Ministry of Public Health

Directorate of policy and plan

Directorate of Gender

MODULE 5. The different types of intervention in MHPSS and GBV

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Facilitator Guide

Purpose:

To help health care providers enhance their knowledge to provide adequate different levels of MHPSS: psychosocial first aid (PFA), psychosocial support,psychosocial counselling follow-up and referrals to survivors of GBV.

Specific Objectives:

At the end of this module, participants should be able to

- Further understand the psychological and social impact of GBV.
- Provide different levels of MHPSS using survivor-centred skills.
- Understand the timelines and variations for follow-up of survivors.
- Understand when to refer a survivor.
- Understand how to best use existing capacities.
- Practice some PSS and counselling techniques

Estimated Time:

11 hours

Resources

Different resources are available; we have focused on the most action oriented ones, and developed further materials adapted to our context.

1. *Accompanying Steps in Clinical Management of GBV Survivors:Counselling the survivor*[1]

Survivors seen at a health facility immediately after a critical incidentor in cases of ongoing violence are likely to be extremely distressed and may not remember advice given at this time. Survivors suffering long term GBV may feel unsafe and guilty when asking for help for the first time. It is therefore important to repeat information during follow-up visits. It is also useful to prepare standard advice and information in writing, and give the survivor a copy before she leaves the health facility (even if the survivor is illiterate, she can ask someone she trusts to read it to her later).

Give the survivor the opportunity to askquestions and to voice her concerns.

Psychosocial and emotional consequences

Medical care for survivors of GBV includes PFA, psychosocial support and treatment/ referral for psychological and social problems, such as common mental disorders, stigma and isolation, substance abuse, risk-taking behaviour, and family rejection. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to the psychosocial counsellors who are working in area of gender-based violence.

The majority of rape survivors never tell anyone about the incident. If the survivor has told you what happened, it is a sign that she trusts you. Your compassionate response to her disclosure can have a positive impact on her recovery.

Provide basic, non-intrusive practical care. Listen but do not force her to talk about the event, and ensure that her basic needs are met. Because it may cause greater psychological problems, do not push survivors to share their personal experiences beyond what they would naturally share.

Ask the survivor if she has a ***safe place*** to go to, and if someone she trusts willaccompany her when she leaves thehealth facility. If she has no safe placeto go to immediately, efforts should bemade to find one for her. Enlist theassistance of the multi-sectorial services. If the survivor hasdependants to take care of, and isunable to carry out day-to-day activitiesas a result of her trauma, provisionsmust also be made for her dependantsand their safety.

Survivors are at increased risk of a range of symptoms and consequences, including:

- feelings of guilt and shame;
- uncontrollable emotions, such as fear, anger, anxiety;
- nightmares;
- suicidal thoughts or attempts;
- numbness;
- substance abuse;
- sexual dysfunction;
- medically unexplained somatic complaints;
- social withdrawal.

Tell the survivor that she has experienced a serious physical and emotional event. Advise her about the psychological, emotional, social and physical problems that she may experience. Explain that it is common to these situations in cases of GBV.

[1]Adapted from Accompanying Steps in Clinical Management of Rape Survivors Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons – Revised ed. © World Health Organization / United Nations High Commissioner for Refugees, 2004.

Advise the survivor that she may need emotional support. Encourage her – but **do not force** her - to confide in someone she trusts and to ask for this emotional support, perhaps from a trusted family member or friend. Encourage active participation in family and community activities.

In most cultures, there is a tendency to blame the survivor in cases of rape. If the survivor expresses guilt or shame, explain gently that rape is always the fault of the perpetrator and never the fault of the survivor. Assure her that she did **not** deserve to be raped, that the incident was not her fault, and that it was **not** caused by her behaviour or manner of dressing. Do not make moral judgements of the survivor.

Special considerations for men

Male survivors of rape are even less likely than women to report the incident, because of the extreme embarrassment that they typically experience. While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.

Pregnancy

Female survivors of rape are likely to be very concerned about the possibility of becoming pregnant as a result of the rape. Emotional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant:

- There may be adoption or foster care services in your area. Find out what services are available and give this information to the survivor.
- In many countries the law allows termination of a pregnancy resulting from rape. Furthermore, local interpretation of abortion laws in relation to the mental and physical health of the woman may allow termination of the pregnancy if it is the result of rape. Find out whether this is the case in your setting. Determine where safe abortion services are available so that you can refer survivors to this service where legal if they so choose.
- Advise survivors to seek support from someone they trust - perhaps a religious scholar, family member, friend or community worker.

