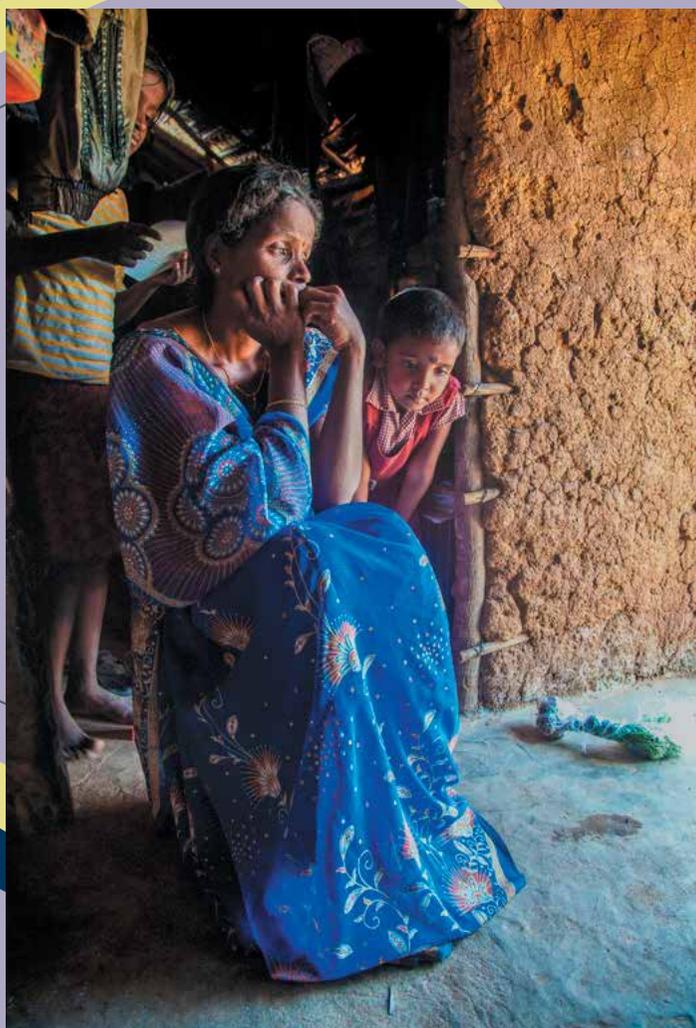


PROVIDING PSYCHOSOCIAL SUPPORT FOR SURVIVORS OF CONFLICT

A toolkit based on
experiences from
Sri Lanka



GIJTR

Global Initiative for Justice
Truth & Reconciliation

ABOUT THE INTERNATIONAL COALITION OF SITES OF CONSCIENCE

The International Coalition of Sites of Conscience (ICSC) is a global network of museums, historic sites and grassroots initiatives dedicated to building a more just and peaceful future through engaging communities in remembering struggles for human rights and addressing their modern repercussions. Founded in 1999, the ICSC now includes more than 300 Sites of Conscience members in 65 countries. The ICSC supports these members through grants, networking and training.



International Coalition of
SITES of CONSCIENCE

www.sitesofconscience.org

Cover photo:

Picture courtesy, Herstories Archive, a Site of Conscience member in Sri Lanka

ABOUT THIS TOOLKIT

Founded by the International Coalition of Sites of Conscience, the Global Initiative for Justice, Truth and Reconciliation (GIJTR) is a Consortium of nine organizations around the globe dedicated to multidisciplinary, integrated and holistic approaches to transitional justice.

Published in 2021, this toolkit was compiled by the Centre for the Study of Violence and Reconciliation (CSVr), a GIJTR partner and an independent nonprofit organization working toward understanding violence, healing its effects and building sustainable peace and reconciliation in South Africa, the region and throughout the rest of the world. This involves engaging in targeted research and advocacy with civil society and state institutions (both nationally and regionally) and working with individuals and communities through the delivery of direct interventions.

Learn More at www.csvr.org.za
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Learn more about GIJTR at
www.gijtr.org

ABOUT THE GLOBAL INITIATIVE FOR JUSTICE, TRUTH AND RECONCILIATION (GIJTR)

Around the world, there is an increasing call for justice, truth, and reconciliation in countries where legacies of gross human rights violations cast a shadow on transitions from repressive regimes to participatory and democratic forms of governance. To meet this need, the International Coalition of Sites of Conscience (ICSC) launched the Global Initiative for Justice, Truth and Reconciliation (GIJTR) in August 2014. The goal of the GIJTR is to address new challenges in countries in conflict or transition struggling with legacies of or ongoing gross human rights abuses. Since its founding six years ago, GIJTR has engaged with people from 46 countries, worked with over 500 CSOs, and has supported over 150 community-driven projects as well as the collection of more than 5,000 narratives of human rights violations.

ICSC leads a Consortium of nine organizational partners: American Bar Association Rule of Law Initiative (USA); Asia Justice and Rights (Indonesia); Center for the Study of Violence and Reconciliation (South Africa); Documentation Center of Cambodia (Cambodia); Due Process of



A plaque at a killing site in Bangladesh sponsored by the Liberation War Museum.

Law Foundation (USA); Humanitarian Law Center (Serbia); Fundación de Antropología Forense de Guatemala (Guatemala); and Public International Law & Policy Group (USA). In addition to leveraging the expertise of the Consortium members, ICSC taps into the knowledge and longstanding community connections of its 300 member organizations in 65 countries in order to strengthen and broaden the Consortium's work.

GIJTR partners, along with members of the International Coalition of Sites of Conscience, develop and implement a range of rapid response and high-impact program activities, utilizing both restorative and retributive approaches to justice and accountability for gross human rights violations. The expertise of the organizations under the Global Initiative for Justice, Truth and Reconciliation includes:

- Truth-telling, reconciliation, memorialization, and other forms of historical memory;
- Documenting human rights abuses for transitional justice purposes;

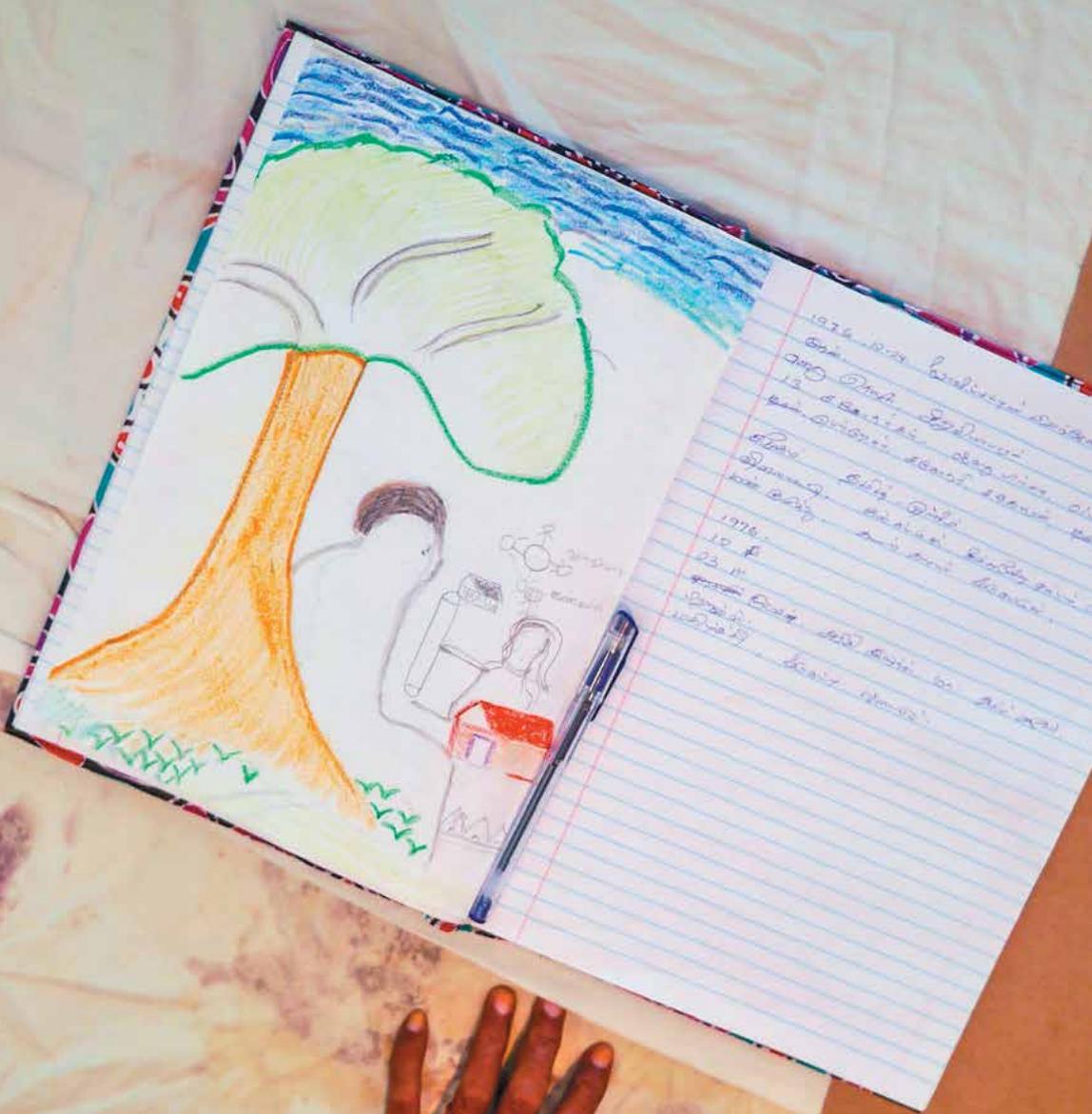
- Forensic analysis and other efforts related to missing and disappeared persons;
- Victims' advocacy such as improving access to justice, psychosocial support, and trauma mitigation activities;
- Providing technical assistance to and building the capacity of civil society activists and organizations to promote and engage on transitional justice processes;
- Reparative justice initiatives; and
- Ensuring gender justice in all of these processes.

To date, GIJTR has led civil society actors in countries such as Gambia Guinea in the development and implementation of documentation and truth-telling projects, undertaken assessments of the memorialization and psycho-social support capacities of local organizations in Sri Lanka, South Sudan and other contexts, and launched six transitional justice “academies” to provide activists and non-traditional actors with training, support, and opportunities to participate in the design and implementation of community-driven transitional justice approaches. Through innovative projects in Colombia, Bangladesh and East Africa, GIJTR has worked with civil society actors in places of active conflict on documentation and assessment initiatives, laying the foundation for future truth, justice and reconciliation processes that are centered on victims' needs and civic participation. GIJTR has also developed and globally disseminated over a dozen toolkits, sharing practical lessons from the field as well as models for local organizations interested in undertaking similar truth, justice and reconciliation projects in other contexts.

Given the diversity of experience and skills within the Consortium and amongst ICSC network members, the program offers post-conflict countries and countries emerging from repressive regimes a unique opportunity to address transitional justice needs in a timely manner, while promoting local participation and building the capacity of community partners.



A 2018 GIJTR exhibition of body-maps in Conakry, Guinea.



A body mapping workshop held in August 2017 and led by the GIJTR Consortium for 20 female survivors of violence in Sri Lanka

“Healing for individuals, families, leaders, institutions and the whole society is no longer a luxury or social service issue. It is now a necessity and a security issue. It is now an economic and development issue. Any attempt to ensure security, development and stability of our country without addressing our collective woundedness is futile. Psychological health is a priority, and it equals a healthy community and a healthy nation.”

– **Nomfundo Mogapi**, executive director of the Centre for the Study of Violence and Reconciliation and clinical psychologist who specializes in trauma

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CHAPTER 1: ABOUT THIS TOOLKIT

1.1 Introduction

This toolkit was developed based on the GITJR work done in Sri Lanka (see appendix A for context). Throughout the work, with different organizations and in different regions, the challenges related to mental health and psychosocial support (MHPSS) for survivors and victims of violence were continuously raised. Identified gaps in knowledge and skill included an understanding of MHPSS services and how to better provide these services in communities, especially for organizations working with victims and survivors.

Please note that in this toolkit, the titles victim, survivor and client are all used to refer to someone affected by violence (e.g., conflict, war, discrimination) and human rights violations (e.g., torture, enforced disappearance, unlawful detention). In addition, psychologist, counselor, clinician, psychosocial support worker or anyone providing mental health and/or psychosocial support is also called a Helper in some instances of this toolkit.

1.2 What Are the Objectives of this Toolkit?

Psychosocial support services have been instrumental in assisting victims of violence and conflict in processing their feelings regarding the trauma and violence they have experienced, the outcome of which includes improvements in:

- Self-awareness (emotional self-awareness, accurate self-assessment, self-confidence)
- Self-management (emotional self-control, transparency, adaptability, initiative, achievement, optimism)
- Social awareness (empathy, organizational awareness, service orientation)
- Relationship management (developing others, inspirational leadership, conflict management, change catalyst, teamwork and collaboration, influence)

This toolkit aims to achieve the following:

- Provide key information on various topics that can be used to shape psychoeducation, awareness raising and advocacy initiatives.
- Provide the basic framework for developing good counseling skills.
- Provide examples of exercises and tools that can assist survivors of violence and conflict to reflect on their experiences and begin to process their trauma.
- Act as a guide to train others on the basics of psychosocial support to increase the access to psychosocial support services.

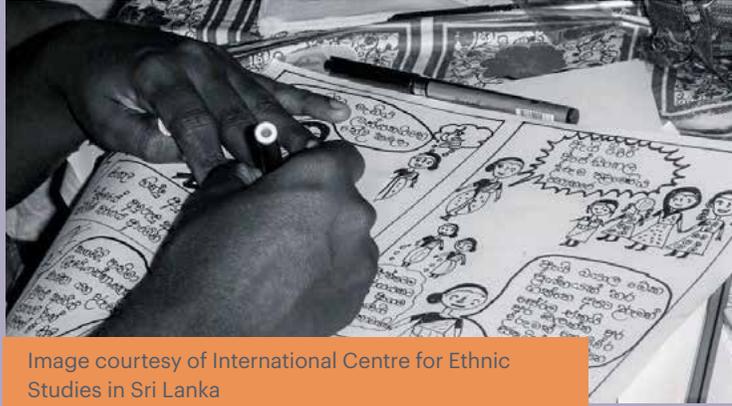


Image courtesy of International Centre for Ethnic Studies in Sri Lanka



A photo taken during “The Body Remembers: Body Mapping of Women in Conflict,” an exhibit presenting body maps drawn at a GIJTR workshop in 2017 by 18 female victims of violence in Sri Lanka.

Each section of the toolkit provides a theoretical framework to help understand the key aspects of the topic as well as some recommended readings to assist. Following this, each section contains some materials that could be used to either provide psychosocial support to survivors of violence and conflict or capacitate others to do so. There is, however, overlap across some sections of the toolkit, and the reader may need to join different aspects across the toolkit to better meet the needs of the person/s they are trying to assist.

1.3 Whom Is this Toolkit for?

- Lay counselors conducting psychosocial support at community level
- Psychologists, counselors, social workers, and other mental health and psychosocial support services (MHPSS)
- Formal and informal community programs and services, including programs provided by nongovernmental organizations (NGOs), faith-based bodies, cultural institutions and communities themselves

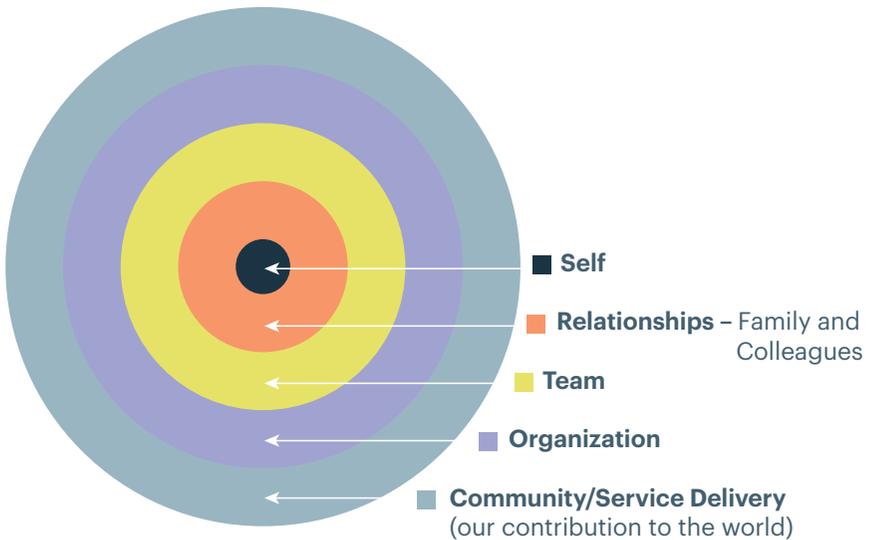
1.4 Guiding Principles of the Toolkit

The information contained in the toolkit is based on the following guiding principles:

- All change starts with the self.

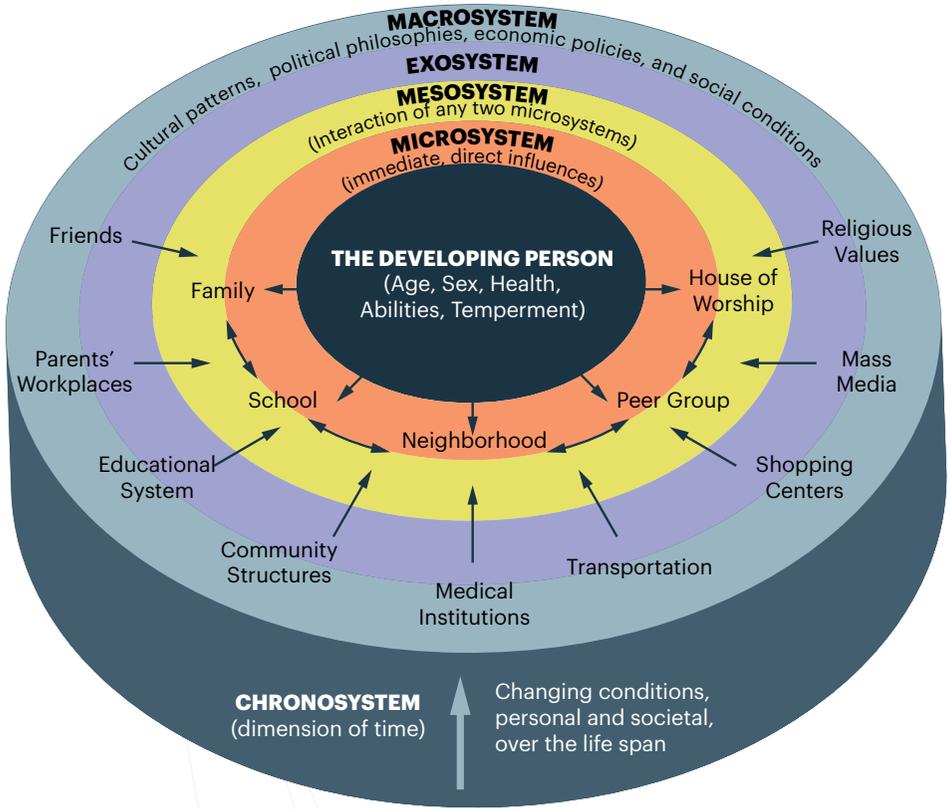
Understanding oneself (and changing one's own knowledge, attitudes and behavior) is the first and essential step toward understanding and influencing change in others (e.g., in the community and broader society). Therefore, it is important that the providers of psychosocial support are not unaware of the impact that their own trauma has had on them, how much of this trauma is resolved versus unprocessed and how this trauma may influence their ability to help others and/or make them more vulnerable to vicarious trauma or to the retriggering of their trauma as they carry out their work with survivors. As Russ Hudson, co-founder of the Enneagram Institute, notes, "The impact we create in the world is dependent on our relationship with ourselves."

The following diagram of concentric circles demonstrates the ripple effect outward from self.



- A person is embedded within a particular context that they influence and by which they are in turn influenced.

To understand a person’s response to trauma, we must look at the person, their immediate surroundings and the interaction of the broader environment as well. American psychologist Urie Bronfenbrenner recognized that a person’s development was affected by everything in their surrounding environment — from the immediate settings of family and school to broad cultural values, laws and customs. When providing psychosocial support to survivors of violence and human rights violations, one cannot remove that person from their environment and needs to consider all the factors affecting them. Bronfenbrenner organized these environmental settings into five levels: the microsystem, the mesosystem, the exosystem, the macrosystem and the chronosystem.



Bronfenbrenner's Ecological Systems Theory

CHAPTER 2

PSYCHOSOCIAL SUPPORT

2.1 Theoretical Framework

What is mental health?

- The term **mental health** is used to denote psychological well-being.
- Psychological well-being is used to describe emotional health and overall functioning. It is not an absence of mental illness or distress but an overall sense of feeling good about oneself and one's life, doing well and feeling as if one is able to cope.
- Mental health interventions aim to improve psychological well-being by reducing levels of psychological distress, improving daily functioning and ensuring effective coping strategies.
- Such interventions are overseen by a mental health professional and target individuals, families and/or groups.



What is psychosocial support?

- The term **psychosocial** denotes the idea that a combination of psychological and social factors is responsible for the well-being of people and that these traits cannot necessarily be separated from one another. It is used to describe the interconnection between the individual (i.e., a person’s “psyche”) and their environment, interpersonal relationships, community and/or culture (i.e., their social context).
- The term directs attention toward the totality of people’s experience rather than focusing exclusively on the psychological aspects of health and well-being and emphasizes the need to view these issues within the interpersonal contexts of wider family and community networks in which they are located (Eyber and Ager 2002).
- Psychosocial support is essential for maintaining good physical and mental health and provides an important coping mechanism for people during difficult times.
- Psychosocial support can include a variety of activities. For example: support groups and self-help groups for women, youth or people with disabilities; structured play activities for children; mind-body approaches such as relaxation and breathing exercises; storytelling; music making; sports; and handicraft or vocational courses.
- Such activities need not be led by mental health professionals.

What is MHPSS?

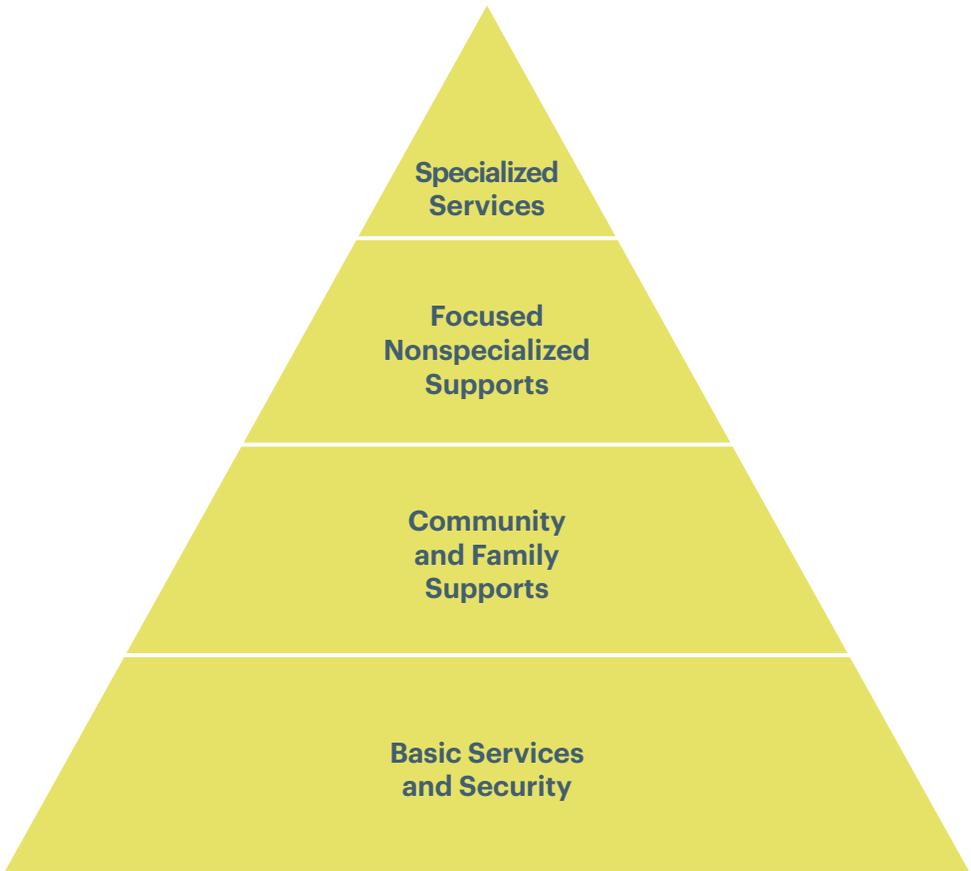
- The composite term **mental health and psychosocial support**, or MHPSS, refers to any type of local or outside support that aims to protect or promote psychosocial well-being or prevent or treat mental disorders.

The term MHPSS problems may cover a wide range of issues, including social problems, emotional distress, common mental disorders (such as depression and post-traumatic stress disorder), severe mental disorders (such as psychosis), alcohol and substance abuse, and intellectual or developmental disabilities.

