, mental, social, spiritual and moral). To save lives, and to improve the *functionality* and dignity of people who have experienced mass violence, all these aspects need attention. The proposed intervention model is based on a comprehensive view of human suffering after mass violence.

B THE PROCESS OF TRAUMATISATION

B.1 What is a traumatic event?

From pre-historic times, humans have developed *stress* appraisal and *adaptation* mechanisms. General theories such as flight, fight and fright reactions[6] and the general *adaptation* system[7] have been proposed about how humans physically and mentally cope with stress. However, a traumatic event is different from a stressful event. The biology of acute traumatic *stress* reactions is different from the biology of other 'general' *stress* responses. *Traumatic stress* is caused by the confrontation with helplessness and death, a complete loss of control.[8] For someone who has experienced trauma, life seems to have lost its meaning and predictability. This may hamper the critical process of survival and *adaptation*.[9] The process used to integrate a traumatic experience is more complex than *adaptation* and coping alone. Other psychological tasks that need to be accomplished are the acceptance of what happened, the recognition that life is never the same again, the giving of meaning to what happened and the development of new future perspectives.

The definition of a *'traumatic event'* has undergone constant change since its original acknowledgement, the modifications in definition reflecting growing developments in research.

In 1980, a *'traumatic event'* was defined as one that 'evokes significant symptoms of distress in almost everyone'. By 1987 this had been revised to one that was 'outside the range of normal experience and distressing to everyone'; and by 1994 to one that 'involved actual or threatened death or serious injury, or a threat to physical integrity of self or others, provoking intense fear, helplessness or horror'.[10] For the purpose of discussing the consequences of mass violence in the context of humanitarian assistance, this last is the definition of a traumatic event that will be used.

Examples of traumatic events would include single or accumulated experience of:

- Being wounded
- Being threatened with death
- Being subjected to gross human rights violations
- Significant loss of people or property
- Confrontation with actual fighting (crossfire, bombardment, shelling) or having witnessed or heard:
- Torture
- Sexual violence
- Killing (of strangers or loved ones)
- Dead bodies, mutilations, severe wounds
- Stories of traumatic experiences

B.2 A *transcultural psychiatry* approach

While the *DSM* has noted a patterning, or typology, in certain *disease* processes, it does not identify cross-cultural definitions and expressions of *illness*. In particular, it does not consider how certain environmental factors such as social, political, economical, spiritual, or moral[11] considerations affect people's definition of trauma,[12] their experience of trauma,[13] and their symptomatic expression of it.[14]

Contemporary approaches to mental disorder recognise that a system of classification becomes relevant only when the context and identities of the people involved are taken into consideration.[15] [i] *Transcultural psychiatry* offers a useful and complementary approach to that of the *DSM* for defining PTSD in international settings. It seeks to combine anthropological information about culture and social groups with epidemiological and psychiatric studies of the aetiology of health and *illness*. *Transcultural psychiatry* employs the anthropological assumption that patterns of thought and behaviour are learned through one's cultural environment. Therefore while people experience the same types of psychiatric and psychological disorders worldwide, they experience and express these conditions in varying ways cross-culturally. As a consequence, psychiatry cannot always identify mental disorders through Western categories of pathology.[16] This is particularly the case with 'culture-bound syndromes', where mental and psychosocial disorders are defined by local patterns of behaviour that do not fit Western classifications.

Mental health and psychosocial health

Implicit in the transcultural psychiatric approach to mental disorder is a distinction between *disease* and *illness*. *Disease* is understood as a condition that is objectively measurable by diagnostic tools by a practitioner: it can be attributed a diagnostic label through Western clinical symptomology. *Illness* is defined as a culturally specific expression of distress. It is the lived experience of *the client* and *the client*'s subjective interpretation of his or her health. *Illness* as such cannot be understood through Western medical diagnostic systems, but must be interpreted within the social, political, economical, spiritual and moral worldview of *the client*.[17] Under this transcultural psychiatric model, clients suffer from *illnesses*, while physicians diagnose and treat *diseases*.[18]

In the context of humanitarian assistance the distinction between *disease* and *illness* is translated into a distinction between mental health and psychosocial health. Mental disorders, such as *disease*, can be measured by objectively verifiable indicators as described in the *DSM*. Treatment thus seeks to restore mental health through conventional Western psychological approaches. Psychosocial disorders are often culture-bound expressions of mental, physical, social, moral or spiritual states of suffering.[19]

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[i] Several disciplines in mental health have emerged over the last few decades that take this into consideration including: cultural psychology, which is based on the notion that no socio-cultural environment exists or has identity independent of the way human beings take meanings from it; cross-cultural psychology, which focuses on performance differences between ethnic groups; psychological anthropology, which examines psychological functioning in socio-cultural contexts; ethno psychology, which investigates indigenous or local conceptions of mind, self, body and person.

Psychosocial treatment aims to reconnect a client to his or her environment, community and culture.

MSF believes a combined mental health and psychosocial healthcare approach is necessary to assist survivors of trauma effectively. By employing Western medical approaches to mental health, as well as local definitions and perceptions of psychosocial health, MSF aims to restore the functioning and dignity of survivors of traumatic experiences.

B.3 Normal reactions to abnormal circumstances: *the coping process*

People develop assumptions and expectations about the world they live in throughout their lives.[20] These are often influenced by upbringing, personal life experiences, personality, cultural norms and individual belief systems. Experiencing violence confronts survivors with information that is generally inconsistent with their pre-conceptions of the world. In order to heal from this experience, this new information must be processed until the potentially traumatic experience is assimilated and integrated into a new or existing worldview. This is called *the coping process*[21] and is considered a normal process experienced by everyone exposed to potentially traumatic experiences.[22] The 'normality' of the reactions refers to the absence of a disorder but should not imply that the psychological process of working through the emotions of helplessness and anger are postponed for better times.[23]

The way in which people cope with violence depends on the culture and their personality and external circumstances such as the availability or otherwise of community and family support. Irrespective of this, each survivor is confronted with two psychological mechanisms during *the coping process: intrusion and avoidance*.[24]

Intrusion (re-experiencing)

Intrusion is the state in which the survivor unconsciously re-lives his or her potentially traumatic experience. Although this confrontation is painful and accompanied by distressing symptoms such as nightmares and flashbacks, *intrusion* enables a survivor to re-evaluate and re-define, and ultimately to recover.

Through re-experiencing a potentially traumatic event, survivors regain a sense of control over their environment. They learn to comprehend their experience in a different light, and ascribe new meaning to it. Stimulus-and-response relationships established during the confrontation with violence are weakened; the world becomes predictable again; and a sense of 'invulnerability' is restored.

Sometimes however intrusive experiences create such a high state of arousal that an individual begins to 'escape' or block out traumatic memories. In this case the experience is not processed effectively, and intrusive memories continue to cause the survivor agony. Some people can continue to experience intrusive memories for many years without recovery.[25]

The re-experiencing of the event can also happen consciously, for instance when people share their experiences with friends and family, or when they discuss their experiences under professional therapy. This is not intrusive because the individual is making a conscious effort to recall the trauma. Controlled self-exposure is less likely to result in *avoidance*.

***Avoidance* (forgetting)**

In an effort to cope with feelings of discomfort provoked by the potentially traumatic experience and intrusions, a survivor will often avoid thinking about the event, for example by:

- avoiding trauma-related thoughts and memories
- avoiding physical trauma reminders (such as conversations, places)
- forgetting important aspects of the trauma (amnesia)
- 'Shutting down' (*emotional numbing*)
- interpreting surroundings as strange or unreal (de-realisation)
- feeling 'not oneself' (*depersonalisation*)

Avoiding or forgetting painful memories is a normal and healthy element of *the coping process*; however, if it becomes a fixed reaction, *avoidance* can hinder recovery. When a person blocks the necessary re-evaluation of a traumatic event, stimulus-and-response relationships cannot be weakened. Symptoms will persist because the traumatic experience remains dormant instead of being integrated.[26]

During therapeutic intervention, survivors must be allowed to control the speed and level of exposure of their intrusive memories. Forcing someone to relive the traumatic memories is counter-productive. It reinforces *avoidance*, induces fear and subsequently hinders integration and *adaptation*.

B.4 *Vulnerability*: who is most at risk?

Any conceptualisation of sickness, but particularly psychiatric *illness*, involves certain assumptions about the individual self and the relationship of the individual's beliefs and behaviour with those of the shared community. Traumatic events are felt and expressed differently across cultures and sometimes even within the same culture. The intensity of a confrontation with violence can therefore not be compared between one individual and another. Generalisations about risk factors associated with potentially traumatic experiences need careful consideration because they may result in value judgments about particular groups or individuals.

Vulnerability is influenced by multiple factors: previous life events, personal attributes and the recovery environment.

Violent-event-related risk factors

Extensive literature has been published about the relationship between psychosocial problems or *mental health disorders* and events-related *vulnerability*.[27] Aspects of the traumatic event that are believed to hinder survivors' coping processes include:

- Feelings of personal danger associated with the trauma [28]
- Physical injury sustained during the experience [29]
- Duration and frequency of the traumatic event(s) [30]
- Proximity to the event, whether that be experiencing first hand *witnessing* (especially if loved ones are killed or tortured) or listening to accounts of the violence, as people such as counsellors and translators do repeatedly.[31]

By nature and definition, a traumatic event is sudden and unexpected. However, the threat may have been present for years (as with refugees waiting for relocation, for example). Psychological preparation is believed to dampen the effects because it reduces uncertainty and increases a sense of control.[32]

Risk factors related to the individual

Certain personal factors have been shown to have a negative effect on survivors' abilities to cope with potentially traumatic experiences. These include a:

- family history of psychiatric *illness*[33]
- history of treatment for mental health disorder[34]
- family history of anti-social behaviour[35]
- history of childhood abuse[36]
- previous exposure to traumatic events.[37]

Women have also been shown to be more vulnerable to PTSD,[38] especially if they are unmarried. The age of the individual and whether or not he or she has children also affects his or her response.[39]

Post-event-related risk factors

The socio-economic and physical conditions and political atmosphere in which survivors find themselves while trying to recover have also been shown to affect the ability to cope. Subjective perceptions of those environments play an equally powerful role in determining how effectively survivors cope with their experiences. Recovery can be hindered by:

- a poor socio-economic situation[40]
- marginalisation in the community[41]
- periods spent in refugee or internal displacement camps[42]
- community denial of traumatic past or events.

Groups who are especially vulnerable to such conditions are: orphans and children on their own, physically disabled people, widows, single-parent households and the elderly.

Coping styles

An individual's ability to cope with a traumatic event can also be influenced by the coping style used during the actual traumatic event and the first stages of *the coping process.*

- *Problem-focused coping* is where a person channels his or her resources to solve the *stress*-creating problem. *Problem-focused coping* is associated with lower likelihood of PTSD.[43]
- The opposite is *emotion-focused coping*, in which the tension aroused by the threat is reduced through intra-psychic activity such as denial or changing one's attitude toward the threatening circumstances. This coping style can be useful for reducing *stress* in circumstances where the survivor has no control over the outcome of the event (where torture or abduction is involved, for example).
- *Dissociation* is a disruption of cognitive functions.[44]
- *Freezing* is a temporary paralysis due to high levels of anxiety.[45]
- *Stupor*, which is a state of mental numbness, or lethargic or submissive behaviour.

B.5 *Resilience*: how people carry on

Resilience refers to an individual or group's capacity to restore a new balance and related worldview when the old one has become dysfunctional due to confrontation with a traumatic event. Therapeutic models emphasise the need to identify (and eliminate) the factors that hinder people's capacity to restore a worldview.[46] *Resilience* has become an important concept in emergency psychosocial programmes since it is directly related to mechanisms of self-help and the restoration of self-control. Traditional medical models that use concepts such as symptom reduction or healing may not be fully applicable to the treatment of traumatic experiences in humanitarian crises for several reasons, including:

- The experiences of many people caught up in humanitarian crises are continual; therefore it is more realistic to focus on coping and self-control mechanisms than on healing.
- The focus on symptom reduction in psychosocial programmes tends to neglect a holistic view of human health.

The following paragraphs highlight how *resilience* factors influence the normal coping process on all levels of human health: physical, mental, social, spiritual and moral.

Physical

Survivors of trauma often have many basic practical problems. Those who have sufficient food and water, good physical health and adequate housing have fewer stressors and are consequently in a more favourable position to cope with their psychological problems. It is important in psychosocial programmes to address the basic practical problems, since this directly improves *resilience.*

Physical fitness facilitates a successful outcome of the coping process. Promoting healthy behaviour and physical activity is helpful.

Mental

About 80 per cent of people in Western settings are able to cope with their traumatic experiences without external support.[47] Normal psychological coping mechanisms are sufficient for most people under normal conditions in relatively stable contexts. The sooner *the coping process* starts, the higher the likelihood of a positive outcome. *The coping process* is promoted through a relative sense of security, a stable environment,[48] feelings of self-control over the situation, and ability to self-help.

Social

Social support affects health by mediating the adverse effects of environmental, social, and other stressors.[49] Many elements make up social support including subjective appraisal of support, supportive behaviour (such as participation in organisations), and the company of family and friends. Participation in group activities has also strong positive effect on physical health and functioning.[50]

A positive social recovery environment in the community could for instance be expressed through its cohesiveness (ie community initiative on for instance organisation of camp/shelter), its caring capacity, acceptance of vulnerable people, the presence of a social order (ie respected leaders), clarity of and respect for cultural and community roles (ie continuation of traditional activities/festivities). This promotes *resilience* because it enhances control, stability and possibilities for self-help and fosters a sense of belonging.

The ability to mobilise and sustain such supports is equally important.[51] The effect of social support on survivors' *resilience* is almost universally positive,[52] but in some groups of people, a large social network made up of many family members can cause a higher level of *stress* due to the obligation to keep everybody satisfied.[53]

Spiritual

Spirituality has been defined in various ways, ranging from a New Age understanding[54] to the criteria defined by the Spiritual Experience Index.[55] The term spirituality was preferred to the term religion because it describes a wider range of religious experiences outside organised groups. Nevertheless, spirituality and religion are inseparable because spirituality is an essential element of religious life.[56] Spirituality presupposes the existence and experience of spirit, something ego-transcendental, something we may call divine power. Spirituality can be defined as the ability of the human mind to relate to transcendental power.[57]

Western medicine, through its technological interest in the 'how', offers individuals with chronic or serious *illnesses* little help in answering the question 'why me?'[58]. The healing process after a traumatic experience in many cultures is not regarded as a simple medical solution to a psychosocial problem or mental health disorder. Traumatic experiences can lead to an important shift in the individual's internal belief systems. They can become powerful sources of motivation for some individuals leading to avoidance of all violence, while for others they can become a destructive force resulting in an obsession with revenge.[59]

Many cultures have strong beliefs in fate, believing for example that suffering is meted out as a punishment by God or exacted to repay karmic debt.[60] Performing rituals (especially burial of the dead) and visiting places of contemplation or worship help to promote spiritual health.[61] Mental health researchers are increasingly acknowledging the importance of spiritual beliefs in the healing processes.

Moral

Moral values can play an important role in coping with adverse psychosocial effects of mass violence, since they can provide a higher meaning or motivation to the situation, a sense of contributing to a greater good: fighting for one's country, for example, or for the sake of the children,[62] or surviving to tell others.

Sometimes moral values, placed above the values of the perpetrator, are used to fortify a survivor's self-control. For example, adherence to a moral code ('I will not do to others what has been done to me'), show compassion, and recognition of rules/ regulations. These values can strengthen *resilience* but, if they fail, they can also cause significant problems such as guilt and shame.

C CONSEQUENCES OF VIOLENCE

The psychological consequences of violence can manifest themselves on all levels of human functioning: physical, mental, social, spiritual and moral.

C.1 Physical health

People with mental health or psychosocial problems have difficulties accessing mental health services.[63] Stigmatisation and fear of coming forward are not the only explanations for this. Often people do not understand the relationship between their physical complaints and mental suffering.[64] Furthermore, people have difficulty articulating their emotional states and use bodily symptoms to communicate their distress (*somatisation*).[65]

Clinicians have developed methods such as symptom checklists to identify people who suffer from *mental health disorders*. Both research and field experience shows that PTSD is often difficult to identify in basic healthcare settings. A holistic view of health, and close cooperation between different health services can improve this. The involvement of agencies such as community centres that are outside medical services, can further improve the identification of vulnerable people.[66]

Increased physical complaints

Chronic *stress*, exposures to traumatic events and/or *mental health disorders* are associated with many physical health complaints.[67] Whether these complaints are functional or the consequence of *stress*-induced disorders such as cardiovascular *disease* can be established only through examination by medical staff.

Increased physical complaints may include the cognitive or emotional, physical or behavioural issues listed in the table below.

Increased physical health disorders

In the long term, traumatic experiences lead to increased physical health disorders: more chronic medical conditions[68] (after controlling for age, gender, social class, psychiatric *illness*),[69] cardiovascular problems, peptic ulcers, increased (up to 15–25 per cent) visits to healthcare facilities,[70] greater functional disability, and more distressing physical symptoms. Traumatic exposure is also associated with increased morbidity[71] and mortality.[72]

Increased unhealthy behaviour

The relationship between exposure to traumatic events and unhealthy behaviour such as cigarette smoking, alcohol and drugs abuse or high-risk behaviour including fighting, dangerous sexual relationships, and sensation-seeking has been well established.[73]

C.2 Mental health

The importance of culture in the diagnosis of *mental health disorders* is the focus of intense debate among mental health professionals. The current diagnostic system of *mental health disorders* (*DSM* IV, text revised)[74] has its shortcomings when used in non-Western settings. Despite these limitations, in the absence of useful alternatives the (Western) diagnostic system is used in this chapter.

Stress and distress

Stress is a neurobiological reaction that facilitates the *adaptation* of the person to external demands. *Stress* reactions can be caused by pleasant and unpleasant events. In the latter case, *stress* increases attention and reactivity to perceived or potentially dangerous situations. Three stages of *stress* can be distinguished: the alarm phase, the reaction phase, and the exhaustion phase.[75] *Stress* can initially improve performance but, after a certain level and amount of time, functioning and health become negatively affected. It is at this point that *stress* becomes distress.

Reactions of *stress* and distress are normal in contexts of mass violence. Despite their normality, attention must be paid to *stress* and distress since prolonged states of either can cause physical and mental damage.[76]

Thirty-one signs of *stress* or distress are currently recognised by the *DSM* IV-TR.[77] Some ways of expressing *stress* and distress are influenced by culture, but most are similar across cultures.

Tbl. 1: Signs of Stress and Distress[78]

Cognitive/emotional	Physical	Behavioural
• Inability to concentrate • Excitability or depression • Nervous tension • Emotional instability • Feelings of detachment, weakness • Feelings of being hunted • Panic attacks	• Excessive sweating • Hyperventilation • Tachycardia • Dry mouth • Dizziness • Extreme tiredness • Frequent urge to urinate • Gastro-intestinal complaints (pain, diarrhoea, vomiting) • Generalised body pains • Migraine • Menstrual problems • Musculoskeletal problems • Skin problems • Sleeping problems	• Impulsiveness • Urge to cry or run away • Aggressiveness • Startle responses • Shaking or 'tics' • Giggling or unstoppable laughing • Hyperkinesias (abnormal agitation) • Lack of appetite or excessive eating • Increased substance abuse (smoking, drinking, drugs)

Acute psychiatric disorders

Acute psychiatric disorders that can result from traumatic experiences include adjustment disorder, delirium, mania/hypomania, psychosis, and mental shock.[79] Other relevant psychiatric disorders are described below.

Post-Traumatic Stress Disorder (PTSD)

PTSD is frequently referred to in connection with traumatic events.[80] The concept, included in both the *DSM* and the WHO's International Classification of Diseases (ICD 10),[81] is appropriate for describing the serious and prolonged disturbances experienced by individuals confronted with traumatic events.

Estimates of lifetime prevalence of PTSD among specific Western groups of trauma survivors range between 15 and 24 per cent,[82] as compared to 8 per cent in the general United States population.[83] The prevalence of PTSD among refugee groups and other survivors of war or mass violence in non-Western settings is similar to Western survivor ranges, though in some study outcomes are substantially higher.[84]

There has been a tendency in Western psychiatric research to focus exclusively on PTSD when describing the mental health or even psychosocial consequences of violence. Human responses to extreme and catastrophic experiences cannot be understood solely in terms of PTSD. First, PTSD is not the only possible disorder after traumatic events, even according to the *DSM* system. Co-morbidity (most notably depression and generalised anxiety disorder) has been found to be more prominent in trauma clients than has been originally assumed. Secondly, and more importantly, it has been found that many people do not develop mental disorders at all. Although nearly all people confronted with war will suffer various negative responses such as nightmares, fears, startle reactions and despair, they will not all develop mental disorders. An emphasis on PTSD overlooks the normal and healthy ways of adapting to extreme *stress*.[85]

Studies show that individuals who spontaneously recover from PTSD do so in the first three months. In Western settings, which are in general more favourable to a speedy recovery, approximately 80 per cent of people have been shown to recover without (para) professional support.[86] For this reason, the *DSM IV* defines PTSD as chronic if the symptoms endure for three months or more.

Tbl. 2: Criteria and Symptoms of Post-Traumatic Stress Disorder[87]

Criteria	Observed as
A. The person is exposed to a traumatic event in which:	• the person experienced, witnessed, or confronted event(s) involving actual or threatened death or serious injury, or a threat to physical integrity of others, • the person's response involved intense fear, helplessness, or horror.
B. The traumatic event is persistently re-experienced in at least one of the following ways:	• unwanted images and/or thoughts, • dreams, • acting or feeling as if the events were recurring (eg reliving the event, flashbacks), • psychological distress at exposure to cues, • intense phsyiological distress at exposure to cues.
C. The person persistently avoids reactions to stimuli associated with the event or numbing of general responsiveness, and exhibits three or more of the following:	• avoidance of thoughts, feelings, conversations associated with the trauma' • avoidance of activities, places, people that arouse recollections, • inability to recall important aspects of the trauma (amnesia), • markedly diminished interest or participation in significant activities (withdrawal), • feeling of detachment from others, • restricted range of affect (emotionally constrained) • lack of future perspective.
D. Hyperarousal, as indicated by at least two of the following:	• difficulty falling/staying asleep, • irritability or outbursts of anger, • concentration problems, • hypervigilance • startled responses.
E. Duration of symptoms at least more than one month	• acute: symptoms appearing within less than three months after incident, • chronic: more than three months after incident, • delayed onset: symptoms start at least six months after event.
F. There is clinically significant distress or impairment in social, occupational or other important areas of functioning.	• problems at work, daily life and daily activities.

Other psychiatric co-morbidity

Survivors of traumatic events have been shown to be two to four times more likely than clients with no history of trauma to develop other psychiatric disorders.[88] Co-morbidity in the form of depression, anxiety disorders, or chemical abuse/dependency is found in 80 per cent of survivors of trauma and PTSD.[89]

Depression

A review of assessment studies shows prevalence of depression ranges from five to 31 per cent in refugee groups that suffer from psychological consequences of violence.[90] Longitudinal research shows that over time baseline psychiatric disorders, most notably depression, among a refugee people remain two to four times higher than that of the general population in the same area.[91]

Suicide or suicidal ideas are common among people with depression. Among those suffering from the psychological consequences of violence, self-destructive impulsive behaviours[92] and high levels of suicide attempts are recognised as associated features,[93] and less critical effects of depression, such as an inability to care for oneself or to engage with one's environment, are common.

Symptoms of depression are sometimes difficult to distinguish from symptoms of anxiety. Although a person may be primarily depressed, for example, he or she may also behave aggressively and report feelings of tension and *stress*. The overlap between depression and anxiety is found in both self-report ratings and clinical reports, in measures of mood such as subjective accounts from clients, symptoms, syndromes and diagnoses.[94]

The *DSM* provides a guideline for categorising depressive symptoms. *Transcultural psychiatry* emphasises that local definitions of 'self' affect a client's experience of depression, and how he or she expresses emotions and symptoms. Causes and symptoms of depression therefore differ according to cultural context and behavioural norms.

Overview of depression symptoms[95]

A person is considered clinically depressed if he or she has for the past two weeks experienced a:

- depressed mood for most of the day and/or
- markedly diminished interest in or pleasure from all or almost all activities,

and exhibited at least four of the following symptoms over the past two weeks:

- significant weight loss (compared to others in the same situation)
- *insomnia* or hypersomnia
- psychomotor agitation or retardation observable by others (not only a subjective feeling of restlessness or slow-down)
- fatigue or loss of energy nearly every day
- feelings of worthlessness or excessive or inappropriate guilt nearly every day
- diminished ability to think or concentrate, or indecisiveness
- recurrent thoughts of death, recurrent suicidal ideas without a specific plan, or suicide attempts.

Generalised anxiety disorder

Anxiety disorder is a generalised term that refers to a group of psychological disorders characterised by excessive arousal, tension and worry.[96] In a generalised anxiety disorder the worry does not focus uniquely on a fear of being in public (social phobia), of being contaminated (obsessive-compulsive disorder), of being away from loved ones (separation anxiety disorder), or of gaining weight (anorexia disorder), having multiple physical symptoms (*somatisation* disorder), or having a serious *illness* (hypochondriasis); nor is the worry uniquely a form of panic (panic disorder). Disorders such depression may also exhibit these signs.

Anxiety disorders may be linked to specific situations or involve general states, definable by the *DSM*. Anxiety disorders or obsessive worrying are frequently described among survivors of violence.[97] In the first days or weeks after a traumatic event, especially if people are displaced, anxiety is part of the normal coping process,[98] so a generalised anxiety disorder can be diagnosed only after six months have elapsed since the traumatic event. Symptoms of anxiety disorder can also be caused by substance abuse or a general medical condition.