Women who are pregnant at the time of a rape are especially vulnerable physically and psychologically. In particular, they are susceptible to miscarriage, hypertension of pregnancy and premature delivery. Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the pregnancy. Their infants may be at higher risk for abandonment so follow-up care is also important.

HIV/STIs

There is a concern about the possibility of becoming infected with HIV as a result of rape. While the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded in settings where HIV and/or STIs prevalence are high. Compassionate and careful counselling around this issue is essential. The health care worker may also discuss the risk of transmission of HIV or STI to partners following a rape.

The survivor may be referred to an HIV/AIDS counselling service if available.

The survivor should be advised to use a condom with all partners for a period of 6 months (or until STI/HIV status has been determined).

Give advice on the signs and symptoms of possible STIs, and on when to return for further consultation. Please refer to the *Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook.Ministry of Public Health and WHO. Afghanistan 2015.*

2. Follow-up care of the survivor

It is possible that the survivor will not or cannot return for follow-up. Provide maximum input during the first visit, as this may be the only visit. Follow the guidance in the above mentioned Handbook.

Care for child survivors

Follow the guidance in the above mentioned Handbook and also remember that:

Health care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that healthcare staff receive special training in examining children who may have been abused.

Create a safe environment

- Take special care in determining who is present during the interview and physical examination if needed. Remember that it is possible that a family member is the perpetrator of the abuse or that the child is suffering due to the situation faced by the accompanying person. It may be preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present. For the examination, either a parent or guardian or a trusted person should be present. Always ask the child who he or she would like to be present, and respect his or her wishes.
- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that he or she is not in any trouble.
- Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favourite activities.

Take the history

- Begin the interview by asking open-ended questions, such as "Why are you here today?" or "What were you told about coming here?"
- Avoid asking leading or suggestive questions.
- Assure the child it is okay to respond to any questions with "I don't know".
- Be patient; go at the child's pace; do not interrupt his or her train of thought.
- Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.
- For girls, depending on age, ask about menstrual and obstetric history.

The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- the home situation (has the child a secure place to go to?);
- how the abuse was discovered;
- who did it, and whether he or she is still a threat;
- if this has happened before, how many times and the date of the last incident;

- ✦ whether there have been any physical complaints (e.g. bleeding, dysuria, discharge, difficulty walking, etc.);
- ✦ whether any siblings are at risk.

It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

3. Assessment, Counselling and Interview

An assessment[2]:

- Is used in a specific context.
- Is mainly used by service providers.
- Has a specific goal, namely: gathering information or data at a given moment of time and evaluating it for the purpose of making an appropriate decision about what course of action to take.
- Uses the process of inquiry, the decision to take action is based on the evaluation of data, less on the opinion of the person who conducts the assessment.
- In an assessment of the needs of a survivor, survivor-centred skills should always be applied.

Examples of an assessment:

- A counsellor or psychosocial worker who conducts an assessment of the psychosocial needs of a survivor.
- A health worker who conducts a medical assessment (also called examination or exam) of a survivor to find out which treatment s/he would need.

Counselling:

- Is used in a specific context and practised by professionally trained service providers: counsellors, psychologists and in some cases other trained health professionals.
- Can exist under different forms, but is often a process in which a client addresses and resolves problems and works through feelings.[3]
- Providing support is among the main goals of counselling.
- In counselling after GBV more specifically sexual violence, the counsellor will assist the client to identify and respond to needs that arise as the result of the assault or abuse. In addition to providing emotional and psychological support, the counsellor can act as an enabler and an advocate for clients. S/he can provide access to information, resources and services, help maintain individual rights and access to the legal and judicial systems, assist with coping, help restore family relationships and attachments, and access community resources and support.[4]

Examples of Counselling:

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[2] RHRC Consortium, Communication Skills Training Manual – Facilitator's Guide, p.23. http://www.rhrc.org/resources/gbv/comm_manual/comm_manual_toc.html

[3] Adapted from: glossary of the Royal College of Psychiatrists - http://www.rcpsych.ac.uk/mentalhealthinformation/definitions

[4] IRC Tanzania, SGBV Counselling Training, p.18

- An NGO counsellor who provides individual counselling to women.
- A health centre counsellor who gives psychosocial support to women who consult in cases of GBV, including after sexual violence, or when attendingwomen at the health centre who ask for other needs; and who may refer them to other services.

Interview:

- Can be used in several contexts and can exist under various forms.
- Has a specific goal, namely: collecting information, establishing facts, history etc. related to the interviewee and/or the situation/assault.
- Does not necessarily aim at *assisting* the survivor (e.g. the aim of the interview can be to collect generic data on sexual violence)[5]
- Has often a fixed structure and consists of a set of specific questions. A survivor-centred interviewer should maintain a supportive attitude towards the interviewee throughout the interview. Survivor-centred skills should always be respected!