Who helps those who have suffered trauma? A description of the different MHPSS roles and functions

As a result of trauma and historical conflicts, the MHPSS needs of individuals, families and communities vary. However, whatever those needs are, they are guaranteed to be complex and multilayered, so an approach to address these needs has to be just as complex and multilayered.

The Inter-Agency Standing Committee (IASC) on Mental Health and Psychosocial Support promotes a multitiered approach to MHPSS service delivery.



Therefore, the MHPSS framework aims to provide the necessary support at the various levels and can be adapted to the context. As one moves up the pyramid, the services become more specialized and the number of people who need or can access the service decreases. For example, specialized services are considered to be those offered by trained professionals such as psychiatrists and psychologists to deal with severe mental health disorders. The reality, though, is that many countries, such as Sri Lanka, do not have enough of these professionals to meet the needs of the community. Therefore, it is extremely important to increase the number of people who are able to support the large number of people at the lower levels of the MHPSS pyramid who present with mild and moderately severe mental health impacts (IASC, 2007). Building this capacity in the area of psychosocial support services is one of the key aims of this toolkit.

Very often in the fields of trauma, human rights and/or mental health and psychosocial support, there are people who work with individuals, groups and communities affected by violence. They support them either directly after or during the course of their rehabilitation. Often there has been limited training on the effects of violence, trauma and human rights abuses such as torture on individuals, families, groups and communities, as well as on how one can assist these categories of people while maintaining their scope of practice (the boundaries of what services you are actually allowed to provide to survivors based on your level of training and expertise).

This section focuses on three elements of psychosocial support that can assist individuals in their work with survivors of violence. One such approach to offering psychosocial support that does not have to be conducted by mental health professionals is psychological first aid (PFA).

2.1.1 PSYCHOLOGICAL FIRST AID

PFA is designed as an early intervention straight after a traumatic event. It has been designed to be used by mental health workers and early responders to scenes of violence or disaster. PFA is used with the intention of helping individuals recover from the trauma of the event by providing systematic, practical helping actions that set them up for recovery (Ruzek et al., 2007). Therefore, it is seen as a “humane, supportive response to a fellow human being who is suffering and who may need support” (the Sphere Project and the IASC).

Factors that affect the response to an event

Not all individuals will experience and react in the same way in relation to a crisis event. Therefore, when assisting individuals and groups, it's important to take into account the factors that may influence how they are responding and reacting to assist:

- The nature and severity of the event(s) they experience
- Their experience with previous distressing events
- The support they have in their life from others
- Their physical health
- Their personal and family history of mental health problems
- Their cultural background and traditions
- Their age (e.g., children of different age groups react differently)

Why PFA and not debriefing?

Research has shown that speaking about an event soon after it happened reinforces the neural pathways in the brain linked to memory of the event and

therefore entrenches the trauma, which in turn may cause a longer recovery time for the individual. However, evidence shows that over the long term, people do better after the crisis event if they:

1. Feel safe, connected to others, calm and hopeful
2. Have access to social, physical and emotional support
3. Regain a sense of control by being able to help themselves

What is PFA?

- More effective than psychological debriefing in the short term
- Nonintrusive, practical care and support
- Assessing needs and concerns of survivors
- Helping people to address basic needs (e.g., food, water)
- Listening but not pressuring people to talk
- Comforting people and helping them to feel calm
- Helping people connect to information, services and social supports
- Protecting people from further harm

What PFA is not:

- Something that only professionals can do
- Professional counseling
- Psychological debriefing
- Asking people to analyze what happened or put time and events in order
- Pressurizing people to talk or describe their experiences if they do not want to
- Putting yourself at risk to help others

What are the goals of PFA?

PFA is designed to be practical and help:

- Calm people
- Reduce stress
- Make people feel safe and secure
- Identify and assist with people's current needs
- Establish human connection
- Facilitate people's social support
- Help people understand the crisis event and its context
- Help people identify their own strengths and abilities to cope
- Foster belief in people's ability to cope
- Give hope
- Assist with early screening for people needing further or specialized help
- Promote adaptive functioning
- Get people through the first period of high intensity and uncertainty after an event
- Set people up to be able to recover

Steps of PFA

This is the four-step model of PFA that is in line with the World Health Organization's guidelines for fieldworkers (WHO, 2013).

1. Prepare

Preparation is the first step. This is centered on learning about the crisis event that happened, the available services and supports, and whether there are any safety and security concerns.

Important related questions to ask:

- What happened?
- When and where did it take place?
- How many people are likely to be affected, and who are they?
- Who is providing for basic needs and medical care?
- Where and how can people access those services?
- Who else is helping?
- Is the crisis over or continuing?
- What dangers may be in the environment?
- Are there areas to avoid entering because they are not secure or because you are not allowed there?

2. Look

This step is for when you arrive at the crisis event. It is vital for you to look around and assess the situation. Check for your safety and whether there are any dangers. Then move on to see whether there are, first, any individuals with obvious urgent basic needs such as medical assistance and, second, whether there is anyone with serious distress reactions.

Questions to ask yourself:

- What dangers can you see in the environment, such as active conflict, damaged roads, unstable buildings, fire or flooding?
- Can you be there without probable harm to yourself or others?

- Does anyone appear to be critically injured and in need of emergency medical help?
- Does anyone seem to need rescuing, such as people trapped or in immediate danger?
- Does anyone have obvious urgent basic needs?
- Which people may need help in terms of accessing basic services and special attention to be protected from discrimination and violence?
- Who else is available around me to help?
- Are there people who appear extremely upset, unable to move on their own, unable to respond to others or in shock?
- Where and who are the most distressed people?
- Do they need more specialized help?

3. Listen

Now that you have assessed the situation and identified who may need help, it is important to remember to listen. Begin by approaching those who may need help or support. Ask them about what their needs and concerns are, as this may be different from what you feel they need. Listen to what their concerns are, and try to help them remain calm.

Throughout this, listen with your:

- **Eyes:** giving the person your undivided attention
- **Ears:** truly hearing their concerns
- **Heart:** with caring and showing respect

When approaching people:

- Approach people respectfully and according to their culture.
- Introduce yourself by name and organization.
- Ask whether you can provide help.
- Find a safe and quiet place to talk.
- Help the person to feel comfortable (e.g., provide a glass of water).
- Try to keep the person safe by removing them from immediate danger and media and making sure they are not alone.

Concerns and needs:

- Always ask what people need and what their concerns are.
- Find out what is most important to them at this moment.
- Help them work out their priorities.

Calming the individual

- Stay close to the person.
- Do not pressure the person to talk.
- Listen in case they want to talk about what happened.
- If they are distressed, help them to feel calm and try to make sure they are not alone.
- Keep your tone of voice calm and soft.
- If culturally appropriate, try to maintain some eye contact with the person as you talk to them.
- Remind the person that you are there to help them.
- Remind them that they are safe — but only if it is true.

- If someone feels unreal or disconnected from their surroundings, you may help them to make contact with their current environment and themselves by asking them to:
 - » Place and feel their feet on the floor.
 - » Tap their fingers or hands on their lap.
 - » Notice some nondistressing things in the environment and ask them to tell you what they see and hear.
 - » Focus on their breathing and to breathe slowly.

4. Link

Last is helping link individuals, based on their identified concern/s, to address basic needs and access services, cope with the problem, get information and connect people with loved ones and social support. Central to this is helping people to help themselves so they can gain control of the situation.

Common needs are often

- Basic needs: shelter, food, water, sanitation
- Health services: for injuries and chronic medical conditions
- Understandable and correct information about the event, loved ones and available services
- Being able to contact loved ones, friends and other social supports
- Access to specific support related to one's culture or religion
- Being consulted and involved in important decisions

Basic needs and services

- Immediately after a crisis event, try to help the person in distress to meet the basic needs they request.
- Learn what specific needs people have, and try to link them to these (e.g., health care, clothing, feeding cups or bottles for children).
- Make sure that vulnerable or marginalized people are not overlooked.
- Follow up with people if you promise to do so.

Skills to cope with the problem

- Help people identify supports in their life, such as friends or family, who can help them in the current situation.
- Give practical suggestions for people to meet their own needs.
- Ask the person to consider how they coped with difficult situations in the past.
- Affirm their ability to cope with the current situation.
- Ask people what helps them feel better.
- Encourage them to use positive coping strategies and avoid negative coping strategies.

Giving information

- People affected by a crisis event will want accurate information about:
 - » The event
 - » Loved ones or others who are affected
 - » Their safety
 - » Their rights

- » How to access the services and the things they need
- » Find out where to get correct information and updates.
- Get as much information before you approach people to offer support.
- Keep updated about the state of the crisis, safety issues, available services, and the whereabouts and condition of missing or injured people.
- Make sure people are told what is happening and about any changes to plans.
- Provide people with contact details for services or refer them, especially vulnerable people.
 - » Explain the source of the information and its reliability.
 - » Say only what you know — don't make up information or give false reassurances.
 - » Keep messages simple and accurate, and repeat the message to be sure that people hear and understand the message.
 - » Let the people know whether you will keep them updated on new developments.

Helping connect to support

- Help keep families together.
- Help people connect with social support (e.g., call a friend).
- Connect with spiritual leaders if asked.
- Help bring affected people together to help one another (e.g., help the elderly).

PFA for children

During a crisis event, children are often a particularly vulnerable group and are often more vulnerable to various forms of violence. Young children in particular may not be able to meet their own needs or protect themselves. Caregivers may themselves be overwhelmed during the event and be unable to care for the child.

A minor's reaction during a crisis event may differ based on:

- Age
- Developmental level
- How caregivers and other adults interact with them

Therefore, these factors need to be taken into consideration when assisting.

Typical reactions in young children

- Return to earlier behaviors such as thumb sucking, baby talk or bed wetting
- Cling to caregivers
- Use of repetitive play depicting the trauma event as a way to process/make sense of what happened
- Reduce their play and display a general lack of energy

Typical reactions in school-aged children

- Believe they caused bad things to happen
- Develop new fears
- Become less affectionate
- Feel alone
- Become preoccupied with trying to protect or rescue people in crisis

Typical reactions in adolescents

- Feel “nothing,” become emotionally numb or display bouts of anger/rage
- Feel different from friends, as if they don’t fit in
- Feel isolated from friends
- Display risk-taking behavior
- Develop negative attitudes

PFA for children

The same four elements (prepare, look, listen and link) apply to children, but certain aspects may differ based on the mentioned differences in minors. Therefore, depending on the age group, there are various things to be aware of.

Infants

- Keep them warm and safe.
- Keep them away from loud noises.
- Give cuddles and hugs.
- Keep a regular feeding and sleeping schedule if possible.
- Speak in a calm and soft voice.

Young children

- Give them extra time and attention.
- Remind them often that they are safe.
- Explain that they are not to blame.
- Avoid separating them from caregivers and siblings.

- Keep to a regular routine when possible.
- Give simple answers without scary details.
- Allow them to stay close to you if they are fearful or clingy.
- Be patient with children who demonstrate behaviors from when they were younger.
- Provide a chance and space to play and relax if possible.

Older children and adolescents

- Give them extra time and attention.
- Help them stick to regular routines.
- Provide facts about what happened, and explain what is going on now.
- Allow them to be sad, and don't expect them to be tough.
- Listen to their thoughts and fears without being judgmental.
- Set clear rules and expectations.
- Ask them about the dangers they face, support them and discuss how they can avoid being harmed.
- Encourage them, and allow opportunities for them to be helpful.

IF THE CAREGIVER IS UNABLE TO PROVIDE FOR THE CHILD

If the caregiver is injured, extremely distressed or unable to care for their children, you can arrange help for the caregiver and then care for the children. Involve a trustworthy child protection agency if possible. Keep children and their caregivers together, and try not to let them get separated. Also, even if the child is not directly affected during the crisis, they may be overlooked throughout the chaos. Therefore, keep an eye out for children, and try to protect them from upsetting scenes and scary stories.

THINGS TO SAY TO AND DO FOR CHILDREN:

Keep safe.

- Protect them from scary scenes.
- Protect them from upsetting stories.
- Protect them from the media or people who may want to interview them.

Listen, talk and play.

- Be calm, talk softly and be kind.
- Listen to their view of the situation.
- Talk to them at their eye level and use language they will understand.
- Introduce yourself by name, and let them know you are there to help.
- Gather information: name, where they are from or other information if they are separated from their caregiver.
- If they are with a caregiver, support the caregiver in caring for the child.
- If passing time with children, try to involve them in an appropriate age-level activity.

BUT ALSO ALWAYS REMEMBER:

Children have their own resources for coping in a crisis. Therefore:

- Learn what these are.
- Help them use their positive coping strategies while helping them avoid using their negative ones.
- Older children and adolescents can often help in a crisis. So try to find safe ways for them to contribute in the situation that may make them feel more in control.

2.1.2 HOW TO HELP LIMIT RETRAUMATIZATION WHEN TAKING A STATEMENT OR DOING AN INTERVIEW

At some point after a traumatic event, a statement or an interview may be required. This may be for several purposes, such as:

- Interviews (e.g., for media stories, criminal cases, advocacy campaigns)
- Documentation of human rights violations
- Witness statements (e.g., truth and reconciliation commissions, criminal cases)
- Memorialization
- Rehabilitation for victims (e.g., intake interviews for the provision of psychosocial support [PSS])
- Evaluation reports of the effectiveness of the responses or interventions provided to manage the crisis event

During the interview process, there are steps (before, during and after the interview process) that may limit the retraumatization of the individual giving the statement.

When starting, identify whether the individual is suffering from any mental health issues that may be affecting their ability to tell their story or whether, in having them tell their story, you may do more harm to the individual, by retriggering their trauma.

If this is the case, assist the individual in getting counseling and work with the counselor in preparing the individual to give the statement. You and the counselor should work together to take the statement and/or conduct the interview by both being in the room during the interview. This will ensure not only that there is a qualified person present should containment and grounding need to take place but also that there is someone in the room whom the client trusts and is comfortable with or is used to telling their story to.

What to be aware of while interviewing

- Identify the individual's trauma experiences and how these may affect their ability to accurately and comfortably engage during the interview process.
- Do they present with mental illness, and if so, what is the severity of their symptoms? How may this affect the statement being given?

- Typical reactions to giving the statement and telling their story may include:
 - » Avoidance, especially of speaking about painful or emotionally overwhelming experiences
 - » Anxiety/panic
 - » A dissociative state (this is explained in the trauma section of the toolkit)
 - » Physical presentations such as headaches, stomachaches, nausea and bodily aches

Other factors that may affect the statement:

- A lack of understanding of the process and why they are giving the statement
- Cultural beliefs and norms
- Gender
- Language barriers between the interviewer and the interviewee
- Age

What You Can Do During the Interview

There are safety aspects that the lawyer/journalist/medical professional/shelter staff member/counselor and other service providers can provide and be aware of during the interview to limit the retraumatization of the individual, such as:

- Commitment to ensuring that the process is ethical (ethical considerations)
- Recognition of the widespread impact of trauma
- Ability to identify trauma and mental health issues
- Recognition of power dynamics within the interview process
- Commitment to ensuring safety
- Empathy

- Cultural sensitivity
- Effective communication
- Monitoring of the interviewee's and the interviewer's reactions to what is being shared during the interview process
- Containment skills (if a participant becomes triggered during the process)

1. Empathy

Empathy is “the ability to communicate understanding of another person’s experience from that person’s perspective” (Fairbairn, 2002). This differs from sympathy and apathy. Sympathy is feeling sorry for the person; usually an individual will then also cry or get upset, and this doesn’t help the person who is emotional or experiencing something challenging. Apathy is not feeling for the individual at all, such as ignoring their feelings and what they are going through.

Empathy can be demonstrated through empathic listening and responding in an empathetic manner. An example of empathetic listening is nodding while the individual is speaking and giving verbal cues such as “mmm.” Furthermore, an empathic response is “I can feel that you are upset” versus “Shame — you are upset.”

2. Safety

Ensuring safety starts from the moment you (as the interviewer) are planning your engagement with the participant. It continues through both your engagement with the participant and beyond your engagement (e.g., ensuring they receive any necessary additional mental health and psychosocial support and how the information is used or presented to others).

Your safety as the interviewer is also important because when you feel safe, you can be more sensitive and empathetic to the participant, better able to recognize the signs and symptoms of trauma and less likely to become stressed or traumatized yourself by the engagement.

Ensuring the Safety of Participants *Before They Arrive*

- Develop data collection tools/interview questions with safety and reduction of risk in mind (e.g., gender-sensitive tools).
- Determine the best methodology to reduce the risk of retraumatization, and encourage collaboration, autonomy and empowerment for the interviewee
- Encourage the participant (interviewee) to bring someone from their support network with them if needed. However, because of the potentially sensitive nature of the information they will be sharing with you, it is best if this person waits outside so that the interviewee feels free to share any information they wish without feeling the need to censor it for the person accompanying them. The interviewee can be told that for confidentiality purposes, the person who accompanied them can wait outside but that they are free to stop the interview to take a break and spend time with their support person before the interview continues, if needed.
- Explain how to reach the office, what to expect when they get there, the names of the people they may encounter and other details.
- Try to match the gender of the participant with that of the interviewer, or ask them whom they would feel more comfortable speaking to because sometimes people prefer to speak to someone of a different gender.
- Address language issues (ensure there is compatibility or an interpreter available).

Work with your environment, and try to ensure that the interview location is as private as possible. In addition, the space should be light, airy, comfortable and so forth so that it does not in any way resemble or remind the person of any of the traumatic spaces they may have been in. This is particularly important for torture survivors, political prisoners, victims of enforced disappearance or any person who has experienced captivity in which their freedom has been taken from them.

When the individual feels safe, it is easier for them to speak. The client should also be given as much control of the space and the interview as possible because often they have had their sense of being in control taken away from them during the trauma experience. This could be facilitated by asking them where they would like to sit, whether they would like any refreshments and

whether there are changes you could make to the space to make them feel more comfortable (e.g., letting them sit by the door or wherever else they would feel comfortable, stopping the interview when they want to and encouraging them to leave out anything they are not yet comfortable sharing).

In addition, trauma shatters a person's beliefs about the world and their sense of a predictable world. Therefore, giving the person as much information as they can absorb and understand regarding what is about to happen is important so that they know what to expect. Examples include orienting the client to the room and the interview process, setting the boundaries of the exchange, and noting how their information will be used, who will have access to it and how it will be kept secure and for how long.

Ensuring the Safety of Participants After They Arrive

- Minimize waiting time and ensure comfort (e.g., provide water).
- Introduce yourself and explain why you are present.
- Remain courteous and nonthreatening, and be honest and direct.
- First clarify and address whatever questions or concerns the person may have.
- Listen to the person in a nonjudgmental way.
- Avoid confrontation; be prepared to differ with the person's perspective.
- Develop shared expectations.
- Establish and maintain boundaries (explain the frame in which you work so they know what to expect).
- Do not touch the person, except in an emergency situation (include in your risk mitigation plan).
- Encourage/assist the person to receive professional mental health assistance (include in your risk mitigation plan).

Ensuring Your Safety

If you are feeling traumatized, anxious or distressed by the interaction with a participant, what would make you feel more secure?

- Set, communicate and maintain boundaries.
- Establish a risk mitigation plan and team.
- Seek peer or professional support.
- Ask a colleague to take over.
- Practice self-care.
- Know your limits and blind spots.
- Actively engage in your own journey of self-awareness, personal healing and transformation.

3. Monitoring

Monitoring is being very aware of how the sharing of information during the interview is affecting everyone in the room and then making adjustments based on this so that you are not retraumatizing the interviewee or becoming traumatized as the interviewer. Monitor both yourself and the individual you are interviewing. Ask yourself the following questions:

- What are you both communicating verbally and nonverbally, through your body language?
- Are you or the interviewee communicating an unintentional or contradictory nonverbal message with your body positioning and mannerisms?
- Are you or the interviewee becoming overly emotional?
- What were they speaking about when you noticed this increase in emotion?
- Why do you think this particular subject matter elicits a strong emotional reaction compared with other information shared during the interview?
- Are you being unintentionally judgmental or prescriptive?

- Is the level of emotion being displayed at risk of being overwhelming for the person experiencing it? Is it necessary to stop the interview for the day, take a break, or engage in containment exercises such as deep breathing, guided meditation, or grounding to bring the person experiencing the overwhelming emotions back to a calm and peaceful state?

4. Communication

This includes both verbal and nonverbal communication (body language) to help ensure the individual is feeling heard and safe in the space, even as difficult as what they are saying may be to hear.



Effective Communication

This includes both verbal and non-verbal communication to help ensure the individual is feeling heard and safe in the space, even as difficult as what they are saying may be to hear.

VERBAL:

- A calm tone
- Simple questions and responses that encourage the participant to answer and tell their story
- Acknowledgements (e.g. “Yes, go on”, “mmm”)
- Summarizing and repeating back what the participant has said
- Reflecting on content, feeling, and meaning.

VERBAL

Tone

How questions are phrased

Acknowledging what is being said

Paraphrasing/reflecting back what is being said

NON-VERBAL

Body language

Eye contact

Facial expressions

SOLER

NON-VERBAL:

- Nodding
- Making eye contact
- Mirroring the participant’s posture
- Mirroring the participant’s facial expressions
- Mirroring the intensity of the participant’s feelings
- Body language: SOLER

Verbal

- Tone: Ensure a calm tone that is intended to help the interviewee feel safe and able to share their information.
- Give simple responses to what they are saying that encourage the interviewee to tell their story.
- Phrasing: Use terms and language that are easy to understand and that do not come across as blame or judgment.
- Provide acknowledgments that you are listening and hear what the interviewee is saying: “Yes,” “Go on,” “Mmm.”
- Reflecting: Repeat what the person is saying in different words. Reflect on content, feeling and meaning.

Nonverbal

- Nodding
- Making eye contact
- Mirroring (copying) the interviewee’s posture
- Mirroring (copying) the interviewee’s facial expressions
- Mirroring (matching) the intensity of the interviewee’s feelings
- Body language: Practice **SOLER**:
 - » **S:** Sit squarely, facing the interviewee.
 - » **O:** Maintain an open posture, and do not cross your arms or legs. Ensure that there is no barrier, such as a table, between you and the interviewee.
 - » **L:** Lean slightly forward.
 - » **E:** Maintain eye contact according to what is culturally appropriate.
 - » **R:** Relax because if you come across as nervous or anxious, the interviewee will feel the same.

5. Cultural sensitivity

Try to understand the interviewee's culture, religion and so forth, and demonstrate your respect for these because this may affect how they interact with you. Cultural differences may include the amount of distance you will need to keep between yourself and the interviewee to make them comfortable, no eye contact versus eye contact as sign of respect, no touch versus some touch and appropriateness of being alone with a member of the opposite sex. Remain open-minded and up-front about things you don't know, and ask questions about a person's culture and beliefs to demonstrate your commitment to understanding them.

6. Containment

Containment is the ability and capacity to manage the troubling thoughts, feelings and behavior that may arise as a consequence of the individual's stress and trauma. Its aim is to make the individual feel safe, and some techniques are grounding and breathing exercises. These are discussed more in depth in the trauma section of the toolkit.

2.1.3 BASIC COUNSELING SKILLS

Therapy and counseling are processes of generating change in which people are supported and encouraged to understand and explore several personal factors, such as thoughts, emotions and behavior, which may be hindering their personal growth (Comier and Hackney, 2012). Although many beginner helpers understand the basic goals of the therapeutic process, they often struggle to understand what the actual process comprises at a practical level. Although the practical nature of the therapeutic/counseling process will look different based on the client and the theoretical frame informing it, there are a few basic steps that can provide the Helper with a basic guide to direct therapeutic work with clients.

Basic counseling skills comprise active listening skills, accurate reflections and summaries of the clients' emotions and content, empathy and empathetic responses, correct body language and tone of voice, being genuine and offering the client unconditional positive regard, and providing appropriate questioning and paraphrasing.

“People will forget what you said,
People will forget what you did,
But people will never forget how you
made them feel.”

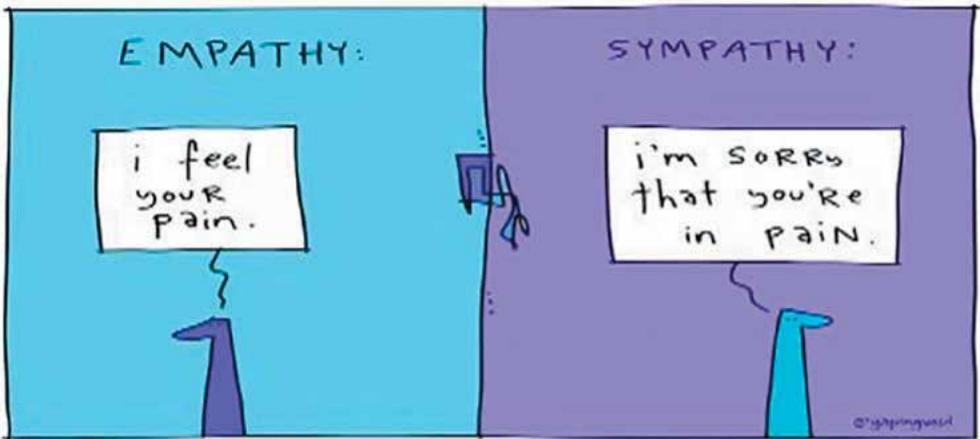
– Maya Angelou

Empathy

“The ability to communicate understanding of another person’s experience from that person’s perspective” (Fairbairn, 2002). This requires you to be nonjudgmental, open and approachable, and gentle and patient, while providing appropriate care, treatment and interventions. It requires you to consider how survivors see the world and how they might be feeling and to communicate that understanding to them. This is essential in helping to validate the survivors’ experiences and to normalize their reactions to the traumatic events they have endured.