Chemical abuse/dependency

Alcohol and drugs are commonly used to soften emotional pain, and to forget or reduce anxiety. Substance abuse among survivors of mass violence is often temporary. However for some it becomes a long-term problem and addiction.[99] Chemical abuse or dependency is proven to have detrimental effects on all areas of health[100] in both Western and non-Western cultures.

Prolonged substance abuse can lead to clinically significant impairment or distress. A person can be identified as suffering substance abuse disorder if one or more of the following occurs within a 12-month period:

- recurrent substance abuse leads to a failure to fulfil major role obligations,
- substance abuse repeatedly places the user in physically hazardous situations,
- recurrent substance abuse leads to (legal) problems (eg disorderly conduct),
- substance abuse continues despite the persistent or recurrent social or interpersonal problems it causes or exacerbates.

C.3 Social, spiritual and moral health

The effects of mass violence on social, moral and spiritual health are less obvious than the effects on physical and mental health, but the damage caused can be equally devastating. Mass violence affects individual and group coping processes. It hampers people's ability to redefine core values and social attitudes.

Evidently, social, spiritual and moral health consequences are strongly influenced by culture. Research about the effects of mass violence on social, spiritual and moral health is growing, but remains scarce compared to that undertaken on physical and mental health.

Social health

Experiences of mass violence have a detrimental effect first and foremost on personal relationships. Problems in marriage, family life and sexual functioning, poor social support networks or withdrawal from society are common reactions across cultures to mass violence. Survivors often experience unstable and unsuccessful work lives such as frequent career and job changes, gravitate towards lower-paid work or pursue highly demanding careers at the expense of family or interpersonal relationships.[101] Socio-economic problems often compound these effects.

The social health of the individual directly influences the social functioning of the group. Mass violence affects the community's social fabric and social capital.[102] Key people in the community such as traditional and religious leaders and village elders may lose their status. A community's set of (un)written rules on rights and obligations (social order) can be eroded. Its ability to care for its vulnerable people through for instance community self-support can be affected. Social cohesion can diminish as individuals withdraw, preoccupied with their own traumatic experience; disharmony can then increase resulting in aggression or schisms. Cohesive mechanisms such as traditional activities may disappear.

Spiritual health

Human beings use spirituality to give meaning to the unimaginable, the unpredictable and the unexplainable. Spirituality, often expressed through religion, ideals, and philosophical ideas, is a strong resource for fostering acceptance and integration of traumatic experiences.

In the aftermath of the traumatic experience, spirituality can become either a major stressor or a source of inspiration. Experience shows that survivors of mass violence can either become more religious – expressing this through for instance increased praying – or lose faith, resulting in spiritual crisis or beliefs of being cursed. The loss of belief in the benevolence of people, authorities, religion or a meaningful future may result in cynicism.

Rituals are symbolic ways of giving spiritual meaning to an event, to come to terms with or to control the unmanageable. Mass violence can reduce an individual's or a group's capacity to perform rituals, for instance because the people who formerly took part are no longer there or willing or able to take part.

Moral health

Moral health is determined by a set of written or unwritten rules constituting what is 'good' or 'bad' behaviour, acceptable and unacceptable emotions or cognitions by a group of people.

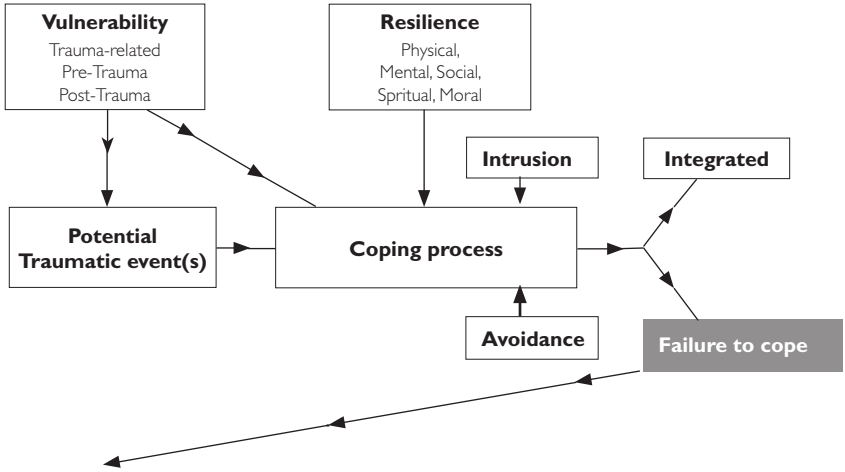
Experiences of mass violence can have serious effects on individual and group moral values. They can affect people's moral judgments; cause feelings of survivor guilt, shame and outrage, and shatter moral beliefs about trust and the benevolence of people.

Anger and frustration about what is lost and what has happened is often high among survivors. Thinking about and seeking revenge can be a sign of affected moral health in certain cultures.

Old community rules may no longer necessarily be regarded as functional for survival or reconstruction. Lack of respect for marriage rules, sexual behaviour and so on may adversely affect moral (and physical) health. Though phenomena such as substance abuse and prostitution are regarded by Westerners as physical and social health problems, in most non-Western cultures these are also regarded as a sign of affected moral health.

Societal, community and individual moral values directly influence mental health legislation. Culture-bound notions about what is normal or abnormal behaviour are translated into legislation as being 'good' or 'bad'; legal or illegal.[103] If a mental disorder is defined by a community/society as abnormal and 'bad', it may be 'criminalised' through sanctions. Conversely criminal behaviour might be 'medicalised' and justified by being given a diagnostic label. Survivors of traumatic events can find themselves in a dangerous situation where the legal system punishes them for their medical status.

Fig. 1: Overview of consequences of violence



Physical eg increased health complaints, disorders and unhealthy behaviour

Mental eg stress, psychosis, PTSD, depression, anxiety disorder, substance abuse

Social eg poor family life, social networks, withdrawal

Spiritual eg spiritual crisis, religious devotees, loss of rituals

Moral eg survivor guilt, shame, revenge thinking, lack of respect

C.4 Children

Children's reactions to mass violence depend on their developmental stage and age. Their reactions differ from those of adults because they are in the process of developing emotional, cognitive, behavioural and sensory skills.

Children who are exposed to single traumatic experiences often recuperate, and do not develop any psychopathology. If traumatic reactions continue for a prolonged period, or if a psychopathology already exists, a child can become fixed in his or her developmental stage or regress to an earlier stage. The child may also feel too insecure to experiment with new situations, which may also result in developmental delays.

Children may exhibit several generalised reactions after they experience a traumatic event:

- *Intrusion*: can happen at all ages, and commonly occurs in quiet moments when the

person is alone. Younger children tend to re-experience only parts of the memory while older ones have full flashbacks. Intrusions often lead children to experience general anxiety.

- Anxiety: children can become afraid to go to bed and subsequently become (extremely) tired. This physical anxiety and fatigue in turn causes concentration problems, irritability and bouts of anger and aggression.
- Post-traumatic play: in children, the capacity for verbal expression is limited. Children use play in various forms and drawing to express what they have experienced. This post-traumatic play is often repeated endlessly. Eventually the theme of the drawing or play changes from helplessness to control as the child gains mastery over the trauma. As a result the child becomes less anxious.
- *Avoidance*: after a traumatic experience, children tend to limit their emotions. They may seem 'flat' and not express emotions while discussing or recounting their experiences. As a result they create the impression that they are doing well. If they are not given sufficient attention they feel detached, lonely and that they are not understood. Some children slowly withdraw. *Avoidance* may also present itself as reluctance to speak or as destructive behaviour.

There are some useful indicators for how well or poorly a child is processing a potentially traumatic event:

- School achievements: achievement levels may drop and concentration difficulties may be reported. Traumatised children may engage their school friends in their post-traumatic play and teachers may report behaviour problems in the classroom. These behaviours may include aggression towards others, increased fighting, and sexualised play, depending on the nature of the trauma experienced.
- Withdrawal and behaviour changes: children may withdraw completely and become isolated, wanting to play alone. Some may exhibit behaviour changes such as changing from being outgoing and engaging prior to the trauma to becoming isolated or angry.
- Feelings of anger: the child may deal with his or her powerlessness, rage or feelings of guilt by having 'rescuer' [ii] or revenge fantasies. Since the child has developed at this stage a sense of right and wrong (conscience), he or she may feel guilty for not having reacted differently during the traumatic experience, and for having revenge fantasies.
- Feelings of anxiety: Childn[ii] n tend to worry about their parents, and are sometimes reluctant to burden them with their own fears. They then may internalise their worries and anxieties, which then can emerge as behaviours listed above (such as anger, aggression, or withdrawal).

Infants and toddlers

The age of infancy and what is expected from children at this stage varies among cultures. However, there is a general and universal understanding that the major task of this age

[ii] Rescue fantasy: A psycho-analytic concept in which the child has the fantasy (s)he needs to protect matured other family members (often the parent(s)) because they cannot protect/ take care of themselves. This may result in the child assuming adult roles such as protecting the parent(s) for bad news/ emotions or overtaking parental roles.

group is to develop basic skills and trust in themselves and others. They increase control over their body and impulses. They develop autonomy and understanding of the world around them.

Infants' and toddlers' perception of what constitutes an external threat is generally determined by the reactions of their parents. Infants and toddlers are highly dependent on their parents' coping skills. The fear of being separated from the parent is shown through clinging behaviour. Following the death of a parent, the extreme form of separation; the child might continue to search for the parent. If the missing parent appears in dreams, children can become confused.

Infants often remember one aspect of the event (not necessarily the most important), and often endlessly repeat themes from their traumatic experience in their play or drawing. Traumatised infants often play alone.

Regressive behaviour such as bedwetting or thumb-sucking can occur. Social behaviour can become either withdrawn and silent or aggressive and demanding. Sleepwalking, talking in the sleep, nightmares and general restlessness are often picked up by the parents as sign(s) of alarm. These reactions eventually disappear in most cases.

School children

Children of around six to 12 years old have gained some independence. They understand better what is going on and depend less on the reactions of their parents. The stage of development permits them to react in cognitive, emotional and behavioural ways as described above.

Adolescents

Adolescence is characterised by major biological, psychological and social changes. Definitions of adolescence vary among cultures in terms of age, roles and responsibilities. The development of social autonomy is important during adolescence. Friends and peers become more important than parents. Fear of rejection, problems in developing independence, and ambivalence towards parents are some of the uncertainties almost every adolescent is confronted with.

A traumatic experience can seriously hinder the process of detachment. Extreme fear may increase the sense of dependency on parents. This regression may be difficult for an adolescent to accept. The associated loss of control and sign of weakness causes the adolescent to feel humiliated before friends.

Adolescents generally exhibit strong emotions and are critical of themselves. While evaluating their past traumatic experience(s), they may strongly denounce themselves or feel guilty. Sometimes these emotions are suppressed and acted out through conflict or aggressive behaviour. Conflicts with parents may increase and substance abuse may start. Self-harming behaviour may emerge as the adolescent struggles to come to terms with

his or her feelings. This can include sexual risk-taking, use of drugs and alcohol, general risk-taking, and physical self-harm such as cutting.

As with children, adolescents have an instinctive urge to re-live their traumatic experience through re-enactment behaviour such as post-traumatic play. In their re-enactment they may take the role of a victim and put themselves at risk of re-victimisation. Adolescent girls are often at greatest risk and are sometimes victims of sexual exploitation. However, to increase control and manage their feelings of shame they may take on the role of the aggressor. Both can result in extremely dangerous situations.

Reactions within the family

Traumatic reactions within a family are often 'contagious'. The traumatic experience of one family member can often be shocking for all. Parents may react by being overprotective. The child may become anxious if separated from his or her parents. If parents and children have been exposed to the same event, children may become worried about their parents. In extreme circumstances they may start to act and care as a parent for others (parentification).

D A GENERAL FRAMEWORK AND POLICY

D.1 Scope of the intervention

The interdependency between the individual and his or her environment is an important element of *the coping process*. Programmes that address the psychological consequences of violence must take into account this specific relationship. In psychosocial projects a joint approach of both individual care and community support is vital. The *'psycho-' and 'socio-' components* should be complementary in order to ensure that individual and environmental healing capacities are mobilised.[104]

Psychological health rests on a continuum of psychological wellbeing. Partly depending on the cultural ideas of a community, an individual's psychological state can be defined as normal and healthy, or as abnormal and mentally ill. Between these two 'extremes' is a large middle category of psychosocial problems.

The focus of any mental health or psychosocial intervention depends on the type of emergency situation that has precipitated it. All medical interventions need to have psychological and social components, but in acute emergencies health projects focus on those mental disorders that cause immediate danger to physical survival. In chronic crises, they generally focus less on mental disorders and more on psychosocial problems that hamper people's coping process.

In an emergency, individuals and communities start the process of coping and *adaptation* immediately. People suffering from *mental health disorders* and psychosocial problems are more vulnerable and may have difficulties in adapting: their needs must be addressed from the beginning. In contrast to debriefing models,[105] research increasingly confirms the importance of early intervention when mental health problems or disorders emerge.[106]

D.2 Objectives

Mental health projects are aimed at reducing suffering caused by mental disorders. The overall objective of psychosocial projects is to reduce the psychological consequences of mass violence. To achieve this, two elements are distinguished. The '*psycho-' component* provides support on the individual level. It facilitates the reconnection of the affected individual to his or her environment, community, and culture. The '*socio-' component* aims to create an environment that facilitates the individual or groups of affected individuals to re-integrate. Both elements need to be addressed in any psychosocial project. The balance between the two depends on cultural and environmental circumstances, the phase of emergency, and other variables.[107]

D.3 The psychosocial package

The *'psycho'- component*

The psychological element of the project is delivered as a package. All components must be in place, in the form of direct services or of a referral, to ensure a comprehensive programme. The package includes the following components:

- **Psychiatric support**: in acute emergencies expatriate and national medical staff gives psychiatric support within the project. If possible clients are referred to existing medical or psychiatric services. When referral is not possible (for instance if services are sub-standard or non-existent) the psychiatric support is continued through medical doctors in the MSF (primary) healthcare service.
- **Counselling:** counselling is offered as emotional support to individuals and small groups. The counselling does not aim primarily to heal or to cure people of their psychosocial problems. In situations of acute or chronic humanitarian crisis and exposure to traumatic events, healing or curing is an unrealistic objective. The role of the counsellor is to support and improve people's coping mechanisms. Supportive counselling provides emotional support and practical advice. It helps people to increase their self-control through education and improvement of their social skills, and to boost their *resilience* by mobilising their own physical, mental or social support mechanisms. The counselling interventions are based on *cognitive behaviour* techniques and *brief therapy* principles that are translated to the existing cultural environment. In order to cope with traumatic experiences, the survivor needs to be able to give them meaning. In many non-Western societies, meaning is given through the spiritual world. Spirituality is an important coping mechanism, but the areas of moral and spiritual health are difficult for Western NGOs and psychosocial counsellors to address. Psychosocial projects can include spiritual leaders as advisors or as referral options. Rituals and ceremonies can be stimulated. Nevertheless, it should be borne in mind that humanitarian aid workers are also bound by their own ethical principles and quality standards.
- **Training**: training of national staff introduces or increases existing skills, knowledge, and competencies. National health staff are trained to identify psychological and psychiatric problems as well as, for instance, in communication skills to offer basic support to their patients. National counsellors are trained to give more intense individual support to survivors of violence and to work in the community. A specific training method has been developed for the training of national counsellors[108] (see Chapter K: Training).
- **Advocacy**: Proximity to clients is essential for showing empathy, solidarity and compassion. The changing environment requires continual monitoring of needs. Where needs are highlighted through interactions with *the clients*, these should be discussed with the project coordinator or Medical Coordinator.

The *'socio-' component*

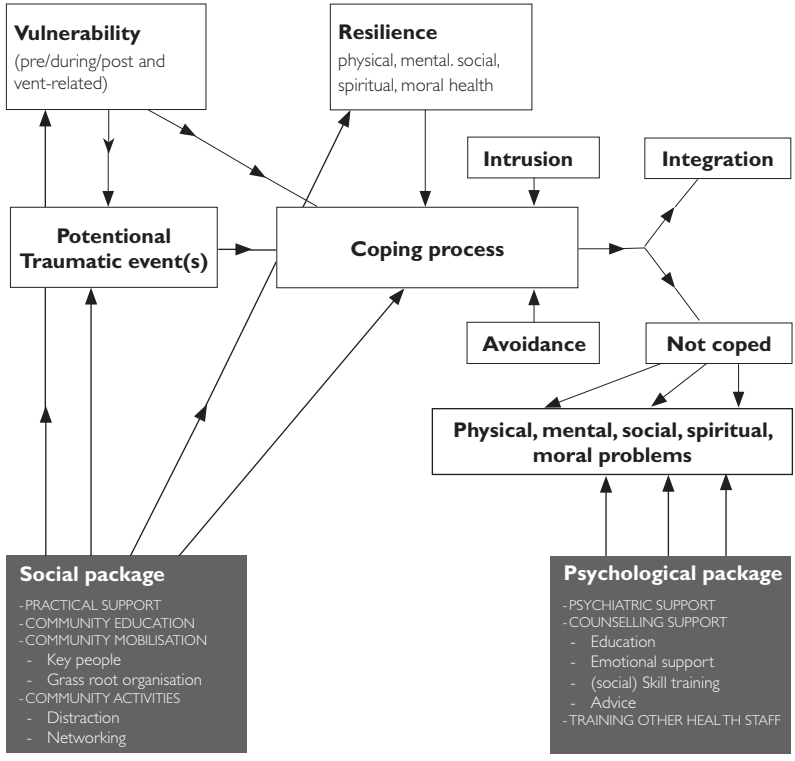
The social component of a project addresses psychosocial problems on a group level. A package of activities is proposed to stimulate the re-integration of traumatised people and to facilitate coping among large groups. The 'social' package includes the following components:

- **Practical support**: traumatised people need practical and physical support to enhance their recovery environment. Medical services, water and sanitation assistance or food support are just some examples. The needs are often overwhelming, so to ensure appropriate referrals of those in need of practical support, expatriates, national counsellors and community workers need to know what is available in the community. A 'social map' must be researched or drawn up and made available. To provide adequate support and to foster self-help mechanisms, a full understanding of social and culturally appropriate methods is vital. Since not all support can be expected from the community, close cooperation among NGOs must also be stimulated.
- **Community education**: large-scale education about prevailing psychosocial problems in the community is necessary to gain maximum advantage from self-help techniques. Education helps to break down taboos about mental health and psychosocial problems and increases awareness about counselling services.
- **Community mobilisation**: communities' social fabric is often affected by mass violence. This results in a reduction of people's protective mechanisms. After mass violence, the regeneration and revitalisation of community structures often needs outside support. Cultural leaders such as chiefs, religious leaders, and elders must be encouraged to re-assume their roles. Grassroot initiatives need assistance and stimulation since they often provide vital practical support. Local cultural groups such as theatre groups or folk/singing companies can do a great deal to improve spirits and community cohesion.
- **Community activities**: The atmosphere in camps for refugees and internally displaced people is often far from uplifting. Community activities can be used to improve the general atmosphere, to stimulate community action on general issues such as hygiene promotion, or to re-start community cultural customs such as dancing or storytelling. These activities improve the sense of belonging. Extensive networking with community leaders and (folk) artists are required to achieve this.

Integration and comprehensive medical services

The nature of mental health and psychosocial care requires a multi-disciplinary approach. The evident relationship between traumatic exposure and poor health emphasises the fact that intense collaboration between primary and specialty medical care[109] is essential to improve early identification and treatment. Mental health interventions must be managed as integrated elements of health interventions as much as possible.

Fig. 2: Intervention model for psychosocial projects to address the psychological consequences of violence through individual and community interventions.



PART II

INTERVENTION APPROACHES

E INDIVIDUAL TREATMENT AND SUPPORT

Individual treatment for mental health and psychosocial problems varies, the approach depending on the type and severity of the complaint, expectations of the client, cultural attitudes, the time available and any previous treatment, for example. Operational constraints such as security conditions, accessibility, the stage of the conflict, other health needs and resources available also influence the choice of treatment.

In methods such as drug therapy, symptom reduction is the major clinical outcome by which efficacy is judged. Other treatments first address the severe disruptive behaviours. Clients suffering from less acute problems or disorders often receive treatment such as psychosocial support, *cognitive behavioural*-oriented *brief therapy*. The support focuses on the improvement of daily functioning: this pragmatic approach, focusing on *the client's* priority, improves adherence. It also shows realism because many problems are caused by the conditions that are unlikely to change quickly. Some treatments seek to enrich the therapeutic process through promoting insight in intra-psychic processes, but these are rarely relevant for acute emergencies or chronic crises and so are hardly ever used in MSF programmes.

E.1 Acute crisis intervention

The aim of treatment for acute psychiatric problems is to provide protection of *the client* or his or her environment, to immediately reduce symptoms, and to restore control either by *the client* him/herself or by the informed support network. A strong and directive attitude in treatment is appropriate. Three interventions should be applied and often combined: social or practical support, *cognitive behaviour* techniques, and drug therapy.

- Social and practical support for the individual requires consideration. Severely affected people require close observation and a family or other social support network should therefore be mobilised. Practical support, for instance a quiet shelter for both caregivers and clients in which to complete case management, should be considered. The principles of Psychological First Aid[110] (see Table 3) can be applied by all aid workers.
- Many *cognitive behavioural* techniques are useful (see below). The priority is to contain the problem. Therapeutic techniques that are not useful in acute crises include: emotion exploration techniques or exposure therapy. Personal or moral judgments, inappropriate reassurance (for example 'at least you survived') or denying of guilt are inappropriate for caregivers.
- Drug therapy: see page 38.

Tbl. 3: Overview of acute crisis intervention strategies in MSF psychosocial mental health projects

Psychological first aid (All aid workers)	**Aim: reduce harm, encourage self help**	**Avoid**
	• Protect from further harm • Where appropriate, inform distressed survivors of their right to refuse to discuss the events with (other) aid workers or with journalists • Provide the opportunity to talk • Listen patiently in an accepting and non-judgmental manner • Convey compassion • Identify basic practical needs and ensure that these are met • Ask for people's concerns and trying to address these • Discourage negative ways of coping (specifically through use of alcohol and other substances) • Encourage participation in normal daily routines (if possible) and positive means of coping (eg culturally appropriate relaxation methods, accessing helpful cultural and spiritual supports) • Encourage, but do not force, company of one or more family members or friends • As appropriate, offer the possibility of further support at a later date • As appropriate, refer to locally available support mechanisms	• Respect the wish not to talk • Avoid pushing for more information than the person may be ready to give
Crisis intervention (Trained, specialised staff)	**Aim: support/treat to protect *the client* or environment, to reduce symptoms, and to restore control (either by *the client* him/herself or by the informed support network).**	**Avoid**
Psychiatric problems • Anxiety disorder • Panic disorder • Suicidal tendencies • Psychosis • Acute stress disorder (or acute PTSD) • Agitation Severely disrupted behaviour • Aggression, • Flashbacks • Shock	*Cognitive behavioural* techniques • Reduce stimuli • Contain emotions • Normalise reaction • Help clients to challenge irrational thoughts • Challenge negative thinking • Restore of the 'Here and Now' • Listen • Structure thoughts (and emotions) • Restore control (eg via behaviour prescription, advice, education) • Encourage relaxation • Restore daily routines Social • Provide practical support • Explore/mobilise support network Drug therapy [see page 38]	• Emotion exploration techniques • Judgments (personal, moral) • Inappropriate reassurance • Denying of guilt

E.2 Severe psychiatric or psychological mental health conditions: Drug therapy[111]

When specific medical conditions are involved, consider and treat the mental disorder only after somatic causes have been identified or excluded. Perform a clinical examination paying particular attention to the history of physical *illness*, especially if the patient is known to have a history of mental *illness*. Sometimes both the physical and mental health *disease* need treatment at the same time, for instance in the case of *delirium*. Other examples: certain neurological disorders may present such as psychosis, hyperthyroidism as anxiety disorder, and hypoglycaemia as confusion.

Equally, patients may have physical symptoms that are rooted in mental *illness*: dyspnoea and heart palpitations may be signs of a panic attack (acute anxiety attack); anorexia and pain part of a depressive syndrome; delusions of organ dysfunction part of a psychotic disorder.

In emergency psychiatry, the DIVINE MD TEST is used for recalling various medical conditions that may present with mental health manifestations.

Tbl. 4: Mnemonic DIVINE MD TEST[112]

Letter	General medical conditions: diagnosis/clinical presentations
D	**D**rug and other substances abuse
I	**I**nfectious *diseases*: meningitis, cerebral malaria, encephalitis, sepsis, HIV/AIDS-related, neurosyphilis
V	**V**ascular *diseases*: stroke
I	**I**nflammatory/immunologic disorders: fever, arthralgia
N	**N**utritional/vitamin deficiencies: vitamin B_{12}, thiamine (Wernicke's encephalopathy related to chronic alcohol abuse), ataxia, ophthalmoplegia
E	**E**ndocrine disorders: hyperthyroidism (tremor, tachycardia, heat intolerance, exophthalmoses), hypothyroidism (lethargy, brady cardia, cold intolerance), Cushing syndrome (buffalo hump, moon face, stria, muscle wasting), rarely Addison's *disease* (hypotension, hyper pigmentation), pheochromocytoma (hypertension, anxiety)
M	**M**etabolic disorders: fluid/electrolyte imbalance (skin turgor, mucous membrane), hyper and hypoglycaemia, liver encephalopathy (asterixis, lethargy), uremic encephalopathy (apathy, lethargy, myoclonus, asterixis), rare *diseases* such as Wilson *disease* (tremor, rigidity, chorea, Kayser-Fleiser ring) and acute intermittent porphyria (bouts of abdominal pain, paresthesias)
D	**D**egenerative/ Demyelinating *diseases*: Neurological signs/ symptoms
T	**T**rauma: subdural haematoma (signs/symptoms of specific trauma)
E	**E**pilepsy: aura, ictal, and postictal stages
S	**S**tructural disorders: headache, papilledema
T	**T**oxins/ heavy metals: depending on agent (headache, tremor, lethargy, encephalopathy, coma)

In culturally shaped manifestations, behaviour that looks pathological may in fact be normal in the given context. For example, if a person in a mourning period relates that the deceased person has appeared and spoken to him/her, this may be a normal phenomenon and not a hallucinatory disorder. It is therefore important to work with an 'informant' from the culture to deal with unfamiliar cultural contexts.