Examples of Interviews in a multi-sectorial environment:

- *A medico-legal or forensic interview in a case of sexual violence:* the health worker will ask specific questions to the survivor to collect the assault history with the goal of allowing this history to guide the medical exam.

Remember:

- A conversation is a tool that can be used by everyone.
- Conducting an assessment, counselling or an interview requires particular training. These tools are therefore used by specific professional groups in a specific context.
- The main goal of a conversation and counselling is usually to provide emotional support. The main purpose of an assessment and an interview is to gather information.
- Survivor-centred skills are tools that should be used by everyone when dealing with a survivor, regardless of the type or goal of the interaction!

[5] Although an interview not always aims at assisting the survivor (e.g. in case of data-collection), it is necessary to ensure that the interviewed survivors have access to minimum services.

Module 5 at a glance:

Sessions	Objectives	Time	Handouts
5.1. Lecture: What kind of psychological support does a survivor need?	Understand the psychological and social impact of GBV	1 hour	Handout 5.1: Psychological first aid
5.2. Discussion: The role of treatment for psychological sequela of GBV	Provide appropriate psychological support/treatment for survivors	1.5 hours	Handout 5.2: Basic guidelines for a mental health evaluation, psychological support and medications
5.3. Lecture: What follow-up is necessary?	Provide appropriate follow-up and referrals for survivors	1.5 hours	
5.4. Support and treatment of more severe mental health problems		6 hours	5.4. Handouts
5.5. Sample techniques for main symptoms and consequences		1 hour	5.5. Handouts

5.1 Lecture: What kind of psychological support does a survivor need?

Materials: Flip chart & markers (or overhead/PowerPoint), watch/clock to keep time

Handouts: Handout 5.1: Psychological first aid

Preparation: /

Group sizes: Whole group

Time: 1 hour

1. During this discussion, the main points can be written on a flip chart, or PowerPoint or overhead slides with these points can be used instead. The material for this discussion is in Participant guide on this module.

2. Introduce this lecture as an overview of psychological support for survivors.

3. Refer participants to **Handout 5.1: Psychological first aid** in their Participant guideat the end of the lecture.

5.2 Discussion: The role of treatment for psychological sequel of rape

Materials: Flip chart and markers, watch/clock to keep time

Handouts: Handout 5.2: Basic guidelines for a mental health evaluation, psychological support and medications

Background from general & psychosocial modules: Lecture 4.3.3: Active listening techniques and 'listening roadblocks'; Handout 5.1: Assessment, Counselling and Interview

Group sizes: Whole group

Time: 1.5 hours

∇ **Good to know!**

Psychological support can and should be used in any context, however consider further adapting further treatment strategies to local culture/religious context in the area where you operate.

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1. Introduce the discussion as a discussion on the role of treatment for psychological consequences of GBV, including sexual violence.

2. Ask participants the following questions and write down the main themes brought up by participants on the flip chart.

    a. *What does "mental health/illness" mean to you?*
    You may find the knowledge of mental health/illness is limited. In many resource limited settings, evaluation of mental health is restricted to severe mental illnesses, such as psychosis (due to the perceived need for prioritizing immediate life-threatening illnesses, time constraints, lack of treatment options, etc.). Illnesses such as anxiety disorder and mood disorder are often not recognized as true illnesses by most patients and some health care providers. Knowledge of diagnosis and treatment is often limited.

    b. *How does your society react to issues regarding mental health, (e.g. psychosis, severe mood disorder or non-pathological anxious feelings*)?
    Address what is considered mental illness, how people are treated and supported, if care is available, etc.

    c. *How does your health care system address issues of mental health?*
    Address what the health care providers are taught in school (evaluation, diagnosis and treatment), in potentially available refresher/short courses on mental health, what happens in their practices, and how they receive clinical supervision, if any.

d. *Are essential psychotropic regularly available? Do all health care providers have the right to prescribe? Which kind of health care provider can prescribe? If not you, can you easily coordinate with them in case of need? Is there a tendency to avoid medication? Or to prescribe too much? Does the treatment load of health care providers allow for time to talk extensively with patients? In your health facility, MHPSS can be taken as a reason to provide enhanced support to a survivor, including additional time from your end?Are health services in the position to refer people with minor mental health problems to general & psychosocial, social supports in the community?*

3. Conclude this part of the discussion by asking participants to consider what the above issues' relevance may be to survivor's experiencing psychological sequelae; how a survivor may be viewed in society; and how she can be appropriately cared for by the health care community.