Below are examples of responses that are not empathetic :

- Giving advice like *“I think you should ...”*
- Explaining your situation: *“But I didn’t mean to ...”*
- Correcting the person: *“Wait! I never said that!”*
- Consoling the person: *“You did the best you could ...”*
- Telling a story: *“That reminds me of the time ...”*
- Shutting down feelings: *“Cheer up. Don’t be so mad.”*
- Sympathizing: *“Oh, you poor thing ...”*
- Interrogating: *“Why you did that?”*
- Evaluating: *“You’re just too unrealistic.”*
- One-upping: *“That’s nothing. Listen to this!”*



Rather, use phrases such as:

- ***“It sounds ...*** as if that was a very painful experience for you.”
- ***“I imagine that ...*** you may have felt angry and betrayed because of what happened.”
- ***“I sense that ...*** you are disappointed in how you were treated.”
- ***“I’m wondering whether ...*** this made you feel rejected.”
- ***“What I am hearing is ...*** that this experience has caused you to feel a lot of regret.”

Unconditional positive regard

Unconditional positive regard is the basic acceptance and support of a person regardless of what the person says or does. “It means caring for the client, but not in a possessive way or in such a way as simply to satisfy the therapist’s own needs,” explained Rogers in a 1957 article published in the *Journal of Consulting Psychology*.² “It means caring for the client as a separate person, with permission to have his own feelings, his own experiences.” What this means is that no matter what negative emotion, thoughts or behaviors a client expresses, you will always think kindly about them and understand that these often stem



A body mapping workshop held in August 2017 and led by the GIJTR Consortium for 20 female survivors of violence in Sri Lanka

from the trauma that they have experienced. You will not judge them or change the way you behave toward them. However, this does not mean that you need to put yourself in danger, violate your boundaries or support the client in behavior that is dangerous to themselves or others. It simply means that the care and support that you provide to the client

and your attitude and behavior toward them will not change.

Genuineness

This is being authentically yourself and not pretending to be different because you think that it will make the client feel more at ease. Once a client finds out that you were dishonest, it will break the trust and jeopardize the quality of your professional relationship. It may even lead to your having to end the counseling because the lack of trust could cause the client to stop being honest about their experiences and how these have affected them.

Active listening

Active listening means fully concentrating on what is being said rather than passively “hearing” the message of the speaker. It involves listening with all senses. In addition to giving full attention to the speaker, an active listener must also physically show, through body language [eye contact, etc], that they are listening; otherwise, the speaker may conclude that what they are talking about is uninteresting to the listener.

BELOW ARE ELEMENTS OF ACTIVE LISTENING TO DEMONSTRATE DURING A COUNSELING SESSION:

Attending behavior

Attending behavior lets the client know you are there with them, showing you are interested in what they are saying. There are both verbal and nonverbal methods for communicating this.

SOLER indicates the nonverbal; and **VAPER**, the verbal.

Sitting squarely

Openness (in posture and mind)

Leaning slightly forward

Eye contact (culturally appropriate)

Relaxed alertness

Volume: not too loud or too soft

Articulation: clearly communicate your message; do not ramble but remain concise and clear in your communication

Pitch: not too high or too low

Emphasis: can change the meaning of a sentence depending on where you place the emphasis

Rate: do not speak too fast or too slow

Questioning

Open-ended questions assist in facilitating communication, assisting clients in sharing their experiences, clarifying assumptions or understandings, and developing new insights or understandings. These questions often start with:

- What
- Where
- Who
- How

These also cannot be answered using a simple response such as yes or no or a number as a response.

- Accessing and clarifying
- Closed questions = *Are ...? Do ...? Is ...?*
- Open questions = *What ...? How ...?*
- “Why” questioning implies judgment and accusation

Client observation skills

- Observe behavior, consciousness, attention, speech, appearance, orientation, mood, affect, content of thought, judgment and memory to get a full picture of a person’s functioning.

Encouraging

- Implies you are with them, that you are listening to what they are saying. It allows you to connect with the person without having to interrupt them. Examples include:
 - » Nonverbal = nodding
 - » Semiverbal = making sounds such as “Hmm,” “Uh-huh”
 - » Verbal = saying phrases such as “Yes, go on”

Paraphrasing

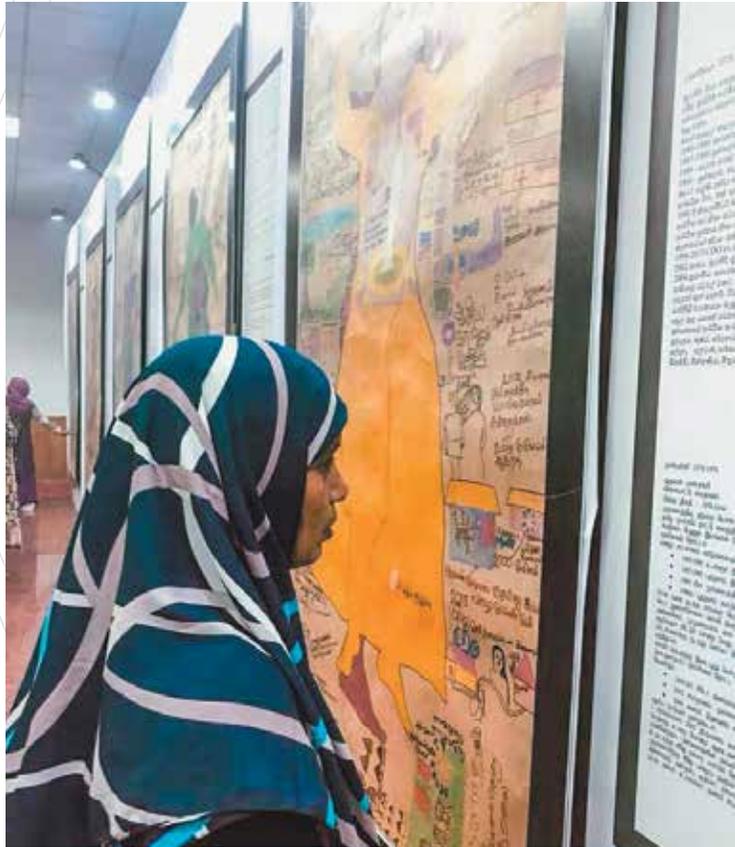
- Periodically repeating the essence of the client’s discourse
- Reassures the client that they have been heard and understood
- Helps the therapist check that they clearly understand the client

Summarizing

- Bringing together the client’s story, experiences and so forth
- Organized, systematic discourse that can be understood (more manageable)
- Capture the essence

Reflection of feeling

- Selective attention to and reflection of the emotional content of the session
- Portraying to the client that there is an understanding of their feelings and perceptions
- Helps articulate emotions or experiences that the client is struggling with



A photo taken during “The Body Remembers: Body Mapping of Women in Conflict,” an exhibit presenting body maps drawn at a GIJTR workshop in 2017 by 18 female victims of violence in Sri Lanka.

An important part of counseling is ensuring that the client has access to all the resources they need to recover from the trauma. These needs are holistic in nature and can range from basic needs such as food and housing to psychiatric care, employment support and so forth. This is where making a correct referral to an organization that can assist with these needs is important.

Making Referrals

Six weeks is generally regarded as the critical time needed for trauma recovery. Referral is necessary if it seems that after this time:

- The person's trauma-related symptoms become worse or get stronger rather than decrease.
- The person experiences ongoing tension, bewilderment, confusion, tension, emptiness and exhaustion.
- The trauma is affecting the person's other social/basic needs such as their ability to work, access health care and education, and provide food and shelter for themselves and their dependents and so forth.

When to refer

While every organization wants to be able to meet all the needs of individuals and communities, the reality is that most can't. Furthermore, in the aftermath of violence and in the trauma healing process, the needs of individuals and communities can vary. Therefore, in taking a holistic approach, we need to consider what all the needs of those we work with may be. This can range from mental health support to medical needs to livelihood support or food support. So we refer when we can identify that this is the need of an individual but that we as an organization cannot provide the service. In addition, we also refer in these very important situations:

- The person is unable to control their feelings of anger and/or depression, exhibits destructive behavior toward others and/or themselves, continues to be withdrawn and apathetic or becomes suicidal.
- The person behaves in sexually inappropriate ways — decreased interest in

sexual activity can be expected immediately after trauma.

- Any psychotic symptoms emerge — such as hearing voices, seeing things and feeling afraid of unreal things.
- The person continues to complain of body pains and injury that do not seem to appear any better.
- Since the event, the person smokes, drinks or takes drugs in excess.
- The person's work performance deteriorates, or they are unable to cope with the ordinary demands of daily living.
- The person's relationships suffer badly, or sexual problems emerge.
- There is a reemergence of previous psychiatric or psychological problems.

How to refer

The first step of the referral process is to do referral mapping in the community that you are working in. You can begin by looking on the internet, but often the most up-to-date information isn't available, so you may need to use your existing work networks to find out about other organizations. The World Health Organization (WHO) recommends the use of the 4 Ws approach to mapping for MHPSS. This is: **Who** is the service provider? **Where** are they situated/located? **When** can they be accessed? **What** do they offer? (IASC, 2012)

Next it's best to try to arrange a meeting with the organization. Referral processes are often more effective if the other organization knows about you and you have a working relationship in which they can refer to you as well. The contact details of the referral site and key contact personnel within that referral site should be captured in your referral mapping so that everyone in the organization has access to the necessary information.

Referrals can be made informally by just informing the client where they should go, while other organizations may require more formal referral pathways such as sending the individual with a referral letter. Get permission from the participant. They should be informed of the referral and what is hoped to be achieved through the referral. Referral information should include:

- Client's name

- Address
- Contact phone numbers
- Age/date of birth
- Date of interview with you
- A very brief description of the nature of the client’s problems. The amount of information that you include depends on what the referral is for and to whom you are referring. Always check with the client about what information they are comfortable with including in the referral letter.
- Name and contact number of the fieldworker/counselor/psychosocial support and so forth.

The referral process is a professional one, designed to further assist the client. Confidentiality should never be broken by passing on more information than is strictly necessary.

For example: Your organization has been doing documentation of human rights violations within a specific community. Through this you encountered one woman who lost her husband eight years ago as a result of a conflict in the area. She was a housewife at the time while her husband was responsible for caring for them financially. After he died, she was responsible for providing for their five children, which she was unable to do. As a result, all the children couldn’t attend school anymore, and she explains that one child may be taking drugs now. She is also incredibly emotional and cries while she tells you this, and just keeps repeating, “I miss my husband. Things were easier with him. I think I should just join him.” Additionally, she could not afford rent, so they have been living on the streets. Your organization only does documentation, so in this case, what do you do?

We refer to organizations that we know will be able to:

- Provide MHPSS support: She appears distressed, and what she is saying may be a sign of how hopeless and depressed she is feeling. She may also be showing suicidal thoughts, which needs to be determined. This could also be the case for the children.
- Provide social support: This will include educational support for the children and livelihood support so she can provide for the children and a place where she may be able to provide temporary shelter.

USEFUL TOOLS TO USE DURING COUNSELING

Rivers of Life

Explain that the Rivers of Life exercise allows us to reflect on our life stories — what has led us to this point today.

Provide clients with:

- Flipchart paper or any large piece of paper
- A range of drawing materials — markers, crayons, colored pencils, playdough/modeling clay and so forth.

Ask the client to draw their individual Rivers of Life

- Pictures demonstrating the source of their rivers, the twists and turns their rivers have taken and where their rivers are flowing to now
- The pictures should include the people and events that have been meaningful and have had an impact on them, the milestones they have achieved, the obstacles they have struggled with and so forth.
- Participants may use symbols to represent different feelings and experiences (e.g., flowers along the bank of the river for good times and rocks in the water for bad times).

Invite the client to share their River of Life with you, or, if it is a group session, with the group. Emphasize that they should share as little or as much as they feel comfortable with.

In a group session, if time permits, after each client has shared their River of Life, ask whether there is any feedback from the group. **Note that feedback should be very brief and strictly limited to *observations* (what participants noticed) and *questions for clarity*.** This is not the time for anyone to give advice, make judgments or share about a time when something similar happened to them. Feedback (from both the counselor/helper and the clients) should focus on what they are seeing and hearing. For example, “I can see that this experience you’ve shared with us still makes you very sad” or “I can hear how lonely you felt when that happened” or “I’m noticing that a number of us have experienced significant loss and that we still feel the pain even if it happened a long time ago.” After all the clients have shared their Rivers of Life, debrief the exercise by asking them how it was: ***How are you feeling about the exercise?***

It is likely that there will have been some discomfort about the show of emotions during the exercise (especially if anyone has cried). Ask clients: **What do we think about emotions?** Clients may share that when people show emotions (particularly when they cry), it is difficult, scary, a sign of weakness and so forth. Emphasize that in the context of the psychosocial support/wellness, we want to reframe this perception of emotions. In our context, all feelings are real and need to be acknowledged, and we will explore appropriate ways of expressing our feelings (rather than ignoring or disregarding them).

In addition, emphasize how this exercise allows us to get to know one another — as whole human beings, with full and colorful and complicated lives. Encourage clients to consider how everyone has a story and that everyone has wounds that they carry with them and that affect the way they engage with others and the way they respond to things.

Close this exercise by thanking everyone in the group session or the individual client for their courage and bravery (in sharing their stories).

HANDOUT: ACCESSING HELP AND SUPPORT

Draw lines indicating the places that you tend to go when you are experiencing the feelings listed in the inner circle.

Use the following guidelines for the number of lines that link the inner circle with the outside ones:

1 line = never

2 lines = once in a while

3 lines = sometimes

4 lines = often

5 lines = always



2.2 Recommended Readings

- Ruzek, J. I.; Brymer, M. J.; Jacobs, A. K.; Layne, C. M.; Vernberg, E. M.; & Watson, P. J. (2007). Psychological first aid. *Journal of Mental Health Counselling*, 29(1), 17-49.
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- Nelson-Jones, R. (2014). *Practical Counselling and Helping Skills* (6th ed). London, England: Sage Publications.

2.3 Activities and Handouts

2.3.1 PRE/POST-TEST ON PSYCHOLOGICAL FIRST AID TRAINING

Provide a blank handout to participants at the beginning and end of the training.

Tick Yes or No for the following statements:	Yes	No
1. Most people who have experienced a crisis event develop a mental disorder.		X
2. Most people who have experienced a crisis event need specialized mental health services.		X
3. Most people who have experienced a crisis event recover from distress on their own using supports and resources.	X	
4. Asking people to recount the details of their traumatic experiences straight after it happened is helpful.		X
5. <i>Counseling, trauma debriefing and psychological first aid</i> are all different words that mean the same thing.		X
6. Giving any reassurance to help someone feel better is helpful (e.g., your house will be rebuilt soon).		X
7. Being sure to say only what you know (e.g., about the situation/services) and not to make up information that you don't know is helpful to the person being assisted.	X	
8. Judging the person's actions and behavior (e.g., you should not have said or done this or that) so they don't make the same mistake next time is a good thing to do.		X
9. Finding out more about the situation and available services so that you can assist people in getting their needs met is helpful.	X	
10. Telling an affected person how they should be feeling (e.g., you should feel lucky, things could be worse) is helpful.		X
11. It is helpful to ask an affected person about their concerns, even when you think you know what their concerns are.	X	
12. As someone providing assistance to others, you should focus on the people you are helping and try to forget your own needs until after the crisis situation is over.		X

2.3.2 PRE/POST-TEST FOR THE TRAINING ON PSYCHOLOGICAL FIRST AID FOR MINORS

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. The answers are included below.

Tick Yes or No for the following statements:	Yes	No
1. Minors are often a particularly vulnerable group during a crisis.	X	
2. All minors respond in the same way in a crisis.		X
3. Age influences how a minor will react.	X	
4. The PFA for minors has the same elements as PFA for adults.	X	
5. It is best to separate the child from a distressed caregiver.		X
6. Children can return to earlier behaviors during a crisis.	X	
7. Children have their own resources for coping in a crisis.	X	

2.3.3 PRE/POST-TEST FOR THE TRAINING ON STATEMENTS AND INTERVIEWS

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. The answers are included below.

Tick Yes or No for the following statements:	Yes	No
1. Giving a statement or giving an interview can retraumatize an individual.	X	
2. It is important to identify whether there are any mental health issues that may affect the person's ability to tell the story.	X	
3. Psychosocial support increases the stress of the individual.		X
4. Empathy is feeling sorry for someone.		X
5. Safety is about only physical safety.		X
6. Containment is to help calm someone.	X	

2.3.4 PRE/POST-TEST FOR THE TRAINING ON BASIC COUNSELING SKILLS

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. The answers are provided below.

Tick Yes or No for the following statements:	Yes	No
1. Counseling is telling people what they should do.		X
1. Empathy and sympathy are the same.		X
1. Counseling is confidential.	X	
1. A nonjudgmental attitude is an important quality of a counselor.	X	
1. Everyone can provide counseling.		X
1. There are limits to confidentiality.	X	
1. Communication is about only the words you use.		X

2.3.5 PFA CASE STUDY AND QUESTIONS

Provide participants with the following case study. Divide them into groups to discuss the questions and provide feedback to the larger group.

Case scenario: violence and displacement

There were violent protests and bombings in the area near you. For their safety, residents are being brought to a new location in trucks and told that they will be staying in this new place. As they disembark from the trucks, some of them are crying, some appear very fearful and some seem disoriented, while others

are sighing with relief. Most are afraid and doubtful of this new place and have no idea where they will sleep, eat or receive health care. Some seem scared when they hear any loud noise, thinking they are hearing the guns again. There are children running around screaming and kicking their parents. You are psychosocial support volunteers working in collaboration with an agency that distributes food items and have been asked to help provide PFA at distribution sites. But take a moment to stay calm and consider the following:

As you PREPARE to help, consider:

- What is the background of the people you will be helping?
- What services are being provided in the place the displaced persons are being received, and how can you coordinate with other helpers?
- **As you encounter the group, what is important to LOOK for?**
- What different types of reactions do you observe among the individuals?
- Who needs assistance? Who can help you?
- **As you make contact with people among the group, how can you best LISTEN to their concerns and give comfort?**
- People who have experienced or witnessed violence may feel frightened. How will you support them and help them feel calm?
- How can you find out the needs and concerns of people who likely need special assistance, such as women?
- **What can you do to LINK people with information, loved ones and services?**
- What accurate information is available about the situation and available services?
- How can you help to keep the affected family together?

2.3.6 ACTIVITY FOR FIRST AID FOR CHILDREN WORKSHOP PRESENTATION

Ask the participants to divide into three different groups.

- **Group 1** — Can you think of things that can be done and to help: infants?
- **Group 2** — Can you think of things that can be done and to help: young children?
- **Group 3** — Can you think of things that can be done and to help: older children and adolescents?

Each group will present their answers to the rest of the group. Facilitate discussion and then psycho-educate them on things the groups did not think of.

2.3.7 UNDERSTANDING EMPATHY

- Instruct participants to draw a metaphorical representation of what empathy means to you as a helper or what it might represent.
- Facilitate discussion and ask whether anyone would like to share their representation.
- Draw a representation of an individual who has fallen down a hole/ditch (depression) and explain the difference between sympathy (pulling someone out of the hole), over identification (sit together and hold hands), and empathy (sitting beside and walking through together).
- If the venue permits, show the participants the “Brené Brown on Empathy” video: <https://www.youtube.com/watch?v=1Ewgu369Jw>.

2.3.8 ACTIVE LISTENING ROLE PLAY ACTIVITY

- Divide participants into pairs. One person from the pair is to be the Helper. Instruct the Helpers to come to the front of the class to receive instructions from the facilitator. Instruct these individuals that there will be two sets of role playing. For the first set, they are to not actively listen when the “client” is talking (look away/down, don’t keep eye contact, slouch in chair, lean head on hand, yawn, look at cell phone and so forth). For the second role play, they must actively listen (eye contact, nod, “mm hmm,” sit squarely, reflect, ask appropriate questions and so forth).
- The facilitator instructs the second group from the pairs, the “clients,” to come to the front of the class to receive instructions. Instruct these individuals to tell a sad story.
- Run the role play sessions.
- Facilitate a discussion regarding the experience of not listening to a sad story as well as the experience of not being listened to.

CHAPTER 3

TRAUMA

3.1 Theoretical Framework

Trauma is defined as damage or injury to the psyche after living through an extremely frightening or distressing event and may result in challenges in functioning or coping normally after the event. These events may include natural disasters, car accidents, death of a loved one, rape, hijacking, war, political conflict, experiencing physical or sexual abuse and other life-threatening events (Sadock et al., 2015).

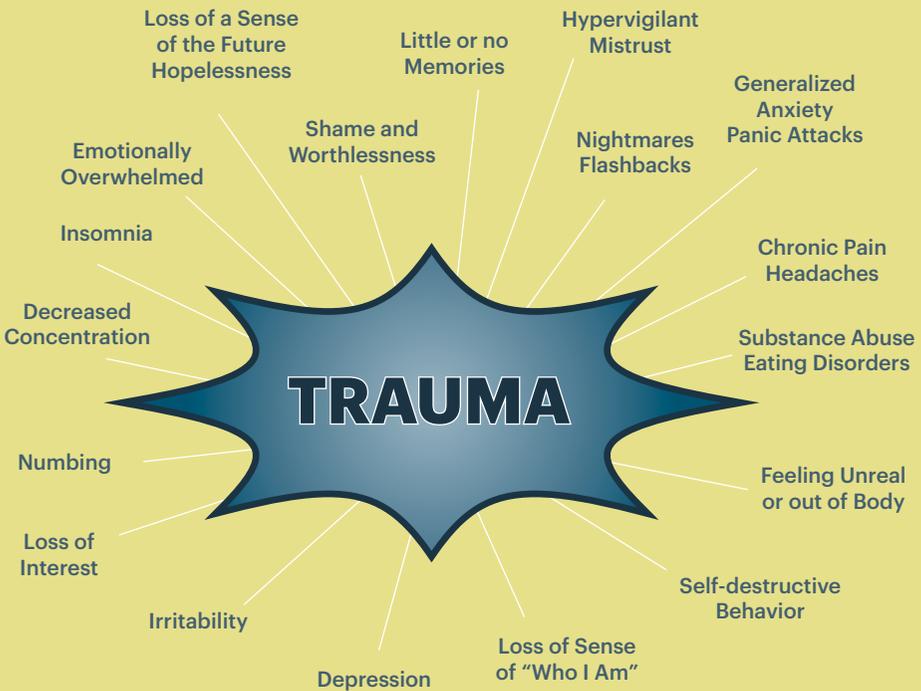
Trauma affects individuals in different ways (so while we have noted some symptoms of trauma, these may differ from person to person), and not everyone who experiences an event becomes traumatized (two people can experience the same event, and one does not become traumatized, while the other does). An event in and of itself is not traumatic; rather, it is the meaning that we ascribe to that event that makes it traumatic. If the event leaves you feeling helpless, out of control or in danger of losing your life or being harmed — or those feelings manifest in someone you care about — then this event may be experienced as traumatic. Trauma shatters all our assumptions that we have about the world and how we interact with it, such as:

- The belief that you are safe in the world and that nothing bad will happen to you
- The view of self as positive



- The belief that the world is a meaningful and orderly place and that events happen for a reason
- The belief that there is an end to suffering
- The trust that other human beings are safe and good and will not harm us

Some of the impacts of trauma include:



“Trauma survivors have symptoms instead of memories.”

Harvey, 1990

3.1.1 POST-TRAUMATIC STRESS DISORDER

Most people who go through traumatic events have temporary difficulty adjusting and coping, but with time and good self-care, they get better. However, if a person fails to recover after experiencing or witnessing a traumatic event, and the symptoms get worse and interfere with their day-to-day functioning, they may have post-traumatic stress disorder (PTSD).