Place and use of drug therapy

Only a physician may prescribe psychotropic drugs. Drug therapy is only one aspect of the treatment of people with severe *mental health disorders*. Additional therapeutic measures such as counselling, family support, psycho education, supportive psychotherapy and addressing relevant social factors must be considered.

Use of certain psychotropic drugs is associated with tolerance and may lead to dependence and withdrawal symptoms when drugs are stopped. The risk of creating iatrogenic addiction must always be considered when prescribing.

- **Phenobarbital** although sometimes used as a sedative, it has no indication in psychiatry and should be reserved for use in the treatment of epilepsy.
- **Benzodiazepines** (eg diazepam) should be used only when there is a clear medical indication. Treatment with benzodiazepines should be limited to a maximum of two to three weeks. Benzodiazepines are strictly contra-indicated in patients with respiratory impairment. Diazepam has a long half-life and therefore the risk of accumulation should be monitored. Absorption of diazepam by the IM (intramuscular) route is less predictable than it is by the oral route
- **Tri-cyclic antidepressants** (eg clomipramine) are contra-indicated in patients with cardiac arrhythmia or with a recent history of myocardial infarction.
- **Anti-psychotics** (eg haloperidol) may lower the seizure threshold. Be aware that using haloperidol or other typical antipsychotic drugs may provoke side-effects such as extra-pyramidal symptoms. Consider reducing the dose but always have a reserve of biperiden 2 mg oral. Diazepam (5–15 mg/d) can be used temporarily if biperiden is not available. Tardive dyskinesia (rhythmic involuntary movements of the face and tongue) is often irreversible and usually occurs after prolonged use or with high dosage. Other side-effects to note are changes in body temperature regulation leading to hypo/hyperthermia.

Different groups of people require different considerations:

- **Elderly patients**: 'start low, go slow'. This usually means half the usual adult dosage.
- **Children**: psychotropic drugs are not usually indicated for children under 15 years old. A psychiatrist (contact with whom can be arranged through your mental health advisor in HQ) should be consulted prior to prescribing.
- **Pregnant and breastfeeding women**: psychotropic drugs should be prescribed only in case of absolute necessity and at the lowest effective dose. A psychiatrist should be consulted if time permits.

E.3 Psychiatric patient presentations and treatment

The violent patient

The best predictor of violent behaviour is a prior episode of violence. Violent episodes in psychiatric patients are most often associated with manic episodes of a bi-polar disorder,

psychosis with paranoia, substance abuse (including withdrawal), delirium, and personality disorders.

- **Protect yourself** and those around you first. Ensure a safe physical environment by removing objects that can be used as weapons. Stay close to a safe exit and, when seeing a potentially violent patient, make sure there is another person in the room whenever possible.
- **Establish a rapport** by introducing yourself, listening, allowing *ventilating* and helping to identify causes of distress. Address physical distress, hunger, and thirst. Offer water in a plastic cup.

The treatment depends on the underlying cause and physical causes should be ruled out early. Clients who do not respond to initial measures and pose an imminent risk to themselves or others may need rapid chemical tranquillisation.

Haloperidol is the most commonly used agent and is particularly effective where psychosis or delirium is suspected. Diazepam is useful for severely agitated patients including those with a history of substance abuse or who are suspected to be in withdrawal.[113] Patients who are receiving chemical tranquillisation require constant monitoring.

- **Haloperidol 2–10 mg PO or IM**, repeated if necessary at intervals of 30–60 minutes. Effect is apparent at ten to 30 minutes after IM injection. Maximum daily dose should not usually exceed 20 mg. If extra-pyramidal adverse effects occur, add biperiden 2 mg one to three times per day.
- **Diazepam 5–15 mg PO or 10 mg IM.** Repeat q1h as needed to obtain desired effect.

Seclusion and restraint can be considered but only with regular monitoring (at least every two hours) of the patient by medical staff. If aggressive patients are common in your setting, train the staff in safe techniques for restraint/ seclusion; also investigate local law on physical restraint in medical settings.

The suicidal patient

Asking people about suicide will not cause them to commit suicide. In fact most people are ambivalent about the act and feel relieved when somebody asks, for example, 'Sometimes when people feel sad or have problems in their lives, they think about suicide. Did you ever think about this?' Most patients who have suicidal thoughts are suffering from a psychiatric disorder (most commonly depression).

Signs of imminent suicidal risk are the presence of a realistic plan for suicide, lethal means at the individual's disposal, concurrent substance abuse, fixed feelings of hopelessness, and poor social supports. Expressions of deep despair and receiving hallucinatory self-destructive commands (psychosis) are other serious indications. Acute treatment focuses on suicide risk reduction.

Tbl. 5: Crisis intervention for suicidal patients

SAFETY FIRST	• Remove potentially lethal objects. Keep the patient in a safe place under constant observation while arranging hospitalisation. • Ask to involve a family member or friend to help deal with the crisis. He or she can help to monitor the patient, and in the longer term help ensure medication distribution and adherence. • Assess the presence of thought disorder (psychosis). If present, admission with constant supervision is warranted and treatment of the psychosis should be instituted.
Achieving rapport	• Use listening, eye contact (if culturally appropriate) and supportive (open) questions. • Encourage talking about the patient's perception of the crisis. • Show you understand through summarisations, paraphrasing and reflection of feelings.
Begin problem identification	Try to find out: what triggered the event, the opinion of the patient of what happened, resulting behaviour/emotions and the influence on daily functioning.
Coping	• Use supportive statements and psycho education to help the patient cope and regain control. • Explore what has helped the patient in the past. • Create hope by exploring the changes the patient needs to want to stay alive. • Plan with the patient what to do in the short term including an emergency safety plan if he or she feels acutely suicidal. • Obtain a firm verbal commitment or written contract from the patient (and family/ friend) that he or she will stay safe, and will return for follow-up appointments. • Make appropriate referrals (case management) for psychotherapy and counselling and medical treatment if necessary.
Medication	• When considering medication, consider the risk of overdose. Fluoxetine is a safer anti-depressant in overdose than clomipramine. Medication is aimed at treating the underlying condition: depression; anxiety; *insomnia*; psychosis.

The acutely psychotic patient

Psychosis is an acute or chronic pathological state characterised by the presence of delusional thoughts (the patient is convinced of things that are beyond reality), hallucinations (seeing or hearing things that aren't there), disorganised speech (frequent derailment or incoherence) and/or grossly disorganised or catatonic behaviour. Psychosis seriously affects social and occupational functioning and can be a life-threatening disorder in acute emergencies.

The symptoms can occur briefly (24 hours to one month as in brief psychotic disorder) or be present as part of a chronic psychiatric disorder such as schizophrenia. Occasionally psychosis is a feature of mood disorders such as depression or bipolar disorder.

Hospitalisation for treatment should be considered and is warranted if the patient does not have a safe and caring environment. Anti-psychotics are the mainstay of treatment. Patients with severe agitation who are a danger to themselves or others will require rapid escalation of doses as per protocol for the violent patient. Otherwise the dosage schedule outlined below should be used:

- Step 1: **haloperidol** 2 mg PO bid or 2–5 mg IM bid. Increase dose to lowest effective dose over several days. Do not change medication too quickly.
  Anti-psychotic medication will take at least four to 14 days to take full effect. If extra-

pyramidal adverse effects occur, consider reduction of haloperidol dosage or add **biperiden** orally (2 mg one to three times a day).

- Step 2: If agitation is present and not sufficiently reduced by haloperidol, consider **diazepam** PO, 5–15 mg a day until stabilised.
- Step 3: If symptoms have improved, continue maintenance medication **haloperidol** PO (4–10 mg a day) for at least four to six weeks. Treatment must include psychotherapy and/or social therapy and, whenever available, care by mental health specialists.
- Step 4: If haloperidol is not effective or the patient does not tolerate it, consider switching to **risperidone** (atypical anti-psychotic agent). Start at 2 mg a day, and increase to 4 mg OD the second day. Usual effective dose is 4–6 mg per day, with occasional need for doses as high as 10 mg a day.
- Step 5: The **family/support network** must be educated about the condition of the patient, the importance of medication adherence for an extended period, and the monitoring of side-effects. If possible, community health workers or counsellors should conduct home visits.

The delirious, confused patient

Delirium is a sudden (ie onset within hours) disturbance of consciousness (inability to focus, sustain or shift attention), perception and/or change of cognition (disorientation, language disturbance, memory deficit) caused by direct physiological consequences of a general medical or post-operative complication. The disturbance fluctuates during the day, which is the major distinction from psychosis.

Tbl. 6: Conditions associated with delirium[114]

Medical conditions		
• Sepsis • CNS infection: meningitis, encephalitis • Cerebral malaria • Dehydration • Obstipation	• Unidentified source of pain • Aspiration pneumonia • Alcohol withdrawal/intoxication • Sedative hypnotic withdrawal • Electrolyte imbalance • Hypo or hyperglycemia • Uremia/ Hepatic failure	• Hypoxemia • Congestive heart failure • HIV-related infections • Stroke • Intracranial bleeding • Intracranial mass with increased intracranial pressure
Delirium differential diagnosis with other psychiatric conditions		
Dementia	• Onset of dysfunction gradually over longer time • Hallucinations uncommon	• Vital signs stable • When advanced, lack of insight into deficits (agitation is often part of dementia) -Onset late in life or as part of HIV/AIDS
Schizophrenia	• Onset early in life • Chronic (history of episodes)	• Hallucinations bizarre and long-term
Mania	• Euphoric and grandiose emotional state	• History of spending sprees, indiscretions, impulsiveness

Depression	• Ability to retain attention is not affected (but there is no desire to pay attention) • Ability to concentrate is only slightly affected	• Feelings of hopelessness, worthlessness, suicidal thoughts

The treatment is focussed on the underlying cause as well as on the delirium. Hospitalisation is often necessary.

- Step 1: To enable physical examination, try to **calm the patient** in a quiet place, with only two people present. Start by talking about physical symptoms: 'as you aren't feeling well, I am going to take your blood pressure', and then proceed with the examination. Try to identify whether the person is oriented (confusion?) and coherent (psychosis?). Explain/ involve family in patient support.
  - Ensure **hydration** and **nutrition**, and **evaluate medication**.
  - Start treatment of physical cause if diagnosed and possible.
- Step 2: Treat delirium:
  - **Haloperidol** 2–10 mg PO/IM. Repeat in 30–60 minutes if needed. When table, provide 2–10 mg one to two times a day (to max 20 mg a day) for several days before tapering off. If extra-pyramidal side-effects occur, consider reduction of haloperidol dosage or add **biperiden** orally (2 mg one to three times a day).
  - In case of insufficient sedation: add **diazepam** PO 5–15 mg or IM 2–10 mg. Always check on respiratory depression.

In special cases, consider referral to an emergency or specialist unit.

Delirium tremens is caused by abrupt withdrawal of alcohol in alcohol-dependent individuals. Onset is generally one to five days after the last intake of alcohol and patients have a high risk of seizures. First-line treatment is high-dose diazepam titrated to symptoms. Start with **diazepam** 10 mg PO. Evaluate symptoms every 30 minutes. If there is no sedation, repeat diazepam PO 10 mg every 30 to 60 minutes to a maximum of 100 mg a day in extreme cases until the patient is drowsy. Continue to evaluate symptoms every 30 minutes. If the patient's symptoms improve, reduce diazepam gradually, tapering over three days.

Thiamine 100 mg IV/IM/PO should be given to patients with a history of alcohol dependence.

The options for sedation are limited where **acute intracranial process** (haemorrhage, bleeding) is concerned: the risks and benefits must be carefully weighed.

Benzodiazepines can interfere with clinical monitoring, whereas anti-psychotics lower seizure thresholds.

The acutely manic patient

Mania is shown through an elevated mood state. Elevated affect may cause the patient to present as irritable and labile, and to exhibit racing thoughts, rapid speech, grandiose thinking/ planning, increased energy, increased psychomotor behaviour, hypersexuality, to have decreased sleep and believe him or herself to be gifted with superhuman abilities. Insight is impaired.

Mania is an essential diagnostic characteristic of two types of bipolar disorder. Both types feature periods of major depression. The difference between the two is the level of mania: full-blown mania is diagnosed as bipolar I; moderate mania (hypomania) is bipolar II. Treatment often requires hospitalisation.

- Step 1: **Exclude physical causes** such as metabolic conditions (electrolyte imbalance, vitamin deficiencies), neurological diseases (brain tumour), infections (HIV, syphilis) and substance abuse.
- Step 2: **Treat** acute mania: see 'The acutely psychotic patient' above.
- Step 3: When mania is reduced, continue with **differential diagnosis**:
  - Exclude schizophrenia: in bipolar, a history of recurrent mood disorder is present along with prominent features of hyperactivity and pressured speech.
  - Substance abuse is high among bipolar patients. Only abstinence can help in making the differential diagnosis between a primary substance disorder and substance abuse secondary to psychiatric disease.
- Step 4: Institute a mood stabiliser: **carbamazepine** 400 mg a day in divided doses. Increase dosage by 200 mg per week until symptoms reduce. The usual dose is 600 mg–1200 mg a day. The haloperidol (Step 2) may be discontinued when the mania is brought under control. The mood stabiliser should continue for the average duration of a mania episode, which can be up to three months.[115]

Involve the **family** where possible. Educate them on the condition; explain what mania is and the impaired self-judgement it causes. Bipolar disorder can cause serious psychosocial and interpersonal impairments for which psychotherapy is indicated.

The severely depressed patient

Depression is a common and under-recognised *illness*, but it is a treatable disease with relatively safe and effective treatment options. The most prominent symptoms are a markedly depressed mood most of the day for at least two weeks; this includes a substantial diminishment of interest or pleasure in all or almost all activities. Elderly patients may present with cognitive changes suggestive of dementia that mask a clinical depression.

In maternal or post-partum depression, symptoms do not differ from 'major' depression except that the mother also reports thoughts of inadequacy or incompetence and feelings of aggression or impulses to harm the infant (though these are rarely acted upon)

and this can induce self-blame. The signs usually manifest within four to six weeks after delivery.

Mild/ moderate depression:
Opt initially for counselling/psychotherapeutic approaches such as *cognitive behavioural therapy* and/or problem-solving techniques.

Treatment of major depression:
The symptom pattern (and the severity) often dictates the treatment using a multifaceted approach using both psychotherapy/ counselling and sometimes medication.

Severely depressed patients who do not respond to psychotherapeutic approaches:
Start medication and follow-up with psychotherapy.

- Step 1: **Fluoxetine** (SSRI) PO 20 mg once a day. In depression associated with severe anxiety or incapacitating *insomnia*, give **diazepam** PO, 5–15 mg a day in two or three divided doses for the first two weeks of treatment.
- Step 2: Supportive counselling, psychotherapy.
- Step 3: If there is no improvement after four weeks, increase **fluoxetine** to 40 mg. Maximum dosage for fluoxetine is 80 mg a day, but the response usually occurs at dosages of 20–40 mg a day.
- Step 4: Second-line and alternate antidepressants:
    - If the patient does not tolerate fluoxetine, or is severely anxious and suffers from *insomnia*, consider **clomipramine** (TCA) as first line treatment. Initial dose of 25 mg once a day, progressively increased over several days to 75 mg once a day. Maximum dose is 150 mg once a day.
    - **Amitriptyline** (TCA) is often prescribed when the depression is accompanied by chronic pain, as for example in neuralgic pain in HIV/AIDS.

Be aware that the side-effects of anti-depressants appear in the first days/weeks of treatment while the therapeutic effects are not seen for three to four weeks. This must be clearly explained to the patient. Suicide risk can also increase early in the start of the medical treatment as energy is restored prior to mood elevation.

Antidepressants should be prescribed when it is reasonably sure the patient can continue treatment for at least six to nine months[116] after treatment response, and if regular follow-up is possible (psychological support, monitoring of compliance and clinical evolution). All anti-depressants require a gradual reduction of dose at the end of therapy to avoid withdrawal symptoms.

All anti-depressants must be re-evaluated if the patient is or becomes pregnant. Expert consultation is advised.

The acutely anxious patient

Patients with anxiety will present with both psychological symptoms (unexplained fear, fear of dying etc) and physical symptoms (such as headaches, dizziness, dry mouth, difficulty breathing/ swallowing, abdominal discomfort, subjective loss of strength in extremities, sweating, shivering, palpitations, hyperventilation). Anxiety may be acute or chronic.

Differentiate between isolated anxiety (as in a panic/anxiety attack) and anxiety as part of an underlying mental disorder.

Isolated anxiety:

- Step 1: **Reassure** the patient and, *normalise* reactions. If the person hyperventilates use the 'paper bag breathing' technique to restore normal breathing pattern.
- Step 2: If reassurance fails, treat with **diazepam** 5 mg orally.
- Step 3: If symptoms do not reduce and are incapacitating, repeat diazepam up to 15 mg a day orally for a few days.

Always look for an underlying mental disorder

- Anxiety is a common feature of depression
- Anxiety as a result of psychosis
- Anxiety is a characteristic feature of a traumatic stress disorder that requires a specific treatment (see *The psychologically traumatised patient* below).

The sleepless patient

The 'sleepless' patient complains of inadequate or poor-quality sleep because he or she has difficulty in falling asleep, difficulty maintaining sleep, or wakes too early in the morning. Sleeplessness results in the feeling that sleep is not restorative and often impairs function during the day.

- Where *insomnia* is linked to life conditions (living rough, in institutions etc), there is no specific treatment.
- When *insomnia* is linked to a physical problem, do not give sedatives but treat the cause (eg give analgesics for pain).
- Where *insomnia* is linked to drug therapy (corticosteroids) or use of toxic substances (such as alcohol), treatment is adapted on an individual basis.
- Insomnia can be linked to a mental disorder: depression, anxiety, the psycho-traumatisation, and delirium.
- Isolated *insomnia* is usually linked to a particular event. When it is severe, consider symptomatic treatment with **diazepam** orally: 5–10 mg at bedtime for a maximum of two weeks.

The psychologically traumatised patient

At least 20 per cent of individuals who have been exposed to traumatic events as witnesses or victims develop long-term problems. These problems are often the cause of repeated consultations. If symptoms persist for more than one month, they rarely resolve spontaneously. A depressive syndrome may appear secondarily. Psychological intervention should be a priority.

- Step 1: Psychological interventions
  - Support *ventilation* and sharing experiences, being guided by the patient. The session should be managed with tact and *the client* should be given complete control over the exposure.
  - Explain that the person's reaction is a normal reaction to an abnormal event (*normalise*).
  - Assure the patient's physical safety and security of basic needs (food, water, shelter).
  - Discourage the use of alcohol and other intoxicating substances.
  - Encourage the patient to participate in social activities and peer support, and help him or her to imagine objectives for the future.
  - Participation in a small group session may be beneficial if one can be organised/is available.

If these measures do not help the patient, specialised individual treatment is recommended.

Avoid:

- Psychological debriefing or diffusion methods such as *Critical Incident Stress Debriefing*
- Giving an opinion or judging, expressing personal opinions
- Reassurance or denying guilt since this may devalue what the patient expresses
- Over-zealous exploration of the patient's emotions (it is up to clients to decide how far they want to go).

- Step 2: Treatment with psychotropic drugs:
  Diazepam PO: 5–15 mg a day. Benzodiazepines must be used with great caution because over use can lead to dependence.
- Step 3: **Fluoxetine** 20 mg once daily and titrate if necessary as described under major depression. The usual effective dose ranges are 20–60 mg a day.
- Step 4: If there is no improvement, stop Fluoxetine start to prescribe **clomipramine** PO: initial dose of 25 mg once a day, to be progressively increased (over several days) to 75 mg a day. Some patients will require doses up to 150 mg once a day. This is effective for management of anxiety and increased arousal, and may reduce flashbacks.

E.4 Supportive counselling

Psychosocial support in the medical setting

Psychosocial problems can be detected and addressed easily in medical settings. However, this does not mean that most mental health or psychosocial problems present themselves in the medical setting. Depending on an individual's age, the local culture and stigma surrounding mental health *illnesses*, people with psychosocial problems can present themselves elsewhere, for instance at schools, community centres or to traditional healers. This is why outreach and community presence is a vital component of psychosocial interventions.

Most people suffering from the consequences of violence are able to help themselves. Psychosocial support in the medical setting aims to recognise and *normalise* psychosocial reactions, to allow expression of emotions in a safe environment, and to reinforce existing, or introduce new, coping behaviour.

Medical staff such as doctors and paramedical staff should receive basic training in communications skills and techniques to provide emotional support if necessary. This is sufficient for the provision of basic psychosocial support in a medical setting. Specific knowledge about topics such as *traumatic stress*, sexual violence or HIV/AIDS can be acquired through guidelines or training in the field.

Individual and group counselling

Few non-Western countries have enough mental health professionals. Counsellors must be trained and allowed to work under the supervision of a senior mental health professional. The role of counsellors should not be mistaken for that of psychologists. The aim of supportive counselling is to enhance *the client*'s functioning by reinforcing his or her coping skills. Symptom reduction is not the main focus because in emergency contexts the risk of new traumatic experiences is substantial.

Counsellors should use a simplified 'diagnostic' system to categorise problems presented by a client into six areas:[117]

- Practical problems and problems due to difficult situations: the lives of victims of armed conflict are full of these kinds of problems. They include lack of information, lack of food and non-food items, tensions or conflicts with other people (such as neighbours and family members). These types of problems often require that *the client* make a difficult decision or choice.
- Lack of skills, for example the social skills that are needed for making new friends after having been separated from old trusted friends.
- Complaints and behaviours related to traumatic experiences or extreme *stress*. For example: physical complaints for which a doctor cannot find causes, or symptoms such as nightmares, anxiety attacks, or sudden unexpected outbursts of anger.
- Overwhelming feelings of sadness, hopelessness, powerlessness but also anger;
- Problems a person has with him/herself. For example: blaming him or herself, inability to find peace of mind.

- Psychiatric problems. Psychiatric patients need proper medical treatment but counsellors can help in creating a safe, understanding, and supportive environment.

These categories are used to give direction to a counselling intervention: they are not used for differential diagnostic purposes. Clients often express combinations of problems such as practical problems and overwhelming feelings. It is part of the counsellor's job to define, together with *the client*, the most prominent complaint or area of dysfunction that should be treated first. Once a person's reaction to therapy has been evaluated, counselling support can be modified.

Lengthy diagnostic intake procedures should be avoided. Counsellors should provide the necessary support and encouragement for the client to make his or her own decisions. The number of sessions should be limited to a maximum of 15. If more than 15 sessions are required, then either the complexity of the problem is too great, the support inadequate or *transference* and *counter-transference* are too intense. However, in most cases two or three sessions are sufficient. If the problems recur or others develop over time, the client can return.

The counselling approach and interventions during the session are based on the principles of cognitive behaviour brief therapy**,** the focus being to improve coping skills, facilitate self-control and enhance clients' *resilience*. Dolls[118] can be used to clarify situations or support the expression of emotions. In addition to the most common interventions detailed elsewhere, advocacy or alerting authorities and local leaders about a problem can contribute to the effectiveness of treatment by, for example, increasing protection.

Tbl. 7: Overview of supportive counselling interventions in MSF psychosocial, mental health projects

Supportive counselling	Treatment/support	Remarks
Medical setting • Psychosocial problems	(Aim of medical setting: to recognise and *normalise* psychosocial reactions, to allow expression of emotions, and to reinforce existing coping mechanisms or to provide advice about adequate coping behaviour) • Active listening • Controlled expression • Problem structuring • Education or information • Enhancement of self-control • Helping client to make own decision • Restoration of daily activities • Stimulating social activities/distraction	• Skills of basic medical training are sufficient • Extra knowledge available through guidelines or field training
Counselling service Most common areas of intervention: • Practical problems • Lack of social skills • Symptoms, complaints and behaviours • Overwhelming feelings • Inner conflicts • Psychiatric problems	(Aim of counselling: to increase client's psychosocial functioning) Mental health • Education/information • Listening • (Re) gaining control • Exploring (thoughts, feelings, coping, own solutions, support network) • Structuring • Clarifying • Helping client to make own decision • Instruction • Behaviour change • Working through emotions (controlled exposure) • Working on acceptance and future perspective Physical, social, spiritual, moral health Referral to health services • Referral to social services/NGOs (for practical support, distraction activities, income generation) • Involvement of support • Collaboration with traditional or spiritual healers • Use of personal and family rituals • Advocacy or alerting authorities/local leaders Role of counsellor[119] • Practical problems: counsellor helps people to think about and to find resources • Lack of social skills: counsellor is a teacher and trainer • Symptoms, complaints and behaviour: counsellor is specialist in identification and provision of support for people with psychological consequences of violence • Overwhelming feelings: counsellor is a listener and comforter • Inner problems: counsellor explores problems and feelings in the context and helps the client to understand him or herself better and to make choices.	• Counsellors receive continuing training • Clinical supervision is mandatory • Focus on main complaint or dysfunction • Maximum 15 sessions (often three are sufficient) • Principles of *brief therapy*

Basic interventions

Basic interventions aim to support children's normal coping process. In most circumstances it is useful to consider the child as a part of the (family) system. Subsequently, both the child and the caregiver should receive support. Otherwise the child might become isolated from the (family) system.

The child and caregiver should receive treatment together. There are several reasons why it might be best to start with separate sessions:

- The parents or caregiver(s) may have their own traumatic experiences that need to be addressed;
- The parents' or caregiver(s)' feelings of powerlessness and fear associated with their inability to protect their child from the traumatic experience may need attention;
- Children may want to protect their parents from the events, fears and other feelings they have experienced and thus not reveal their emotions in front of them.