PTSD is characterized by elevated stress and anxiety levels that are experienced by individuals who have been exposed to a traumatic or stressful event (Sadock et al., 2015). PTSD requires that an individual directly experiences a traumatic event, witnesses a traumatic event, hears about a traumatic incident happening to someone close to them or is repeatedly exposed to details of traumatic events. As a result, for over a month after the event, the individual will experience a specific set of reactions, related to the event, across four categories: intrusive symptoms, avoidance, negative alterations in cognitions and mood, and alterations in arousal and reactivity. The condition may last months or years, with triggers that can bring back memories of the trauma accompanied by intense emotional and physical reactions. Symptoms may include panic attacks, flashbacks, nightmares, severe anxiety and depression. Other typical reactions may include fear and helplessness (negative changes in cognition/thoughts and mood). Individuals may persistently relive the event as though it were happening again in the present through their dreams and flashbacks (symptoms of intrusions), and they may avoid reminders of the event or being reminded of the event (persistent avoidance of stimuli associated with the traumatic event). They may also experience alterations in arousal and reactivity such as hypervigilance, startle response, anger and irritability, poor concentration, problems with sleeping too much or too little and reckless or destructive behavior.

Intrusive symptoms	Avoidance	Negative changes in thoughts and mood	Changes in arousal and reactivity
Recurrent, involuntary and distressing memories	Avoidance of memories, thoughts or feelings associated with the event	Unable to remember parts of the events	Irritable behavior and angry outbursts
Recurrent distressing dreams	Avoidance of external reminders (e.g., places, people, activities, colors or objects)	Constant or exaggerated negative beliefs about the self (e.g., "I am bad")	Reckless or self-destructive behavior
Dissociative reactions (e.g., flashbacks)		Incorrect beliefs about the event that cause the person to blame themselves	Hypervigilance (always on high alert for danger/threats in one's environment)
Psychological distress when exposed to a reminder of the event		Constant negative emotional state (e.g., fear, anger, guilt or shame)	Startle response
Physical reactions when exposed to external or internal reminders		Decreased interest or participation in important activities	Difficulty concentrating
		Feeling detached from others	Sleep problems such as difficulty falling or staying asleep
		Unable to experience positive emotions (e.g., happiness or love)	

All of the above cause significant difficulty in the person's life, whereby they feel unable to do the things they previously did, such as work and socializing, or the dynamics have an effect on other important areas of their life.

"X" thought the world was a relatively good and happy place where everyone in his community looked after and cared for one another. He worked at the nearby market and loved selling the things he made himself and always talking to his customers. Then X heard rumors that there was some tension and conflict in the neighboring area due to fights about land. X did not pay much attention to this because he believed the people of his country would never fight with or hurt one another. Then one day while at the market, X heard screaming and saw people running. The people who had attacked the neighboring area were now claiming their land too. X heard gunshots and started running home to see how his family was and get them to safety. When X arrived, he met a rebel standing outside his burning house, with his family inside. The rebel then shouted at him and started beating him. X says that is all he can remember — he woke up a few days later in a neighboring town. Six months later, X keeps waking up at night hearing his family screaming, and his heart starts beating fast and he finds it hard to breathe. It can take him hours to go back to sleep. He no longer leaves the house and finds it difficult to even leave to go to the shops because he says he is always scared and doesn't know whom he can trust. The family who is caring for him finds his behavior difficult because he gets angry at the smallest things. Because of this, X also can't work or go to the doctor for his follow-up treatments. X may be experiencing PTSD.

Treatment includes different types of psychotherapy as well as psychiatric medications to manage symptoms. Thus, the treatment for PTSD is outside the scope of psychosocial support and your role if you come across someone exhibiting these symptoms is to refer onwards for psychological and psychiatric care.

3.1.2 COMPLEX PTSD/TRAUMA; CONTINUOUS TRAUMATIC STRESS AND COLLECTIVE TRAUMA

Complex PTSD is precipitated by repeated and chronic traumatic events, more commonly in childhood and often in a circumstance of captivity such as child abuse, domestic abuse, prisoner of war camps and so forth. Its symptoms include feelings of terror, helplessness and worthlessness and a damaged self-concept and identity.

Whereas PTSD involves feeling threatened and frightened even when one is no longer in danger, continuous traumatic stress (CTS) involves living in conditions in which there is a real and ongoing risk to one's safety. The ongoing nature of CTS leaves very little space to be able to address past trauma. In addition, CTS builds on the impact of past trauma and reduces one's resilience. People who are exposed to danger repeatedly and/or over a long period of time may develop continuous traumatic stress disorder (CTSD). Symptoms may include panic attacks, dissociative disorders, general sickness and immune deficiency, impulsive behavior, insomnia and self-destructive behaviors such as substance abuse. Treatment for CTSD involves a combination of medical treatment, counseling, education and skill development, designed to help patients develop new ways to manage their responses to stress.

Collective trauma refers to a traumatic event that is shared by a group of people. It may involve a small group, like a family or an organization, or an entire society. Traumatic events that affect groups may include things like a plane crash, a natural disaster, mass shootings, famines, war or pandemic (such as the COVID-19 pandemic).

People don't necessarily need to have experienced the event firsthand to be changed by it. Watching the event unfold on the news can be traumatic, for example. Sometimes the shared pain of collective trauma can lead to solidarity and promote healing. For example, individuals may defend against a common threat and find meaning in their experience together. However, when an entire society is traumatized, healing is often more difficult. Pain may be widespread, unhelpful responses may become normalized and entire communities may struggle to move forward. For example, an entire society may begin to hoard food after a famine, even when food is plentiful again. Generally, collective trauma leads to significant shifts in the way people in a culture behave, feel, work together, raise their children and so forth.

3.1.3 DEPRESSION

The diagnosis for major depressive disorder notes that the individual must present with at least five of the following symptoms for at least two weeks (Sadock et al., 2015): a “depressed or irritable mood,” “a loss of interest or pleasure,” “failure to make specific weight gains, daily insomnia or hypersomnia, psychomotor agitation or retardation, daily fatigue or loss of energy. Feelings of worthlessness or inappropriate guilt, diminished ability to think or concentrate, and recurrent thoughts of death” (Sadock et al., 2015, p.1228).

3.1.4 DISSOCIATIVE DISORDERS

Dissociation is defined in psychiatry as “an unconscious defence mechanism” that separates groups of mental or behavioral processes from the rest of the individual’s psychic activity (Sadock et al., 2015, p.451). Dissociative disorders involve this defense mechanism that results in a disruption in one or more mental functions, such as memory, identity, perception, consciousness and motor behavior (Sadock et al., 2015). Dissociative disorders have the potential to disrupt every area of psychological functioning (American Psychiatric Association, 2013). The disturbance can occur either suddenly or gradually and can be either transient or chronic (Sadock et al., 2015). Psychological trauma is seen to be the cause of the signs and symptoms of dissociative disorders (Sadock et al., 2015).

In therapy or when speaking to someone who is experiencing this, the trauma can often present as if the individual is not paying attention. They are not making eye contact and seem lost in fantasy. For further examples, read http://www.turner-white.com/pdf/brm_Psy_V7P2.pdf.

3.1.4.1 DISSOCIATIVE AMNESIA

Dissociative amnesia is characterized mainly by a person being unable to recall important personal information, especially traumatic or stressful information “that is too extensive to be explained by normal forgetfulness” (Sadock et al., 2015, p.451). For example, many times when we ask people about details of the traumatic event or what they can remember, they will say nothing. Or, at very stressful periods, they will “black out” and say they do not remember what happened.

CASE EXAMPLE

A 35-year old woman came for assistance and explained that over the past month, she has been unable to sleep and is always tired. She says she is feeling unable to do the day-to-day things that she used to do such as waking up to get her children ready for school. She is also very irritable and has outbursts of anger or sadness at the smallest things, so she finds herself shouting at the children all the time. Even while she is speaking to her counselor, she finds it hard to be attention, and the counselor has to repeatedly asked the same questions. She explains that this started happening after her husband left and that she is feeling very hopeless about her future and that of her children.

3.1.4.2 DEPERSONALIZATION/DEREALIZATION DISORDER

Depersonalization is characterized as the “persistent or recurrent feeling of detachment or estrangement from one’s self,” in which the individual describes feeling like an “automaton or watching himself or herself in a movie” (Sadock et al., 2015, p.454). Derealization is associated with feelings of unreality or being detached from one’s environment (Sadock et al., 2015). The individual may report feeling as if they are dreaming or dead, as their “perception of the outside world [lacks] lucidity and emotional colouring” (Sadock et al., 2015, p.454).

3.1.4.3 DISSOCIATIVE FUGUE

Dissociative fugue is characterized as an individual’s “sudden, unexpected travel away from home or [their] customary place of daily activities, with inability to recall some or all of [their] past” (Sadock et al., 2015, p.457). Along with this, the individual is confused about their personal identity and may even adopt a new identity (Sadock et al., 2015).

3.1.4.4 DISSOCIATIVE IDENTITY DISORDER

Dissociative identity disorder was previously known as multiple personality disorder (Sadock et al., 2015). It is distinguished by the existence of “two or more distinct identities or personality states” (which are sometimes called alters, self-states, alter identities or parts) (Sadock et al., 2015, p.458). The distinct identities or personality states are characterized by one another, as each is seen to have its own “pattern of perceiving, relating to, and thinking about the environment, and self” — its own personality (Sadock et al., 2015, p.458). This is not a common disorder and is associated with chronic trauma at a young age. However, many people can dissociate when asked to speak about the trauma they have experienced.

If you are trying to assist someone and they disassociate temporarily (they look as if they are not listening or their eyes are glazed over as if they are thinking of something else) or become extremely emotional, you can use a grounding technique to bring them back into the present, as often they may be reexperiencing the traumatic event as if it is happening again, which can be very distressing for them.

Containment and Grounding

When a person finds themselves overwhelmed with emotions or unable to stop thinking about or imagining something that happened. The ‘grounding’ technique can be used to feel less overwhelmed.

Grounding works by bringing the person’s attention away from their inner thoughts and back to the present (and the external world.)

ANXIETY GROUNDING TECHNIQUE

Focus on your breathing, then identify



3.2. Loss, Grief, Bereavement and Mourning

Types of loss

People may experience many forms of loss over a lifetime. Loss can be both a physical loss, such as the loss of someone we care about through death or disappearance or the loss of possessions and land, and a symbolic loss, which is described as an intangible psychological loss such as a loss of identity, a loss of a sense of self. The loss of a loved one can be one of the most unbearable forms of loss and results in several different psychological processes. Loss can affect the physical, social and psychological well-being of an individual. The context in which the loss occurs is also a major determining factor of mental health impacts.

Description of grief, bereavement and mourning

- **Ambiguous loss:** This is the process in which the loss is not clear. There is no tangible proof of the loss. Because the loss is unclear, the individual is unable to process the loss or move into the grieving process. Individuals often hold on to the hope that the loss is not real and that there is a chance that the person is alive. This is very common in the case of enforced disappearances or extrajudicial killings or when people are separated from family when they need to flee a country. For example, “Y”’s husband was taken from the house one night by government officials. They heard he had been placed in the one prison nearby, but no one could confirm. Then they heard rumors that a few prisoners had escaped and that he may be among them, but there were also rumors that many people never left the prison. For many years, Y was unsure about what had happened to her husband. She could not grieve because she did not know whether he was alive or dead and kept holding on to the hope that one day he would return home.
- **Grief:** Grief is a process as well as a reaction to loss. This is a normal reaction to a loss, and through the process, the individual disinvests the energy attached to the object. At the end of the process, the individual is able to accept the loss. Although it remains a significant event in a person’s life, they are not governed by the loss. Grieving a loss is a normal process, but when the process is either prolonged or delayed and affects the individual’s

level of functioning, it can become complicated grief. “Z” went through a difficult period after the loss of her husband. Everyone told her it would be fine and that with time, she would feel better. But two months later, Z finds that she forgets to eat for days at a time, that she is unable to get out of bed sometimes and can sleep the whole day. She has lost her job because she didn’t arrive for work for a whole week, and her children have gone to live with family, as she was finding it hard to care for them. Z may be experiencing a depressive episode.

- **Bereavement:** Bereavement is the period after the loss in which the individual takes to adapt.

Common reactions to sudden loss

- A search for meaning about why this happened
- Changes in sleep, appetite and energy
- Overwhelming feelings of sadness

These are normal responses, and only when these are either prolonged or delayed and affect the individual’s level of functioning can they become cause for concern.

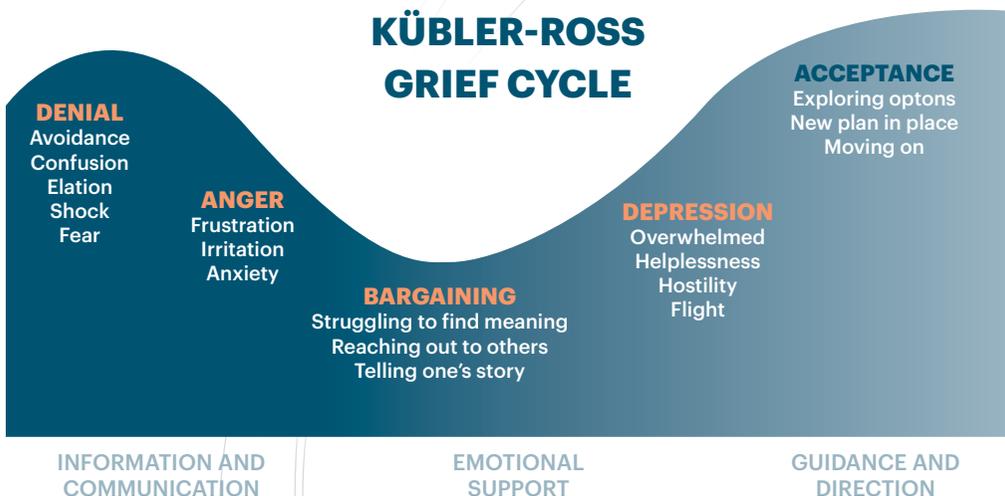
Process of grief

Kübler-Ross and Kessler (2005) describe five stages of grief that most individuals experience when confronted with a potential loss or in the aftermath of a loss.

1. **Denial:** This is denying the reality of the situation and loss and often becoming numb.
2. **Anger:** Once the reality has been accepted, many will become angry (at different people or situations) and try to search for answers. “Why me?” or “This isn’t fair.” This provides the individual with a defense against what is happening.
3. **Bargaining:** This is the pleading and bargaining for things or the situation to be different.

4. **Depression:** This is normal and is the stage in which the individual is overcome with the sadness of the reality of the situation.
5. **Acceptance:** The individual accepts the loss.

This is not a linear process; rather, individuals may move forward and backward between stages or start at different at stages.



Psychosocial support guidelines for working with individuals and families of enforced disappearances

Many families who have lost a family member as a result of enforced disappearances often experience ambiguous loss or complicated grief. Therefore, when working with a family, we need to be aware of these psychological responses. Various factors determine how one may respond to someone experiencing ambiguous loss or complicated grief. Their context, personal characteristics, the type and level of engagement/relationship with the person and the nature of their psychosocial needs all play a role in determining the best way to assist.

Counseling and psychosocial support

Because of the individual or the family being unable to get closure, the counseling process and PSS often focuses on trying to support this process. In cases in which the death of the loved one has been confirmed, we can help the individual or family think of different practices that may help give them closure. As we know, the burial process is the main process that helps individuals and families, but in cases in which there is no body, this can be difficult. Therefore, help the individual think of something, such as a memory box or a family prayer process. We can help them think about and implement this in line with their culture and religion.

Forensic processes

The key thing to remember is that many of these individuals or families have often been waiting an incredibly long time for some answers about what happened to their loved one, and our main task is to not raise their hopes prematurely, as this will cause secondary traumatization. It is important to be honest and transparent and manage expectations. Often the biggest mistake we make is wanting to relieve the pain that they are experiencing, so we give false hope. So be clear about the timelines of the process. Be honest about what the chances are that their loved one's remains will be found and/or that they will achieve justice for their loved one. In the case of forensic processes, it is better to first meet with one family member first. This is to explain the process and also to gather the necessary information about the disappeared person and the family structure. We are often not aware of all the family dynamics, and often if we just call a whole family in, conflict may arise. This is more common with extended families and polygamous marriages.

Often in a post-conflict context, one of the main things families and communities ask for is information and the truth about those who have disappeared. In some cases, this is uncovered through truth-telling processes, documentation or forensic investigations. In the cases of mass events or losses, memorialization can be an important way of helping people remember those they have lost and a way of creating closure, especially in cases in which they have not been able to retrieve the remains. Even at an individual level, counselors can help clients in this process by creating memory boxes related

to the one they have lost. Memory boxes contain different items that remind the person of their loved ones and can include things such as photos, jewelry, birthday cards and clothing. Remembrance and mourning are key components of trauma recovery but are also very important after the often ambiguous and traumatic loss of a loved one.

3.2 Recommended Readings

- Herman, J. L. (1992). *Trauma and recovery: The aftermath of violence*. New York: Basic Books
- Epstein, M. (2013). *The trauma of everyday life*. Penguin.
- Petersen-Coleman, M. N., & Swaroop, S. R. (2011). Complex trauma: A critical analysis of the Rwandan fight for liberation. *The Journal of Pan African Studies*, 4(3).
- Kanninen, K., Punamäki, R. L., Qouta, S. (2003). Personality and trauma: Adult attachment and posttraumatic distress among former political prisoners. *Peace and Conflict: Journal of Peace Psychology*, 9(2), 97–126.
- Berger, S. S. (2014). Whose trauma is it anyway? Furthering our understanding of its intergenerational transmission. *Journal of Infant, Child, and Adolescent Psychotherapy*, 13, 169–181.

3.3 Activities and Handouts

3.3.1 PRE/POST-TEST FOR THE IMPACT OF TRAUMA TRAINING (CAPACITY-BUILDING FOCUSED)

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. The questions with the correct answers are supplied below.

Tick Yes or No for the following statements:	Yes	No
Trauma affects all people in the same way.		X
Trauma affects only the individual who experienced the crisis event.		X
Trauma affects a person's mind and body.	X	
Trauma is the same as grief.		X
The response to the traumatic event involves intense fear, helplessness and horror.	X	
All people exposed to a traumatic event become traumatized and develop PTSD.		X
Nightmares, body pains and feelings of helplessness and hopelessness are all symptoms of being traumatized.	X	

3.3.2 INTER/TRANSGENERATIONAL TRAUMA

The concept of intergenerational or transgenerational trauma states that trauma and especially the effects of unresolved trauma can be passed from one generation to the next through genetics as well as how a child was raised within a family. In working with families, this may include children displaying signs of avoidance and mistrust following observations of parents' behavior (e.g., symptoms of PTSD), which may stem from their own parents' or collective experiences of violence (e.g., war trauma, conflict, torture).

Working with this type of trauma in a family setting may require working with parents' unresolved trauma and, depending on a child's age, reflecting on how their behavior may relate to their parents' behavior or experiences. Occasionally, the traumatic experiences are not acknowledged or verbalized within a family but children feel a tension that they do not understand. This often causes distress and is also a vehicle for the transmission of trauma. It is sometimes more distressing because they cannot name the cause of these feelings. Children often internalize and blame themselves for these unidentified feelings or tensions.

In adults, the goal in managing intergenerational trauma is to help the person:

- Identify and acknowledge that they did experience this type of trauma.
- Reflect on the impact that this trauma has had on them and their interpersonal relationships.
- Help them identify the type of attachment they formed as a result of this trauma.
- Help them to improve their childhood attachment.
- Help them to “re-parent” themselves.

All of the above work requires long-term support from a psychologist. The role of psychosocial support is to provide psychoeducation around intergenerational trauma and its impacts.

3.3.2. PRE/POST-TEST FOR THE TRAINING ON INTER/TRANSGENERATIONAL TRAUMA

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. The questions with the correct answers are supplied below.

Tick Yes or No for the following statements:	Yes	No
1. Family trauma and collective trauma are the same thing.		X
2. Family trauma can be based on an event that one family member experiences that then affects the entire family.	X	
3. Trauma has a direct impact on the parents' psychological well-being and can manifest itself in a number of complex ways.	X	
4. Transgenerational trauma is about only the individual.		X
5. Transgenerational collective trauma may cause angry and depressed young people and adults.	X	
TOTAL SCORE:		

3.3.3 ACTIVITY: TRAUMA ACTIVITY/ICEBREAKER

This activity can be used with an individual client, as part of a group session or as an icebreaker for a capacity-building training.

Explain to the participants/client/s that we all live in Sri Lanka, which is riddled with violence and trauma. Ask the participants to think of a trauma that has happened to themselves or one they have witnessed or heard about. Ask them to write a short paragraph about this trauma.

Reflect with the participants/client on the experience of the exercise. How was writing about a traumatic experience for you? Would anyone like to share? Facilitate a discussion promoting thinking of trauma and emotions related to it.

This is a very simple yet powerful way for individuals to begin understanding what it is like to experience a traumatic event. It will be important to set aside enough time to talk to individuals about their reactions to doing this exercise. It is also important to consider giving individuals the option to not participate if they feel this activity might be distressing to them or they do not want to share in the group space. Let individuals know in advance that they do not need to share any information that they feel uncomfortable discussing. Then end with a positive exercise like a guided meditation to their safe place or a reflection exercise on the things that make them happy:

GUIDED IMAGERY EXERCISE

The purpose of this exercise is to relax your mind and guide you to imagine your own peaceful, safe place. This place will be an imaginary area that you can visualize to help calm and relax your mind when you are feeling overwhelmed by your thoughts and emotions.

- Find a comfortable position.
- For the next few moments, focus on calming your mind by focusing on your breathing. Allow your breathing to center and relax you. Breathe in...and out.
- In.... Out....
- In.... Out....
- Continue to breathe slowly and peacefully as you allow the tension to start to leave your body.
- Release the areas of tension, feeling your muscles relax and become more comfortable with each breath.
- Continue to let your breathing relax you....
- Breathe in...2...3...4.... Hold...2...3.... Out...2...3...4...5....
- Again...2...3...4.... Hold...2...3.... Out...2...3...4...5....
- Continue to breathe slowly, gently, comfortably....
- Let the rate of your breathing become gradually slower as your body relaxes.
- Now begin to create a picture in your mind of a place where you can completely relax. Imagine what this place needs to be like for you to feel calm and relaxed.

- Start with the physical layout of the place you are imagining.... Where is this peaceful place? You might envision somewhere outdoors...or indoors.... It may be a small place or a large one.... Create an image of this place. (pause)
- Now picture some more details about your peaceful place. Are you alone? Or are there other people present? Animals? Birds? Imagine whether it is you only, or whether you have company. (pause)
- Imagine even more detail about your surroundings. Imagine the sounds around you in your peaceful place.
- Now imagine any tastes and smells your place has to offer.
- Imagine the sensations of touch.... What is the temperature like — is it warm or cool? Is there a breeze? What type of surface are you standing or sitting on?
- (continued)
- Focus now on the sights of your place — colors, shapes, stones, plants, water...all the things that make your place enjoyable.
- Imagine yourself there. What would you be doing in this calming place? Perhaps you are just sitting, enjoying this place, relaxing. Maybe you are walking around....
- Picturing yourself in this peaceful place, imagine a feeling of calm...of peace.... A place where you have no worries, cares, or concerns.... A place where you can simply rejuvenate, relax and enjoy just being. (pause)
- Enjoy your peaceful place for a few moments more.... Memorize the sights, sounds and sensations around you.... Create a picture of this place in your mind.... This picture that you are imagining, you can return to it whenever you need a break.... Whenever you need to regroup....
- Turn your attention back to the present. Notice your surroundings as your body and mind return to their usual level of alertness and wakefulness.
- Keep with you the feeling of calm from your peaceful place as you return to the present.

Adapted from <http://www.innerhealthstudio.com/peaceful-place.html>

REFLECTION EXERCISE

Instructions:

- Ask participants to write down the name of a very close loved one whom they feel supported by.
- Ask participants to write down their favorite activity that brings them joy
- Ask them to write down their favorite place where they feel the most at peace

3.3.4 ACTIVITY: TRAUMA IN ONE'S COMMUNITY

Instruct the participants to get into groups of five and discuss the following:

1. What trauma have you noticed in your community?
2. How in your culture/religion/community/family/worldview do you define trauma?
3. What are the narratives around what are acceptable ways of coping with trauma in your community?

Facilitate a discussion around the answers to this question, or ask each group to answer one question.

3.3.5 IMPACT OF TRAUMA CASE STUDY AND QUESTIONS

During the training, provide the group with the following case study. They can then be divided into groups to discuss the questions and then provide feedback within the larger group.

Tommy is a 37-year-old employed man with a wife and three children. One evening while walking home from work, Tommy was robbed by a group of five men. During the robbery, they attacked him and stole his cell phone and wallet. He was nearly beaten to death and was lucky that a passerby called an ambulance. During the attack, Tommy thought that he might die before he passed out. He woke up two days later in the hospital. Because of his injuries, he was in the hospital for three weeks before going home, and it was a month before he went back to work.

During his time in the hospital, he kept having nightmares about the attack, so he was also finding it difficult to sleep. When he was awake, memories of the attack would enter his mind, as much as he tried to avoid them. When this happened, Tommy's heart would beat really quickly and he would find it hard to breathe.