Separate sessions may provide the child a better opportunity for self-expression. Of course, if the child wants the caregiver to be present, this wish should be respected. Providing support to children in groups is useful. Children can learn a lot from each other and provide mutual support. To be part of a group enables a child to increase social interaction and receive recognition. However, the composition of the group needs careful attention. The counsellor must be sure that the child can participate as an equal member, which means paying special attention to age and developmental groupings, to behaviours that could potentially disrupt the group, and to what extent a child's stories may harm others. Children and their caregivers who have severe traumatic experiences should first receive individual support.

To stimulate normal coping, several things can be done.

- Physical support: the child must be protected. When this fails, support has to be rovided. The provision of other basic material such as medicine, nutrition, water, shelter is also essential.
- Psychological support: the child needs to reconstruct the events related to the traumatic experience. By re-conceptualising it in a new light, the child can create order and ultimately regain control. This can be facilitated in a basic healthcare centre, in the caregiver's home, or even in schools. Playing and drawing are appropriate methods to stimulate a child's reconstruction, because verbal expression is more difficult for them. When a sense of personal control is re-instilled, and a greater understanding of the traumatic event is reached, the content of the play or drawing will change. Reconstruction can happen naturally for instance through *post-traumatic play* or under the guidance of a trained counsellor who is clinically supervised. Especially for children suffering from nightmares and flashbacks it is necessary to improve their knowledge concerning these symptoms and how to exert control over them. A partial reconstruction of the event helps the child to find out what images

are intruding. The counsellor's role is to help the child restore control if the process of reconstruction is too painful. Initially the counsellor should try to mobilise existing coping mechanisms. Other methods such as relaxation and distraction can also help.

- Social support: stimulation of contact with peers is important. A child's social circle needs to understand what is going on.

The child and caregiver must understand that the process they are going through is unpleasant but normal after such experiences. Counsellors should provide tips on how the child can deal with unpleasant thoughts or feelings and manage his or her fear. These tips should be explained in simple language, and build on existing coping mechanisms from the child's past.

The child and caregiver should also establish a daily structure of routines and activities. This should include activities that help the child to distract him or herself.

Caregivers must be informed about how to support the child's coping process. Special attention should be given to caregivers themselves, since it is not easy to deal with a traumatised child. It is important that they understand how the child's condition can influence their own behaviour. If appropriate, relate this behaviour to the caregiver's own traumatic reactions provoked by the traumatised child.

Children at risk should be identified, monitored and followed-up.

F INTERVENTIONS AT THE COMMUNITY LEVEL: THE SOCIAL COMPONENT

F.1 Acute emergencies: practical support, information and group debriefings

Community services in acute emergencies focus on the provision of direct care for the purpose of ensuring survival.

Practical support

Refugees and internally displaced people are usually not prepared for their flight, and thus have many practical needs. In acute emergencies basic materials such as plastic sheeting, hygiene materials, and food, water and sanitation must be provided.

Cross-referral to other agencies or increasing awareness of other services should form part of the practical support given in order to cover the range of practical needs such as family tracing and so on.

Information provision

Information is in certain circumstances vital for survival, and for *stress* or panic reduction. Where there is a threat of chemical/biological warfare, epidemic, or highly contagious *illnesses* such as Ebola, for example, information centres can be used to disseminate information about health-related issues and to give practical information on what services or remedies are available and where they can be found. Centres can also be used for monitoring protection and humanitarian affairs issues. In later stages the information centre can be the base from where to instigate distraction activities.

To avoid rumours or misunderstandings, and to build trust, information management must be transparent, strictly accurate and consistent. Cooperation with respected members of the community such as teachers and religious leaders improves the local acceptance and validity, and ensures information is given in an understandable and culturally appropriate manner.

Group debriefings

Over the past decade, large group debriefings designed to prevent the adverse psychological consequences of violence have become popular. In emergencies this approach is tempting since it assumes that large numbers of people can be helped using limited human resources. However, this approach requires serious consideration.

First, if the debriefing is undertaken in groups of more than 15 people, management of emotions may become problematic. The risk of people being re-traumatised or of their *ventilating* despair without proper attention is high. Furthermore, the beneficial effects of methods such as *Critical Incident Stress Debriefing*,[120] in which *the clients* are led through seven stages in a single one- to three-hour session, are disputed and therefore not recommended.[121] While some debriefing methods, as described by for instance Raphael[122] and Dyregrov,[123] seem to improve symptoms of PTSD, it remains uncertain whether there

is a significant difference between the prevalence of PTSD in people who have been debriefed, and in those who have not.[124] This may be due to the fact that studies have quantified the prevalence of PTSD in terms of its symptoms, and not by its effects on other processes such as grieving and substance abuse.[125] Nevertheless, large group debriefings as an intervention strategy are not recommended.

A useful alternative is a health education approach in which emotional *ventilation* is limited and contained. The focus is on self-control and self-help. Large-group education is used more often in chronic crises.

F.2 Chronic crises: practical support, *community mobilisation* and health education

Practical support

The practical needs of the chronic emergency are usually different from those of an acute emergency as people try to re-start their daily life and activities. Essentials such as water and sanitation and medical care are provided. To cover other practical needs it is important to involve and refer to community networks and NGOs.

Community mobilisation and education

Conflict nearly always affects the social fabric of a community. After mass violence the regeneration and revitalisation of new or former community structures often requires assistance from outside. *Community mobilisation* and education can be used to stimulate the existing coping mechanisms of large groups. Socially and culturally appropriate methods should be employed to stimulate social support and self-help (for example through peer groups), and to re-establish self-control among community members.[126]
Several steps must be taken to ensure effective *community mobilisation*:

- Identify the purpose: *Community mobilisation* is often used to encourage social cohesion through distraction activities and stimulate awareness about local organisations such as grassroots groups for women. MSF mobilises communities to increase knowledge about important health issues such as malaria, traumatic *stress*, and awareness about the availability of services such as vaccinations, health clinic, and psychosocial services.
- Analyse the situation: Once the purpose of *community mobilisation* is clear a situation analysis can be executed to clarify operational issues. For medical issues the analysis addresses topics such as: what knowledge is needed, what information is already known, what attitudes or reasons influence local behaviour, what mechanisms are or were used to spread information within the community and with whom it is useful to cooperate. An important part of the situation analysis is the definition of the target group. Issues influencing that choice may include people's age, gender, whether they have been marginalised or stigmatised or are influenced by local taboos; and the group's security: are large gatherings possible, for example.
- Define mobilisation strategy: An appropriate *community mobilisation* strategy should be defined after the situational analysis. In general one of the following three strategies should be chosen:
    - A top-level approach is appropriate if the involvement (and accountability) of the

authorities is wanted. Formal health authorities and other agencies such as chiefs and religious leaders should be asked to mobilise the target group.

- If the target group is mobilised through community networks such as youth, sport or women's groups, or schools, the middle-level approach is applied.
- the bottom-up approach, also called 'do it yourself', is conducted by contacting individuals directly – going from door to door, for example, or using gathering places such as markets or health clinics, or organising discussion groups in the community.

- The method of mobilisation can vary from simple methods such as songs, slogans, banners, to further-reaching methods such as radio and newspapers.

Health education is a specific form of *community mobilisation*. The involvement of the local community in the design and content of the health message is essential. Health educators must speak the local language, use the appropriate symbols, understand local sensitivities and dynamics and know how to approach the people. Only through their involvement can a culturally appropriate method be ensured.

Health education messages should accomplish the following:

- Provide information about (culture specific) psychosocial and health problems caused by violence in the community. Members of the community must be able to understand and identify the symptoms of mental health or psychosocial problems, behaviour and mental conditions associated with trauma. This will result in enhanced acceptance and normalisation of the psychological consequences of violence. It will encourage people to seek appropriate care and soften the stigma/taboos associated with mental conditions.
- Provide a comprehensive health message. Violence has adverse effects on life-style behaviour such as smoking, substance abuse and aggression. Health education messages should include general information about healthy living. Specific messages about psychosocial topics – *stress* for instance – can be easily combined with other healthcare messages (eg HIV/AIDS, hygiene). A broad contextual perspective on health education decreases psychosocial and physical morbidity.
- Stimulate individual or community self-help mechanisms.
- Improve self-monitoring: community members need to know when they should look for further support and what this entails.
- Provide information about back-up services. It makes little sense to increase awareness about certain health issues if there is no follow-up support. If health education is given about issues that have strong psychosocial or mental health components such as *traumatic stress* or sexual violence, appropriate referral services such as medical staff, psychosocial support or mental health services must be in place. Where to access services must be part of the health message.
- Health messages must be attractive and engaging: the more fun the message, the more people will listen and the more they will remember. Engage the audience in health education. Interact with the group when problems or solutions are explored, or use cultural elements such as (street) theatre, role-play, poetry, storytelling, folk dances and drawing exhibitions to disseminate the message.

Tbl. 8: Overview of community mobilisation and health education

Steps for *community mobilisation* and health education	Comment
Define specific objectives	• Improve understanding • Reduce unhealthy behaviours • Improve knowledge/skills (self-control and self-help) • Improve social cohesion • Improve awareness about availability of services • Promote local services
Situational analysis	• Target group: general population/specific groups • Operational topics: determine what knowledge is needed, what is already known, what attitudes or reasons influence the behaviour, what mechanisms are or were used to spread information, with whom to cooperate, and where to refer
Strategy	• Local people design message and material a. Top-down approach b. Middle-level approach c. Bottom-up/do-it-yourself approach
Method of mobilisation	• Low tech (eg songs, slogans, health clinics) • High tech (eg radio, newspapers)
Content of message	• Integrate (physical and mental) healthcare messages • Provide information about situations, signs etc • Stimulate self-help • Improve self-monitoring • Provide knowledge about availability of back-up services
Engage audience	• Interact with the group (avoid lecturing) • Include culturally accepted ways to disseminate message (eg theatre, songs, role-plays)

Networking

Networking is essential for understanding and addressing the needs of a local people. It involves establishing and maintaining relations of trust with relevant members of a people, including community and spiritual leaders, representatives of vulnerable groups and local and international NGOs. Networking is done with a long-term perspective and must be beneficial to all parties. It is particularly useful to:

- Mobilise and support local self-help mechanisms;
- Increase the referral capacity of a project by connecting it to existing local care systems (eg women's groups, income-generating projects);
- Negotiate the service delivery with the community.

Local informants can be helpful in developing culturally accepted approaches that improve the delivery of support.

Distraction activities

Relaxation, recreation and enjoyment contribute to the *adaptation* process after a traumatic event. The feeling of being a member of some form of community helps people to restore daily functioning. Distraction activities can contribute to this. Examples include:

- Cultural activities such as traditional dance, exhibitions, drumming, music concerts, street theatre and storytelling. As the name says these are based on the culture of the people. They are often much appreciated because they give the spectators a sense of belonging and continuity.
- Physical exercise such as football, dancing, clowning and acrobatics improve relaxation and promote social interaction.
- Occupational activities such as for instance camp cleaning, jointly cooking, teaching children, labouring the land, repairing or maintaining buildings and machinery and caring for vulnerable people are useful for increasing feelings of ownership and improving self-control.

G INTEGRATION OF SERVICES

Approaches focusing on the separate psychological, physical, or social dimension of *the client*'s experiences have limited value. A separation between these entities assumes, incorrectly, a separation of body and mind, or the human from the environment. This separation does not hold for Western medical-philosophical reasons nor is it in tune with non-Western worldviews. Consequently medical interventions always need to have psychological and social components, even in emergencies. This approach is reflected in the integration of psychosocial or mental health components in basic healthcare programmes through joint *logical frameworks*, an attitude of comprehensive medical thinking (patient- instead of disease-oriented) and an integrated management style.

Medical professionals such as nurses and doctors come into regular intimate contact with the emotional and psychological worlds of their clients. The practitioners' curative and palliative role cannot simply end with the provision of technical support. Providing emotional support is critical to a comprehensive treatment process that takes into consideration people's psychological, social, spiritual and moral functioning. It involves being compassionate about people's feelings, applying basic communication skills and sharing knowledge on for instance techniques for recovery. Providing emotional support to a client directly benefits the healing process and does not require a specialist.

G.1 Basic healthcare setting

Psychosocial care components are integrated in a variety of ways in basic healthcare services. When the provision of emotional support given by the medical staff is insufficient to meet a client's psychosocial needs, referral to other psychosocial services may be necessary. Clients should be referred only to the non-MSF services that have been quality-checked by the medical team.

In the absence of local psychosocial support services, a trained local counsellor or expatriate mental health specialist working in the basic health clinic can take the case referrals.

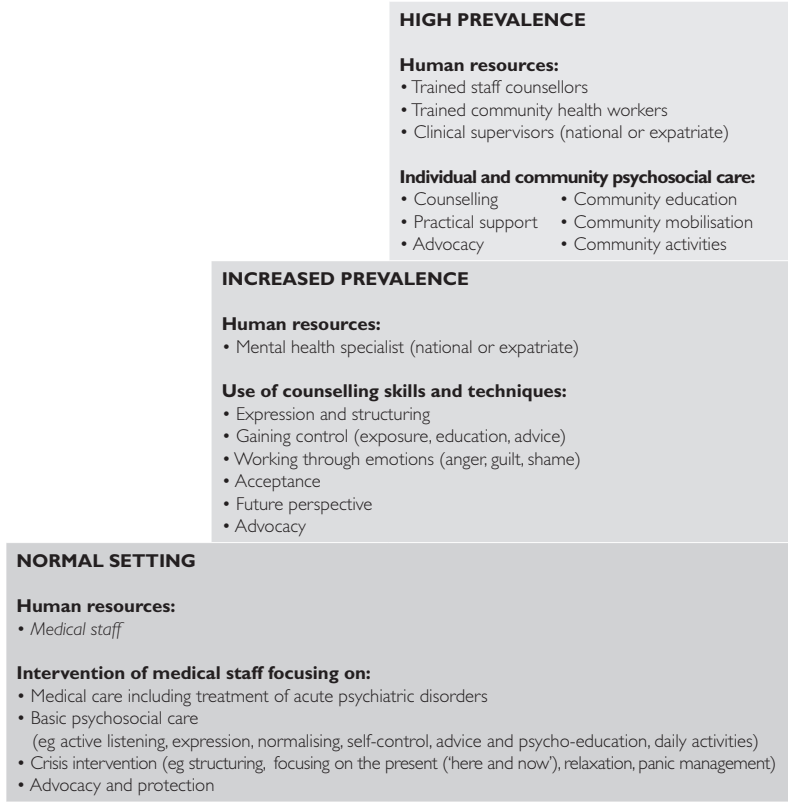
When the psychosocial needs overwhelm the existing local or expatriate services, a community-based psychosocial component is implemented. The component has to be integrated into existing Ministry of Health or medical services provided by an international NGO.

Psychosocial activities should also be linked to other types of medical programmes such as those specialising in nutrition, TB, HIV/AIDS, health education or dealing with sexual violence, reproductive health, and safe motherhood. Staff must have a holistic medical approach and project management must endorse the integration.

Though integrated activities are preferred, vertical interventions may be considered in the following circumstances:

- Acute emergencies
- Areas where conflict-related psychosocial needs are high and no other medical needs have been identified
- Contexts in which the local or NGO health system is functioning but unable to address significant psychosocial needs caused by mass violence.

Fig. 3: Levels of psychosocial integration in basic healthcare programmes



G.2 Nutrition programmes

Malnutrition (eg kwashiorkor)[127] affects mental functioning directly by causing lack of concentration and unclear thinking (confusion). Poorly balanced diets low in vitamins, minerals and essential fatty acids are also related to antisocial behaviour, including violence.[128] Several vitamin deficiencies such as lack of vitamin B_3 are related to depression while lack of others such as vitamin C, vitamin D, and other B-vitamins cause generalised body pains.[129]

Nutrition and mental health are closely interlinked. A serious depression or traumatic experience is associated with a lack of appetite, and a decrease in production of breast milk.[130] Even when food is available some people do not eat because they have given up hope and the will to live. The close relationship must be reflected in the set-up and management of feeding programmes.[131]

Inpatient therapeutic feeding centres

Complicated severely malnourished children are initially treated for one to seven days in an inpatient facility. As soon as the child's condition improves he or she is referred to an outpatient component of the therapeutic feeding programme.

Psychosocial care is an essential element in inpatient programmes. The intensity and type of support is related to needs, staff capacity and contextual circumstances. The staff in all feeding programmes must provide basic psychosocial support such as offering a listening ear if the child or caregiver wants to relate what has happened.

The effect of traumatic exposure on the caregiver–child interaction can be significant.[132] First, caregivers often have their own experiences and losses to deal with. Attention is diverted from others while they are preoccupied with their own experiences. Caregivers face serious time constraints because they also need to find daily essentials such as firewood and water, often in unfamiliar areas.

Basic play and games for mothers and children are offered to enhance the caregiver–child interaction. Health staff should monitor the emotional and psychosocial condition of the caregivers as well as the children.

The positive effects of a special focus on the caregiver–child interaction, by encouraging hugging of the infant, for example, promoting nurturing skills, and organising small play activities if the child's condition improves, increase efficacy of the nutritional treatment in emergency settings.[133]

In areas of massive traumatisation an intense and more systematic approach is justified. The mental state of each child and caregiver is screened at admission. The counsellor or health staff may refer clients directly to the counselling services if necessary. All newly arrived caregivers are briefed by counsellors in groups on the available services, feeding programme and *stress*-related issues.

Peer group activities for the caregivers are initiated to discuss all types of practical issues, provide education, and share emotions or experiences. Specific problems are addressed concerning, for example, the challenges caregivers face when they re-enter 'normal' life. Often these groups continue to support each other after they have left the feeding programme.

Group counselling and individual sessions are made available to help caregivers with specific psychosocial issues. Trained counsellors work under the clinical supervision of mental health or medical staff. Often the number of clients in need of intensive psychosocial support is high and the services need to be staffed with a mental health expatriate.

Mobile feeding programmes for severely and moderately malnourished
The later stages of treatment of severe malnutrition and the treatment of moderate malnutrition are usually organised on an outpatient basis. The patient is seen once a week or even fortnightly. These programmes have an outreach system to trace defaulters and identify people who need nutritional help.

Outreach staff and those undertaking the weekly medical checkups should be trained in recognising psychosocial problems, especially when a child is not gaining weight or is failing to thrive. Health education at the food pick-up point can inform people about how they can access psychosocial support and organise referral possibilities to initiatives such as 'food for work' or free food programmes.

G.3 Tubercolosis (TB) programmes

TB programmes are now routinely implemented in conflict areas. The success of the treatment depends on adherence and compliance to the regimen. Long hospitalisation (up to 12 months for multi drug-resistant TB) (it can be twice this at least – please check) enables regular contact between medical staff and *the client*. It provides an opportunity to help people with psychosocial and emotional problems related to their *disease* or otherwise. The integration of psychosocial services is especially important because a client's ability to adhere to the drug programme is closely related to his or her psychological and social health.

Clients may be traumatised, worry or feel guilty about neglecting their family, cease to take their medication, experience severe side-effects from treatment, exhibit disruptive behaviour due to drug side-effects or boredom, react to lack of privacy and freedom, and be subject to stigmatisation and marginalisation. They may also have serious psychiatric disorders and/or co-morbidities associated with previous traumatic experiences, or have HIV/AIDS.

In addition to medical and psychiatric care, psychosocial support is helpful in, for instance, the provision of information and support to clients and family members; in the exploration of motives for medication refusal or adherence problems; in helping people with emotional problems such as isolation and home-sickness; in the management of aggression, in the re-establishment of daily routines and patient engagement in inpatient facilities.

The psychosocial care is provided as part of the basic care or provided by specially trained health staff or counsellors.

Tbl. 9: Examples of possible psychosocial problems and interventions in TB projects

Possible problems	Psychosocial activity responses
• Client ceases to take medication	• Provide information to clients and family
• Client exhibits disruptive behaviour	• Assess the reason behind behaviour
• Treatment causes side-effects	• Refer to medical doctor • Introduce crisis intervention techniques (eg relaxation exercises)
• Emotional problems related to past and resent situations or experiences	• Provide individual counselling
• Alcohol abuse	• Provide support to change behaviour • Organise support groups
• Boredom, lethargy, lack of motivation	• Stimulate daily routines that address cognitive, social and physical needs • Initiate activities in the hospital • Provide distraction material • Initiate group activities
• Psychiatric disorder	• Screen to detect at an early stage; monitor • Stabilise • Organise drug therapy
• Patient may also have HIV/AIDS	• Refer to medical services • Offer pre-test counselling and testing • Provide post-test and follow-up counselling support

G.4 HIV/AIDS programmes

This section outlines a comprehensive, community-based and integrated model of care for people living with HIV/AIDS. While this comprehensive approach is considered important to meet clients' and caregivers' psychosocial and mental health needs, it is not always desirable or possible to implement the full range of activities.

Cooperation with local agencies is preferred when possible. Local grass-roots organisations, NGOs and peer supports are often already reasonably well organised. Programme activities may therefore act to complement or support existing local HIV/AIDS programmes to ensure complete access to comprehensive care.

Mental health disorders related to HIV/AIDS

The HIV–virus penetrates the central nervous system at an early stage (day 16), via macrophages that cross the blood-brain barrier. The virus affects only the microglial cells and not the neurons. Nevertheless, both neuronal dysfunction and psychiatric disorders are common in people infected with HIV.[134]

People infected with HIV have a higher risk than others of developing psychosocial or mental health problems. This may be because:

- The mental health disorder existed before the HIV virus was contracted;
- The psychosocial problem was triggered by a significant change in the person's status, eg shock of diagnosis, experience of first HIV-related *illness*, first AIDS symptoms, stigmatisation by the local community;
- HIV infection and AIDS pathology themselves increase *vulnerability* to *mental health disorders*. Neurotoxins may cause neuronal dysfunction such as neuropathy or changes in gait. The brain and limbic system may become dysfunctional as a complication of AIDS and cause complaints such as mood disorders, sleep disturbances, memory and concentration complaints, mental slowing and agitation.

Mental health disorders commonly associated with HIV/AIDS include:

- anxiety
- mood disorders (are the following subsets of mood disorders? If so, then indent)
- depression and thoughts of suicide - manic disorder
- psychosis
- sleep disorders
- cognitive disorders (are the following subsets of cognitive disorders? If so, indent)
- minor cognitive motor disorder
- dementia complex
- substance abuse
- delirium.

Differential diagnosis is often difficult because of co-morbidity such as combinations of depression and anxiety disorder. Psychiatric symptoms can also be caused by physical factors such as drugs side-effects, or as interaction effects. Some symptom expressions such as trance-like states and psychosis are influenced by cultural patterns.

Psychosocial problems related to HIV/AIDS infection

HIV infection affects all dimensions of a person's life: physical, psychological, social, moral and spiritual. People who test HIV-positive may experience a range of emotions including denial, anger, despair and suicidal thoughts (or ideation). Strong emotions and psychological reactions are not abnormal for people confronted with an HIV-positive diagnosis.[135]

Special attention should be paid to issues surrounding stigmatisation. Stigmatisation of HIV/AIDS in the community hinders the re-integration of the person affected by the virus. This often leads to marginalisation and isolation.

If the *disease* progresses, *the client* may be confronted with other psychosocial problems caused by a high dependency on a support network, worries about his or her family, the onset of the symptoms of serious *illness*, and about death.

Treatment of *mental health disorders*: counselling and drug therapy

Psychiatric disorders usually respond well to treatment. The treatment of mental health problems associated with HIV/AIDS often involves a combination of counselling (psychotherapy if available) and drug therapy. Counselling is always considered first. If drugs are prescribed, supportive counselling for *the client* and his or her support network improves treatment outcome.[136]

If drug therapy is applied, a possible physical origin of the symptoms or possible drug interactions[iii] must be investigated.

When prescribing psychiatric drugs to people affected by HIV/AIDS:

- start with a low dose, observe, and raise dosage slowly to avoid harm;
  polypharmacy is common among people affected by HIV/AIDS so be aware of drug interactions, protease inhibitors, such as amprenavir, indinavir, lopinavir/ritonavir, nelfinavir; saquinavir (soft and hard gel cap), generally inhibit the metabolism of psychotropic drugs, most notably: buproprion, benzodiazepines, and clozapine;
  efavirenz has frequent psychiatric signs due to its penetration of the central nervous system.[137] It can manifest itself through depression, confusion and nightmares.

Management of psychosocial problems: MSF's role in the continuum of care

Counselling and testing (CT) in the health facilities is the main entry point for HIV-positive individuals into a programme. (Testing a patient must always be voluntary and with informed consent.)

In the context of an HIV/AIDS project, a counsellor is often referred to as a CT-counsellor. People from diverse medical and non-medical backgrounds train as counsellors yet the role is often limited and misconceived. There can be a strict focus on the testing component at the expense of follow-up or emotional support.

UNAIDS strongly recommends[138] that the counsellor's role be expanded beyond CT services for several reasons:

- The counsellor is in a good position to establish a close relationship with the HIV-positive person. A trusting relationship between client and counsellor has been shown to positively influence behaviour change (safe sex, healthy living), the early identification of symptoms, the facilitation of social functioning, and improved adherence[139] to drug regimens.
- If a counsellor's professional responsibilities are limited to CT, he or she may be more likely to experience burn-out or motivation problems.

Counselling and Testing (CT): psychosocial support

Lay, professional and senior counsellors should be trained to give information to people who are considering taking an HIV/AIDS test, and to discuss their reason for coming forward. An environment of trust and confidentiality is essential for *the client* to make an informed decision.

iii For detailed up-to-date information, see www.medsape.com.

If a person tests positive, the CT counsellor should provide emotional support and information about possible next steps of care. To manage the client's feelings of fear, anger, profound sadness and shock, the counsellor must have at least basic counselling skills.