When Tommy was back home, all the above continued, and his family was not managing to cope with them. Tommy's wife could also not understand why he no longer wanted to go to temple or do anything outside the house. When Tommy eventually went back to work, he would avoid the route he previously took to and from work. At work he was struggling to concentrate and get his work done. His co-workers tried to be supportive, but he would just get angry and shout at them. Eventually Tommy started drinking in the evenings to help him sleep. While doing this, he found out that the drinking helped to prevent some of the memories of the attack, so he started drinking in the morning before work too.

His boss noticed this and immediately fired him, without trying to understand why Tommy had gone from being one of the best workers to

drinking at work. Because Tommy had lost his job and could no longer support his family, his wife took the children with her to go stay at her mother's. This made Tommy feel even more worthless and depressed.

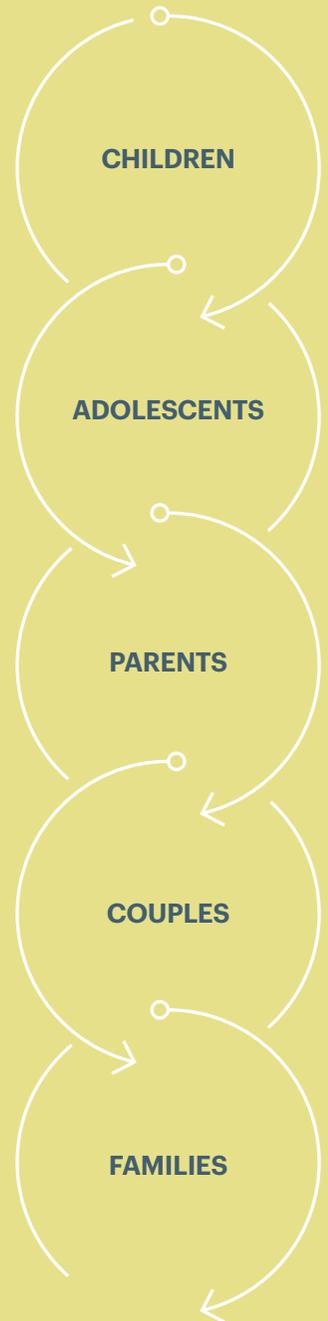
Tommy's life continued like this for six months before he realized that he needed help and looked for counseling. After counseling Tommy was able to get a job again and get his family back.

Questions

- What type of traumatic event was experienced?
- Does everyone experience trauma in the same way?
- What protective factors may have been present?
- What stressors may have been present?
- What hyperarousal symptoms does Tommy have?
- What reexperiencing or intrusive symptoms does Tommy have?
- What avoidance symptoms does Tommy have?
- Besides the hyperarousal, reexperiencing and avoidance, what other symptoms does Tommy have?
- What areas of Tommy's life have been affected, and in what way?
- Do you think Tommy was treated fairly by his family and boss? Why? Why not?
- How do you identify an individual who is traumatized?
- What would you have recommended to help Tommy straight after the attack?

CHAPTER 4

WORKING WITH TRAUMATIZED FAMILIES



4.1 Theoretical Framework

4.1.1 WORKING WITH CHILDREN

Section 4.1 of this toolkit focuses on themes that may be unique to working with children and their parents. It also highlights points that may be important to consider when working with children.

4.1.1.1 CONSIDERATIONS FOR WORKING WITH CHILDREN

- Clinicians/Helpers should attempt to create an environment that encourages a sense of safety and the child's freedom to express different emotions.
- Feelings that children can engage in and identify from as young as 3 years old include angry, happy, scared and sad. It is important that Clinicians/Helpers have these four faces visible on, for example, cue cards, pictures on the wall and so forth so children can point at them during the session and learn them and so they know that expressing

any of these in this space is accepted and normal.

- Clinicians/Helpers should always look at the emotions linked to the play or emerging from the play and use this in therapeutic ways and for therapeutic goals.
- Get to a child's level — sit on or play on the floor if the child is doing so. Be directed by the child. Be expressive in your voice, and use your body.
- Engage with children in their world (work with their fantasies, using materials as props to explore this). The Clinician/Helper will take on multiple roles in the play; they may also be the “naughty” or “bad” one.
- Children should not feel like therapy is “work.”
- Very angry children may have learned that anger is dangerous and that their anger is scary to themselves and others. They may have also not been able to manage their anger (both the feeling and the behavior). It is crucial that these children get to express their anger and learn the skills of emotional containment and regulation within therapy. This includes learning that they can be angry and express it safely, that there are good reasons for being angry but that nobody has to get hurt when they get angry. They can control their anger.
- As with adult counseling, it is important for a Clinician/Helper to model containment and maintain healthy boundaries in play. Children can often find it easier to act out rather than verbally express their emotions. An example might include a clinician observing that a child may be getting



Participants at a GIJTR workshop in Conakry, Guinea learning about self-care while assisting survivors with trauma

close to hurting themselves, the Clinician/Helper or breaking a toy, while experiencing an emotion such as anger. Instead of allowing a child to break a toy, within a resource-constrained context, a Clinician/Helper could offer the following reflection and redirection: “It looks like you are quite angry when you are pulling on that doll. [Allow a pause to see how the child reacts.] How about you come tear this paper with me, or let’s see how hard you can throw this ball against the wall.” The Clinician/Helper can then gradually attempt to probe around the anger.

- It is not helpful to ask “Why?” in play, as most children cannot answer this question. Clinicians/Helpers can attempt to reframe a why into a what, how or when question; for example: “What made you angry?” versus “Why were you angry?” A Clinician/Helper may offer an interpretation of a child’s behavior based on observations and stronger themes that have emerged through therapy. For example: “You told me that you were bullied at school yesterday. Maybe that is something that you are still angry about.” Such interpretations may be accepted or rejected but can assist a child with internalizing this curious voice and assist in developing their inner voice or self-talk.

4.1.2. THEMES IN WORKING WITH CHILDREN

There are a number of themes that are unique in working with children. The presence of these themes may depend on the unique context, culture, age, nationality, gender and family dynamics (e.g., birth order, child-headed households, parented children) and so forth of each child and family.

- **Intergenerational trauma:** The concept of intergenerational trauma suggests that trauma and especially the effects of unresolved trauma can be passed from one generation to the next. In working with families, this may include children displaying signs of avoidance and mistrust following observations of parents’ behavior (e.g., symptoms of PTSD) that may stem from their own parents’ or collective experiences of war trauma, torture or other traumas.

Working with this theme may require working with parents’ unresolved trauma and, depending on a child’s age, reflecting on how their behavior may relate to their parents’ behavior or experiences. Occasionally, the

traumatic experiences are not acknowledged or verbalized within a family but children feel a tension that they do not understand. This often causes distress and is also a vehicle for the transmission of trauma. It is sometimes more distressing because they cannot name the cause of these feelings. Children often internalize and blame themselves for these unidentified feelings or tensions.

- **Effects of parental functioning on children:** Similar to the previous theme, this theme suggests parents' physical and mental well-being can affect the different areas of children's lives (emotional, psychological, physical, social, cognitive, academic and so forth). Parents who may be struggling with mental health conditions can potentially find it more difficult to tolerate what may be normal children's behavior and may also find it difficult to sit with, hold or manage their children's psychological needs. Perhaps also as a result of not having their emotional or psychological needs met regularly, children may act out as a means of gaining their parents' attention and being held in their parents' minds. In addition, the aspects of support that parents prioritize are usually directed at the physical/basic needs of their children rather than their emotional needs. This may be linked to either cultural norms around parenting or the vast lack of resources available to families, which results in a preoccupation with needs linked to survival. It has been noted that parents can hold the belief that especially younger children are not aware of the struggles or tensions within a family and thus do not require emotional support. Because of practical reasons, such as parents who do not speak a commonly used language or are illiterate or whose poor mental health is debilitating, children often have to step into unexpected roles; for example, managing the family's finances, managing the household needs, dealing with landlords around late payment of rent, renewing document and permits and so forth.

Where a parent, or no other parent or caregiver, is able to fulfill certain roles may contribute to children having to take up or occupy these roles. This relates to the parentification of children, where children parent themselves and/or act as caregivers to their siblings or even parents. This may include the seemingly understated role of providing emotional or psychological support to a parent, parents or siblings through household responsibilities such as cooking, cleaning or childcare.

This theme represents one of the reasons why it is important that Clinicians/Helpers work with different members of the family. Parents may need to receive psychosocial or other forms of support to improve their overall levels of functioning, whereas play therapy and other interventions represent a space where children can express different needs or parts of themselves — including those needs or parts that may be more difficult to fulfill or express at home.

- **Learning difficulties:** Parental and child psychological well-being as well as current stressors (e.g., poverty, hunger and poor accommodation) can negatively affect children’s capacity to learn and meet their full academic potential. In particular, clinical observations have quite strongly linked a child’s ability to thrive to their nutritional deficiency. Nutritional deficiency has been noted as an adverse childhood experience factor that affects long-term development.



A body mapping workshop held in August 2017 and led by the GIJTR Consortium for 20 female survivors of violence in Sri Lanka

As the factors that contribute to these learning difficulties are multifaceted, treatment approaches to learning difficulties often also require more holistic interventions. This could include the use of play therapy and other psychosocial interventions to support children’s psychological well-being, providing parents with psychoeducation regarding learning difficulties, providing parents with psychosocial support and referring children to other professionals (e.g., therapists, interns or students in the fields of occupational therapy, speech therapy, audiology or optometry). However, the context of Sri Lanka appears to not have many health care workers, and these services may be difficult to access for many people.

While recognizing the learning difficulties that some children experience, it is important to also point to children's resilience and ability to thrive at school despite the challenges that they may be experiencing in other areas of their lives. This suggests that well-managed classrooms or schools can represent a coping mechanism or buffer against such challenges.

- **Parental feedback sessions:** These sessions form an important theme or part of working with children. Recognizing the need to maintain trust with children, Clinicians/Helpers may discuss with children the themes or points that they might want to raise with their parents. This also provides children with the opportunity to assess what information or how information is shared with their parents.

Parental feedback sessions should occur after three to four sessions with a child. The space represents an opportunity for both parents and Clinicians/Helpers to think about the themes emerging in their children's play. These discussions also represent a form of holding or mentalization, in which parents can hold their children in their minds — which may not always be an easy activity given the level of functioning or stressors that parents may experience. This space also represents a space for psychoeducation, learning and knowledge exchange in which Clinicians/Helpers and parents can attempt to better understand children's difficulties or how to implement changes at home (e.g., changes in communication, parenting techniques, discipline).

4.2 WORKING WITH ADOLESCENTS

Many of the themes from working with children also apply to working with adolescents. This includes considering intergenerational trauma, how parents' physical and psychological well-being affects children's psychological well-being, bullying, learning difficulties and parental feedback sessions. The section that follows represents an integration of therapeutic considerations as well as themes more specifically related to working with adolescents.

- **Building trust or rapport:** While building trust and a therapeutic relationship with clients of all ages is important, there may be some initial challenges in this regard when it comes to working with adolescents. This may include

adolescents being slightly more closed or resistant to talk therapy in the initial phases. Considering this point, using a combination of more practical or experiential tools or tasks with talk therapy can be an effective means of building more open communication with adolescents. This could include tools that make it easier for adolescents to share information about their everyday lives.

- **Identity and belonging:** Aligned with Erikson's theory of psychosocial development, Clinicians/Helpers have noted how adolescent clients may grapple more strongly with individuation, questions of who they are and developing a sense of self. The broader themes of adjustment and acculturation, as well as parents' psychological well-being, play an important role in this theme.

In terms of adjustment and acculturation, there can be a tension between parents who were raised and grew up in a different context and era and their children, who are growing up in a context where they are exposed to different traditions, cultures and ways of being because of globalization. For parents, there may be a sense of wanting to raise their children in the same way that they were raised, in a more traditional way that may or may not align with the modern contexts of their children.

Adolescents may also find it difficult to develop a true sense of self if their parents' lower levels of psychological well-being made it difficult for them to express parts of themselves or to have certain psychological needs met by their parents. In such instances, the Clinician/Helper can provide a space where adolescents can express and explore these parts of themselves, which may assist with the identity exploration suggested by Erikson — greater integration of the self and easing of potential underlying tensions.

- **Depression:** An increased likelihood of experiencing depression during adolescence is perhaps easier to understand when considering the hormonal, physical, cognitive and social changes that adolescents experience during this period. For adolescents in families affected by violence and human rights abuses, these normal difficulties are intensified by the previously mentioned themes of intergenerational trauma, parental psychological well-being and current stressors. Depression has many faces within this age group. Children may present differently, with violence or

aggression versus a low mood and lethargy. It is important to be aware of this and look for depression in behavior that may be experienced as violent, anti-social, conduct oppositional, attention-deficit/hyperactivity disorder and so forth. There is often the temptation to treat with only medication and overlook the psychosocial and emotional counseling aspect. A more complementary approach to treating psychiatric diagnoses is needed.

Given the potentially complex nature of depression, Clinicians/Helpers may work with adolescents to become more attuned to their emotional state, the factors that may contribute to this and means of managing symptoms associated with depression.

- **Communication:** Communication in families affected by violence can be more closed or avoidant. While being a concern for children, it is also a concern for families with adolescent children, as more open communication and negotiation around roles and expectations is a developmental requirement for both adolescent children and their parents. Clinicians/Helpers may attempt to work with both adolescents and their parents to explore different ways of communicating and resolving conflicts. This can include conversations around conflict with adolescents and their parents, Clinicians/Helpers modeling good communication skills in these conversations, more explicit conversations around communications skills and communication traps such as criticism, contempt, stonewalling, bulldozing, debating and a lack of accountability.

4.3 WORKING WITH PARENTS

The section that follows commences with a theme that also relates to therapeutic considerations in working with parents. It then moves on to discuss prominent themes in working with parents.

- **Empathy and building rapport:** It is important to recognize that parents are often giving their utmost to support their families and children in what are difficult circumstances. It is important to consider this when thinking about some parents' actions. For example, one may view a parent leaving young children at home as neglectful, but the realities of poverty, needing to find employment, a lack of familial or social support, unsafe neighborhoods or

not being able to access a childcare grant may make leaving children at home the only or most rational option in the situation.

Recognizing or reflecting on physical and psychological demands of parenting can provide parents with a sense of validation, which is important considering the challenges that they face as well as the sense of inadequacy and guilt that so many parents experience. This empathy can also make it easier for parents to see the Clinician/Helper in the light of a co-parent or an ally in parenting rather than a professional such as a social worker — with some parents often mentioning their concern about their children being taken away given their occasional inability to provide adequate food or shelter.

- **Negotiating safety through the therapeutic frame and boundary setting:** There may be times when the content or themes emerging in sessions make it unsuitable for children to be included in sessions or waiting for their caregivers just outside a counseling room. However, these cases may be unavoidable because of a lack of childcare services during these times. In these instances, Clinicians/Helpers may need to work with caregivers to think of alternatives; for example, delaying this content until a caregiver can be found, asking a staff member to look after the child for the duration of the session or, if the child is older and the parents feel comfortable, leaving a child in the waiting room while this sensitive content is discussed.
- **Identity and belonging:** As tradition, nationality, religion and culture are important aspects of identity for parents, they may attempt to transfer these aspects or hope that their children also identify with them. Parent-child conflict may arise when this is not the case. Having conversations with parents around this topic can assist them in exploring their own ambivalence or the emotional tensions they may experience around identity and belonging, what makes it important for them that their children have a shared identity, as well as being able to express this importance to their children. Alternatively, elements of psychoeducation can also be utilized to help parents consider how identity is a formative process and how the aspects of the self (identifiers) that children find important may change over time (as is the case with adults).
- **Intergenerational and previous trauma:** In addition to their own traumatic experiences, parents may also carry their parents', communities' or

countries' traumas. As with the vast majority of people, parents are often unaware of how these traumas may affect their mental well-being as well as their relationships with their partners and children. Part of working with parents may be to support them in unearthing or considering the factors that may contribute to some of the behavior or actions that may negatively affect their children or broader family dynamics.

- **Mentalization:** This theme refers to a parent's ability to recognize, think about, attempt to understand and potentially resolve their child's feelings and experiences. As noted, previous traumas and current stressors can reduce parents' capacity to mentalize or tolerate their children's more psychologically demanding states. These difficulties can contribute to children's psychological needs being unmet, which can in turn contribute to difficulties such as a failure to thrive (infants), depression, anxiety and behavioral difficulties.

Working with parents on this theme often requires providing them with a space where they can unpack their own mental burdens and create greater space to contain or hold their children's psychological well-being in mind. Clinicians/Helpers may also use parental feedback sessions as a space to mirror or model this mentalizing, where a parent or parents are posed with (empathic) questions that facilitate their thinking about the factors that may underlie their children's difficulties.

As previously noted, it is important to approach such conversations with empathy, recognizing parents' difficulties, or parents may experience a greater sense of inadequacy and guilt in not being able to meet their children's physical or psychological needs.

- **Communication:** Both children and adults rely on their interpretation of previous experiences as well as other sources of information (such as parents, siblings, peers, teachers, the media) to make sense of or interpret new experiences. There are many themes that come up in working with families that require more open communication for children to interpret these experiences in healthier or more constructive ways.

For example, Clinicians/Helpers have found that it can be valuable to work with parents who are struggling with their mental health to find age-appropriate ways of talking to their children about their mental health, how

it affects them and how they may be trying to manage these concerns. Similarly, parents can be assisted in talking to their children about their previous traumas and how certain situations or factors may trigger symptoms such as reexperiencing, hypervigilance and avoidance.

This might help children understand that their parents' behavior is not because of them or their fault. Knowing that their parents are getting support could perhaps also relieve the sense of responsibility that children have for their parents' happiness or well-being.

- **Psychoeducation:** Having conversations with parents about the challenges that they or their children' may be experiencing can also assist parents in understanding what may be developmentally appropriate behavior or how to best manage or support their children. There are various topics that emerge in working with parents and children that can require psychoeducation and for which Clinicians/Helpers may need to turn to their peers or other professionals for additional information.
- **Supporting parents who have children living with chronic physical illnesses or psychological conditions:** Individual and group work can be beneficial to parents whose children experienced physical and psychological conditions such as cerebral palsy, heart conditions and autism. Work with parents often involves providing a space for parents to share their thoughts and feelings regarding their children's conditions and possibly normalizing thoughts and feelings that may have been viewed as socially unacceptable — for example, the sense of loss or grief associated with having a child who struggles with a physical or psychological condition. This sense of loss can be made more complicated by aspects of culture, where having children means having someone to carry your name and taking care of you in your old age. There is also increased guilt because the child's special needs or health challenges are often attributed to being cursed or something that the parents did or failed to do. At a time when social support is most needed, parents often face social isolation because of these reasons.

This work often also requires Clinicians/Helpers to consult with other professionals and conduct further readings to answer some of the questions that parents may have.

4.4 WORKING WITH COUPLES

In the context of this toolkit, couples work includes work with a married or cohabiting couple who may or may not have children. Couples work often occurs when initial assessments highlight high levels of parental or couples conflict or the need to strengthen the spousal (couple) dyad as a means of strengthening the broader family. The following are common themes in working with couples.

- **Adjustment, roles and responsibilities:** Couples are often faced with the need to adjust to current stressors and other contextual changes. This may include the need to adjust roles and responsibilities within the family given a partner's physical or mental health or employment status. Traditional gender roles often represent a barrier to adjustment in roles and responsibilities where, in some instances, a female partner would perhaps find greater work opportunities because work that is deemed appropriate for her gender is more available, but she would still need to take on the responsibilities of childcare and household responsibilities such as shopping, cooking and cleaning. Conversations around such difficulties may highlight a male partner's potential shame in not being able to meet traditional role expectations. In such instances, a Clinician/Helper may work with a couple to explore themes related to identity, traditional gender roles, status and concepts of partnership in the hopes of reducing stigma and shame and improving cooperation and partnership.
- **Religious beliefs:** Linked to gender roles, social norms and expectations are often also shaped by religious beliefs. Each partner's identity may also be shaped by these beliefs to the same or to different extents. Conflict may arise when partners have different ideas around the extent to which these beliefs should shape their lives and relationship. This theme is often interlinked with the themes of gender, culture, religion and others. MHPSS interventions may include developing a deeper understanding of how such beliefs emerged, the meaning that they hold, how differences in beliefs play out in their lives and what their relationship and lives may look like if they were to consider accommodating changes.

- **Coupling and partnership:** In working with couples, Clinicians/Helpers may find the need to explore each partner’s understanding or perceptions of the concepts of partnership and being a couple. These conversations can help to identify attitudes and beliefs that may hinder a couple’s ability to adjust and support each other in difficult times. These conversations may move around traditional roles and expectations as well as unique or idiosyncratic roles or needs that partners occupy or require from each other given the contextual challenges they experience.
- **Communication:** As previously mentioned, cultural and traditional patterns of communication, whereby patriarchal ways of being are upheld, often contribute to avoidance or a difficulty in talking about topics that may contribute to conflict or relationship difficulties (such as difficulties with intimacy). Such avoidance and communication difficulties are amplified for couples in whom a partner or both partners have experienced previous traumas such as physical or sexual torture — traumas that may contribute to a sense of shame or fear or rejection. In such instances, Clinicians/Helpers would aim to provide a holding space that may help partners make links between previous traumas and current difficulties as well as make sharing such traumas with a partner feel a bit safer. In addition, Clinicians/Helpers will provide options and model more supportive and open patterns of communication.
- **Sexual intimacy and trauma:** Considering the previous forms of physical or sexual torture that clients may have experienced, as well as high prevalence of gender-based violence, Clinicians/Helpers have noted how couples may present difficulties with sexual intimacy in their relationships. In some instances, a partner may have shared details of previous sexual traumas with their partner, but in other instances, the potential shame and fear of rejection or abandonment may have contributed to silences around these traumas. Previous traumas may not be the only cause of difficulties related to sex. Expectations around a partner’s duty to perform sex, especially in marriage, represent an issue that abounds across the globe. Such expectations may develop through culture, religion, peer social groups, ideas around masculinity, the media and a partner’s means of coping or emotional regulation (in which sex can represent a means of emotional regulation).

As with other themes, Clinicians/Helpers often approach this topic by using a combination of unpacking the theme, attempting to develop a deeper understanding of the meaning of the topic and potential psychoeducation — in which expectations around what is normal can be discussed or compared with literature around sexuality or the role of sex in relationships or links can be made between previous traumas and sexual difficulties. As with all work with different family members, psychoeducation represents an important theme as well as a tool when working with couples. A broad range of topics can include aspects of psychoeducation, from conversations around gender roles and expectations to conversations around previous traumas and parenting practices.

- **Separation resulting from violent conflict:** Often in the context of conflict, many men may leave their homes for military service or to fight on the front lines. Upon returning, they may often find it difficult to readjust to the family, but also, because of what they have witnessed, many develop PTSD. This can finding work difficult, so often the wife may have to take over this responsibility, which may not be part of the traditional roles or what was expected when she got married. The way she was raised may also have prepared her to play the role of wife, mother and caregiver rather than that of a provider. The religious beliefs that she was raised with also may have told her that this is how it should be. So the fact that she now has to fulfill this additional role causes tension between the wife and husband. Her husband says he cannot explain to her what he saw and that she does not understand what he is going through. Because of this, he leaves the house for long periods to avoid any fights and sleeps on the couch instead.

4.5 WORKING WITH THE WHOLE FAMILY

Working with the entire family can be beneficial, but factors such as presenting concerns, family members' level of functioning, levels of parental conflict, previous traumas and socioeconomic concerns may make this type of intervention more difficult. In addition to the themes discussed for different family members, the following considerations and themes in working with the entire family are also important.

- **The identified patient:** From a systemic understanding, problematic behaviors or challenges within the family should be understood as being systemic rather than individualistic. Thus, the identified symptoms or concerns placed on a family member should be viewed as representing symptoms of broader difficulties within the family.
- Working with the broader family on challenges or difficulties could involve developing a better understanding of how each family member thinks about or understands the challenges that the identified patient or family is experiencing. These understandings often locate the problem within the individual, and the clinician's role would be to work with the family toward more systemic understandings of their challenges — how problems can be located between family members or in patterns of interaction.
- **The identified hero:** Clinicians/Helpers have also noted how a family member may also be identified as the family's hero or savior. This may include a father who may save the family through gaining a good job or employment and lifting the family out of poverty or a child who is doing well academically and may also save the family from their current situation through his or her academic exploits.
- While such hope can represent an important means of coping for some family members, it may also be important for the family to recognize and discuss this hope and the pressures that may be experienced with it and what might happen if this family member (hero) were not able to succeed. For some family members, their entire identities may be wrapped around being the family savior, which may have different effects on their mental health or well-being.