However, the counselling is not limited to the post-test session. Follow-up sessions should be offered to give additional information for instance about what to expect, future planning and support groups; to discuss practical problems such as family planning and condom distribution, or dilemmas such as partner disclosure. Also regular emotional support should be available to help clients deal with grief, guilt, adjustment difficulties, physical and emotional isolation. Acceptance of the diagnosis and a positive emotional state help to combat the development of the *disease.*

***Community mobilisation* and outreach**

The need for *community mobilisation* and outreach services in a programme depends on the prevalence of HIV/AIDS in the community. In contexts of low prevalence this has lower priority and it is more useful to focus on the mobilisation of the person's personal support network. In high prevalence areas, however, *community mobilisation* is important to prevent new infections and to ensure continuity of care. An active community approach that includes education and awareness sessions creates an atmosphere of acceptance, reduces stigma, and promotes self-help mechanisms such as post-test clubs. *Community mobilisation* initiatives should be closely connected to health education, medical and CT services. Outreach to isolated clients can be organised through post-test clubs, peer and lay counsellors.

Adherence to anti-retroviral therapy

The use of anti-retroviral drugs can prolong the asymptomatic period of HIV. Patients may find adherence to antiretroviral medication difficult despite the fact that it significantly reduces symptoms. The initial side-effects, as well as a poor mental health status (eg mood problems), may contribute to this. Special adherence groups should be organised. Facilitators must have a basic understanding of counselling and group processes. Professional and senior counsellors should have regular contact with these support groups. Clients who have serious psychosocial or psychiatric problems must be referred to a professional counsellor.

Home-based and end-stage palliative care

Clients in the last stages of AIDS often become dependent on outside support, and home-based care teams are essential to ensure basic physical and psychosocial care. Individual counselling support and if necessary psychiatric care must be available. It should focus on helping clients and caregivers to deal with chronic symptomatic HIV infection and provide support in terminal stages of the *disease.* The role of the home-based care team and the counsellor is not only technical, it also provides emotional support to both *the client* and the caretakers. Care includes making practical arrangements following death.

Meeting the needs of specific groups and MSF staff

Some national staff including CT counsellors may develop work-related psychosocial problems. A 'Helping the Helpers' system to provide psychological support to staff is mandatory for every HIV/AIDS programme.

Policy implications

The following practical and policy issues are especially relevant to CT counsellors and must be considered before initiating any comprehensive and community-based programme:

1. Determine to what degree comprehensive care is possible.
2. Ensure that counsellors are aware of all existing medical and social support networks for client referrals.
3. In HIV care, ensure that the counsellor works in the context of a multi-disciplinary team (medical, para-medical and psychosocial support staff).
4. Integrate support services into other medical services. Parallel (or vertical) mental health or psychosocial programmes are not recommended in the context of HIV/AIDS programmes.
5. Provide psychosocial support in large HIV/AIDS programmes via a (national) counsellor and specialist mental health professional (expatriate or national);
6. Ensure counsellors have full responsibility for CT and follow-up supportive counselling in all phases of the *disease.*
7. Ensure that counsellors have a part-time facilitating role in post-test clubs, community education, adherence, home-based and, where provided, palliative care.
8. Train counsellors in both CT and emotional supportive counselling skills.
9. Extend the training content and policy with specific knowledge and skills required for CT and specific HIV/AIDS-related problems (eg adherence).
10. Continue training during programme implementation.
11. Provide training appropriate to counsellors' levels of experience and job[140] description within the continuum of care. Implement a staff care system in each HIV/AIDS programme.

Tbl. 10: Qualifications, roles and responsibilities of (CT) counsellors

Level and qualification of counsellors	Roles and responsibilities include:
Senior counsellor • Has significant counselling experience and advanced counselling training • Has knowledge of psychiatric disorders and palliative care • Is experienced in providing training and clinical supervision	• Supervision and training of counsellors • Mentoring of less experienced counsellors • providing support and clinical supervision • Accepting referrals of difficult cases (psychosocial and adherence) • Occasional facilitation/supervision of adherence groups • Community networking

Professional counsellor • Has a professional background (eg nursing, teaching) • Has received CT pre/post training • Has received community education/facilitation training • Is receiving (psychosocial) counselling training on various psychosocial topics • Is receiving regular clinical supervision	• Conducting pre-/post-counselling for complicated cases • Couple counselling • Follow-up counselling • Adherence counselling • Support for home-based teams (eg palliative care) • Support for lay and peer counsellors • Occasional facilitation/supervision of post-test clubs • Regular facilitation of community education/ awareness raising • Community networking
Lay counsellor • Has received CT pre/post training • Is receiving (psychosocial) counselling training • Is receiving regular clinical supervision	• Pre-/post-counselling of routine cases • Follow-up and supportive counselling for uncomplicated cases • Community outreach to vulnerable cases • Regular facilitation/supervision of post-test clubs • Community networking
Peer counsellor • Has a similar background to clients (including post-test negative, People Living With HIV/AIDS) • Has attended an HIV/AIDS course • Has received basic community education/facilitation training • Has received an introduction course to (psychosocial) counselling	• Advocacy and *community mobilisation* • HIV education and preventive counselling • Basic follow-up counselling of uncomplicated cases • Running/supporting of post-test clubs • Community outreach to vulnerable cases

G.5 Sexual violence

Sexual violence is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work.'[141] *Rape* is defined as an act of non-consensual sexual intercourse using force or threat of force or punishment. It covers penetration of vagina or anus with penis or other object or penetration of the mouth with the penis of the perpetrator. Any penetration without consent is considered *rape*.[142] Efforts to rape someone that do not result in penetration are considered attempted *rape* or sexual assault. MSF defines *rape* as any sexual act or penetration committed on another person by means of violence, compulsion, threat or surprise.[143]

The main risk groups are: women, children, disabled people and prisoners. Though *rape* is mainly associated with women, men are also subject to sexual violence. *Rape* has many physical and psychological consequences in both the short and long term[144] and it is associated with a high prevalence of PTSD.[145] Psychological consequences also take the shape of other *mental health disorders* such as depression or anxiety disorder, or surface in less obvious ways such as shame, guilt, fear, sleeping problems, difficulties in daily functioning, withdrawal and sexual or relationship problems.

Care for victims of sexual violence must be available in all medical programmes. The type of psychosocial services provided will differ in every context, and is determined by the prevalence of sexual violence in the area and availability of quality local psychosocial services.

Both the medical and non-medical staff who works in the project must be thoroughly prepared. Sex, sexuality and sexual violence are surrounded by myths, assumptions, rules, gender-related roles, and morality in all cultures. These issues should be addressed prior to project implementation to ensure the staff are confident in dealing with the issues and have an appropriate client attitude.

To create a non-judgmental climate for clients, the staff must experience a similar non-judgmental attitude towards their own belief systems. Knowledge and practice-oriented training must be included and should be continued to ensure the staff's skills and their own psychological health. *Clinical supervision* is useful here, and appropriate staff care should be ensured. All staff should be made aware of the Sexual Violence Guidelines[146] developed by MSF.

In all medical programmes, medical care including prevention of HIV through post-exposure prophylaxis and prevention of unwanted pregnancy must start immediately. Psychosocial and mental health assistance to survivors of sexual violence has been shown to be effective.[147] The most basic psychosocial intervention is to prepare the survivors of sexual violence for the physical examination. It is important to take time to explain what is done and why, to check whether the person understands and to make clear that the person can stop the physical examination at any time if they wish to.

All health staff must be prepared to give basic psychosocial support to survivors of sexual violence by:

- engaging in active and non-judgmental listening;
- supporting (not forcing) the expression of emotions;
- acknowledging and normalising the reactions of the survivor;
- providing psycho-education and advice;
- encouraging self-control, over the situation
- stimulating the re-initiation of daily activities;
- giving attention to re-socialisation and/or affected family relationships.

The skills necessary to undertake these activities are part of regular paramedical and medical training. Health staff must undertake these basic psychosocial interventions themselves as much as possible.

Panic attacks and high levels of anxiety are normal among survivors of sexual violence.[148] Crisis intervention such as the structuring of thoughts, restoration of here and now, relaxation and reassurance may be necessary.

Referral to a specialist in the health system or to a local organisation specialising in counselling may be necessary in some cases. Staff must verify the quality of local counselling services prior to referring clients. Important criteria of quality include: regular training of staff, clinical supervision, confidentiality, and satisfied clients.

Advocacy or speaking out against sexual violence should be considered. A successful referral to legal assistance or human rights organisations, should *the client* require them, can form part of the healing process. Verification of quality of referral services is also necessary.

Where the prevalence of *rape* is elevated:
In these situations, basic psychosocial support provided by health staff may be insufficient. Medical staff may be overburdened with patients, or not have the expertise to provide intensive psychosocial support for the most serious cases. Extra capacity is therefore needed, either through referral to a local organisation or through the extension of medical services to include a psychosocial component. A trained local counsellor or a mental health professional can provide the psychosocial care. Support in these circumstances should include basic psychosocial support as well as specialised counselling such as *cognitive behavioural therapy.*

Even in contexts of mass *rape,* the creation of programmes focusing exclusively on sexual violence should be avoided. Psychosocial care for survivors of sexual violence should be integrated into existing or new services such as reproductive or basic healthcare, because this increases accessibility for clients and avoids stigmatisation. MSF's basic healthcare centres extend their services to include a psychosocial support unit where trained national staff counsellors work under a mental health professional.

Where prevalence is high, the issue of sexual violence also needs to be addressed on a community level. Community health workers can organise activities (eg theatre) and health education events to increase knowledge and awareness about health issues, including sexual violence. Discussion groups can be formed for specific community groups such as teenagers, sex workers or men for a targeted approach to changing attitudes towards sexual violence. Authorities such as chiefs and elders must be involved in the process of awareness-raising and fighting the occurrence of sexual violence. Advocacy against sexual violence should be considered as it can be effective to stigmatise offenders.

Tbl. 11: Psychosocial support after sexual violence

Prevalence	Level	Staff involved	What to do
Normal	Health clinic	• Medical staff	• Prepare *the client* for physical examination • Offer medical care • Offer/refer for basic psychosocial care • Advocacy
Elevated	Health clinic Outpatient department or specific NGOs	• Medical staff, • National or expatriate counsellor	• Medical care • Offer/refer for basic psychosocial care • Intensive counselling support either individually or in small groups • Focused education in medical facility • Advocacy
High (mass *rape*)	Health clinic Community-based	• Medical staff, • National trained counsellors and community health workers	• Offer medical care • Offer /refer for basic psychosocial care • Train local counsellors • Offer intensive counselling support either individually or in small groups • Raise community awareness • Offer community education • *Community mobilisation* • Advocacy

G.6 Chemical and biological warfare

Little research has been done on the physical and psychosocial effects of chemical and biological warfare[149] (CBW). The World Health Organization (WHO) is in the process of designing a document to address the public health response to CBW.[150] It is generally assumed that CBW causes a high number of casualties. The reality, however, is often that the number of direct casualties from immediate exposure is limited due to the unpredictable contextual variables such as wind and rain.[151] The long-term consequences of exposure remain unknown.

The provision of psychosocial care is important not only in situations where CBW exists, but also where it is a threat. Psychosocial interventions can assist in dealing with individuals' fears and anxiety as well as in the management of the social disruption.

Supportive counselling in the threat of CBW

The threat of becoming ill through 'undetectable' agents affects the basic human need for control and predictability. Threat of CBW can cause profound excitation among authorities and civilians, and trigger irrational and strong emotions among individuals. It often results in increased alertness and the implementation of monitoring, preparedness and prevention activities on behalf of individuals and the state. Social disruption such as rumouring, chaos, scapegoating, paranoia, denial and aggression, and augmented health complaints for instance can cause the misinterpretation of bodily signs (*somatisation*) and stress-related complaints can follow.[152]

Panic can seriously impair effective CBW monitoring and preparation interventions.[153] Although experience shows that people generally act in a cooperative and adaptive manner during crises, panic prevention mechanisms such as structured, consistent information dissemination are important.[154] Expatriates should foster relationships with community leaders to help efficiently compose and convey information.

Mental health support in the aftermath of CBW

Few non-governmental organisations have the technical knowledge or capacity to provide medical care in areas recently affected by CBW. The ability to initiate a mental health intervention for people affected by CBW depends on assessments of security and on the proximity to the biological and chemical agents.

After an attack by chemical or biological weapons, psychobiological reactions may be imminent. Rapid, accurate triage and treatment including immunisation and containment strategies are essential to cover the direct psychiatric and psychological consequences of exposure such as disorientation, *depersonalisation*, hallucinations or delirium. In order to make an accurate diagnosis and intervention, it is essential to realise that some biological agents have psychiatric/psychological effects causing specific neuropsychiatric syndromes or symptoms.

- Anthrax: meningitis, which can be rapidly progressive.
- Brucellosis: depression, irritability, headaches (fatalities associated with central nervous system penetration).
- Q fever: malaise, fatigue (found in a third of those affected); encephalitis, hallucinations (in advanced cases).
- Botulinum toxin: depression, due to lengthy recovery period
- Viral encephalitis: depression, cognitive impairment; other mood changes have also been reported.
- All biological agents are associated with delirium, acutely impaired attention, memory and perceptual disturbances.

Exposure to chemical or biological weapons may also trigger psychological or psychiatric complaints that are not related to the chemical or biological attack such as acute (traumatic) *stress*, psychosis, shock, anxiety/panic disorder and unclear psychological signs.

CBW can cause many types of psychosocial problems. Increased *stress,* arousal and misinterpretation among a people for instance as result of confusing autonomic arousal (such as increased heart beat, elevated blood pressure, increased body ?????) with infections or intoxication. Information and education about prevention and treatment options for exposure to chemical and biological agents may be helpful in these circumstances.

Staff care

An extra consideration for situations of mass threat or attack of CBW is the management of national and expatriate staff. Programme management must take into account:

- Safety of staff, which includes proximity to chemical agents, and also the possible security risks caused by the scarcity of evacuation possibilities or angry reactions of the host community;
- Staff reactions directly related to exposure (eg impaired concentration and cognitive functioning, disturbances in memory, over-dedication);
- (Traumatic) reactions among staff caused by the exposure to panic or high mortality.

To manage these risks the project manager must monitor and assess the situation daily and not depend solely on reports from the field. A 'Helping the Helpers' programme must be in place to identify and support staff affected by the direct or indirect consequences of working in areas affected by CBW.

Tbl. 12: Management and staff considerations for mental health interventions in areas affected by CBW

Phase	**Management and staff considerations** (dependent on security assessment and monitoring)

All phases	Management considerations:
	• Assess security situation daily
	• Establish clear security and evacuations plans and procedures
	• Establish 'Helping the Helpers' system (peer or professional psychosocial care unit)
	• Address ambiguous situations by making strict rules for behaviour. This reduces *stress* and enhances performance
	• Monitor work/rest cycles of staff, and watch out for masked symptoms and over-dedication
	• Organise regular, fixed 'drink breaks' for staff to avoid heat casualties
	• Create openness between staff members and regularly discuss concerns about safety and contamination
	• Institute a zero tolerance policy for alcohol in and around the work place
	• Be sensitive to staff concerns, especially regarding exposure to low-dosage CBW
	• If low-dosage exposure is suspected, do not hesitate to send people to an outpatient department immediately
	• Prepare for panic management:
	  • Compose a preparedness plan
	  • Disseminate structured and consistent information to the community; build trusting relationships with leaders and involve the host community in composing and conveying information
	  • Implement appropriate public self-protection mechanisms
	  • Conduct community education about relevant health issues
	  • Consider establishing an information centre

First aid (Outreach, triage ground)	Management considerations: • Brief first responders on their security management and medical, mental health case management Staff considerations: • Bring clients to safety immediately • Prescribe anti-psychotic and anxiolytic medication where necessary • Use crisis counselling intervention techniques (eg containment) • Stabilise those people who have acute traumatic *stress* • Inform clients or family about normal side-effects of drugs • Where possible, involve family members in the care of clients
Second phase (Basic healthcare unit)	Staff considerations: • Prescribe anti-psychotic and anxiolytic medication, keeping treatment simple and conservative • Use crisis counselling intervention techniques (eg containment) • Stabilise those people who have acute traumatic stress • Provide time and resources for emotional *ventilation* (or frank and open discussions) • Provide focused psycho-education and information • Involve natural caregivers as client monitors • Organise (camp) outreach for clients with medical and psychological needs
Stabilisation phase	Management and staff considerations: • Run a psychosocial programme

H ADVOCACY

The Chantilly document describes MSF's principal focus not only as providing medical aid but also of bearing witness and speaking out. The advocacy it undertakes is based on its medical action. In psychosocial projects or components addressing the psychological consequences of violence, mental health counsellors hear many powerful stories and, through their client relationships, have access to information that is relevant for advocacy. However, the role of counsellor and the person taking witness statements such as a humanitarian affairs officer should not be mixed for several reasons:

- Using information derived from a therapeutic relationship for public advocacy is a violation of confidentiality within the counsellor–client relationship.
- Counselling is not concerned with discovering 'the truth' or reliable accounts of what happened, but with the perceptions of *the client.*
- If the roles are not clearly separated, clients may not trust a counsellor's pledge of confidentiality. Sometimes, this is justified, given the historical abuse of psychiatry and mental health information in some contexts, such as those involving political dissidents.[155]

Despite these challenges, *witnessing* and advocacy activities in psychosocial or mental health programmes can facilitate a client's healing. If properly handled,[156] advocacy can be an important part of the process. It can strengthen clients' coping mechanisms and help to empower them.[157] Advocacy can be effected at the local level – lobbying for better hospital management, for example. When local initiatives fail, public advocacy is considered.

In order to acquire useful advocacy material, and to secure *the client*'s healing process:

- All national staff should be trained in the principles of confidentiality, including limitations in access to client files.
- General programme information can be used for advocacy purposes. The use of data as part of a public report requires the involvement of headquarters line-management and humanitarian affairs advisors.
- Counsellors should not directly ask clients to provide witness statements.
- If a client wants to testify his or her story, in the absence of a humanitarian affairs officer in the project, expatriate staff together with national staff can examine advocacy options for *the client* in the local context.
- *The client* should receive supportive counselling during the advocacy process if requested.

MSF Advocacy Guidelines[158] and management should be consulted prior to initiating any major advocacy activity.

PART III

SPECIFIC TECHNICAL TOPICS

I FIELD ASSESSMENT

Psychosocial assessments are prompted by needs in the field. If possible, field teams such as expatriates and emergency team members should execute the assessment under the supervision of the Medical Coordinator and with support from headquarters staff. To execute an in-depth assessment, a person with experience in psychosocial interventions is needed.

The goals of a psychosocial assessment are:

- To identify the physical and locally defined mental health needs of people affected by mass violence;
- To look into *the clients'* positive and negative coping and *resilience* mechanisms;
- To understand the factors that influence people's access to healthcare (eg 'socio-' political and ethnic dynamics);
- To discover the outcome *the clients* expect of the intervention (having established indicators of success);
- To identify appropriate programme strategies.

Public health principles that aim at the highest possible health impact are not the guiding principles for assessments. Particular focus should be given to identifying the needs of vulnerable or marginalised groups. *Vulnerability* of groups is defined in terms of morbidity (eg presence of symptoms), mortality (eg suicide), exclusion from care, human rights abuses, denial of dignity and specific conditions that increase *vulnerability* (eg psychiatric *illness*).

Psychosocial assessments range in duration from one day, in acute emergencies that require immediate intervention, to three months in pre-established projects that require fine-tuning and anthropological analysis. The average assessment lasts three weeks. Informal psychosocial assessments should continue throughout project implementation to enhance fine-tuning of the activities.

Tbl. 13: General characteristics of an MSF psychosocial assessment

	General characteristics
Who undertakes the assessment	• Field teams guided by medical coordinator • Final stage: person experienced in psychosocial components for in-depth assessment and intervention advice
Focus on	Mental health and psychosocial consequences of violence
Perspective	Immediate support to survive or cope
Duration	Average: three weeks with exceptions of emergencies (one day) and in case of special topics (how many?? months)
Priority	Individuals, then group components
Target group	Most vulnerable

I.1 Ethics

All staff involved in the needs assessment must respect the professional ethics and principles of humanitarian aid.[159] Those applicable to needs assessment are: do no harm, be aware of and respect cultural or ethnic variation and concerns, and maintain confidentiality.

To protect the rights of interview subjects, informed consent must be obtained. Informed consent has various criteria:[160]

- Information about the assessment and objectives must be clear to the participant;
- The procedures, time investment and possible remuneration must be clear;
- The participant should always be free to stop his or her cooperation;
- The benefits of the assessment for the community should be made clear;
- The possible use of data/findings and the possible consequences for the individual should be explained;
- It should be clear to the participant that refusing to participate will not have any effect on his or her treatment or wellbeing;,
- Preferably, the participant should sign an informed consent paper.

The process of obtaining information may burden or even emotionally upset informants. During the assessment the need for information must be balanced against the potential harm it might cause to participants. A useful way of addressing this dilemma is to continually ask yourself: what is the relevance of this information for the overall analysis? The person or team who executes the assessment is obliged to secure basic medical or psychosocial follow-up for those participants who need it.

Special support should be provided to national staff such as translators, who may be exposed to potentially harmful and emotionally upsetting stories. The support includes: preparation, limitation of exposure, provision of emotional support when necessary, daily operational debriefing, and counselling support when necessary.

I.2 Assessment approach and principles

The implementation of psychosocial programmes in the context of international humanitarian assistance is still a relatively new phenomenon. Although aid organisations are building on operational knowledge to improve programme efficiency, several conceptual questions remain unanswered.[161] For instance, how is the clinical significance defined in individuals and in groups in the absence of culturally validated measurement scales? What is the relationship between the prevalence of the problem and the functioning of the individual or group? How are the concepts of clinical significance, healthy functioning, mental and psychosocial disorder, translated in different cultures?

These conceptual difficulties impede the development of a universal assessment methodology and complicate the development of survey instruments. The absence of clear cut-off criteria such as morbidity or mortality figures may lead to discussions about the assessments' conclusions. To limit and streamline discussions, criteria of good practice have been developed. Those listed below are useful to consider in situations of chronic crisis.

Qualitative and quantitative methods

Each psychosocial assessment must combine qualitative and quantitative methods. Quantitative methods provide objective, measurable data about a people's mental health and psychosocial needs. Qualitative methods provide information about the subjective perceptions of individuals in a people; they give information about the range, depth and meaning of people's experiences. The methods are complementary.

Assessment instruments

- Each assessment must use at least two different *quantitative* and three different *qualitative instruments*. The use of more instruments enlarges the scope and improves the reliability and validity of findings.

Quantitative instruments

- **Healthcare data** and **mental health statistics** from health posts, clinics or hospitals are the most easily accessible type of quantitative information. They provide a quick overview about the extent of medical and mental health problems met by a health system, and any changes in evidence.

Please note that for the application of the instruments below, Ethical Review Board approval is necessary.

- ***Psychosocial questionnaires***[162] are structured interviews used for the large-scale appraisal of psychosocial needs in closed (camp) and open (community) settings. They are used when medical data are unreliable, but substantial psychosocial needs are expected. Design, *adaptation* and translation for local circumstances are required. *Psychosocial questionnaires* provide insight into the events (exposure, *witnessing*), the psychological impact (Impact of Event Scale or IES[163]), the prevalence of specific health complaints and *stress* (General Health Questionnaire 28, GHQ 28[164], Self-Reporting Questionnaire 20, SRQ 20[165]) and local knowledge, attitude, and self-help mechanisms.
- **Symptom checklists** such as the Hopkins Symptom Check List,[166] IES, SRQ 20, and GHQ 28 can be used to assess the prevalence of psychosocial *stress* symptoms. Symptom checklists are in general not validated for non-Western cultural environments. There is no instrument that measures the complete range of traumatic experiences of refugees.[167] The use of symptom checklists has important shortcomings.

- A diagnosis is possible only after professional clinical assessment and should never be based on a symptom checklist alone.
- When the symptom checklist is not validated for the culture, the outcomes have only limited value when used in combination with other data (*triangulation*) or a standardised clinical interview method such as The Schedules for Clinical Assessments in Neuropsychiatry.[168]

- ***Self-completion questionnaires*** are useful for obtaining specific information on a topic rapidly. These short, open-ended questionnaires are used to obtain information about sensitive subjects. Knowledge Attitude Practice and Behaviour studies are used to gather basic information about local context.

Qualitative instruments[169]

Qualitative instruments are essential to understanding clients' perspectives on the local psychosocial consequences of violence in terms of health and functioning, on ways of expressing emotional distress (including vocabulary used), on psychosocial self-help (coping) mechanisms and on other sources of relief and expected outcomes of an intervention among *the clients.*

- **Literature review**: review the existing background literature (eg on history or anthropology) as well as previous assessment reports by other organisations. The use of a good literature review avoids unnecessarily burdening clients and saves time.
- **Focus group discussion** is a technique to facilitate discussion about a pre-defined and limited topic among a selected group of clients. It is an informal and quick way to assess needs, survey results (eg accessibility of healthcare) and become familiar with local ways of thinking, opinions, perceptions of *the clients*, and their suggestions for intervention.
- ***Key-informant interviews*** are obligatory in psychosocial assessments. Several formats are available such as general interview, psychosocial consequences of violence and coping mechanisms. These qualitative instruments are easy to use and easily adapted to varying contexts regarding depth and content.
- ***Structured or checklist observation*** (direct, walking around or clinic observation) is an ideal method to see whether people act as they say they do in interviews.
- **Diaries** are used to further validate information such as prevalence of symptoms, and to measure social contacts.
- **Mapping**: the relationship between the beneficiary and his or her environment is important to consider in assessments and interventions. 'Participatory mapping' can be used discover individual perception on certain issues such as social dynamics. Clients draw the way their community is structured:
  - Social mapping details what inside or outside social resources are available;
  - Hierarchy mapping addresses questions such as: who is in power and who is responsible for what.

  These environmental tools are helpful in the identification of social, spiritual and moral resources and *resilience* mechanisms. But the mapping method is also used for researching other types of information such as how security information is disseminated.

- **Other tools**: if time and security permit, other anthropological tools can be used to gather detailed information about clients' perspectives on mental disorder (eg causation and symptomology), local health management strategies (eg religious healing, herbalism, witchcraft) and their expected outcomes. Several qualitative anthropological tools are available to achieve this. If possible, these should be used at the beginning of an assessment:
  - **Free listing** can be used to access clients' perspectives' about prominent psychosocial problems in the community and to identify vulnerable groups.
  - The inter-relationship between these psychosocial problems and vulnerable groups can be understood through **pile sorting**. This technique results in a list of the most important psychosocial problems within a community.
  - **Pair-wise ranking** (what is this?) is then used to find out their order of priorities according to *the clients.*
  - **A Venn diagram exercise** is used to find out which group(s) must be included to address the most pressing problem. Through this exercise it should become clear which people are most affected by the problem, who is responsible for addressing it inside and outside the community, who is currently addressing it and with which groups or organisations cooperation is required.
- **Workshop**: it is useful in nearly all circumstances to organise a workshop with interested parties to discuss the assessment. During the workshop a facilitator should be present. He or she then offers assessment results, analysing the relationship between problems (the problem tree) and what needs to be done (the intervention). This is also a good opportunity to discuss how changes and results can be observed and measured as indicators of success.
- **Dictionary**: during the assessment, special words, definitions, expressions, symbols, explanatory mechanisms and rituals related to psychosocial problems can be described in a designated file.

Tbl. 14: Overview of assessment methods and instruments

Quantitative methods	**Instruments**
Always use:	• General medical monitoring • Mental health statistics (also police registers for suicides)
One of the following preferred (depending on time available):	• Specific topic information: self-completion questionnaire (for quick results and to obtain sensitive information), Knowledge Attitude Practices Behaviour-study (for in-depth knowledge) what is this? explain • Checklist of individual symptoms of psychosocial *stress* • Population survey using a psychosocial questionnaire
Qualitative methods	**Instruments**
Always use:	• Literature (report) review • Focus Group Discussion dealing with health needs, expressing emotional distress, psychosocial self-help (coping) mechanisms, other sources of relief, expected outcomes of intervention • Interview: *key-informant* or other forms can be considered.
If time and security issues permit, use several of the following:	• Validation: walking about, structured observation, *diaries* • Environmental resources/*resilience*: participatory mapping, social mapping, hierarchy mapping • Language: dictionary • Client perspective: free listing, pile-sorting, pair-wise ranking, Venn-diagram, workshop (results, *problem tree* analysis, intervention, expected outcomes)

Validation of information

To ensure the validity of information (especially from qualitative methods) various sources of information are used. Expatriate and national staff from local, national and international organisations should all be consulted, as well as staff from government healthcare institutions, local care providers and key people in the community.

The clients themselves play an important role in this process. The extent to which they are included in the assessment process depends on the situation and the time available.

As a minimum requirement, an assessment should include subjects of different age groups, male and female, and of various educational and social backgrounds who have been mildly and seriously affected. The validity of the assessment increases with the variety of methods used and the number of clients from different social strata who are included.

Triangulation of data

Triangulation is the use of different sources and methods to verify validity or to find 'the truth' when information is conflicting or inconsistent. A conclusion can be drawn based on triangulated data, and *triangulation* adds value to the assessment.

Psychosocial consequences of violence cannot be reduced to sets of symptoms and signs. Especially in contexts of chronic crisis the loss of functioning, the impairment and suffering of individuals and communities escape the medical nosology of symptoms and disorders.

A comprehensive view is required to increase understanding about *the clients'* **p**erspective and suffering.

During psychosocial assessments, various types of information should be gathered using different methods. Exposure to potentially traumatic incidents and environmental conditions contributes to psychosocial suffering. This suffering affects all segments of the individual's health. However, individual and group coping and *resilience* mechanisms, or availability of resources reduce the overall impact of the traumatic exposure.

The clients' severity of trauma should be analysed, as well as their conflict-related health needs, their *resilience* mechanisms and available resources to determine appropriate programme responses.

I.4 Early warning and basic field assessment

Many people in countries where MSF works suffer mental health and psychosocial problems stemming from mass violence. A high level of or a sudden increase in the prevalence of psychosocial problems may trigger the need for an assessment. The need for mental health and psychosocial services is often suspected or inferred by a field team while working, or while communicating with the health authorities and other relevant aid organisations.

A formal needs assessment is required to confirm suspected health needs, and to modify project objectives accordingly. Any needs assessment consists of two steps: a general assessment (by the field team) and an in-depth assessment (by a specialist).

Most early indicators are related to trauma severity such as high incidence of human rights abuses. The most striking indication of increased psychosocial needs is a high level of conflict-related health problems such as war-wounded cases of sexual violence, *mental health disorders* **s**uch as psychosis, depression, suicide attempts and PTSD, and stress-related problems such as *traumatic stress*, psychosomatic complaints and sleeping problems. Clients often report and complain about changes in their social environment, evident for instance through increased levels of community violence, disharmony and conflicts; and about poor recovery environment.

The question to ask at this stage is: to what extent are the observed needs indicative of a structural problem? A medical line manager can ask the team to substantiate their first impressions of trauma severity and conflict-related health needs. Quantitative information such as general monitoring, mental health statistics; as well as qualitative methods such as observation, reports, *key-informant interviews* with clients and focus-group discussion are used.

To understand the scope of the psychosocial problems people experience, the medical line manager and project team should also analyse information about *the clients' resilience*, their resources or what supports *the coping process*. The *resilience* indicators are:

- physical health such as the absence of *disease* and disability, the existence of an acceptable living environment
- mental health such as the feelings of control
- social health such as the availability of social support and the existing psychosocial resources should be compared with the quantitative and qualitative outcomes on trauma severity and health needs.

There are no strict criteria for initiating a mental health or psychosocial programme. The decision to initiate or scale up the psychosocial care component of a project depends on current project priorities, needs and resources. Clearly, where mass needs are discovered, immediate intervention should follow. In other cases, a specialist continues the assessment of:

- high indicators of psychosocial problems, low signs of *resilience* and poorly developed resources;
- normal levels of psychosocial problems, low signs of resilience and poorly developed resources; or
- specially affected groups (eg the elderly, single-parent households).

Tbl 15: Overview of factors important for early assessment and monitoring of psychosocial needs

Early indicators and general needs assessment (field team)		**Assessment Tool**
Trauma severity (events) • Events [Context of mass violence, duration and frequency of events, proximity to event, life danger, loss (people, material)] • Recovery environment (displacement, 'socio'-economic, poor-quality housing/ camp) conflict-related health problems (signs and functioning) • Physical health [increased war wounded, sexual violence, stress-related complaints and morbidity, mortality (infant, suicide), consequently unhealthy behaviour (eg smoking, drugs, alcohol, sexually transmitted disease, HIV/AIDS,] clinic attendance/ return, placebo prescription • Mental health [high levels of psychosis, PTSD, anxiety disorder, depression, substance abuse, suicide (attempts), psychotropic drugs use, increased demand or use of mental health services] • Social health [community disharmony (eg conflicts, (family) violence, child abuse, vulnerable groups (eg marginalisation)]		Quantitative • General health monitoring • Mental health statistics Qualitative • Reports • Focus group discussion • *Key-informant interview* (clients, leaders) • Listening, • Observation
***Resilience* indicators**	**Resource availability**	**Assessment Tool**
Physical health • Good health • Healthy behaviour • Physical activities • Favourable living circumstances	• Functioning health services (formal and informal) • Traditional healer	Quantitative • Health statistics • Number of mental health specialists per 100,000 [IV] • Policy document
Mental health • No increase mental health pathology • Feelings of control • Previous ways of coping • Knowledge/ information • Training/ preparation	• Mental health professionals (psychiatrists, psychologists, social workers) • Psychiatric hospitals • Mental health policy and legislation • Traditional healer • Religious leader	
Social health • Social and emotional support • Ability to mobilise social support • Cohesive community (caring capacity, community sense, acceptance of vulnerable people) • Active community member • Social structure/ order • Safety, security • Community in 'relative' harmony • Continuation of traditional activities/festivities • Respected leaders in the community • Self-control (eg income generation, authority of significant leaders) • Initiative (eg with regard to camp/shelter organisation) • Self-help	• Family/friends • Self help groups • NGOs (local and international) • Institutions (social welfare, schools, work-related) • Community leaders • Communal places and festivities	Qualitative • Reports • Focus group discussion • *Key-informant interview* mental health education,) • Listening • Observing
Response intensity:		
Acute, mass needs: direct intervention **High:** continuous assessment in the event of: • High prevalence of psychosocial problems, low signs of *resilience* and poorly developed resources • Normal level of psychosocial problems, low signs of *resilience* and poorly developed resources • Specially affected groups **Low:** stop assessment		

IV The number of psychiatrists per person in Europe varies from 30 per 100,000 in Switzerland and 26 in Finland, to three in Albania and one in Turkey. The median number of psychiatrists per 100,000 in the 41 countries that provided information is nine

I.5 In-depth assessment

The objectives of the in-depth assessment are to confirm the findings of the general field assessment; to clarify the social, spiritual and moral health issues further (signs and disruption, *resilience*, resources); and to give advice on future intervention possibilities. A person with experience in psychosocial programming should execute the in-depth assessment in close cooperation with the field team management.

Problem tree

An in-depth assessment gives insight in the root causes of the problem(s), the effect they have on individuals, the functioning of the community and an appropriate project response. The analysis results in a *problem tree* that shows possible causes, effects and relationships between the various aspects of the problems and those involved. If time permits it is useful to discuss the contents of the *problem tree* with client representatives.

The decision to add a psychosocial component to existing services (or in some circumstances to start a vertical programme) depends on the outcome of the in-depth assessment and the problem tree.

Tbl. 16: Overview of factors important for an in-depth assessment of psychosocial needs

In-depth indicators		**Assessment Tool**
See early indicators and general assessment: continue what is not finished in the early assessment (tbl 15) Conflict-related health problems (signs and functioning) • Social health: community disharmony [conflicts, (sexual) violence, schisms, family violence, child abuse]; loss of cohesion (vulnerable groups, lack of caring capacity, lack of trust, apathy, withdrawal); social disintegration (lack of social order, unclear roles and leaders, status loss of significant people, no self organising capacity, disruption of customary/traditional activities); loss of self control (ability to care for basic survival); increased risk behaviour (substance abuse, prostitution, delinquency) • Spiritual health: inability to give meaning (eg preoccupation: why did it happen to us?); decreased spirituality; religious fundamentalism; belief in being cursed or punished by God; loss/neglect of rituals; intrusions of the dead (anxiety, dreams); spirit possession (disorderly behaviour, inconsistent and unusual speech, somatic symptoms); neglect of spiritual places; cynicism • Extras: (new unexplained material not helpful) * local idioms of expression of (violence-related) emotional distress; * Local mechanisms to express distress; * Knowledge/beliefs on psychosocial consequences of violence (in terms of *functionality*) • Project proposal-related: beneficiary perspective (on assessment outcomes, problem-tree analysis, ways to intervene, expected outcome (in terms of *functionality*), how to measure improvement), practical issues (eg possible partners, national staff, geographical area)		Quantitative • General health monitoring • Mental health statistics • Individual psychosocial *stress* symptoms • Psychosocial questionnaire • Self-completion questionnaire • Knowledge Attitude Practices Behaviour-study • Bolton tool Qualitative • Reports • *Focus group discussions* • *Key-informant interview* (clients, leaders) • Listening • Structured observation • *Diaries* • Social mapping • Hierarchy mapping • Village drawing • Dictionary • Workshop (results, problem-tree analysis, intervention, expected outcomes)
***Resilience* indicators**	**Resource availability**	
See Physical, Mental, and Social health in early indicators: continue the unfinished elements of the general needs assessment Spiritual • Religious or spiritual belief • Beliefs about the event • Rituals • Properly buried people • Places of contemplation and worship Moral • Ability to forgive, have compassion • Acknowledgment of and adherence to ethical rules/regulations • Sense of contribution to a greater goal • Drive to survive to serve a higher purpose	• Religious institutions (formal/ informal) • Places of worship • Possibility and frequency of healing rituals (eg memorials, burials) Justice system Law (In) formal rules on marriage, heritage etc	Quantitative • Existence of laws and justice mechanisms Qualitative • Literature • Focus group discussion • *Key-informant interview* • Listening • Observing
Overall conclusion about response intensity and possibilities for intervention		
High response intensity: implement psychosocial project or component • High indicators of psychosocial problems, low signs of *resilience* and poorly developed resources • Normal level of psychosocial problems, low signs of *resilience* and poorly developed resources • Marginalised or other affected groups **Possibilities for intervention** • Psychosocial component added to other programme activities or to a full community-based programme • Intervention is supported by staff • Realistic plan		

J PROJECT PLANNING

J.1 Definitions

Humanitarian aid has traditionally consisted of providing life-saving assistance to people in danger during acute emergencies such as violent conflicts, natural disasters, and epidemics. This type of assistance is considered distinct from development assistance, which focuses on 'socio'-economic rehabilitation in relatively secure areas. Today, NGOs find themselves working in contexts that do not conform to either description but lie somewhere in the middle of the emergency development continuum. Often these situations are defined as 'chronic emergencies' because health and security environments are under constant threat. In such situations, neither a pure emergency nor a pure development assistance approach is appropriate. Projects in chronic crises must combine objectives, activities and strategies from both models of assistance to ensure effectiveness.

The critical question for programme managers is, then: which operational strategy will best meet the people's needs? This question occupies many health professionals working in contexts of chronic crisis. The strict separation between emergency and development action is useful when addressing this problem.

In this chapter the strict separation between three forms of assistance is used as a model to explain what psychosocial projects should look like in the various contexts.[170] Three types of indicators are generally used to describe the success of a project.

- *Outcome indicators*: related to Project Purpose
- *Output indicators:* related to Specific Objectives
- *Process indicators:* related to Activities.

Process indicators assume a positive correlation between the activities and the specific objective. The assumption is mentioned in the logical *framework. Outcome* and *output indicators* prove (instead of assume) the relationship between the activities and project purpose or specific objective.[171] Ideally, all psychosocial projects strive to define *outcome indicators* to provide a basis from which to measure the effectiveness of their intervention. Realistically, most projects define *output indicators*.

The areas of conflict or high instability in which MSF intervenes hardly ever allow for the definition of *impact indicators* (related to the overall programme purpose).

J.2 Acute emergencies[172]

The project purpose is to support individual human physical survival by delivering care to preserve lives and provide basic subsistence. The use of standard specific objectives and indicators is justifiable for an emergency context where actions are limited by time and security. Within mental health or psychosocial services, direct treatment and care for mentally affected clients is the highest priority in emergencies. When possible these activities should be provided along with psychosocial care activities.

Mental health projects may also enhance the efficacy of other life-saving services in the outpatient department. A large flow of shocked, distressed, anxious and somatising outpatient visitors can, for example, be referred to the mental health services. Outreach services are useful to enhance the identification of physically and mentally vulnerable people. Psychosocial education should be used to stimulate the self-help mechanisms of individuals or small groups.

The preservation of human dignity and assurance of protection are important: an ethical imperative in emergency medical assistance.

Indicators
The identification of reliable *outcome* and *output indicators* is not possible in emergency settings due to the fast-changing situations. *Process indicators* related to activities are often the most valid indicators of programme effectiveness in emergencies.

Target group
As part of the emergency medical package, mental health services should focus on the most vulnerable.

Time perspective
Emergency mental health projects range in length of implementation from days to several weeks, and up to a maximum of three months.

Activities of care
Once the target population has been defined, and clinical and outreach services with appropriate referrals have been established, several activities of care are in place:

- Social support for instance food distribution, shelter and hygiene material;
- Primary support that focuses on stabilising *the client* through drugs, crisis counselling, and that ensures clients have an (informed) social network to support them;
- Psychosocial counselling that allows for expression and *ventilation* of emotions, promotes self-control and provides advice;
- Outreach services that identify vulnerable clients with physical and mental health problems;
- Education and cooperation with existing social networks;
- Psychiatric services.

Structure of services
Psychosocial services must be integrated into an outpatient department. Access can be maximised through outreach workers who identify mentally and physically vulnerable people at an early stage. A referral system between physical and mental health services should be encouraged. Sometimes an information and educational facility is identified to further reduce strain on the medical and mental health services.

In contexts of limited accessibility, mobile services are an option. In these cases, mental health and, secondarily, psychosocial assistance focus only on acute cases.

All services are executed under the *clinical supervision* of a certified mental health worker.

Human resources
Expatriate psychosocial worker(s) with a team of caregivers (counsellors and outreach) are responsible for providing mental health and psychosocial care services. Though the involvement of local professionals is preferred, expatriate caregivers such as psychiatrists, (clinical) psychologists, social workers and pedagogues can participate in the provision of care.

A basic unit of one expatriate, five trained national counsellors and eight outreach workers can effectively cover curative and basic (solution-focused) counselling first-line activities for approximately 10,000–15,000 people. If possible, staff should be recruited among clients. If the prevalence of psychiatric disorder is high, consider opening a position for a psychiatrist.

When psychosocial services are implemented through mobile teams, staff is often limited to one or two.

Training
Training of (expatriate or national) medical and outreach staff is limited and focused on the execution of standardised tasks. Training medical doctors on the treatment of acute psychiatric disorders is essential in the absence of a (functioning) local mental health service.

Strategic aspects
To increase the efficacy of overall medical services, mental health support should be implemented within existing medical activities. Additional or parallel psychosocial activities should not be excluded as an option, but need further justification before implementation.

Projects specifically address needs resulting from a crisis situation; therefore sustainability is not a priority. Cooperation with local health authorities is important, but often of limited value in acute emergencies.

J.3 Chronic crises

Project purpose
The purpose of a psychosocial project in a chronic crisis is to improve the daily functioning of the most vulnerable. Long-term survival is no longer limited to basic physical survival, protection and human dignity alone. It also includes social and emotional endurance (coping).

Specific objectives

Specific objectives for psychosocial projects in chronic crises cannot be standardised for two reasons:

- First, the nature of a chronic crisis is that of uncertainty. Both deterioration and amelioration of the social and security context are possible. Inevitably, a mixture of acute emergency and post-crisis specific objectives are necessary to ensure a built-in flexibility.
- Secondly, projects in chronic crises need to address the specific, locally defined consequences of violence. Therefore, a context- and culture-specific *problem tree* is needed to further define the specific objectives.

Often specific objectives include *the clients*' gaining improved knowledge and skills for self-management of psychosocial problems and improved functioning.

Indicators

In principle, psychosocial projects in chronic crises need to design cross-culturally validated *outcome* or *output indicators*. Whether or not it is possible to do so depends on the context, the willingness of the team, and the time and resources available to the project. An obvious **outcome indicator** for a medical intervention is the complaint or problem reduction as observed by the mental health professional or counsellor. However, interventions focusing on *functionality* improvement are often difficult to evaluate with symptoms only. Therefore, locally developed *outcome* or *output indicators* should be developed with the assistance of the local people. Through focus group discussions and *key-informant interviews, the clients*' perspective of the psychosocial problems can be researched. Consideration should be given to how locals interpret the improvement of their physical, mental, social, spiritual and moral health, and to how it can be measured. It is helpful to describe the locally defined outcome, or *output indicators* for both the *'psycho-'* and the *'socio-' component* in terms of *functionality* and coping, for instance the improvement of social contacts, ancestors are resting in peace, (this has not yet been explained) decreased worrying, improved physical activities, improved ability for self-care, improved family relationships, and increased daily activities etc.

It may not always be possible to develop locally defined outcome, or *output indicators* for instance in situations with security constraints, that lack of human resources, and have insufficiently well educated staff or an inexperienced expatriate or project team. It must be noted, however, that the use of *process indicators* hinders a proper effect evaluation of the specific objective or project purpose.

In these circumstances *process indicators* can be used to describe the effectiveness of the programme. Assumptions have to be described in the *logical framework*. A combination of qualitative and quantitative indicators is highly recommended:

- Quantitative indicators of success describe: increased number of people seen in the counselling services, improved functioning ('psycho-'component), increased number of community activities (education or other), increased number of people attending, increased number of people supported through community outreach services ('*socio-' component*) and monitoring of human rights abuses or protection issues.

- Qualitative indicators of success describe: high-quality services provided, improved restoration of human dignity, perceived improvement of complaints, (meaning?) client satisfaction (*'psycho-' component*), proximity to the target population (eg presence in the community), the connectedness and quality of the community network (*'socio-' component*) and a specific indicator for advocacy action.

Target group

The target group comprises individuals who suffer from the psychosocial consequences of violence. The psychological or emotional suffering can be caused either by a direct impact from traumatic experiences or indirectly through lack of protective mechanisms.

Time perspective

Project implementation can vary in from six months to up to three years.

Activities

The types of care offered by a psychosocial programme depend on the level of intervention. The situation (what situation?) is likely to last for long time. Endurance is promoted through increased functioning of the individual. Thus clients' coping mechanisms and *resilience* resources (physical, social, spiritual and moral) mechanisms are reinforced.

- On an individual level, coping is supported through crisis and supportive counselling. This is the *'psycho-' component.*
- To further reinforce *resilience* mechanisms for the individual, community resources can also be included in the intervention (the *'socio-' component*).
- If protection and human rights issues emerge they need to be monitored and, if possible, addressed.

Structure of services

Psychosocial projects in chronic crises have to decide whether to integrate mental health into existing services or establish a separate vertical system. In many non-Western countries psychosocial or even mental health services are often non-existent or underdeveloped. The chances of building a sustainable service are low. Despite this, MSF chooses to realise psychosocial and mental health interventions. Sustainability of the services has low priority in programme implementation. The choice must not exclude close collaboration with the community (local representatives, NGOs), and with existing health and social services.

MSF has chosen to address psychosocial and mental health needs when there is a marked prevalence of mental or psychosocial dysfunction. Systems building and sustainability are not a priority. The first priority is to establish a proximity to *the clients* that enables us to address their needs through the provision of quality care. In extreme circumstances this may result in our initiating a separate, temporary programme that is parallel to existing national health services. Most psychosocial projects in chronic crises are closely connected to the existing healthcare system (eg through training or referral). Experience shows that the services are seldom continued by the local health system after the crisis.

Psychosocial support in chronic crises can take on a variety of forms:

- Basic support as provided in each medical relationship;
- Psychosocial referral service (local NGO, national or expatriate specialist);
- Psychosocial community-based programme.

Psychosocial care should be implemented in an outpatient department. Services must be undertaken under the *clinical supervision* of a certified mental health expatriate. Where possible, a local counterpart (mental health professional) can also participate in the clinical supervision process.

Connectedness to the community (the social component) is important. To stimulate self-help of the individual and the community, a local referral support network outside the health system should be used.

The implementation of psycho-educational awareness activities in the community is possible only when clinical back-up is available.

Human resources

A team of one expatriate, five to ten trained national counsellors, and ten community workers can effectively assist 15,000–20,000 people. Local staff should preferably be recruited from the existing health system. However, in reality the lack of professional health workers means that clients and the host population provide the recruitment pool. If the psychosocial activity involves only a psychosocial referral component, then one or two mental health staff is usually sufficient.

Training

Training improves health workers' ability to support clients. It is not the aim to create certified mental health specialists or expert community workers. Medical staff may need training about how to provide basic psychosocial support in medical settings, and how to identify and refer people suffering from psychological or psychiatric problems. When high-quality local psychiatric services are not available, medical staff must be trained to treat acute psychiatric disorders.

Community workers and counsellors should be trained about *community mobilisation,* and (mass) psycho-education. They should also continue to receive extra training on counselling skills.

Strategic aspects

Psychosocial support activities should preferably be part of a basic healthcare project or a component of a specialised programme such as TB, HIV/AIDS, or nutrition. Vertical psychosocial project activities focussing only on mental health should not be discarded as an option, but need justification.

Psychosocial projects combine *'psycho-'* and *'socio-'* activities. Programmes that focus on

only *'psycho-'* or only *'socio-' components* are less effective. The balance between both activities depends on the local situation and culture.

Having an exit strategy is important, but should not influence the decision to start a project.

The psychosocial project should maintain close communication with the people it is serving. This promotes coping, facilitates self-help and other *resilience* mechanisms. Daily presence of expatriates in the community, strong links to NGOs, community systems and significant people who can support the social, spiritual and moral health issues are vital.