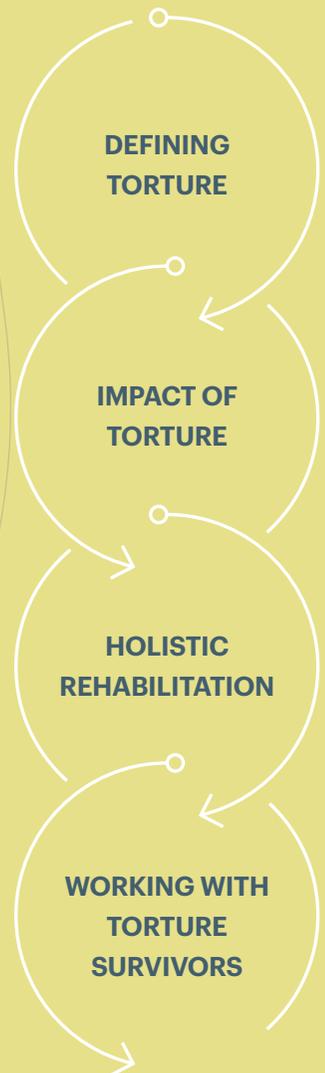
- **Family observations:** Observations of family interactions before, during and after sessions represent an important source of information for Clinicians/Helpers. Observations by the clinician, co-therapist or other Clinicians/Helpers (via a one-way mirror or sitting in on a counseling session) can assist in working with family members to reflect on patterns of interaction, unspoken rules or boundaries that may relate to the presenting concerns or other areas of family functioning.
- **Therapeutic tools:** It is crucial to find existing and potentially create activities, exercises or tools that can provide families with more tangible, concrete, practical or visual ways of exploring different topics. Tools such as the River of Life have been noted in this toolkit.

CHAPTER 5

TORTURE AND REHABILITATION



A workshop on women's stories hosted by the Herstories Archive, a Site of Conscience member in Sri Lanka.



5.1 Theoretical Framework

5.1.1 BACKGROUND

The United Nations Convention against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment defines torture as (UNCAT, 1984):

“...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.”

- causes severe mental and/or physical pain or suffering;
- is intentionally inflicted;
- is inflicted for a purpose or reason;
- Is committed by, or at the instigation of, or with the consent of, or compliance of a public official or other person acting in an official capacity.

Who are the possible torturers?

- Police
- Military
- Paramilitary forces
- Special forces/intelligence personnel
- Prison officials
- Death squads
- Health professionals (including psychologists)
- Co-detainees
- Rebel forces

Who is being tortured?

Anyone who is deprived of their liberty is vulnerable to being tortured:

- War captives/hostages
- Victims of enforced disappearance or unlawful detention
- People tortured in their homes, or in public places (like at political rallies or in the street);
- Women, men, and children are all vulnerable to torture
- People held involuntarily in places such as:
 - » Places of safety for children
 - » Police holding cells, prisons
 - » Lock-up psychiatric hospitals
 - » Drug rehabilitation centers
 - » Holding facilities for migrants

5.1.2 EFFECTS OF TORTURE

Torture affects individual survivors, their families and whole societies. Extensive work and research with people who have been tortured and work in repressed societies and communities, whose members have been tortured, identify common and unique physical and psychological symptoms. Torture affects the psyche and the body simultaneously, and its effects extend beyond the



Participant of the 2017 GIJTR body-mapping workshop in Guinea.

individual to affect families and communities.

5.1.2.1 COMMON PSYCHOLOGICAL AND PHYSICAL SYMPTOMS EXPERIENCED BY TORTURE SURVIVORS (CVT, 2005).

PTSD	Depression	Physical Symptoms
<p>Reliving the trauma</p> <p>Nightmares</p> <p>Bad thoughts or memories of the torture entering your mind</p> <p>Acting or feeling as if the torture is happening all over again (flashbacks)</p>	<p>Feeling sad or angry</p> <p>Difficulty thinking or making decisions</p> <p>Difficulty concentrating</p> <p>Feeling worthless or hopeless</p> <p>Feeling excessive guilt</p>	<p>Headaches</p> <p>Feeling dizzy, faint or weak</p> <p>Chest pain</p> <p>Heart beats very fast</p> <p>Stomach hurts or a sick feeling in the stomach</p>
<p>Avoiding the trauma</p> <p>Trying to forget the torture, trying not to think about it</p> <p>Staying away from anything that reminds you of the torture</p> <p>Inability to remember important things that happened during the torture</p> <p>Numbness</p> <p>Feeling as if you do not care about life or what happens to you</p> <p>Feeling as if no one understands or cares about you, as if you are alone and cut off from others</p> <p>Feeling numb, as if there are no feelings inside you</p> <p>Feeling as if you have no future or that you may die sooner than most people</p> <p>Heightened arousal</p> <p>Difficulty falling asleep or staying asleep at night</p> <p>Feeling angry often, easily upset</p> <p>Difficulty concentrating</p> <p>Inability to relax or feel comfortable, often afraid something bad will happen</p>	<p>Feeling that you do not care about life, that you are not interested in things</p> <p>Feeling too hungry or not hungry at all, gaining or losing a lot of weight without trying</p> <p>Sleeping too much or too little</p> <p>Feeling tired often, not having energy</p> <p>Thinking about death often, thinking about killing yourself (suicidal thoughts)</p>	<p>Shaking or trembling</p> <p>Hands or feet feel cold</p> <p>Hot or burning feelings</p> <p>Numb or tingling sensations</p> <p>Sweating</p> <p>Diffuse or generalized sense of pain, weakness, misery</p> <p>Other pains in the body</p>

PTSD and depression are often among the most common effects of torture.

Other psychological symptoms include:

- Anxiety
- Unusual fears and phobias
- Feeling self-blame
- Feeling ashamed
- Feeling aggressive toward others
- Inability to relate to others, resulting in breakdown in interpersonal relationships
- Inability to engage in intimate relationships
- Substance abuse disorders including drug and alcohol addiction

The physical symptoms with which torture survivors present can be the result of actual damage done to their bodies by torturers and/or bodily expressions of emotions. Symptoms of physical damage include head injuries, spinal cord injuries, loss of vision, loss of hearing, bone fractures, muscle damage, dislocation of joints, weakness in limbs, skin damage, difficulties urinating, difficulties in moving bowels, damage to sexual and reproductive organs (uterus, vagina, breast, penis, scrotum), venous problems and necrosis in the feet or toe.

5.1.2.2 SOCIOECONOMIC EFFECTS

Many torture survivors face loss of employment, either because their physical and psychological symptoms make it difficult for them to sustain jobs or because those who have fled their communities/countries find it difficult to access work in a new location. Survivors who remain in their own countries may be marginalized by their communities and therefore find it challenging to integrate back into society. For survivors who have been marginalized and are impoverished, the struggle to access basic services aggravates feelings of disempowerment and hopelessness.

5.1.2.3 LEGAL ISSUES

Seeking and achieving justice constitutes a significant problem for torture survivors for whom justice is elusive and uncertain. They are usually up against powerful government agencies, which leaves them feeling hopeless. Even worse, many survivors of torture are unaware of their legal rights and thus are left with an overall sense of injustice and anger. Furthermore, many face the challenge of having to prove their torture and provide sufficient evidence of it. This is a challenge because many are unaware at the time of the torture that it is a crime and thus seek justice only a significant time period later, making it harder to provide the evidence the court requires to make a prosecution.

5.1.2.4 MEDICAL EFFECTS

As noted above, torture often results in physical damage that leaves survivors with chronic medical conditions requiring long-term medical care. For impoverished torture survivors, the cost of private medical care is excessive. On the other hand, there is fear about accessing health care in state facilities because staff in these facilities may display prejudice toward victims of torture, especially groups such as youth, migrants/people from different ethnic or religious groups or those who have been in conflict with the law.

5.1.2.5 EFFECTS ON FAMILIES

The effects of torture on individuals radiate into the family system. Survivors with altered identities, lost dignity and shame find it difficult to take up their previous positions and roles in the family system. Where survivors lose occupational functioning, financial burdens create added tensions. Pain, anger and grief that are not processed are instead acted out in verbal or physical abuse. Family members themselves cannot bear to hear stories of trauma reinforcing the silence and thereby negating the survivor's experience. Without family support, symptoms are reinforced (SANToC, 2010). As a result, the following effects may be seen:

- Marital or intergenerational conflict
- Parental functioning is affected, often making parents less emotionally attuned and attentive to children.

- Parents have low tolerance for negative emotions. For example, a parent cannot stand to hear a baby cry because it may remind the survivor of other prisoners' screams.
- There is silence within the family regarding the torture and other trauma, leading to confusion, misunderstanding, multiple versions of what happened and unaddressed blame, shame, anger, disappointment and sadness.
- Parent-child role reversal occurs because parents experience disempowerment due to trauma-related symptoms and the loss of their traditional roles in a new culture. Children prematurely assume adult roles because of more rapid language acquisition and acculturation.
- Children's identity development is affected.
- Children experience loss of basic trust.
- There can be pressure on children to succeed and to make up for what the family lost (CVT, 2005).

5.1.2.6 EFFECTS ON COMMUNITIES

At the community level, collective effects of torture include silence or denial about what happened, which permeates the community and can lead to apathy and hopelessness. Chronic fear and distrust among community members can result in constriction of social networks, leading to fragmentation, social isolation and polarization.

5.1.2.7 EFFECTS ON CHILDREN

Children often don't experience direct torture but are seen as indirect victims of the torture. There are exceptions, of course, such as child soldiers or survivors of conflict-related sexual violence who are often kidnapped to become wives to rebel groups. Depending on the changes within the family, children can sometimes experience a variety of the following:

- Anxiety
- Psychosomatic symptoms
- Sleeping problems
- Problems in school
- Symptoms of depression
- Problems in the family
- Features of regression
- Behavioral changes (CVT, 2005)

In children this can often be misunderstood and not addressed, especially when children are very young, as the common assumption is that they are too young to be affected by what happened or is happening.

5.1.3 REHABILITATION

“Rehabilitation refers to the restoration of function or the acquisition of new skills required by the changed circumstances of a victim in the aftermath of torture or ill-treatment. It seeks to enable the maximum possible self-sufficiency and function for the individual [victim (individual and or collective)] concerned, and may involve adjustments to the person's [victim's] physical and social environment. Rehabilitation for victims should aim to restore, as far as possible, their independence, physical, mental, social [cultural, spiritual] and vocational ability; and full inclusion and participation in society” (UNCAT, GC, para. 11; African Commission, GC 4, para. 40).

Why Is Specialist Rehabilitation Needed for Torture Survivors?

The effects of torture often extend past those of trauma on the individual, whereby the impacts are deeper and have many levels. This requires specialist intervention by individuals trained on the varying impacts of torture and the necessary protocols to document the torture if required. An example of this is the Istanbul Protocol.

The UN Voluntary Fund for Victims of Torture describes holistic services provided to victims of torture as follows.

- **Psychological assistance** is provided to enable victims of torture to overcome the psychological trauma they have experienced.
- **Medical assistance** treats the physical aftereffects of torture. Following diagnosis by a general practitioner, treatment is provided by medical specialists in the fields of orthopedics, neurology, physiotherapy, pediatrics, sexual health, urology and traditional healing and complementary medicine.
- **Social assistance** complements the abovementioned forms of assistance by providing various services to reduce the sense of marginalization that many victims experience.
- **Legal assistance** may be provided in several ways, including covering the costs of lawyers, courts, translations and legal proceedings.
- **Financial assistance** enables victims to meet their basic needs and gain access to other types of assistance, such as health care.

Context-Sensitive

It is also important to take into account the past and current context of the individual to ensure that services offered are holistic, meet their unique needs and:

- consider the cultural background and practices of the individual and family;
- are gender specific;
- take into account the political context and socio-historical and community context of the individual;
- are aware of the economic impacts and means of the individual and the social attitudes and beliefs of the individual, their community and society at large.

The aim of rehabilitation is to restore independence; physical, mental, social and vocational ability; and full inclusion.

5.1.4 WORKING WITH VICTIMS OF TORTURE

The first ethical obligation of service providers and professionals is to ensure no harm to clients. This includes not retraumatizing survivors by causing further psychological or emotional harm through the way they are treated.

5.1.4.1 TALKING ABOUT THE TORTURE

Comprehension of torture and its long-term effects on survivors, their families and their community is vital. However, it is not always necessary or even appropriate to address the trauma directly. Addressing torture-related trauma must be tailored to the setting and the services provided. Minimizing the potential for retraumatization can be addressed through the following:

- Short-term involvement
- Ongoing involvement unrelated to trauma symptoms
- Involvement that specifically addresses some aspect of the trauma, whether expressed or not (CVT, 2005)

The table below provides examples.

Levels of addressing trauma	Short-term involvement unrelated to trauma (humanitarian organizations and those that offer socioeconomic assistance)	Ongoing involvement unrelated to trauma (teachers, general practitioners and social workers offering social services)	Assessment intervention related to trauma (e.g., mental health professionals, legal professionals, medicolegal professionals, immigration officers)
Do not identify trauma to help	X	X	
Know about appropriate referral resources	X	X	
Consider culture and traumatic experiences	X	X	X
Avoid/reduce potential for reactivation of trauma	X	X	X
Respond to spontaneous disclosures of trauma	X	X	X
Respond to expressions of distress (crying)	X	X	X
Acknowledge prevalence of trauma for torture survivors		X	X
Psychological education and validation		X	X
Explore relevant trauma experience		X	X

5.1.4.2 WORKING WITH SURVIVORS OF TORTURE: PSYCHOSOCIAL, LEGAL, MEDICAL, HUMANITARIAN AND ECONOMIC

Striking the right balance in working with torture survivors requires awareness, trust and acceptance. Some argue that service providers must take their cue from survivors allowing them to dictate the pace of giving testimony. Being able to do this requires sensitive judgment that can come only with a good grasp of torture and its effects. Working holistically and cooperation among service-specific professionals will provide the survivor with a more positive outcome and a better transition or reintegration into society. This way of working can also enhance the healing process (SANToC, 2010).

5.2 Recommended Readings

- Herman, Judith Lewis (1992). *Trauma and recovery: The aftermath of violence*. New York: Basic Books.
- Steel, Z., Chey, T., Silove, D., Marnane, C., Bryant, R.A., van Ommeren, M. (2009). Association of torture and other potentially traumatic events with mental health outcomes among populations exposed to mass conflict and displacement: A systematic review and meta-analysis. *JAMA*, 302(5).
- Robertson, M. (2011). Expert witness report: Psychological treatment of trauma, specializing in working with refugees and asylum seekers including torture survivors.
- Brown, C. (2012). Rape as a weapon of war in the Democratic Republic of Congo. *Torture*, 22(1), 24-37.
- Johnson, H., Thompson, A. (2008). The development and maintenance of post-traumatic stress disorder (PTSD) in civilian adult survivors of war trauma and torture: A review. *Clinical Psychology Review*, 28, 36–47.
- Fisher, J. (2017). *Healing the fragmented selves of trauma survivors: Overcoming internal self-alienation*. New York: Routledge.
- Loewenstein, R., Brand, B. (2014). Treating complex trauma survivors.

- Miller, K.E., Rasmussen, A. (2010). War exposure, daily stressors, and mental health in conflict and post-conflict settings: Bridging the divide between trauma-focused and psychosocial frameworks. *Social Science & Medicine*, 70, 7–16.
- Follette, V., Pistorello, J. (2007). Finding life beyond trauma: *Using acceptance and commitment therapy to heal from post-traumatic stress and trauma-related problems*. Oakland, CA: New Harbinger.

5.3 Activities and Handouts

5.3.1 PRE/POST-TEST FOR THE TRAINING ON TORTURE AND REHABILITATION

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. A blank copy is provided in the participant book.

Tick Yes or No for the following statements:	Yes	No
1. Torture is an intentional act.	X	
2. Torture is only physical.		X
3. Torture is committed by police only.		X
4. Individuals who are tortured have the right to holistic rehabilitation.	X	
5. Torture affects only the individual.		X
6. There can be mental health impacts of torture.	X	
7. Both men and women can be tortured.	X	

5.3.2 REPRESENTATION OF TORTURE ACTIVITY

Ask participants to work individually or in pairs. Give them one minute to draw a quick sketch on a piece of paper that sums up what they understand by the word torture. Point out that participants *shouldn't* create a still image that involves any real pain or one that might be offensive. Count down from three and ask participants to show their still images all together. Facilitate a discussion.

Explain that we use the word *torture* in an everyday context to refer to all sorts of experiences that we find painful (e.g., listening to our parents sing or their coming to school!). However, the word has a very specific meaning in international human rights law, on which the world's governments have agreed. Under that definition, torture is any "act by which severe pain and suffering, whether physical or mental, is intentionally inflicted on a person by ... a public official ..." (Article 1 UN Convention Against Torture and other Cruel, Inhuman and Degrading Treatment 1984).

(Adapted from <http://www.teachtrauma.com/educational-tools/classroom-activities/>)

5.3.3 TYPES OF TORTURE ACTIVITY

Ask the participants to think of different types of torture. Discuss and psycho-educate on the different types of torture; for example, **physical torture** such as beatings, electrocution; **psychological torture** such as sleep deprivation, starvation, threatening a victim's loved one, mock executions; and **sexual torture** such as rape, child marriage during conflict, sexual assault.

5.3.4 IMPACTS OF TORTURE ACTIVITY

Case Study:

“K” is a 72-year-old man. He is married and has five children. K has a postgraduate degree in social studies and is a member of a human rights activist group. K is very passionate about advocating for justice, freedom and peace. He is known in his family as one who stands up for his beliefs and is an activist for change. K and other members of the human rights group held a protest, urging the government to take action against acts of inhumanity and cruelty. Because of the political situation in the country, this protest led to the police arresting K and others. K was tortured. During his torture, he was beaten and electrocuted. He was later hospitalized because of his injuries and was able to escape from hospital. The torture experience resulted in K suffering a stroke. This left K partially paralyzed on his left side, making it hard for him to walk or use his left hand. He also struggled to speak, and his words were at times not audible, making it hard for K to talk and explain his experience, which resulted in his social and legal needs not being easily met. He came for counseling services with much difficulty, assisted by his wife and a crutch. In the counseling session, he reported feeling depressed, angry and frustrated by his current situation. He feels he is not the man he once was. He feels powerless because of his situation and physical disability. He receives no financial support or means of earning an income, and he and his family live with a kindhearted person who took them in because they felt sorry for his family, as they were old and on the street. He has a heavy uncertainty about what the future holds for him and his wife. He just breaks down when he retells his torture experience. He has escaped his torturer physically, but the feelings of disempowerment (physically and mentally), fear and despair still loom, as he is reminded of his experience and how it has taken away from him his self-esteem and peace, leaving him with nightmares, fear and dread.

Regarding the case study and impacts of torture, ask the participants to get into four groups, and have each group discuss a different impact of torture.

- **Group 1: emotional impacts**
- **Group 2: cognitive impacts**
- **Group 3: impacts on personality and identity**
- **Group 4: physical impacts**

Each group is to present to the rest of the group the impacts they managed to think of. Facilitate a discussion regarding these impacts and psycho-educate on any impacts that have not been discussed.

5.3.5 REHABILITATION INTRODUCTION/ICE-BREAKER

Inform the participants that individuals who have experienced complex trauma and torture need specialized treatment and rehabilitation. Ask the participants to discuss what specialized treatment they believe these individuals need. Facilitate a discussion and psycho-educate on the specialized holistic rehabilitation.



Participants at a GIJTR workshop in Conakry, Guinea learn about self-care while assisting survivors with trauma.

CHAPTER 6

SELF-CARE

6.1 Theoretical Framework

Being a Helper is very rewarding, but it can also be very challenging. As with many helping professionals, being exposed to others' pain and trauma on a regular basis increases the risk of stress and burnout. Thus, taking care of ourselves is critical — for our own long-term health and well-being and so that we can effectively support the people we work with.

Self-care is the ability to proactively enhance our health by building resilience and preventing illness and disease. There is a preventive focus. As helpers, we often listen to very tragic and emotionally difficult stories from our clients/survivors of violence. This can open us up to feeling their pain. The ultimate challenge is finding ways to stay connected to our clients while maintaining a strong and deep connection with our own experience. We need to be able to understand ourselves, just as much as we need to understand the individuals we are trying to help. This means devoting time to self-reflection, self-renewal and quality time far away from the issues of work.

The path to finding this balance begins with recognizing the warning signs and not feeling ashamed of them. No one is immune to the effects of the work. When we can view our emotional responses to our work as normal and natural (rather



than as something we are doing wrong), we are more likely to seek support, talk about our stress with others and engage in self-care practices to support our overall wellness. And when we are well, we are better able to connect with our clients, to be more attentive and creative in our work and are less likely to make errors or violate boundaries.

When Helpers are isolated — working in rural areas or working alone — maintaining wellness can pose an even bigger challenge. Without other colleagues to learn from, vent with or lean on for support, stress is more likely to build. Therefore, finding a support system (through formal or informal networks of other professionals) to meet with for consultation and camaraderie is vital. Technology can also help bridge the gap. The Internet, email, Facebook and the phone provide useful means to connect with other people.

What are the warning signs?

Trauma-focused treatments can be emotionally difficult and taxing for therapists and caregivers, leading to vicarious traumatization, burnout, secondary stress disorder and compassion fatigue. These are various terms used in explaining the different ways that work can affect us and the changes that we may notice in ourselves.

Vicarious Trauma: This term is adapted in relation to therapists and workers who may vicariously experience aspects and effects of a client's trauma as though it were a trauma they themselves had experienced. This is specifically centered on the trauma discussed with a client, generally in the counseling/therapy relationship.

Secondary Trauma: This is similar to vicarious trauma in that an individual can present with signs of PTSD even though they have not experienced a traumatic event. The distinction is that this is developed through the witnessing of the other's experience. This can be both through work and outside work, such as having a family member who has experienced a traumatic event.

Compassion Fatigue: This is a very general term to describe individuals who may be experiencing difficulties because of their work as a helping professional.

Burnout: This is often seen as the most extreme, whereby an individual's outlook and health have shifted negatively and is specifically due to a work overload (Rothschild & Rand, 2006).

BURNOUT

Common signs that one is heading toward burnout:

Behavioral:

- Unconscious coping mechanisms such as distancing yourself from others, numbing your emotions, detachment from feelings or people, cutting clients off, staying busy/overworked
- Avoiding listening to clients' stories of traumatic experiences
- Experiencing symptoms similar to those seen in clients (intrusive imagery, somatic symptoms)
- Affecting personal relationships and ability to experience intimacy
- High overall general stress level
- Overextending yourself and taking on the client's traumatic experiences and symptoms as your own
- Difficulty maintaining professional boundaries with the client

Emotional:

- Feeling overwhelmed, drained and exhausted, overloaded and burned out
- Feeling angry, enraged or sad about client's victimisation

Cognition:

- Preoccupied with thoughts of clients outside your work
- Overidentification with the client
- Horror and rescue fantasies
- Loss of hope, pessimism, cynicism nihilism
- Questioning your competence and self-worth, experiencing low job satisfaction
- Challenging basic beliefs of safety, trust, esteem, intimacy and control
- Feeling a heightened sense of vulnerability and personal threats

Stress Management

- Managing stress is an important aspect of self-care. Stress management includes dealing with or coping with negative effects. Techniques to relieve stress include deep breathing, meditation and exercise.

6.1.1 HOW YOU CAN PRACTICE SELF-CARE:

1. **Identify what activities help you feel your best.** Self-care for one person will mean something completely different for another. One person may need more alone time, for example, while another may nurture herself by spending more time with friends. Rediscover your passions and sense of purpose by finding out what makes you feel good about being you.
2. **Put it on your calendar — in ink!** Take a close look at your calendar and carve out chunks of time for self-care.
3. **Sneak in self-care where you can.** If you don't have huge chunks of time, you can still fit in little moments of relaxation. Don't wait to add self-care to your life until your schedule frees up (you might be waiting forever!). Even taking five minutes to close your eyes and take a few deep breaths, or a few minutes of listening to music, can help your stress level.
4. **Take care of yourself physically.** This means getting enough rest, eating nutritious foods and exercising. Eat more greens, fruit, nuts and pulses, and don't overindulge in coffee, alcohol and foods high in fat and sugar. Exercise releases the endorphins that give you a feeling of well-being. Even taking a 10-minute walk (alone, with friends or with your children) can make a big difference.
5. **Know when to say no.** Your health and well-being come first. So if you have a hard time saying no, cultivate the skill of setting boundaries.
6. **Check in with yourself regularly.** Ask yourself the following critical questions: Are you working too much? Do you feel tapped out? What do you need to take away, and what would you like to add? Check for the warning signs listed above.
7. **Surround yourself with great people.** Make sure that the people in your life are upbeat and positive and know how to enjoy life.

8. **Consider the quality of self-care.** Go for quality, especially when the quantity is lacking. Focus on relaxing activities such as prayer, deep breathing, listening to music, journaling and practicing mindfulness. This could also include taking vacations, going to therapy/counseling and taking advantage of peer support groups.
9. **Remember that self-care is nonnegotiable.** To live a healthy and rewarding life, self-care is a necessity. With that attitude, it becomes very natural and easy to do.