Tbl. I 7: Summary of essential features of a psychosocial intervention in chronic crises

	Psychosocial care in chronic crises
Project purpose	Enhanced *functionality* and improved coping of the most vulnerable
Specific objective	Defined locally depending on assessment and problem-tree analysis (eg to improve client's knowledge and skills about self-management of psychosocial problems; to improve client's daily functioning)
Indicators	*Outcome indicator*: is defined by the local people in terms of individual and group improvement in daily functioning. Process indicators: both quantitative and qualitative
Time perspective	Six months to three years
Activities	• Psycho-component: supportive and crisis counselling • Socio-component: health education, *community mobilisation*, connection to other NGOs, promotion of self-help (eg traditional care and support mechanisms), stimulation of distraction activities, restoration of community-repair mechanisms. • Monitoring of human rights and protection issues
Structure of services	• Dilemma of short-term effectiveness or long-term sustainability • Organisation of services depends on needs and staff availability • Services in outpatient setting and closely connected to existing health systems • Referral network to the formal health system and to community organisations • Implementation of psycho-educational activities in the community only when there is clinical back-up • *Clinical supervision* of MSF mental health expatriate preferably with a local counterpart
Human resources	One expatriate, five to ten trained national counsellors, ten community workers cover 15,000–20,000 clients
Training	• Training is a tool not a project goal • Medical staff: training about provision of basic psychosocial support in medical settings (eg communication skills, crisis interventions), identification and referral of people suffering from psychological/psychiatric problems. Training of medical doctors on the treatment of psychiatry is necessary when the local health system does not provide these services. • Community workers: training about *community mobilisation*, and (mass) psycho-education • Counsellors: training about *community mobilisation*, and (mass) psycho-education, and extra, continuing training on counselling skills.
Strategy	• Part of other medical intervention (eg basic healthcare, TB, nutrition, HIV/AIDS) • Strong community connection and involvement to increase efficacy • Balance *'psycho-'* and *'socio-' components* • Exit strategy and sustainability are secondary priorities (though attention must given)

J.4 Post-crisis / rehabilitation

MSF rarely works in post-crisis or rehabilitation settings. Nevertheless, this section is included for three reasons. First, certain components of psychosocial care programming for post-crisis projects are also used in projects in chronic crises. Secondly, HIV/AIDS interventions in which psychosocial activities play an important role do not necessarily follow the emergency-development continuum. Thirdly, a typical issue that is addressed in rehabilitation projects, the de-stigmatisation and sometimes de-criminalisation of mental health, is often relevant for mental health and psychosocial projects in chronic crises.

Project purpose

Psychosocial care in most post-crisis settings aims to improve all people's mental health (in the broadest definition) instead of being limited to violence-related complaints. Project purposes encompass care, cure, protection and health-system autonomy.

Specific objectives

Specific objectives for the project should be identified and developed by *the clients* or their representatives. The objectives often include the specific aspects of the mental health problems that need to be improved, support for capacity-building, service design (sometimes implementation) and technical guidance etc.

Indicators

Outcome and *output indicators* of success should be defined in terms of quality, efficiency, effectiveness, participation, protection, autonomy and exit strategy.

Target group

The target group is all those in need of psychosocial support.

Time perspective

The intervention is aimed at sustainability and requires a long-term perspective.

Activities of care

Sometimes technical support is provided and capacity-building facilitated in post-crisis situations. However, the emergency-focused knowledge and limited time commitment of emergency NGOs nearly always excludes them from these types of programmes.

Psychosocial care activities in post-crisis situations should integrate curative and preventive care with health promotion. Healthcare should be provided in a 'holistic' manner that takes into account the physical, psychological and social dimensions of health and wellbeing.

Activities of psychosocial and mental health services in basic healthcare include: symptom relief, counselling, psychotherapy, drug therapy; assistance for coping with the inevitable; and prevention of further deterioration through continuous health education.

Quality aspects of the relationship between clients and healthcare provider such as: active client participation, supportive relationships, trust in the caregiver, maintenance of beneficiary's autonomy and family ties, shared decision-making etc, are important aspects of the activities.

Special activities related to destigmatisation or decriminalisation can be implemented when relevant. In the case of human rights or protection issues of the mentally ill, activities must include the monitoring of clients.

Structure of services
To increase the efficacy of prevention, decrease suffering (by early identification) and increase self-help (by psycho-education), psychosocial care services need to be community-based. Psycho-education is effected through the established community health-worker systems.

A basic organisation unit can cover approximately 10,000–15,000 people. Referrals should not be limited to the health and community system, but include all structured government and private initiatives. A national mental health specialist should be responsible for clinically supervising the services.

Human resources
Expatriates should provide hands-off advice and not be involved in any client relationship. They should function only as specialists who give training and technical advice about clinical and organisational issues. National professionals execute the psychosocial/mental health services, and have long-term employment contracts.

Training
Training of staff about clinical and organisational issues is one of the major activities. Training should be in-depth to develop knowledge and skills that are important for the long term. Human and client rights training should be considered as important subjects .

Strategic aspects
In post-crisis situations, psychosocial and mental health support should exist within an effective, and integrated basic healthcare system. It has to balance, both collectively and individually, the professionally defined needs and the demands expressed by *the client.*

Psychosocial services should be developed in harmony with other aspects of culture and society such as local belief systems, political, economic and religious systems. If de-stigmatisation, de-criminalisation, clients' rights and inpatient care are defined as specific project purposes, the intervention is focused on catalysing change. Collaboration with local administrators and political authorities is necessary to achieve commitment and to promote autonomy. Ideally the programme should be implemented through the Ministry of Health, which acts as the major implementing partner. The Ministry of Health should be consulted all decisions regarding policy, resource allocation (by the overall budget)

and priorities in setting norms for both change and expected behaviour or attitude. Sustainability of services is important and often the exit strategy is a planned objective.

Tbl. 18: Summary of essential features of a psychosocial intervention in post-crisis/rehabilitation

	Psychosocial care in post-crisis/rehabilitation
Project purpose	To respond to all people's mental health needs and demands
Specific objectives	• Locally defined by clients (often in terms of capacity and service-building). • Extra specific objectives regarding destigmatisation, decriminalisation or clients' rights can be included
Indicators	*Outcome* and *output indicators* should be defined in terms of quality, efficiency, effectiveness, participation, autonomy and exit strategy
Time perspective	Long-term
Activities	• Curative care • Psychosocial assistance • Preventive actions • Promotion of health as physical, social and mental wellbeing • Destigmatisation • Lobbying, advocacy (optional) • Monitoring rights (optional)
Structure of services	• Community-based • Budget from health system • Basic unit serves 10,000–15,000 people • *Clinical supervision* by national mental health specialist
Human resources	One expatriate who acts as advisor
Training	In-depth training on clinical and organisational issues
Strategy	• Integrate services within the national health system • Autonomy, participation and collaboration • Partnership with Ministry of Health • Harmony with other social, spiritual and moral aspects of the society and culture • Catalyst for change (optional)

K TRAINING

Training in a psychosocial project is an important tool but never a project goal in itself. Training should be practical and focus on helping clients with psychosocial problems. Except for the psychosocial skill training of the medical staff, it is never a stand-alone activity. There are serious ethical risks, such as doing harm, involved in exposing national staff to knowledge and skills without proper clinical back-up for community workers or clinical supervision for counsellors.

Therefore, if community workers are trained, proper referral mechanisms (to medical staff, clinically supervised local counsellors, or a mental health specialist) have to be ensured. Training counsellors without daily clinical supervision by a mental health specialist is potentially harmful for clients and for the staff themselves.

K.1 Trainer's attitude and methodology

Being a trainer requires a modest, open and curious attitude. Inappropriate ways for a trainer to manage anxiety and uncertainty such as creating an expert status and lecturing can hinder the process of exploration and dialogue with participants. An interactive process between the trainer and participants is vital to bridge cultural differences. The trainer should be responsible for facilitating this process. Cross-cultural training is based on three principles:

1. (Re)discovery of knowledge already available among participants. Instead of arriving with a fixed curriculum about the knowledge, attitude and skills required for effective counselling, existing knowledge among participants is taken as the point of departure. The trainer's role is to facilitate the discovery process and to encourage participants to share their knowledge, skills and self-help mechanisms while using local language and concepts.
2. Attention to the personal needs of participants. Almost all participants in the training will have their own personal, traumatic experiences, for which they need some support. The training is not only educational for participants, but also therapeutic. Education and therapy are nicely combined during training through practice activities. Counselling techniques learned in class can, for example, be put into practice by having participants counsel each other. Participants thereby benefit doubly by learning about counselling and having their personal suffering alleviated. The trainer must ensure a safe environment that protects participants from re-traumatisation. Where necessary, the trainer can conduct individual consultations.
3. Sharing of Western knowledge and translation to local culture. Western insights can be shared and, when accepted, adapted for the local culture. Participants need a concise, short-term and practice-oriented training without professional jargon that is appropriate to their level of formal education.

K.2 Medical staff

Training is necessary for all national and expatriate medical staff working in projects that have a mental health or psychosocial component. The purpose of staff training is to improve knowledge about the psychological consequences of violence, (local) coping mechanisms, case identification, and referral options. Special attention should be given to the attitude and skills required to give psychosocial and emotional support in a medical setting such as the ability to listen, convey compassion, deal with emotions, provide or mobilise company, encourage (not force) social contact, intervene in crises and protect from further harm. The two or three days of training do not aim to turn the medical staff into counsellors. In emergency situations the duration of the training can be reduced.

K.3 Training about psychosocial support in the community

MSF presence in the community is vital for psychosocial projects. The social package materialises through community work. It is important to create an environment that enables traumatised survivors to reconnect with their environment. Community presence also ensures improved understanding about *the clients*' needs.

Community-work training should be given to both community workers and counsellors. Counsellors should be exposed to this training to ensure that they see their job as a combination of psychological and social tasks.

Preferably, the local people give the training. However, in most cases the mental health expatriate has an instrumental role. An initial training lasts two weeks. Formal and on-the-job training should continue regularly during the project.

Knowledge

Information about the programme and its services should be provided during its course. Specific topics such as *stress*, mood problems and other major issues such as suicide or substance abuse in the community as identified in the assessment should be discussed. Local self-help mechanisms such as peer support should be explored and if relevant extended with other techniques. Issues such as confidentiality, advocacy and monitoring should also be addressed.

Skills and attitude

Practical issues such as *community mobilisation*, planning and making health topic presentations and organising distraction events should be covered. Special attention should be given to the design of education material such as leaflets and posters.

Working in the community confronts the workers with immediate problems that need intervention. Therefore, support skills such as listening, compassionate attitude, knowledge of how to deal with emotions, provide or mobilise social networks, crisis intervention, protect from further harm, case identification and referral should be part of the training package.

Community exposure

Some exposure to problems in the community should be included in the training. Participants can learn to compose a social map of community resources, and to introduce themselves and the programme to the community and its leaders. They can practise data-collection methods such as in-depth interviews and focus-group discussions.

K.4 Counsellors

Training for counsellors is mainly technical, providing supportive, emotional counselling skills. A cross-cultural training methodology, based on experiences in various parts of the world, has been developed. To ensure continuity in the development of counsellors, external mental health professionals trained on capacity-building of local counsellors should provide formal training in close cooperation with the mental health expatriate.

As with training programmes for community health workers, the curriculum for counsellor training cannot be designed in advance. The initial training must cover the following topics: introduction and evaluation of the training, the work of the counsellor, communication and interviewing, problems of the people in counselling, how to help, personal growth, physical exercises and counselling as profession.

Initial training should last two weeks and should continue with on-the-job training and clinical supervision. Formal follow-up training should be conducted at least once a year.

Tbl. 19: Overview of psychosocial training curricula

Target group (length of course)	Proposed general curriculum
Medical staff (expatriate, national) (two or three days with follow-up, given preferably by national staff)	Knowledge • Confidentiality • Psychological consequences of violence • How to explain (psycho-education) • What others should do about it (local coping mechanisms) • How to help yourself (self-help techniques) • Case identification, and • Referral options Attitude and skills • Listening and communication • Dealing with emotions • Crisis intervention

Community workers and counsellors (two weeks, given by expatriates)	Knowledge • Programme and its services • Specific topics: *stress*, mood problems and other major issues • Self-help mechanisms • Confidentiality, advocacy and monitoring Skills and attitudes • Programme and self introduction • Listening and communication • *Community mobilisation*, planning and making health-topic presentations or organising distraction events • Design of education material • Crisis intervention, relaxation, dealing with aggression and conflicts • Case identification Community exposure • Community problems, social map of community resources • Programme and self introduction programme introduction
Counsellors (two weeks, given by external trainer volunteers)	• Introduction and evaluation of the training- Confidentiality, advocacy and monitoring • The work of a counsellor • Listening and communication • Interviewing • Problems of *the clients* • Counselling: how to help • Personal growth • Physical exercises

K.5 *Clinical supervision*[174]

In mental health organisations the term *clinical supervision* refers to professional guidance by a senior mental health professional. Professional guidance does not imply a hierarchical relationship between supervisor and supervisee.
Clinical supervision is a complex activity that has several functions. It is a way of giving additional education; promoting the quality of work, ensuring the follow-up of specific MSF protocols and offering emotional support to the supervisee.[175]

Clinical supervision benefits *the clients* because it increases the knowledge, improves skills, and matures the counsellor's attitude (allowing him or her to become more independent). MSF nearly always works with national, lay (trained) counsellors. The *clinical supervision* often has a strongly educational and supportive purpose.

Three categories of problems are discussed in clinical supervision.
1. Case-concept: difficulties in understanding/approaching the case.
2. Emotional impact of the case on the counsellor:
    - Empathic enmeshment (too much empathy eg over-involvement, no distance, feelings of helplessness, lack of progress, anger in therapists)
    - Empathic repression (mechanical, distanced approach, lacking empathy, disappointment, helplessness and guilt feelings)
3. Other problems (eg handling aggression in a patient, ethical problems).

Preconditions for *clinical supervision*

The clinical supervisor must be a mental health professional, trained to supervise and experienced in the treatment of traumatised people.

A contract must be drawn up specifying goals, dealing with psychological problems in the staff, duration and frequency of sessions, costs, payments and agreement about the evaluation of the supervision. Basic rules include confidentiality, the usual exceptions to this (danger to oneself or others) but also a procedure in case the work of the supervisee is inappropriate and/or not in line with professional ethical standards. In this case the supervisor has the responsibility to protect *the clients*, terminate the supervisee's client contact and refer to a different counsellor. The incident may lead to line-management disciplinary actions such as warnings or even contract termination, but this is outside the scope of the clinical supervisor's duties.

Mental health professionals are scarce in settings where MSF works. Though in other organisations clinical supervisors are contracted from outside the organisation, in MSF programmes the Mental Health Officer undertakes the *clinical supervision*. The combination of being clinical supervisor and manager (or at least being perceived as such) may be difficult to manage for both the counsellor and the Mental Health Officer. In these situations the contract between clinical supervisor and counsellor(s) should specify the boundaries of the supervision. For instance, limit the focus of the clinical supervision to case concept, leaving the initiative to bring up the emotional impact problems to the supervisee.

Safe environment

It is the clinical supervisor's duty to create a safe environment. This entails more than guaranteeing confidentiality. During the *clinical supervision* sessions, the supervisee needs to feel protected against personal attacks and unconstructive criticism. The supervisor facilitates exploration rather than questioning or lecturing. Safety and respect are shown through cultural awareness: for instance not being alone with a female supervisee as male supervisor if this is culturally inappropriate.

Supportive attitude of the supervisor

The attitude of the clinical supervisor towards the supervisee is similar to the attitude desired for a supervisee towards his or her client. As a model the clinical supervisor also needs to be open to criticism and show self-criticism. After all, the *clinical supervision* session is also part of a continuing learning process for the supervisor. Model behaviour is even more important in cultural environments unfamiliar to the clinician. Extra effort should be made to understand what the supervisee means, the importance of certain habits, behaviours etc.

Motivation

At the start of the supervision the supervisee will be motivated to engage in the learning process. If the supervision develops well, the supervisee's motivation will grow.

During supervision the supervisee should not focus on keeping up the appearance of knowing everything, being mentally balanced and in control of his or her own behaviour. Supervisees must be willing to challenge their practices, to acknowledge problems with their skills, and also examine and evaluate their attitudes, feelings, and emotions.

Forms of supervision

One-to-one supervision is often case-concept oriented. The privacy may also stimulate the supervisee to bring up the emotional impact of a case. In areas of mass conflict the privacy of individual clinical supervision can also be necessary to ensure safety and security of clients and/or the counsellors themselves. Mental Health Officers who are new in the project can start with individual clinical supervision as a way to familiarise themselves with staff, the project and the culture.

Group supervision usually takes place in small groups of four to six counsellors with a group of people who feel comfortable with each other. Hierarchical differences should be avoided. Group supervision allows mutual support, a larger variety of reactions, and role-play. The clinical supervisor facilitates the structure, the process, and guarantees safety. The group members help the supervisee to answer the supervision question.

Process of *clinical supervision*

Clinical supervision often resembles what is happening in the therapeutic process. Creating a structure, focusing on a problem, skills such as listening, making summaries, making an analysis, setting objectives, as well as the constant process of evaluation are also undertaken in *clinical supervision*. The supervisor can model through his or her supervision almost all aspects of a therapeutic process and therapist skills and attitude. The process of group *clinical supervision* is not very different from that of individual *clinical supervision* except for the management group dynamics. The framework for the process of *group clinical supervision* is frequently used in the field and is easily adapted to suit different contexts. It is also easily applied to the process of individual *clinical supervision.*

Clinical supervisor introduction

The supervisor explains to all the group members the background and goals of *clinical supervision*, his or her role, the non-hierarchical relationship, the role of the group, the position of supervisee, the duration, confidentiality including the exceptions to it: danger, malpractice, ethical breaches (such as discussing client details with non-relevant others), and the expected outcomes. The group can set its own rules regarding communication within the framework discussed. The supervisor manages the agreed objective, principles and rules.

The supervision question

The session starts with the supervisee question. What is the focus of the supervision (which type of problem)? It should be one question that is specific (if possible) and understood by all. In this stage the group can ask questions for clarification only.

Case presentation

The supervisee must be able to present ***the*** *client's* story in a coherent manner leaving out information that is not relevant to his or her question. The presentation should last a maximum of 15 minutes (preferably less). It often contains element such as the genogram (drawing of relevant relatives network), normal life, previous (traumatic) experiences, the (trauma) history, personal reactions during and after, *the client's* own explanation of the problem, assistance during and after, coping strategies, *resilience* mechanisms, and what *the client* wants from therapy.

Case concept and intervention

The supervisee is invited to give a conceptualisation or theory of *the client's* problem in relation to this supervision question. The theory can include a 'diagnostic' label using the six categories:

- Practical problem
- Lack of skills
- Symptom/ complaints/ behaviour related to traumatic experiences or extreme *stress,*
- Overwhelming emotions
- Inner problems
- Psychiatric problems.

Diagnostic systems such as *DSM* IV and ICD 10 (WHO International Classification of Diseases, version 10) can also be used.

The supervisee continues to explain the focus, objectives and methods of the therapeutic intervention (including how it was done, results, reactions of *the client*) and client's understanding of the problem.

Questions from the group

After the uninterrupted presentation the group asks clarifying questions. The clinical supervisor should ensure that exploratory questions (to gain additional information outside the presented frame) are asked only when there is full understanding of the presented information. It is important that the supervisor manages this well. Inexperienced counsellors often have difficulty listening and start to make immediate interpretations and give advice too early.

Supervisions with lay counsellors often focus on the case presentation only. Therapeutic interaction is discussed marginally and only to give emotional support and make the supervisee aware of the effect of his or her behaviour and communication style on *the client.*

Counsellors with sufficient skills, substantial experience and proven ability of self-reflection or those with a professional mental health background, may probe further by analysing the supervisee's own feelings and interactions with *the client.*

Therapeutic interaction

The clinical supervisor who decides to analyse the therapeutic interaction asks the group to take on different perspectives when reviewing the case and the supervision question.

The counsellor perspective: this may lead to issues related to the supervisee's personal style and methods, capacity for establishing a relationship, respect for *the client* (and his or her self-image), his or her own reactions towards all that happens in the counselling, what is thought before during or after, and the understanding of this. Sometimes personal problems of the supervisee are brought up. The clinical supervisor is responsible for safe management of the supervisee. Sometimes, the clinical supervisor postpones the issue until individual *clinical supervision.*

Identification with *the client* as a person. After reflection, group participants are invited to share what they feel about the case from the patient's perspective. Sometimes this is sufficient to stimulate combined reflection in such a way that the supervisee's question is answered, the emotion reduced or given a new perspective.

An important topic to discuss when taking the position of *the client* is whether **the client** understands what is going on. Often problems in counselling such as lack of motivation or even drop-out are caused by a poor introduction of what is to be done, *the client's* understanding of the problem and of the intervention. Realistic expectations are important but so is ensuring that *the client's* complaints for which treatment is sought actually match the supervisee's goals and intervention. Such questions are instrumental in the success of the counselling support and need to be discussed with the supervisee. If there is a translator present the importance of his or her presence should be considered here.

The process of identification may continue by taking the perspective of the supervisee as counsellor. It is not necessary to identify with the supervisee as a person, only with the position of the supervisee as a counsellor. At this stage the group is given the opportunity to reflect on the cognitive and emotional aspects of the case, as if it were their own. The group shares reactions on the question: 'how do you feel in this position' and NOT on 'what would you do'? Participants can also add emotions they experienced themselves when providing support in a similar case. The supervisee has often gained so much that the *clinical supervision* can stop at this stage.

The process can be continued from the supervisor's perspective. This gives the other participants and the supervisor the opportunity to give advice based on their own experiences. The clinical supervisor should protect the supervisee from negative, unconstructive criticism. The discussion focuses on the question: What would you do in this case?

Supervision interventions

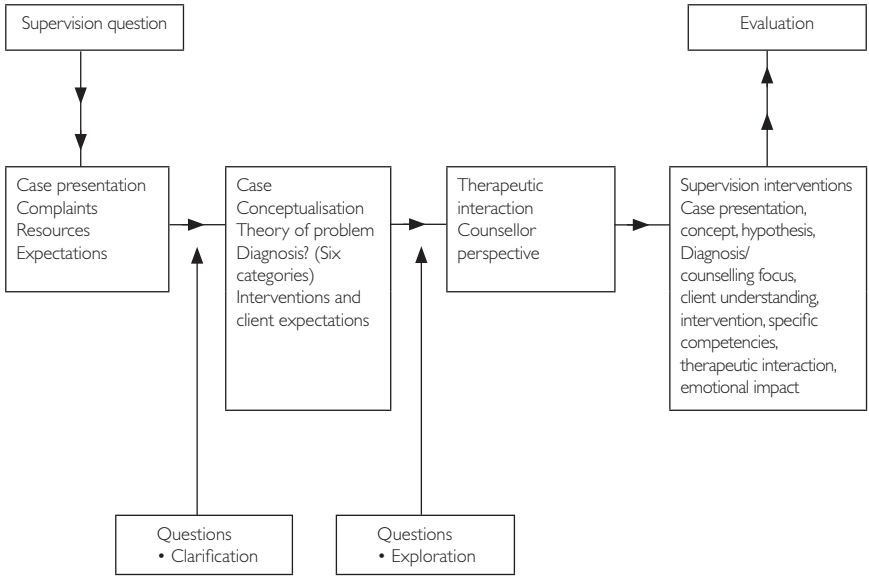
Once the case has been fully presented and group participants have had opportunity to ask questions, they are then invited to give their comments, formulations, hypotheses, advice and suggestions regarding the supervision question.

Evaluation

Once participants have had the opportunity to give their feedback the supervisee is invited to evaluate their contribution. The supervisee knows *the client* best and is therefore able to decide which recommendations may be most helpful in respect of the original supervision question. The supervisee can share with the group if he or she will incorporate the feedback/advice into the management of the case.

If supervision has not been helpful for the supervisee then an opportunity can be made to discuss the case in a future supervision (individual or group).

Fig. 4: Overview process of clinical supervision



General points about supervision process

What is supervised?

The most important issues to supervise:

1. The skills of psychosocial work. Some examples: communication (questions of exploration, summaries), capable of making contact (connecting to people), using understandable language, able to make logical hypothesis about the case, being able to test the hypothesis (questions outside frame of client's reference), is he or she able

to find a good rationale that is understandable and acceptable to *the client,* master special treatment techniques (eg mirroring in counselling, reinforcement techniques in behaviour therapy)?

2. Is the case-conceptualisation sufficient? Does the supervisee understand the case, does he or she have enough knowledge?
3. The professional role and boundaries: what is the personal style of the therapist, are theories and methods used in a flexible way, how are questions and demands of *the client* handled (eg visiting someone's home)?
4. Emotional sensitivity to the patient and to him or herself: are *the client's* expectations recognised and respected, does the counsellor have an eye for culturally sensitive aspects (eg shame, honour), does he or she monitor his or her own feelings closely in therapy, is there a balance between empathy and distance, is empathic enmeshment or repression recognised, does he or she shows signs of emotional impact or burn-out?
5. Self-evaluation: it is most important for a counsellor to recognise the limits of his or her competence (in relation to his or her training, to *the client's* needs, in the given situation), to what degree is the supervisee dependent on the comments of the supervisor, is there an evolution (eg is he or she growing more autonomous/ confident?). this, does he or she recognise progress and the effects of his or her interventions?

<u>Supervisor interventions are intended to:</u>

- Monitor and evaluate the supervision process and counsellor's skills. Regular comments are made to the group and the supervisee (one-sided) to ensure safety, an appropriate process and that the supervision question is addressed.
- Instruct when the competency level is low and advise when the supervisee's self-reflection is sufficient to explore new possibilities.
- Model the way the supervisee formulates, reflects, self-evaluates as well as his or her attitude.
- Facilitate mutual reflection on the case and counselling process, stimulate non-judgmental self-evaluation of therapeutic behaviour.
- Support and share with empathic attention, encouragement, constructive confrontation.

Role-playing can also be very instructive. The supervisee role-plays certain parts of the case in the position of counsellor or as client.

L MONITORING AND EVALUATION

It is difficult to measure and monitor the effectiveness of psychosocial programmes[176] in emergencies for several reasons:

- Conventional monitoring and evaluation criteria are not applicable or valid in changing, unpredictable and unstable contexts. Field reality challenges conventional evaluation criteria such as determinants of effectiveness. Documentation and systematic measurement of outputs is often not possible in emergencies.
- Epidemiological evaluation models advocated by Western psychiatry are insufficient to prove the effectiveness of humanitarian actions.[177] For example, evidence-based psychology and medicine use effectiveness or impact as justification for psychosocial interventions, but epidemiological data does not tell us anything about the fundamental motives for humanitarianism: compassion, empathy and a sense of justice.
- The cultural differences in the perception of trauma, expression of suffering, and the mechanisms for coping make it difficult to generalise from one context to another.[178]
- Culture-specific models and instruments to evaluate improved *resilience* require extensive time and resources and a long-term investment.