Adapted from the following sources:

<http://psychcentral.com/lib/how-Clinicians/helpers/Helpers-practice-self-care-9-tips-for-readers/>

<http://ct.counseling.org/2011/01/taking-care-of-yourself-as-a-counselor/>

<http://www.helpguide.org/articles/stress/preventing-burnout.htm>

Social Support

Social support is important because no person is an island, and we need others to help us manage difficult times and lead a happy, manageable life. Social support does the following:

- Helps us manage stress
- Gives us support when we need it most
- Provides us with energy when we are struggling
- Allows us to understand that we are not alone, that others are there and willing to listen when things feel too much
- Provides us with relief and helps us continue

All of us go through tough times, and social support helps us manage these times.

Ways of accessing social support:

- Talk to a friend either at home or at work — talking about difficulties can help us to manage and express our feelings, leaving us feeling relieved.
- Sometimes talking about things allows us to think about things differently and see them from a different perspective.

- Try to manage tough times before they get tougher; this means that if you are having a tough time, make others aware of this so they can look out for you.
- Always ask for support if you need it. Asking for help takes strength, and everyone needs help at some time.

6.2 Recommended Readings

Rothschild, B. (2006). Help for the helper: The psychophysiology of compassion fatigue and vicarious trauma. WW Norton & Co.

6.3 Activities and Handouts

6.3.1 PRE/POST-TEST FOR THE TRAINING ON SELF-CARE

Provide a blank handout to participants at the beginning and end of the training. After the post-test, you can go through the correct answers. A blank copy is provided in the participant handbook.

Tick Yes or No for the following statements:	Yes	No
1. Stress, burnout, compassion fatigue and vicarious trauma are the same thing.		X
2. Stress can affect you physically and emotionally.	X	
3. It is more important to care for others than to care for yourself.		X
4. Your self-care is someone else's responsibility.		X
5. It is important to maintain a balanced lifestyle.	X	
6. Signs of vicarious trauma are similar to those of PTSD.	X	
TOTAL SCORE:		

6.3.2 SELF-CARE ACTIVITY

Instruct the participants to get into pairs and discuss the following:

- What problems do you think that you may struggle with in your interaction with your client group? Try to be honest and open about things that may be difficult for you.
- How would these problems affect your ability to do your work?
- What could this mean for the effectiveness of your work?
- What does that mean for the client and you?
- How do you care for yourself to make sure that your service provision to clients remains effective and empowering?

Facilitate a discussion around the answers to these questions and how the participants experienced discussing these questions.

6.3.3 SELF-CARE ASSESSMENT TOOL HANDOUT

Hand out to participants to complete either in the workshop (if time permits) or in their own time.

SELF-CARE ASSESSMENT WORKSHEET

This assessment tool provides an overview of effective strategies to maintain self-care. After completing the full assessment, choose one item from each area that you will actively work to improve.

Using the scale below, rate the following areas in terms of frequency:

1=It never occurred to me 2=Never 3=Rarely 4=Occasionally 5=Frequently

Physical self-care

_____ Eat regularly (e.g., breakfast, lunch and dinner)

_____ Eat healthy

_____ Exercise

_____ Get regular medical care for prevention

_____ Get medical care when needed

_____ Take time off when needed

_____ Get massages

_____ Dance, swim, walk, run, play sports, sing or do some other physical activity that is fun

_____ Get enough sleep

_____ Wear clothes you like

_____ Take vacations

_____ Take day trips or mini vacations

_____ Make time away from phones

_____ Other:

Psychological self-care

_____ Make time for self-reflection

_____ Have your own personal psychotherapy

_____ Write in a journal

_____ Read literature that is unrelated to work

_____ Do something at which you are not an expert or in charge

_____ Decrease stress in your life

_____ Let others know different aspects of you

_____ Notice your inner experience — listen to your thoughts, judgments, beliefs, attitudes and feelings

_____ Engage your intelligence in a new area; learn or experience something new

_____ Practice receiving support and care from others

_____ Be curious

_____ Say no to extra responsibilities sometimes

_____ Other:

Emotional self-care

_____ Spend time with others whose company you enjoy

_____ Stay in contact with important people in your life

_____ Give yourself affirmations; praise yourself

_____ Love yourself

- _____ Reread favorite books; watch favorite movies again
- _____ Identify comforting activities, objects, people, relationships and places and seek them out
- _____ Allow yourself to cry
- _____ Find things that make you laugh
- _____ Play with children
- _____ Other:

Spiritual self-care

- _____ Make time for reflection
- _____ Spend time in nature
- _____ Find a spiritual connection or community
- _____ Be open to inspiration
- _____ Cherish your optimism and hope
- _____ Be aware of nonmaterial aspects of life
- _____ Try at times not to be in charge or the expert
- _____ Be open to not knowing
- _____ Identify what is meaningful to you and notice its place in your life
- _____ Meditate
- _____ Pray
- _____ Sing
- _____ Spend time with children
- _____ Have experiences of awe
- _____ Contribute to causes in which you believe

_____ Read inspirational literature (talks, music and so forth)

_____ Other:

Workplace or professional self-care

_____ Take a break during the workday (e.g., lunch)

_____ Take time to chat with co-workers

_____ Make quiet time to complete tasks

_____ Identify projects or tasks that are exciting and rewarding

_____ Set limits with your clients and colleagues

_____ Balance your caseload so that no one day or part of a day is overwhelming

_____ Arrange your workspace so it is comfortable and comforting

_____ Get regular supervision or debriefing

_____ Negotiate for your needs (benefits, pay raise)

_____ Have a peer support group

_____ Develop a nontrauma area of professional interest

_____ Other:

Balance

_____ Strive for balance within your work life and workday

_____ Strive for balance among work, family, relationships, play and rest

Source: Adapted from: *Transforming the Pain: A Workbook on Vicarious Traumatization*. Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996).

6.3.4 PROFESSIONAL QUALITY OF LIFE SCALE (PROQOL)

Provide participants with the **Professional Quality of Life Scale** (ProQol) handout to complete.

Professional Quality of Life Scale (ProQOL) Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009) (Hudnall Stamm, 2009)

When you [help] people, you have direct contact with their lives. As you may have found, your compassion for those you [help] can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a [helper]. Consider each of the following questions about you and your current work situation. Select the number that honestly reflects how frequently you experienced these things in the past 30 days.

1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often

- _____ 1. I am happy.
- _____ 2. I am preoccupied with more than one person I [help].
- _____ 3. I get satisfaction from being able to [help] people.
- _____ 4. I feel connected to others.
- _____ 5. I jump or am startled by unexpected sounds.
- _____ 6. I feel invigorated after working with those I [help].
- _____ 7. I find it difficult to separate my personal life from my life as a [helper].
- _____ 8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].
- _____ 9. I think that I might have been affected by the traumatic stress of those I [help].
- _____ 10. I feel trapped by my job as a [helper].
- _____ 11. Because of my [helping], I have felt on edge about various things.
- _____ 12. I like my work as a [helper].

- _____ 13. I feel depressed because of the traumatic experiences of the people I [help].
- _____ 14. I feel as though I am experiencing the trauma of someone I have [helped].
- _____ 15. I have beliefs that sustain me.
- _____ 16. I am pleased with how I am able to keep up with [helping] techniques and protocols.
- _____ 17. I am the person I always wanted to be.
- _____ 18. My work makes me feel satisfied.
- _____ 19. I feel worn out because of my work as a [helper].
- _____ 20. I have happy thoughts and feelings about those I [help] and how I could help them.
- _____ 21. I feel overwhelmed because my case [work] load seems endless.
- _____ 22. I believe I can make a difference through my work.
- _____ 23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].
- _____ 24. I am proud of what I can do to [help].
- _____ 25. As a result of my [helping], I have intrusive, frightening thoughts.
- _____ 26. I feel bogged down by the system.
- _____ 27. I have thoughts that I am a success as a [helper].
- _____ 28. I can't recall important parts of my work with trauma victims.
- _____ 29. I am a very caring person.
- _____ 30. I am happy that I chose to do this work.

(B. Hudnall Stamm, 2009. *Professional Quality of Life: Compassion Satisfaction and Fatigue* Version 5 [ProQOL]. www.isu.edu/~bhstamm or www.proqol.org.)

YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCREENING

Based on your responses, place your personal scores below. If you have any concerns, you should discuss them with a physical or mental health care professional.

Compassion Satisfaction _____

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel as if it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job. The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57, and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, either you may either find problems with your job or there may be some other reason — for example, you might derive your satisfaction from activities other than your job.

Burnout _____

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of compassion fatigue (CF). It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a nonsupportive work environment. Higher scores on this scale mean that you are at higher risk for burnout. The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57, and about 25% of people score below 43. If your score is below 43, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57, you may wish to think about what at work makes you feel as if you are not effective in your position. Your score may reflect your mood; perhaps you were having a bad day or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress_____

The second component of CF is secondary traumatic stress (STS), which refers to your work-related, or secondary exposure to extremely or traumatically stressful events. Developing problems because of exposure to others' trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called vicarious traumatization. If your work puts you directly in the path of danger — for example, field work in a war or area of civil violence — this is not secondary exposure; your exposure is primary. However, if you are exposed to others' traumatic events as a result of your work — for example, as a therapist or an emergency worker — this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind or avoiding things that remind you of the event. The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43, and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or whether there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague or a health care professional.

WHAT IS MY SCORE, AND WHAT DOES IT MEAN?

In this section, you will score your test so you understand the interpretation for you. To find your score on each section, total the questions listed on the left and then find your score in the table on the right of the section.

Compassion Satisfaction Scale

Copy your rating on each of these questions onto this table and add them up. You can then find your score on the table to the right.

3. _____ 6. _____ 12. _____ 16. _____ 18. _____

20. _____ 22. _____ 24. _____ 27. _____ 30. _____

Total: _____

The sum of my compassion satisfaction questions is	So my score equals	And my compassion satisfaction level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

Burnout Scale

On the burnout scale you will need to take an extra step. Starred items are “reverse scored.” If you scored the item 1, write a 5 beside it. The reason we ask you to reverse the scores is because scientifically the measure works better when these questions are asked in a positive way, though they can tell us more about their negative form. For example, question 1. “I am happy” tells us more about the effects of helping when you are not happy, so you reverse the score.

<u>You Wrote</u>	<u>Change to</u>
1	5
2	4
3	3
4	2
5	1

*1. _____ = _____ *4. _____ = _____ 8. _____ 10. _____

*15. _____ = _____ * 17. _____ = _____ 19. _____ 21. _____

26. _____ *29. _____ = _____

Total: _____

The sum of my burnout questions is	So my score equals	And my burnout level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

High Secondary Traumatic Stress Scale

Just as you did on compassion satisfaction, copy your rating on each of these questions onto this table and add them up. You can then find your score on the table to the right.

2. _____ 5. _____ 7. _____ 9. _____ 11. _____
13. _____ 14. _____ 23. _____ 25. _____ 28. _____
Total: _____

The sum of my secondary trauma questions is	So my score equals	And my secondary traumatic stress level is
22 or less	43 or less	Low
Between 23 and 41	Around 50	Average
42 or more	57 or more	High

6.3.5 SELF-CARE MAINTENANCE PLAN

A self-care maintenance plan refers to the activities that you have identified as important to your well-being and that you have committed to engage in on a regular basis to take care of yourself. There is no one-size-fits-all self-care plan, but there are some general principles that will help you manage your self-care:

- 1. Take care of your physical health.**
- 2. Manage your stress and reduce it where possible.**
- 3. Honor your emotional and spiritual needs.**
- 4. Nurture your relationships.**
- 5. Find balance in your personal and work life.**

There are some straightforward steps to guide us in this process:

- 1. How do you cope now? Identify what you do now to manage stress in your life and assess whether they are working for you.
- 2. What would you like to do? Complete the self-care assessment tool. What ideas did you get from the tool? What would you like to add to your routine?
- 3. Outlining your plan. Use the self-care maintenance plan worksheet to complete what you currently do and a preferred alternative across each domain.
- 4. Obstacles to implementation. Once you have identified these practices, it is useful to identify possible barriers or obstacles that could get in the way of implementing and/or maintaining them.
- 5. Make a commitment to yourself. Preparing a plan is important; it identifies your goals and the strategies to achieve them. However, your success in implementing your plan is ultimately based on the level of genuine commitment you make to your own self-care.
- 6. Share your intentions. Once you have developed your plan and made your commitment, share it with others.
- 7. Follow your plan. Once you have completed the assessment and worksheet, you will have identified the core elements of your personal self-care maintenance plan. The final step is to implement your plan and keep track of how you are doing.

(Adapted from: Lisa D. Butler, PhD, based in part on materials provided by Sandra A. Lopez, LCSW, ACSW, University of Houston, Graduate School of Social Work)

My Self-Care Maintenance Plan Worksheet

Consider what you do now for self-care, and list those activities within each dimension of self-care on this worksheet (or you can add new dimensions at the end that represent other aspects of your life). Identify new strategies that you will begin to incorporate as part of your ongoing self-care maintenance plan — pay particular attention to domains that you have not been addressing in the past.

On the last page identify barriers that might interfere with ongoing self-care, how you will address them and any negative coping strategies you would like to target for change.

MIND	BODY
<p>Current practice:</p> <p>New practice:</p>	<p>Current practice:</p> <p>New practice:</p>
EMOTIONS	SPIRIT
<p>Current practice:</p> <p>New practice:</p>	<p>Current practice:</p> <p>New practice:</p>

Work	Relationships
<p data-bbox="96 192 311 222">Current practice:</p> <p data-bbox="96 527 270 557">New practice:</p>	<p data-bbox="595 192 810 222">Current practice:</p> <p data-bbox="595 527 770 557">New practice:</p>
Emotions	Spirit
<p data-bbox="96 939 311 968">Current practice:</p> <p data-bbox="96 1262 270 1291">New practice:</p>	<p data-bbox="595 939 810 968">Current practice:</p> <p data-bbox="595 1262 770 1291">New practice:</p>

Barriers to maintaining my self-care strategies:	How I will address these barriers and remind myself to practice self-care:
Negative coping strategies I would like to use less or not at all:	What I will do instead:

6.3.6 STRESS MANAGEMENT ACTIVITY

Provide the handout to participants, ask individuals to write ways to manage their stress with each of the topics and facilitate a discussion of ways to alleviate or manage one's stress related to:

- **Physical** – exercise, nutrition
- **Mental** – focusing on your beliefs and changing your attitude to become positive, reading inspirational books, saying affirmations to yourself repeatedly
- **Emotional** – releasing emotions (express your feelings): Talk to someone, write in a journal, dance, garden, sing.
- **Social** — involves our relationships. Look at how much support you allow others to give to you, which people drain your energy and which people add energy and add to your life in a positive and healthy way. Become more assertive — state what your needs are.
- **Spiritual** — involves your connection with your maker – includes praying, praise singing, meditation, walking or sitting still in nature

Stress Management Activity Handout

Write ways in which you manage stress in each of the topics.



6.3.7 RELAXATION EXERCISE

The facilitator should read the script below. The facilitator should begin by asking group members to sit comfortably and listen carefully to their voice.

The script below is taken from Focus family resiliency training manual, 2015.

Ask the group to close their eyes, if they feel comfortable doing so, and task a couple of deep breaths. Breathing is from the diaphragm or stomach and not the shoulders. Imagine that there is a balloon in your stomach (can put hands on stomach if it helps) that inflates when you breathe in and deflates when you breathe out.

Now just relax (feel where in your body you feel tense and release this tension), let yourself go and just keep on breathing in and out slowly. 1, 2, 3.

Now I want you guys to breathe in and let the air fill your stomach. 1, 2, 3. And now breathe all the air out. 1, 2, 3.

Think about a place that makes you feel comfortable, calm and relaxed. This can be a beach, a field, a rain forest, a room in your house, your favorite getaway place. Think about whatever place helps you feel comfortable, calm and relaxed.

Continue to breathe in ... 1, 2, 3 ... and out ... 1, 2, 3.

Think about the place that makes you feel comfortable, calm and relaxed.

Imagine you are at that place now; it is just you, nobody else. This is your place where you can feel comfortable, calm and relaxed. Imagine how the place looks. Is it sunny? What colors do you see? As you imagine yourself in this special place, pay attention to every little detail there, smells, the sounds. What objects are around you? Is there water? Are there trees? Is there

grass? Or sand? Can you see the sky? What color is the sky?

Now I want you to focus on the sounds. Can you hear any wind? Do you hear the water? Think about the sounds? Do you hear any birds? Do you hear the trees? How does the ground sound when you walk?

Now think about how it smells. What are the different scents that are going into your nose? Breathe in deeply ... 1, 2, 3, 4, 5 ... and breathe out ... 1, 2, 3, 4, 5. Focus on those smells.

Next focus on how it feels to be there. How does your skin feel? How do your feet feel walking around your special place? Do you feel warm? Or cool? How do your eyes feel? Do you feel calm, relaxed and comfortable?

Take a few more moments and savor how it feels to be here. Think about the sights, sounds, smells and sensations in your body when you are here.

Now bring your awareness back to your breathing.

Focus on your breathing.

Bring your awareness back into the room.

When you are ready, open your eyes.

The group members can discuss the reflections on the process.

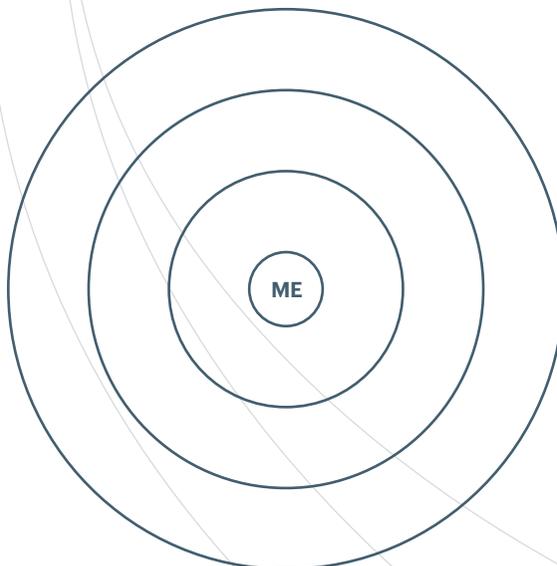
6.3.8 SUPPORT SYSTEM ACTIVITY

This exercise can be conducted with individuals, families and groups.

Provide each member with the relationship circle handout provided below. Explain that the central circle represents you and the concentric circles represent relationships in your life and the closeness to you. Ask members to position smaller circles on this drawing (containing the initials of the family member, friend, acquaintance and so forth), representing how close in relationship these people are to you now. Ask the group to reflect on these relationships, and then to do the exercise again on the other side of the handout. This time, they should plot their relationships where they would like them to be. Ask group members to identify which relationships moved most. Ask group members to share what insights they learned when completing the relationship assessment grid exercise. Discuss what can be done to improve those relationships that they would like to be closer.

Group members are to identify the important relationships in their life that make up their support system. They are encouraged to reflect on which relationships they would like to improve and are beneficial for their growth and which relationships are not constructive and have a bad influence on them, thus requiring less energy.

Relationship Circle Handout



6.3.9 SOCIAL SUPPORT SYSTEM

Ask group members/participants to draw a tree. Ask them to write the names of their support system on the leaves of the tree.

Facilitate a discussion around the experience of this activity. Do you feel you have enough people in your support system? How else could you create a support system? (Family, friends, partner, therapy, social groups/sports groups, lecturers and so forth.)



A participant of the 2021 body-mapping workshop in Liberia.



A 2018 GIJTR exhibition of body-maps in Conakry, Guinea.

CHAPTER 7

ADDITIONAL INFORMATION

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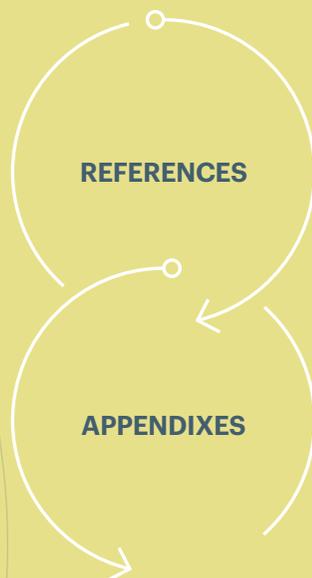
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7.2 Appendixes

7.2.1 APPENDIX A: BACKGROUND

Sri Lanka is a South Asian island country located in the Indian Ocean, with a population of about 21 million. According to the 2012 census, 74.9% of the country's population are Sinhalese, 15.3% are Tamil and 9.3% are Sri Lankan Moor. Furthermore, 70.1% consider themselves Buddhist, 12.6% Hindu, 9.7% Muslim and 6.2% Christian. The majority of Sinhalese are Buddhists, and the majority of Tamils are Hindus, although religious identity in many cases crosses ethnic lines (DCS 2012).

Over the past 50 years, Sri Lanka has faced a prolonged internal armed conflict, ethnonationalist violence and socioeconomic inequality, in addition to a devastating tsunami, which have had serious impacts on the mental health of much of the population.

Sri Lankan Civil War

The main conflict that has shaped Sri Lanka's modern history is that between government forces and the rebel group, the Liberation Tigers of Tamil Eelam (LTTE). In response to colonial-era preferential treatment toward Indian Tamil migrants who settled in Ceylon, successive governments elected by the Sinhalese majority after independence in 1948 enacted discriminatory laws that favored the Sinhalese population while limiting Tamils' rights. In 1972, the government changed the country's name to Sri Lanka and identified Buddhism as its primary religion. Tamil politicians and activists called for secession and the formation of a Tamil eelam, or homeland, in northern and eastern Sri Lanka, where the majority of the Tamil population resides.

As tensions escalated throughout the 1970s, leading to anti-Tamil riots in 1977, the LTTE was formed and began engaging in small-scale armed struggle against government forces. The government responded by banning the group, centralizing power in the presidency and enacting the Prevention of Terrorism Act of 1979, along with other legislation and emergency regulations that further constrained Tamil rights in the country (Bose 1994). In July 1983, an LTTE ambush that killed 13 Sinhalese soldiers sparked widespread attacks on Tamil civilians, alongside activists and militants. Estimates indicate that the Black July riots resulted in up to 3,000 deaths and the displacement of up to 150,000 Tamils in the capital, Colombo, alone. At this point, the LTTE developed into a full-scale insurgency and the conflict escalated into civil war. More than 100,000 people were killed in the ensuing 26 years of armed conflict, and up to a million were displaced (Project Ploughshares 2009; Kumar 2011).

Both government forces and the LTTE, as well as LTTE splinter groups, engaged in forced disappearances, extrajudicial killings, torture, sexual violence and recruitment of child soldiers, with the LTTE also using suicide bombings against high-level targets as a terror tactic. Repeated states of emergency and restrictions on the freedom of association and movement during the war affected the entire population, although Tamils faced particular hardship, with government forces regularly subjecting them to harassment and arbitrary detention, in addition to intermittent restrictions on access to food and medical supplies (Sriram 2014).

After a Norwegian attempt to broker a peace deal fell apart in 2006, hard-line president Mahinda Rajapaksa, who came into power in 2005, consolidated his

influence through an alliance with nationalist Sinhalese political parties and oversaw the launch of a large-scale military offensive against the LTTE. In May 2009, the government declared victory over the rebel group. The final months of the offensive were particularly brutal, with estimates indicating that between 40,000 and 70,000 civilians — largely Tamils — were killed between January and May 2009 alone, mainly as a result of military shelling (UN 2011; 2012).

Following Mahinda Rajapaksa's surprise electoral defeat by opposition candidate Maithripala Sirisena in 2015, the new government co-sponsored United Nations Human Rights Council Resolution 30/1 to promote reconciliation, accountability and human rights in Sri Lanka. It committed to establishing an office of missing persons, a truth commission, a reparations body and a hybrid court to address gross violations committed during the civil war, in addition to removing government forces from civilian land in the northeast of the country and repealing the Prevention of Terrorism Act. The transitional justice process has been undermined by lack of political will, however, in a similar manner to the Lessons Learnt and Reconciliation Commission and the Presidential Commission to Investigate Complaints Regarding Missing Persons, established by the Rajapaksa administration in 2010 and 2013, respectively (ITJP 2018).

The Office on Missing Persons opened in 2018 to deal with what is reported to be the second-highest caseload of missing persons in the world (UN 2019), but it has been criticized for the slow pace of its investigations and lack of victim participation. The government approved legislation on the Office for Reparations in October 2018 and was reportedly close to doing the same for the Commission for Truth, Justice, Reconciliation and Non-Recurrences, but the establishment of these bodies has been repeatedly delayed. In 2019, the government dismissed the idea of a hybrid court in Sri Lanka, while making no moves to release occupied land or repeal its terrorism legislation (Kersten 2020).