As a consequence, most projects depend on *process indicators* and qualitative research outcomes to determine the effectiveness of their activities.

Since 1990, MSF and other organisations have progressively improved their evaluation models and criteria for psychosocial interventions through evidence-based research[179] and evaluating techniques.[180]

L.1 Acute emergencies

Acute emergency contexts change quickly. There is insufficient time to determine cross-culturally validated *outcome* (impact) or *output indicators*. *Process indicators* (measuring activities) are therefore used for programme planning and monitoring. The relationship between acute mental health interventions and positive treatment *outcome* is well established in other settings. For instance, administering a psychotic client with anti-psychotic drugs is proven to be effective in many settings.

Outpatient departments

General clinical monitoring in the health services should include the registration of psychiatric disorders including referral/treatment, and stress-related complaints or disorders. Referrals should be registered to monitor cooperation between the physical and mental health/ psychosocial services.

Mental health and psychosocial services

A standard mental health data tool is available for programme monitoring. The following quantitative *process indicators* are registered in acute emergencies: demographics, main presenting complaint, counselling focus (six categories), number of sessions, status at last visit, and referral.

The appropriateness of psychosocial support (qualitative indicators) given by the counsellors is monitored through *clinical supervision* and case discussions. General issues such as humane treatment, decent waiting areas, a sense of privacy, compassionate attitudes of health staff, understanding of emotional suffering and confidentiality are observable *process indicators* in an acute emergency.

Outreach

The main tasks of outreach services are to identify vulnerable individuals and refer them to health or other services accordingly. In addition, outreach activities should provide information and assist with the case identification.

Tbl. 20: Overview of a monitoring system in acute emergency psychosocial care

Process indicators	Source of verification	Monitoring/evaluation tools
• Number of *stress*-related complaints and disorders in outpatient service	• Outpatient medical monitoring	• Health monitoring file
• Number of psychosocial and psychiatric clients seen	• Psychosocial monitoring tool	• Client files • See Mental health Standard Data Tool
• Appropriate cross-referrals by physical, mental health, and outreach services	• Outpatient department medical monitoring • Psychosocial monitoring tool	• See health monitoring file • See Mental health Standard Data Tool [where?] • Community outreach file (areas overed, types of cases identified, intervention, number of people attending)
• Adequate intervention	• Observation • Interviews	• Regular *clinical supervision* • Case discussions • Client interviews
• Respectful treatment of the individual	• Observation • Interviews	• Eg humane treatment, attention to emotional suffering of *the client*, decent waiting areas, a sense of privacy, compassionate attention, understanding of emotional suffering, confidentiality

L.2 Chronic crises

Psychosocial projects in chronic crises combine emergency and development objectives, activities and strategies. In principle, psychosocial projects in chronic crises need to develop cultural-specific and locally defined outcome, or *output indicators*. Often, a standardised and locally validated symptom or functioning checklist is not available. To create one, the local people need to be consulted and further research is required. This increases proximity and allows for fine-tuning of the project to meet clients' needs. A promising methodology is described by Bolton.[181]

Output indicators

Validated quantitative *output indicators* should be defined during project assessments, and modified during implementation of a programme as knowledge about the local community and context increases.

Interventions focusing on *functionality* improvement are often difficult to evaluate with symptoms only. Therefore, locally developed *outcome* or *output indicators* should be developed with the assistance of the local people. Through focus group discussions and *key-informant interviews, the client* perspective of the psychosocial problems can be researched. It is helpful to describe the locally defined outcome, or *output indicators* for both the *'psycho-'* and the *'socio-' component* in terms of *functionality* and coping. The Mental Health monitoring guideline accompanying the data tool describes how to use both client- and counsellor-rated scoring.

Output indicators are described in qualitative and quantitative terms using local individual and group perspectives. The following information can be included:

- Complaint and functional rating by client at first visit compared to final visit.
- Local signs and symptoms of trauma-related dysfunction and pathology (can be done in local terms of physical, mental, social, spiritual and moral health),
- Local terms used to describe the improvement of psychosocial functioning or the reduction of disability for instance in terms of improvement of social contacts, ancestors are resting in peace, decreased worrying, improved physical activities, improved ability for self-care and care for others, improved self-control over daily activities (eg self-sufficiency in resources), reduced number of conflicts, improved family relationships, and increased number of daily activities or social contacts.
- Knowledge improvement, for instance on *stress*-related behaviour and familiarity of psychosocial services as a result of social and educational activities.

The appreciation of services as qualitative *output indicator* is measured by means of structured interviews focusing on *the client* perspective. The validity of the questionnaire depends on the baseline knowledge that the team has of what is expected from the services.

Process indicators

It may not always be possible to develop locally defined *outcome*, or *output indicators* for instance due to security constraints, lack of human resources, insufficient educational level of the staff or an inexperienced expatriate or project team.

In these circumstances only *process indicators* are used to describe the effectiveness of the programme. *Process indicators* cover only the activity level of the project. In other words the decision to use *process indicators* limits future programme evaluation to the activities level. Moreover, unlike in emergencies, the assumptions between the indicators and the effect on the psychosocial condition of *the client* are less evident. For example, it is not certain whether *cognitive behavioural* techniques that function in Western cultures have similar positive effects in non-Western societies.

Process indicators are described both in qualitative and quantitative terms. To monitor quantitative indicators MSF uses the Mental Health Standard Data Tool. Qualitative indicators can further describe the extent to which activities affect the condition of *the client* or community, and include: quality of services operationalised as sufficient client-contact time, file-keeping, confidentiality, training and knowledge of counsellors, level of case discussion etc; improved restoration of human dignity, client satisfaction (*'psycho-' component*), proximity to target population, for instance presence in the community; connectedness, quality of the community network such as contacts with other NGOs, chiefs, leaders and traditional healers (*'socio-' component*), and a specific indicator for advocacy action.

Methods of obtaining data can include:

- Exit interview, where clients leaving the counselling session are interviewed on certain topics (eg satisfaction with services, reduction of complaints, increased functioning etc)
- Drop-out analysis, in which a randomly selected number of people of the group who did not follow up on their appointments are interviewed about their reasons for dropping out, and their current level of symptoms, complaints, etc is recorded.

M HUMAN RESOURCES MANAGEMENT

The project management is responsible for recruiting national staff (counsellors and community health workers). Selection criteria such as age, gender distribution and professional background should be developed locally. Staff selection should not be limited to those with a professional background. Other criteria are equally important, such as: attitude (eg the applicant should be compassionate), interpersonal skills (eg good communication), interest in and motivation for the work, previous counselling experience, training, and the ability to analyse, plan and intervene when faced with difficult or complex cases.

Tbl. 21: Criteria for staff recruitment

	Criteria
Expatriate	• Professional background (Eg psychiatrist, psychotherapist, clinical and counselling psychologist, social worker, social psychiatric nurse) • Work experience (preferably clinical, community-based) • Attitudes/expectations of humanitarian work
National	• Professional background • Attitudes and compassion • Interpersonal skills • Level of interest and motivation for the work • Previous counselling experience and training • Ability to analyse, plan and intervene when faced with difficult or complex cases (tested through the use of three short case studies) (explain)

M.1 Job descriptions

The job descriptions of all psychosocial workers must contain an explicit statement about the obligation to respect the confidentiality of the counselling relationship.
In the job description of expatriates or national staff it seems logical to divide tasks along the lines of the *'psycho-'* and the *'socio-' components* of the programme. However, this may result in a distinct separation between the two activities. Clinical people should not feel responsible only for the Psycho-component and community people only for the 'socio-' component. Such separation can seriously reduce the success of the project. To avoid this problem it is advisable to combine clinical and community components in the job descriptions.

M.2 Staff support

Members of national staff (including management, translators and drivers) are often traumatised themselves. Additional daily confrontation with clients' problems, traumatic stories, sadness and loss are demanding and potentially draining. This is especially the case when faced with clients who have little chance of significant improvement such as terminally ill clients. Therefore, the risk of professional burn-out is high among national staff.

Signs of burn-out can be cognitive/emotional, physical or behavioural[182] and include:

- Frequent bad moods
- Feelings of anxiety or generalised fear
- Constant tiredness
- Undiagnosed physical complaints
- Hyperventilation
- Increased consumption/use of alcohol, cigarettes, drugs
- Difficulty in relaxing or concentrating
- Apathy
- Aggression
- Constant intellectualisation
- Cynicism
- Sleeping problems
- Excessively demanding behaviour (involving for example salary or working conditions)
- Constant talking

Each project must have a burn-out prevention policy and its own 'Helping the Helpers' system for national staff. Burn-out management is essential and mainly focuses on prevention. It involves:

- Task management: job rotation of *'psycho-'* and *'socio-'* tasks, and case diversification;
- Professional growth: *clinical supervision*, and continual training;
- Team management: team work, regular team meetings, regular social events, planned holidays, and regular pay;
- Psychological support when required: a structure of peer support, and a formalised 'Helping the Helpers' system.

Someone preferably outside the organisation should provide psychological support to the national staff. However, when this is not possible the expatriate mental health worker should provide the psychological care.

Expatriate staff have access to two forms of care: team members can give social and technical support. Specific technical advice is available from the medical line manager and technical advisors from the headquarters. If the mental health expatriate needs personal support, the organisation's psychosocial care unit can provide the care.

Tbl. 22: Elements of staff support

Staff support	Content
National staff: burn-out management	• As a part of the job (combination of *'psycho-'* and *'socio-'* tasks, case diversification), • Professional growth (group and individual *clinical supervision* training), • Organisational structure (team work, regular team meetings, regular social events, planned holidays, regular pay)
National staff: Helping the Helpers	• Peer support • Psychological support (preferably external) • Psychosocial Care Unit (Headquarters)
Expatriate staff:	• Team work • Technical support • Psychosocial Care Unit (Headquarters)

N LOGISTICS

Medical as well as mental health projects depend heavily on logistics. Transport, communication and security management are important, especially in projects serving a large group of people.

The creation of a private space for counselling is another area in which logistics becomes involved in psychosocial programmes. Understanding what people with psychosocial problems need (eg confidentiality, privacy, and quiet rooms) is essential. The counselling space should preferably be located within the medical facilities.

In emergency contexts special attention should be given to people who are severely ill. Both a resting area (day care) and a special waiting area for clients are needed. Community activities, distraction or education activities should also be arranged.

O DEFINITIONS

Adaptation in its strict definition adaption is any evolutionary change in the characteristics of an organism that makes it better able to survive in its environment. In mental health adaptation complaints refer to all mental distress and complaints that are caused in an individual due to a change in the person's internal (such as *illness, disabilities) or external conditions.*

Avoidance is a common reaction following a traumatic experience whereby an individual forgets, ignores, denies information or painful recollections about the traumatic event. *Avoidance* is generally a temporary response and a normal part of *the coping process.* If it becomes a habitual reaction or permanent state, *avoidance* can impede both *the coping process* and healing.

Brief therapy or **brief psychotherapy** 'is an umbrella term for a variety of approaches to psychotherapy. It differs from other schools of therapy in that it emphasizes (1) a focus on a specific problem and (2) direct intervention. In brief therapy, the therapist takes responsibility for working more pro-actively with the client in order to treat clinical and subjective conditions faster. It also emphasises precise observation, use of natural resources, and temporary suspension of disbelief to consider new perspectives and multiple viewpoints.

Rather than the formal analysis of historical causes of distress, the primary approach of brief therapy is to help the client to view the present from a wider context and to use more functional understandings (not necessarily at a conscious level). By becoming aware of these new understandings, clients will de facto undergo spontaneous and generative change.

Brief therapy is often highly strategic, exploratory, and solution-based rather than problem-oriented. It is less concerned with how a problem arose than with the current factors sustaining it and preventing change. Brief therapists do not adhere to one "correct" approach, but rather accept that there are many paths, any of which may or may not in combination turn out to be ultimately beneficial'

Client refers to someone who has been admitted into a mental health or psychosocial programme to receive care, and is involved in a therapeutic relationship with a counsellor/ mental health practitioner. *The client* is not called a patient (as in the medical setting) because psychosocial or mental health support is not necessarily restricted to medical disorders.

Clinical supervision is a contracted activity; it is a shared reflection on a client case between the clinical supervisor, often the expatriate, and the counsellor (also referred to as the supervisee). The focus of reflection is on the supervisee's work in order to give the supervisee a more cognitive, more emotional and more independent perspective on his or her client's case.[183]

Cognitive behavioural therapy is an action-oriented form of psychotherapy that assumes that maladaptive, or faulty, thinking patterns cause counter-productive behaviour and 'negative' emotions. Treatment focuses on changing an individual's thoughts (cognitive patterns) in order to modify his or her behaviour and emotional state, and involves a collaborative effort between counsellor and client. Clients are taught to view automatic thoughts (maladaptive cognitions) as hypotheses subject to empirical validation, rather than as established facts. Therapy gives clients an active role in their healing process and empowers them by providing them with skills and experiences that create adaptive thinking.[184] *cognitive behavioural therapy* is typically administered in an outpatient setting in either an individual or group session. It is currently popular because of the relatively low number of treatment sessions and its (proven) efficacy.

Community mobilisation is a process that begins a dialogue among members of the community to determine who, what, and how issues are decided, and also to provide an avenue for everyone to participate in decisions that affect their lives.

Coping process is a way in which the individual (or group) deals with situations by managing them adequately without necessarily mastering them completely.[185] After a traumatic experience, new information needs to be processed, assimilated and integrated into a new 'worldview'. According to cognitive processing theories the two most common elements of *the coping process* are *intrusion* and *avoidance*.[186]

Counselling and Testing combines psychosocial support and the provision of information to people who are considering being tested for HIV/AIDS (pre-test) or those who have been tested and need to know the result (post-test). If *the client* is tested positive the service is often the first point of entry for a client into an HIV/AIDS programme. The decision to go for testing is always voluntary.

Critical incident debriefing is a specific technique designed to assist others in dealing with the physical or psychological symptoms that are generally associated with trauma exposure. Debriefing allows those involved with the incident to process the event and reflect on its impact.

Depersonalisation is feeling strange, 'not oneself' or disconnected from one's surroundings. It is a feeling of watching oneself act, while having no control over a situation.

DSM: Diagnostic and Statistical Manual of Mental Disorders is the standard international diagnostic classification system and coding reference for mental disorders. It contains categories, criteria and descriptions designed to assist the process of diagnosing individuals with mental disorders. The DSM is intended for use by individuals who have appropriate clinical training.[187]

Diaries are qualitative tools used to validate information from interviews concerning such matters as the prevalence of symptoms and reduction of social contacts.

Disassociation is a psychological coping mechanism that involves the disruption of cognitive functions that are usually integrated, such as consciousness, memory, identity, or perception of the environment.

Disease refers to the way practitioners recast *illness* in terms of their theoretical models of pathology.[188]

Drop-out analysis involves the random selection of a number of people who previously received counselling support but who did not return follow-up appointments. This is followed by an interview about their reasons for drop-out and current level of symptoms and complaints.

Emotion-focused coping is a process where tension aroused by a traumatic experience is reduced through intra-psychic activity such as denial or changing one's attitude. It is the opposite of problem-focussed coping.

Emotional numbing is the condition in which the person has difficulty experiencing emotions – both positive such as happiness and love, and negative, such as anger and sadness. People often complain about not feeling anything.

Functionality is a dynamic term that refers to physical survival, and psychological and social performance. It is defined in close connection with other parts of the local society, the context and the prevalent culture. Unlike indicators in post-crisis programmes, functionality is described in terms of (long-term) survival and coping, not in terms of wellbeing.

ICD-10 mental health disorder classification system designed by the World Health Organization.

Illness refers to *the client's* perception, experience, expression and pattern of coping with symptoms. Because language, *illness* beliefs, personal significance of pain and suffering and socially learned ways of behaving when ill are part of that process of mediation, the experience of *illness* (or distress) is always a culturally shaped phenomenon.[189]

Impact indicators Impact indicators are similar to SMART objectives (Specific, Measurable, Achievable, Relevant and Time Bound) in they are specific, measurable statements that describe what the successful outcome will look like.

Insomnia is the inability to fall or stay asleep. *Insomnia* can be classified as transient (short term), intermittent (on and off) and chronic (constant). Chronic *insomnia* is more complex and often results from a combination of factors, including underlying physical or mental disorders.

Intrusion is a process whereby a person unconsciously re-lives a traumatic experience through intrusive and emotionally upsetting recollections and symptoms such as

nightmares or flashbacks. It is a normal part of *the coping process* and enables a survivor to re-evaluate and re-define his or her worldview. If the intrusions persist for longer than three months it is an indication of a mental disorder.[190]

Key-informant interview is a qualitative tool for acquiring detailed information about client perspectives. There are several types of *key-informant interviews* including: in-depth, individual or group and case-study interviews. *Key-informant interviews* are obligatory in psychosocial assessments. Several formats such as general interview, psychosocial consequences of violence and coping mechanisms can be used.

Logical framework is a management tool mainly used in the design, monitoring and evaluation of international (development) projects. It is useful to distinguish between the two terms: the *logical framework* Approach (LFA) and *logical framework* (LF or LogFrame). They are sometimes confused. The *Logical framework* Approach is a project design methodology, the LogFrame is a document.

Mental health disorders are disturbances in the biological and/or psychological functioning. They are diagnosed according to a standard system of criteria that allows a generally accepted definition of the condition. The most frequently used diagnostic systems are the *DSM IV*[191] and *ICD-10*.[192]

Mental health problems are culturally defined. Consequently various categorical systems can be described. However, it is universally accepted that mental health problems are medical.

To normalise is to become normal or return to a normal state.

Outcome indicators measure, in relation to a stated project purpose, the results of the combined project activities including those of others.[193]

Output indicator measures the products of a program's implementation or activities. These are generally measured in terms of the volume of work accomplished, such as the amount of service delivered, number of staff hired, systems developed, sessions conducted, materials developed, policies, procedures, and/or legislation created.

Problem-focused coping is a style of coping in which a person or group focuses all energy and resources to solve the *stress*-creating problem. It is a practical approach, and the opposite of *emotion-focused coping.*

Problem tree is a core tool in the *logical framework approach.* The purpose is to identify the main problems and establish the cause and effect relationships between these problems (so that these are sufficiently addressed in a project design). Perform this exercise with a group of different stakeholders.

Process indicators (sometimes referred to rather confusingly, as 'performance indicators') are readily identifiable as the sorts of indicator that can be 'ticked off the list when you've done them'. The main problem with *process indicators* is that they do not necessarily tell you if you are meeting the overall objectives that led you to carry out the process.

Psychological package Psycho-social illness is the result of a disturbed relationship between psychological and social effects. *'Psycho-'* refers to psychological, that means problems of behaviour or needs of personal emotions, thoughts and feelings such as fear and despair. 'Social' refers to the interaction between the individual and a larger group such as family, community and/or its environment (physical, moral, spiritual). That means, for instance, problems or needs that are related to displacement, refuge, suppression, poverty, domestic violence, family, child abuse etc. Social problems can easily affect the psychological status of the individual. Psychological problems can affect the individual's social wellbeing.[194]

The 'psychological package' is the part of a psychosocial programme that focuses directly or indirectly through the training of health staff on the problems of behaviour or personal emotions (eg fear, despair), and thoughts.

- *Psycho-' component* **f**acilitates the reconnection of the affected individual to his or her environment, community, and culture. It consists of psychiatric support, counselling, training and advocacy.
- *'Socio-' component* stimulate the re-integration of traumatised people and to facilitate coping among large groups. It consists of practical support, community education, mobilisation, and activities.

Psychosis is a mental disorder sufficiently severe to result in personality disorganisation and a loss of contact with reality.

Psychosocial questionnaires are structured interviews used for the large-scale appraisal of psychosocial needs in closed (camp) and open (community) settings. They provide insight into potential traumatic events through exposure or witnessing, the psychological impact, the standardised Impact of Event Scale (IES),[195] the prevalence of specific health complaints and *stress* (General Health Questionnaire 28, GHQ 28) and some questions on knowledge, attitude, and self-help mechanisms.[196]

Qualitative assessment instruments provide subjective data about individuals or groups.

Quantitative assessment instruments provide objective data about individuals or groups.

Rape is defined as an act of non-consensual sexual intercourse using force or threat of force or punishment. It covers penetration of vagina or anus with penis or other object

or penetration of the mouth with the penis of the perpetrator. Any penetration without consent is considered rape. Efforts to rape someone that do not result in penetration are considered attempted rape or sexual assault.[197]

Resilience is the capacity to restore a new balance when the old one is challenged or dysfunctional. *Resilience* is defined through physical, mental, social, spiritual and moral systems. The popular translation of *resilience*: 'the ability to bounce back', is inadequate because after traumatic experiences a new balance (or worldview) needs to be established, rather than old ones restored.

Self-completion questionnaires are quantitative instruments containing short open-ended questions. They are used to obtain information about sensitive subjects quickly.

Sexual violence is a form of gender-based violence, which includes rape or attempted rape, sexual assault, and child sexual abuse. It is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work.'[198]

Social package or *'Socio-' component* see 'psychosocial package'.

Somatisation involves the translation of emotions such as distress or sadness into physical signs and symptoms. Somatic symptoms serve as cultural idioms of *stress* in many ethno-cultural groups and, if misinterpreted by the mental health specialist, counsellor or medical professional, may lead to unnecessary diagnostic procedures or inappropriate treatment.[199]

The Stress Model is used to explain how social environment influences personality development and the origin of mental and other disorders. Serious perturbations, or stressors, disturb an individual's psychological equilibrium and cause him or her to initiate coping activities to restore mental health. Mental disorders and distress may arise from the interaction between the stressor (eg a life-changing event) and the individual who perceives the event as 'stressful', threatening, or uncontrollable, and worsen in the absence of adequate social support and other coping responses.[200]

Traumatic stress and Stressful events have not yet been distinguished successfully. The qualification of an event as being traumatic or stressful is bound individually. Events that do not involve extreme *stress* (immediate survival) can be perceived as challenging by some or as threatening by others. Traumatic stress is often associated with wars, captivity, torture, disasters and racial discrimination.[201]

Structured or checklist observation is a qualitative tool for rapidly acquiring information about clients and includes: direct observation, walking around to take stock and clinical observation. This is a good way of assessing the accuracy of information given in interviews.

Stupor is defined as mutism and akinesis: a client appears alert because of eye movements, but is unable to initiate speech or action. Consciousness is clouded and attention to environmental stimuli is diminished. Anxiety and neurological symptoms are absent; respiration, pulse and blood pressure are stable.

Supplementary feeding programme provides nutritional support (in the form of daily wet rations or weekly dry rations) to moderately malnourished individuals.

Symptom checklists see **psychosocial questionnaires**.

Therapeutic feeding programme provides intensive medical and nutritional support to severely malnourished individuals. Treatment is given under clinical supervision over a two-week period.

Transcultural psychiatry combines anthropological information about culture and social groups with epidemiological and psychiatric studies of the aetiology of health and *illness*. It employs the anthropological assumption that patterns of thought and behaviour are learned through one's cultural environment. Therefore while people experience the same types of psychiatric and psychological disorders worldwide, they express mental disorders in varying ways cross-culturally.

Transcultural psychiatry recognises three types of 'abnormal' behaviour and cognition: those considered abnormal in the West, but normal in other societies; those perceived as normal in the West, but abnormal elsewhere; and those that occur in exclusive socio-cultural environments (eg culture-bound syndromes). By identifying a set of symptoms as being 'abnormal' from a Western or non-Western perspective it is possible to ascribe an accurate (Western) psychiatric label to non-Western expressions (symptoms) of *illness*.

The transcultural psychiatry concept of 'self' differs from the traditional Freudian one. It sees the 'self' as culture-dependent, (eg not a static ego) and is constantly evolving parallel to changes in its socio-cultural environment.

Transference is the process by which a client's outside relationships strongly influence the nature of his or her relationship with the counsellor (or therapist). In *transference*, people ascribe characteristics of people who have significantly shaped their development to new acquaintances (eg the counsellor).

Counter-Transference refers to the same phenomenon in the counsellor (or therapist) who, however, is trained or clinically supervised to recognise it and prevent it from adversely affecting the therapeutic relationship.[202]

Traumatic event involves a confrontation with helplessness and death, and a complete loss of control. Definitions of what constitutes a trauma are often subjective and culture-bound, but generally include a direct encounter with or witnessing of life-threatening

events and violent personal assaults. By nature, a traumatic event is sudden, unexpected and overwhelming; involves actual or threatened death or serious injury, or a threat to physical integrity of self or others, provoking intense fear, helplessness or horror. The very essence of an acute traumatic stress reaction is that it hampers the critical processes of survival and *adaptation.*

Triangulation is the use of different sources and methods to check validity of certain information, or to identify 'the truth' when client information is conflicting. It is a useful technique to analyse a group of people's severity of trauma, conflict-related health needs, their *resilience* mechanisms and available resources and to determine programme responses (response intensity).

Vulnerability, in the context of traumatic experiences, refers to an individual's ability to cope with trauma. *Vulnerability* is defined by three major factors:

- events related to the trauma (eg intensity, life danger, extent of physical injury, number of experiences, duration, proximity, and preparation);
- personal-related attributes (eg pre-trauma experiences, coping style) and the recovery environment (socio-economic setting, poverty, and marginalisation).
- In the context of mental health and psychosocial programmes, *vulnerability* is further defined in terms of morbidity (eg the presence of symptoms), mortality (eg suicide), access to care, lack of humane treatment and specific conditions that increase *vulnerability* (eg being in a psychiatric institution).

Ventilation in psychology is used for situations in which the client expresses his/her emotions. Ventilation results often (though not always) in an instant decrease of distress (anger, anxiety, sadness or other).

Witnessing (also referred to within MSF as 'témoignage') involves the presence of volunteers among people in danger. *Witnessing* is motivated by a concern for the fate of fellow human beings and a willingness to listen to them, care for them (at their bedside), and report on their behalf about their situation.[203]

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