After his election to the presidency in late 2019, Gotabaya Rajapaksa, brother of Mahinda Rajapaksa and a proponent of Sinhalese nationalism, announced his intention to reverse many of the policies of the previous government, including in relation to Resolution 30/1, claiming it undermines Sri Lanka's sovereignty and the memory of its war heroes (ICG 2020). While civil society in the country and the diaspora has attempted to deal with the civil war past through memorialization practices and awareness raising (Orjuela 2020), denial of the extent of violations committed during the war is widespread, and transitional justice and its proponents are under threat in Sri Lanka's current political context.

fundamentalism, vandalizing mosques and Muslim-run businesses and inciting mobs to violence. The government has largely stood by as these attacks have occurred, despite the historical alliance between Sinhalese authorities and Muslim groups, which led to Muslims being targeted by the LTTE during the civil war. Similar tactics at a more localized level have been used against Christians in the country, based on claims that they are offering financial and other incentives to convert Buddhists to Christianity, again to alter the country's demographics (Devotta 2018). Non-Theravada Buddhist and Hindu temples have also been subject to attack (CPA 2013).

A new form of religiously motivated violence emerged in Sri Lanka in 2019, with a coordinated suicide bomb attack on churches and Christian gathering places around Colombo on Easter Sunday, which killed more than 250 people. The government has blamed local Islamist groups for the attacks and embarked on mass arrests, which in some cases have been used to harass Muslims citizens as well as human rights defenders, including via the Prevention of Terrorism Act (Imtiyaz 2019). This is part of a broader pattern of rights abuses since the end of the civil war, as police and intelligence agencies, as well as the pro-government media, have been known to target human rights defenders, lawyers, journalists, victims of past violations and ordinary civilians suspected of a critical position toward the government. The practice has accelerated since Gotabaya Rajapaksa's election in 2019 (HRW 2020).

2004 Tsunami and Socioeconomic Impacts

On the morning of December 26, 2004, an earthquake sent massive waves across the Indian Ocean to bring devastation to 2,260 km of coastline in the north and east of Sri Lanka. According to official estimates, about 35,000 people were killed, two-thirds of whom were women and children, while more than 500,000 were displaced by the disaster. Between 1 million and 2 million people were directly affected by the tsunami, with the economic costs rising above US\$1 billion. As such disasters are rare in the area, the country did not have an early warning system and was unprepared for the emergency, humanitarian and reconstruction efforts that would be required in the tsunami's aftermath (Athukorala and Resosudarmo 2005; Minas et al. 2017).

While Sri Lanka's economy eventually recovered from the disaster, with wealthier, largely urban areas of the country reporting rising incomes over

time, low-income households in affected areas saw serious negative effects on their income and food consumption levels even a decade after the tsunami (De Alwis and Noy 2019). The disaster had a particularly deleterious effect on Tamil-majority areas affected by the civil war, which already struggled with underdevelopment. The Tamil population of Sri Lanka in all areas faces higher rates of poverty than other ethnic groups, as well as less access to education and basic services (WB 2015).

Sri Lanka's wider population is experiencing rising rates of inequality, with the wealthiest 10% earning more than the income of 70% of the population combined in 2016 (IPS 2018). In the face of economic pressures, a growing number of Sri Lankans from low-income households have become international migrant workers, taking low-skilled jobs, primarily in the Middle East, and sending remittances back to their families. Over 2 million Sri Lankans are currently working abroad as labor migrants (IOM 2020).

Mental Health Effects

The combination of large-scale violence, the tsunami and socioeconomic challenges has had widespread mental health impacts on the population of Sri Lanka, including individual and collective trauma. Although the country ranks high in terms of the Human Development Index overall, the deaths of loved ones, changes in family structure, displacement from home, loss of property and livelihoods, interruptions to education and the loss of security occasioned by these human and natural disasters have contributed to significant mental health challenges (AF 2016). Sri Lanka had among the highest rates of suicide in the world in the 1990s, and although the rate started falling in the 2000s, self-harm remains the second-largest cause of premature mortality and morbidity in the country, especially among men (Minas et al. 2017).

Among those affected by the civil war, PTSD, major depressive disorder, somatization disorder and anxiety disorders are common, particularly in the north and east of Sri Lanka (Muraleetharan 2016). Children have also been affected, with a study conducted in the northeast showing that 92% of the children surveyed reported experiencing severely traumatizing events and 79% had some form of combat experience. A quarter of the children met the criteria for PTSD, while 12% of those children suffered anxiety disorders and were more

likely to experience depressive and/or somatic symptoms (Elbert 2009). Studies suggest that conflict-related trauma in the country is linked to higher rates of substance use and domestic violence among men, with ongoing negative effects particularly on children, adolescents and women, including elderly women (Minas et al. 2017).



A picture taken during GIJTR's Body Mapping workshop in Sri Lanka

The tsunami also had serious and lasting effects for those affected, with a study conducted almost two years after the disaster showing that the prevalence of PTSD among those surveyed was 21% , depression was 16% and anxiety was 30% (Hollifield 2008). These effects have been particularly pronounced among people affected by both conflict and the tsunami, especially those who were internally displaced (AF 2016).

Ethnonationalist attacks since the end of the civil war, in the form of not only physical violence but also hate speech, particularly on social media, are reported to have spurred suicides and contributed to depression and other common mental health challenges among Muslims and other affected communities in the country (Wijayaratne 2019; Kallivayalil et al. 2020).

The prevalence of labor migration has further contributed to mental health burdens. Studies indicate that about 43% of children of international migrant workers, 14% of spouses and 30% of family caregivers who are not spouses (usually older women) face depression and other mental health challenges (Wickramage et al. 2015; Siriwardhana et al. 2015).

Mental health problems are highly stigmatized in Sri Lanka, carrying connotations of “bad blood” in the family and personal responsibility in the form of “karma” and often leading to social exclusion and comparatively high levels of

poverty among not only affected individuals but also their family members (AF 2016). The widespread effects of the tsunami raised awareness and promoted greater acceptance of mental health concerns in the country, which also helped raise awareness of the need to address the mental health impacts of the civil war (Minas et al. 2017). However, efforts to do so in the north and east of Sri Lanka continue to be politicized and viewed as “security sensitive,” to the point that people in the region have often been “denied adequate spaces to systematically facilitate healing processes through broad-based individual, family or community based interventions” (AF 2016: 10).

Mental Health and Psychosocial Support Frameworks

Indigenous and Ayurvedic practices that precede colonialism continue to influence mental health approaches in Sri Lanka, particularly in rural areas. In these practices, mental health issues are commonly ascribed to astrological factors, sorcery, demon possession or black magic, with healing depending on astrological and religious ceremonies as well as herbal medicine (Minas et al. 2017). The University of Colombo and the University of Kelaniya provide standardized training in Ayurvedic medical practice, and there are a number of registered practitioners of indigenous medicine in the country, in addition to many unregistered, informal practitioners. In the public sector, however, the government early on adopted a Western therapeutic model for its MHPSS services (AF 2016).

After a focus on psychiatric institutions from the late 1800s to the 1930s, Colombo General Hospital was among the first internationally to establish an outpatient clinic for mental patients in 1939 as part of the country’s public health system. This was the start of a rapid expansion of public mental health services, which included an increasing number of public positions for psychiatrists, the opening of the Psychiatry Department at the University of Colombo in 1968, the integration of psychologists, social workers, mental health nurses and occupational therapists into psychiatric services as part of a community-oriented approach in the 1950s and 1960s and the establishment of community mental health clinics starting in the 1970s. This expansion was focused primarily on urban centers and slower-to-reach rural areas, however (Minas et al. 2017).

The start of the civil war curtailed mental health services in the northern and

eastern parts of Sri Lanka and pushed most practitioners to leave the region. For example, in 2003, North-Eastern Province had only two practicing psychiatrists, working with limited resources, while Western Province, where Colombo is located, had 25 practicing psychiatrists (Minas et al. 2017). Starting in the 1980s, the effects of the civil war spurred research and interventions based on psychosocial approaches, which made the best of scarce resources and built on community processes, traditional practices, resources and relationships, particularly in the north and east. These have included, for example, family-friendly and community-based practices in the treatment of patients at district hospital mental health units, engagement with traditional healers, psychosocial support programs for children and training for counselors in schools, and collaboration between state services and nongovernmental organizations (NGOs) such as Nest, BasicNeeds, Shanthiham and the Family Rehabilitation Centre (AF 2016).

The 2004 tsunami, which further weakened the limited mental health services available in some areas, brought renewed recognition of the need for improved and widely accessible public MHPSS services, along with financial support from the donors operating in the country in the aftermath of the disaster. The government initiated a relatively broad-based consultative process with psychosocial practitioners, mental health professionals, academics, legislators and other stakeholders that resulted in the adoption of a Mental Health Policy for 2005–2015 (MHD 2005). Although Sri Lanka’s legislation relating to MHPSS has not been updated since the Mental Disease Ordinance of 1956, the Mental Health Policy represented a significant step forward. The Directorate of Mental Health developed an action plan for implementing the policy, which included funding allocations, provisions for the establishment of a multisectoral National Mental Health Advisory Council to oversee implementation, a focus on strengthening human resources for mental health and a formal shift from mental hospital-based treatment to community-based services and integration of mental health services into primary care (Minas et al. 2017).

Human resource limitations have proved to be a lasting problem, occasioned by funding constraints, coordination problems and “brain drain.” In 2015, there were still only 89 consultant psychiatrists serving a population of 21 million, and the number of psychiatric nurses, social workers, psychologists and occupational therapists remained very low. To address this problem, Sri Lanka has developed new categories of mental health workers. These include

“medical officers” with either a one-year diploma or a one-month certificate in psychiatry to provide basic services in subdistricts around the country, as well as volunteer “community support officers,” whose short training enables them to refer people for MHPSS services and assist with people’s reintegration after an inpatient stay, for example. Most districts now have public mental health care facilities and services, including a psychiatric inpatient unit, an intermediate care unit and community outreach clinics, under the supervision of at least one psychiatrist or a medical officer in most subdistricts. Given resource constraints, however, mental health workers report heavy workloads and little institutional support (Minas et al. 2017).

The government has committed to a more community-based approach to MHPSS, in part to help address human resource issues, but it has been slow to institutionalize the shift. The psychological and psychosocial components of public mental health services are often compartmentalized (AF 2016). One example of a more integrated approach is that taken by public sector mental health professionals in collaboration with NGOs in Northern Province starting in the 1990s, which combines “psycho-education” through the media, pamphlets and public lectures; basic mental health care training for teachers, primary health workers, priests, traditional authorities, traditional healers, youth and elders, usually in the local language; and working with local resources to strengthen community-based psychosocial support (Somasundaram 2014). Another is a community-based rehabilitation program for children with disabilities affected by conflict, which promoted collaboration among families, NGOs and communities while bringing members of Sinhalese military and Tamil militant groups together to share common experiences of disability and enable mutual assistance (Betancourt et al. 2013).

In addition to advocating for more community-based practices as part of an approach that combines psychological and psychosocial interventions, local practitioners and researchers have called for an MHPSS model that promotes the integration of Western and traditional practices, ranging from indigenous and Ayurvedic medicine to religious and cultural practices. They have also called for interventions that are tailored to the needs of those affected and that explicitly address the ongoing and intergenerational mental health impacts of Sri Lanka’s civil war and ethnonationalist attacks, which are exacerbated by socioeconomic marginalization. Related to this, they have highlighted the need for a more equitable distribution of human and other resources across different regions of the country and between urban and rural areas (AF 2016).

The Directorate of Mental Health notes that the aims of the Mental Health Policy for 2005–2015 “were to provide mental health services of good quality at primary, secondary and tertiary levels; to ensure the active involvement of communities, families and service users; to make mental health services culturally appropriate and evidence based; and to protect the human rights and dignity of all people with mental health disorders.” The Directorate is now in the process of revising the country’s Mental Health Policy for 2016–2025, “as mental health promotion and services in Sri Lanka and [sic] has undergone significant changes” (MoH 2020). It remains to be seen how the policy will affect MHPSS services in the country, if it is adopted, particularly given the current political context.

In the meantime, public and NGO-run MHPSS services in Sri Lanka are wide-ranging, including individual psychosocial care to multidisciplinary support within collective interventions to respond to crisis and disaster situations. Among the MHPSS interventions are counseling, befriending, play activities for children and youth, protection, rehabilitation and reintegration, raising awareness, networking and coordination, addressing practical needs that affect psychosocial well-being, capacity building and initiatives to improve quality of services, facilitating support groups and conducting specialized mental health related interventions, family tracing and reunification and supporting children’s education through Accelerated Learning Programmes; life skills programs; psychiatric care, facilitating traditional healing (rituals and religious practices and so forth), and use of expressive methods such as psychosocial drama (AF 2016: 18).

Sri Lanka’s government has to date recognized the need for widespread MHPSS services to address the diverse mental health needs of the population, particularly given the crises that have affected the country over the past half-century. Civil society has worked with the government and independently to develop innovative and contextually relevant MHPSS interventions and to fill the gaps in public mental health care. In addition to addressing human resource constraints, coordination issues and budgetary shortfalls, the country’s MHPSS framework requires significant work in terms of integrating psychosocial approaches. It also needs to acknowledge and address the past and ongoing politicization of mental health care in communities affected by violence.

Hence the need for toolkits such as this one, which aim to provide at least basic information on psychosocial support (PSS) and its delivery.

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7.2.1 APPENDIX A: ICEBREAKER EXAMPLES

Icebreakers are facilitation exercises used to assist a group in the process of forming a team in which they will collectively learn and grow on a specific workshop topic. Icebreakers help “break the ice” between the group whereby they will feel more comfortable within the group to share and engage in the rest of the workshop. This warms up the group, energizing and bringing them together.

These exercises are important for participatory learning and are used to keep participants’ levels of motivation high and to raise their energy levels. The following icebreakers are examples that can be utilized:

- 1. Ask the group to introduce themselves (their name) and to pick a color that best describes how they are feeling right now.** Ask them to describe what that color reminds them of, represents to them or feels like to them.
- 2.** Ask the group to tell the story of how they got their name. Each person gets one minute. This will need to be timed.
- 3. Split the group into pairs.** Each person in the group must tell the other person what their name is and who their hero is and why. Each person in the pair must introduce the other person to the rest of the group.
- 4. “I have never ... but I would like to someday.”** Each says the sentence.
- 5. Group members are to think of an adjective that describes how they are feeling,** which starts with the same first letter as their name. Group members are then to say their names and how they are feeling; for example, “I am Alex, and I feel anxious.”
- 6. The icebreaker is titled “Best or Worse.”** The facilitator should ask the group members to share their high (fun) and low (most stressful) moments of the day/week.
- 7. The group members are to close their eyes and become comfortable in their seats.** Ask them to focus all their energy on their feet while in a relaxed state. Ask them, “If your feet were a color, what colour would they be?” and/or “If your feet were telling you something, what would they say?” Do this for the feet, knees and stomach areas. This exercise enables the participants to become mindful of their bodily feelings and how these relate to their inner emotional feelings and awareness.

- 8. Each group member is to stand up from the group circle and walk around the room greeting each other without using words or their hands.** The group members are to use, for example, their eyes, smile and small finger to communicate their intention of greeting each other.
- 9. Ten-second socializing.** Group members spend time with each other separately for ten seconds, briefly introduce themselves (name), one thing they like (e.g., popcorn), one thing they dislike (e.g., snakes) and then how those two things make them feel. Do that with each group member as quickly as you can. Spend ten seconds with each group member.
- 10. The facilitator should have a container with a variety of emotions written on separate pieces of paper** (e.g., “in love,” “frustrated,” “surprised”), and a separate container with papers presenting different situation options (e.g., “shopping,” “at the movies,” “at a restaurant,” “at home”). Three volunteers choose a paper from the emotion container (e.g., “in love”) as well as the situation in which they should act it out (e.g., while shopping). The group gets a few minutes to plan their skit before enacting it in front of the group. Each skit must not be longer than a minute. The rest of the group must guess what the scenario depicts. Everyone should get a turn to act an emotion and situation out.
- 11. Group members write down one true statement about what they are really struggling with and two things they just made up.** The group then has to guess which one is true and which two are false. Facilitators are to take note of whether containment is necessary at any time should any sensitive information be shared and ensure that rules such as confidentiality and respect are reinforced before the icebreaker in case sensitive information is shared.
- 12. The “Juggling ball game.”** Group members stand in a close circle. Co-facilitators start by throwing the ball to a member of the group in the circle, while saying that group member’s name. Group members continue catching and throwing the ball to establish a pattern for the group. Each member of the group should remember who threw the ball and received the ball.

Once everyone has had a turn to throw and receive the ball, the co-facilitators will introduce one or two more balls so that there is a continuous pattern of balls being thrown at the same time. Group members need to be able to communicate and share ways to keep balls moving without dropping the ball (International HIV/AIDS Alliance, 2002). This gives them a sense of responsibility and teamwork.

- 13. Each group member must think of something/an object that personally relates to who they are** (e.g., a ball if one enjoys playing sports). Each group member must try describing what it is without saying the word. All the other group members must try guessing what is being described (e.g., act out with your hands and body that it is round, you can play with it and you can kick it).
- 14. What we have in common.** The facilitator calls out characteristics of people in the group (e.g., having children), and all those who have children should move to one corner of the room. The facilitator calls out more characteristics of the group (e.g., soccer), and people with the characteristic move to the indicated space.
- 15. Shoe swap exercise.** Tell the group members to take off their left shoe, pass it to the person to their right and receive the one from the person to their left. Put on the other person's shoe. (Members might say no or might look at you strangely or might do it.) Ask the group members how they felt during this exercise. Reflect on feelings of discomfort, not wanting others feet in their belongings and so forth. Discuss how this was a breach of their personal boundary.
- 16. Broken telephone.** Players must sit in a circle or stand in a straight line. To begin the game the facilitator will whisper a word or phrase into the ear of the person sitting or standing to their right. That person will then whisper what they heard to the next person to their right, and so on. Explain that they are not allowed to repeat their sentence and they must pass on the message they hear. The last person in the line or circle must say what was whispered into their ear out loud, and then the facilitator can say what the first word or sentence was, and the group can see whether the messages are the same or changed and discuss who heard wrong or who said the wrong message. This exercise will show them that a message can get lost and each one will interpret the message differently.
- 17. The facilitator divides the group members into pairs.** Each group chooses a person who will tell the rest of the group more about the other person. The following guidelines will be offered: favorite color, favorite food, favorite movie, hobbies and so forth. This activity aims to demonstrate that communicating the correct information is important, and interpreting the received information is just as important. If the one member does not communicate properly to the other member, the presenting member cannot give an accurate summary to the group, and the group's perception of the individual may be tainted.

- 18. Ask the group to privately think of a time when someone did something for them that was just what they needed or wanted,** and they just felt so cared for (maybe it was someone bringing them a meal when they were ill, or an afternoon of special time spent together, or perhaps it was just the kindest words at the right time and so forth). Then ask them to imagine never receiving this kindness again and reflect on how that would make them feel. This exercise needs to be well managed and be done by someone who is able to contain what is coming out for people.
- 19. Tell the group that when you tap one person on the shoulder, they are to flash the biggest smile to anyone else in the group, who then flashes the biggest smile to the next person and so on and so on.** Ask the group how receiving a big smile made them feel. Reflect to the group that nonverbal communication is powerful and that both negative and positive nonverbal communication are equally as contagious.
- 20. I like you because** Each group member must say one thing they like or admire about the person to their right. For example, “I like you because you always greet me with a smile,” “I admire your strength.”
- 21. If you had to pick one object or symbol to represent who you are, what would it be? And why?** (Or give the participants five minutes to go outside and physically pick an object/take a picture of an object, and bring it in to present.)
- 22. Life boat:** The participants are told they are on a ship that is sinking. They have to get into life boats, but the capacity of the life boats is limited based on what the facilitator calls out — two people, three people, five people and so forth. When the facilitator calls out the size of the life boat, the participants have five seconds to form groups of that size. The facilitator eliminates those who have drowned — groups that are bigger or smaller than the announced number. The facilitator announces new numbers so that regrouping is necessary until there is only one group left. This exercise allows people to move around quickly, interact with one another and make quick decisions.
- 23. The sun shines:** Participants and the facilitator sit in a circle on the exact number of chairs minus one. One person (the facilitator to begin with) stands in the middle and announces, “The sun shines for those who ... [for example] are wearing black shoes [don’t like fish, are wearing a white shirt, are parents, have two or more siblings and so forth]”. The participants who are wearing black shoes, for example, have to change chairs. The person in

the idle chair seizes the opportunity to sit on one of the empty chairs. The one who is left without a chair now stands in the middle and begins again with “The sun shines for those who...” This exercise gets people to move around and to discover things about one another.

- 24. Simon says:** All stand in a circle. The facilitator says: “Simon says [for example] touch your nose with your left hand, hold up two hands, form a fist, say hello [and so forth],” demonstrating the action at the same time. Everyone is asked to follow Simon’s orders as demonstrated. But if the facilitator does not mention Simon and some participants follow the orders, those participants are out. The game goes on until only a few participants are left and the facilitator cannot trick them any longer. This exercise increases concentration and energizes the participants for the next task.
- 25. Bang:** The participants sit in a circle on the floor, counting out loud; the first participant begins with “one” and it goes around the circle, with each person saying the next number. However, every time they come to a number that can be divided by 3 (such as 12), or that contains a 3 (such as 13), the person whose turn it is must say “bang” when they are supposed to; if they say “bang” when they are not supposed to, they are removed from the group.” This exercise demands concentration and is useful at the beginning of serious group work.
- 26. Person A and Person B:** Each person privately selects one person out of the group as Person A and another as Person B. No one should know their choice. Then everyone tries to get as close to their Person A as possible. Once that has happened, and the participants have stopped moving, the facilitator tells them to get as far away from their Person B as possible. The group will do two opposite movements: contracting and expanding. This is a quick, humorous exercise. (The participants should not be asked to reveal whom they picked as their Person A and Person B, as some may feel left out.)
- 27. Association:** The group sits in a circle. Someone says the name of a fellow participant and a word that they associate with that person (whatever comes to mind). The next person says the name of another participant and a word they associate with that person, and also repeats the name and word that the first person said. The next person does the same and so on. If someone does not answer quickly, they are removed from the game. This exercise helps with creative thinking and gets the participants to call one another by name. Negative word associations should be discouraged from the beginning of the game.

28. The facilitator writes 20 “if “cards and places them in a hat. Each person should get a chance to draw a card from the hat and answer the “if” question. The facilitator can generate their own “if” cards or use the ones provided below.

(Idea retrieved from

https://insight.typepad.co.uk/40_icebreakers_for_small_groups.pdf).

1. If you could go anywhere in the world, where would you go?
2. If you could watch your favorite movie now, what would it be?
3. If you could talk to anyone in the world, who would it be?
4. If you could wish one thing to come true this year, what would it be?
5. If you could live in any period of history, when would it be?
6. If you could change anything about yourself, what would you change?
7. If you could be someone else, who would you be?
8. If you could have any question answered, what would it be?
9. If you could watch your favorite TV show now, what would it be?
10. If you could have any kind of pet, what would you have?
11. If you could do your dream job 10 years from now, what would it be?
12. If you had to be allergic to something, what would it be?
13. If you sat next to your favorite celebrity on a bus, what would you talk about?
14. If money and time were no object, what would you be doing right now?
15. If you had one day to live over again, what day would you pick?
16. If you could eat your favorite food now, what would it be? If you could learn any skill, what would it be?
17. If you were sent to live on a space station for three months and were allowed to bring only three personal items with you, what would they be?
18. If you could buy a car right now, what would you buy?
19. If you had to be an animal, which would you choose?

29. People bingo: The facilitator hands out the people bingo handout, and the participants have to go around the room and find a person who fits the sentences (e.g., Amy is taller than her father). The participants then fill out the name of the person who fits the sentence. No name/person can be used twice. Once a person has filled out their whole card they shout, “Bingo!” and win the game.

People Bingo

1. _____ is a lefty (left handed).
2. _____ has tried bungee jumping.
3. _____ has traveled to another African country.
4. _____ has traveled overseas.
5. _____ speaks more than two languages.
6. _____ plays an instrument.
7. _____ is taller than their father.
8. _____ doesn't drink coffee.
9. _____ has more than three siblings.
10. _____ enjoys reading books.
11. _____ enjoys cooking.
12. _____ loves soccer.

7.2.3 APPENDIX B: CHECKING IN AND CHECKING OUT

7.2.3.1 Sample check-in questions

- What is present for you at the moment? (What thoughts, feelings, concerns, hopes, and so forth, are you bringing with you into the room?)
- What are you noticing? (About yourself, the group, this process and so forth?)
- What new insights or new thoughts are emerging for you?
- What are you learning about yourself? (What are you seeing in yourself?)
- What would make this workshop meaningful for you?

7.2.3.2 Sample check-out questions

- What will you take away from today's session?
- What stood out for you today?
- What **one word** describes how you are feeling now?
- With everything in life, there are thorns (challenges/obstacles) among the roses (the beauty/the gifts)! What has been your biggest thorn, and what has been your biggest rose during this workshop?
- Share an appreciation about the person sitting to your left — what have you appreciated about them and their participation in the session?
- Stand in a circle and imagine a big pot in the center of the circle. While pretending to stir the pot, ask each person to share one thing that they are putting into the pot (something they are contributing to the workshop) and one thing that they are taking out of the pot (something that they are taking away with them).



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