4. The next part of the discussion will be a review of a case study. We will discuss the story of Fahima.

Case study: Fahima, 25 years' old

Ms.Fahima came to your clinic two days after being raped. The perpetrators entered her home at night and raped her and threatened to kill her and her family. She has two living children.

She has come for her 6-week follow-up evaluation after receiving treatment. She completed all of her medications without any significant problems.

You ask her how she is doing and this is what she replies:

"I am okay, but I have not been able to sleep since that night. I have nightmares about those men coming to attack me and kill my father. I wake up sweating and my heart is racing. I stay in the house now and don't leave unless I have to – my sisters are doing my chores. So during the day, I am home alone and all I do is think about what happened to me and how dirty I am. My job now is only to cook for the family, I can manage that, but I don't go to the market. I don't have the energy and I don't want people to see me. But even though I cook, I don't eat, I don't want to. I have not been intimate with my husband because I am ashamed."

You note she lost 10kg since the incident.

5. Ask participants the following questions (write the main points on the flip chart):

   a. *What symptoms have you identified?*
   Symptoms include nightmares, social withdrawal, guilt and shame, fear, decreased appetite, unable to carry out her usual daily activities.

   b. *How could you support her?*
   Possible answers include psychological first aid, psychosocial counselling and referrals for further support.

   c. *Are there more questions you would have for her? If so, what?*
   Possible answers include "Does she have anyone she talks to at home?", "How does she try to deal with the feelings she is having?"

   d. *Is there a role for medications in this case?*

Possibly, antidepressants. may be considered but you need to coordinate with an authorised professional in case you cannot prescribe medication, or in case you feel she needs some type of support you cannot provide.

e. *When would you consider medications for treatment for survivors? And what would you use?*
Participants should give their own opinions based on what they do in their practices. You will review treatment recommendations at the end.

f. *What types of support outside of your clinic could you offer or organize for Fahima?* (Do not restrict the discussion to what is actually available in the participants' areas but the discussion should reflect the reality of the supports available in most settings).
Possible answers include support groups, counsellors, mental health specialists, etc. In case some of the service are not available in your areas but exist somewhere else or there is a reference to them in the national documents, is there anything you could do about it?

g. *How would you evaluate Fahima for suicidal thoughts? And what could you do if she does have suicidal thoughts?*
Again, participants should give their own opinions based on what they do in their practices. You will review treatment recommendations at the end.

6. Next refer participants to **Handout 5.2** in their Participant Guide and review the basic mental health evaluation, treatment options and referrals with the participants.

5.3 Lecture: What follow-up is necessary?

Materials: Flip chart & markers (or overhead/PowerPoint), watch/clock to keep time

Handouts: None

Background from general & psychosocial modules: Module 3

Group sizes: Whole group

Time: 1.5 hours

∇ Good to know!

Since MHPSS for GBV cases is part of an integrated system, AfghanistanNational protocols and technical documents also provide information about appropriate follow-up and referrals. Those documents should always guide our interventions. Please consider:

- Basic Package of Health Services 2010
- Psychological First Aid
- Professional Package for PsychosocialCounsellors Working in the BPHS in Afghanistan Mental Health Department of the MoPH, Kabul-group-08
- Standard Package for Midwife and Community Supervisor or Nurse, Delivering Basic Psychosocial Counselling Services in the BPHS in Afghanistan- from MHD of MoPH

And two core documents:

- Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook Ministry of Public Health and WHO. Afghanistan 2015.
- Model of Healthcare Sector Response to GBV, UNFPA Afghanistan (Attachment 1)

1. During this discussion, the main points can be written on a flip chart, or PowerPoint or overhead slides with these points can be used instead. The material for this discussion is in your Trainer Packet.

Introduce this lecture as an overview of the follow-up needed for survivors

MODULE 5. The different types of intervention in MHPSS and GBV

Participant Guide

Handout 5.1: Psychological first aid[6]

Most individuals experiencing acute mental distress following exposure to extreme stressful events are best supported without medication. All aid workers, and especially health care providers, should be able to provide very basic psychological first aid (PFA). PFA is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support. PFA is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress. PFA reflects the principles of a survivor-centred approach. It encompasses:

1. Protecting from further harm (in rare situations, very distressed persons may take decisions that put them at further risk of harm);

2. Providing the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the survivor may be ready to give;

3. Listening patiently in an accepting and non-judgmental manner;

4. Conveying genuine compassion;

5. Identifying basic practical needs and ensuring that these are met;

6. Asking for survivor's concerns and trying to address these;

7. Discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other substances; explaining that people in severe distress are at much higher risk of developing substance abuse problems);

8. Encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods, accessing helpful cultural and spiritual support);

9. Encouraging, but not forcing, company from one or more family member or friends;

[6]Adapted from ***IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings***, Action Sheet 6.2, pg. 119-120. © Inter-Agency Standing Committee 2007. http://www.humanitarianinfo.org/iasc/content/products/default.asp

10. As appropriate, offering the possibility to return for further support;

11. As appropriate, referring to locally available support mechanisms or to trained health care providers.

Handout 5.2: Guidelines for a mental health evaluation, psychological support and medications

Guidelines for a mental health evaluation

Evaluation of a patient's psychological well-being should be done for every patient (survivor or not). It does not have to be a formal evaluation. Most of the time, you can assess this by simply observing someone's body language and how she responds to your questions and to her surroundings. With a survivor, it is important to not only observe but ask directly about psychological symptoms.

Survivors may or may not suffer from acute symptoms. However, it is the health care provider's responsibility to evaluate, educate and follow-up survivors to assist them in case of GBV, also informing them that some of the symptoms or reactions may appear weeks and even months after the incident, or when the violence is already over.

It may feel uncomfortable for you to ask these types of questions, but it is important for you to obtain this information in order to provide proper care. Once you have asked these kinds of questions a few times, it will get easier.

Survivors may also not feel comfortable answering these questions. Remember to use your survivor-centred skills and never force anyone to answer a question s/he is not willing to answer. For survivors who are suffering psychological sequelae, your role is to provide support (and treatment, when necessary), but not to force someone into receiving psychological support (severe suicidal ideation is the one exception. In that case the survivor at risk should not be left alone).

What do you want to know? Here are some basics to evaluate:

1. Are you eating okay? (And if not, why? Is it a problem with appetite/taste of the food/lack of availability/a physical problem like nausea, vomiting or diarrhoea?)

2. Are you sleeping okay? (And if not, why? Nightmares, feeling anxious, issues with safety, oversleeping because of no energy, etc.)

3. Are you able to do the things you want or need to do during the day? (And if not, why? Physical complaints, no energy, fear of leaving the house, difficulties in concentrating).

4. How is the relationship with the spouse/family? Do they know what happened? (If yes), how did they react? Is it affecting your relationship (if so, how)? How is the support from your spouse (and family)? How do you feel the assault has affected your relationships with your spouse and family?

5. How is the relationship with your friends and neighbours? Are there any difficulties?

6. Do you have any thoughts of hurting yourself? (If yes), can you describe what thoughts you have been having? Possible follow-up questions include: Have you thought of how you would hurt yourself? What is your plan? Do you think you would actually do it?

   The reasons to ask these follow-up questions are to establish how far the thoughts of suicide have progressed. Many people (survivors and others) have had thoughts of hurting themselves, but have not actually made a plan. Making a plan for suicide establishes an increased level of commitment to the act and should be taken more seriously. If you conclude that someone is at acute risk for suicide, immediate intervention is necessary (do not leave the person alone) (see below).

Psychological support

Psychosocial support should be offered to all survivors. Remember to use the principles of psychological first aid. You do not need to be a trained counsellor to provide basic psychosocial support. If there are no adequate psychosocial support services (or mental health services) available, YOU can use basic active listening skills to provide support.

Often having someone the survivor can trust and who will listen to them without judgment is an effective treatment. You, as her/his health care provider can be that person- do not underestimate the help you can provide by just offering your time to listen. You can also suggest confiding in someone else (spouse, friend, etc.).

What should I say?

As long as you remember your survivor-centred skills, you will be able to help. Use open-ended questions and allow the survivor to speak freely without interruptions. Do not force the survivor to talk, share emotions, etc. Inform her/him that it is common for people to have strong, negative emotions or feel numb after such a serious physical and emotional event. Also, inform the survivor that s/he may suffer from difficulties in sleeping, eating, and continuing daily activities. While these will often decrease with time, s/he can come to the clinic to discuss these problems with you at any time.

What to do if psychological support services are available:

Know the psychological and social support available in your community and how the survivor can access the services (where, when, cost, confidentiality, quality etc.).

Not all survivors will need referrals. Referrals are appropriate in cases where you feel you cannot properly treat the survivor's psychological and social problems – either on the initial evaluation or on follow-up visits or if there is someone else appointed to do so. In most cases, a referral on the initial visit is not appropriate, but information that a referral is possible, it isappropriate to give to the survivor at the initial visit. This will help the survivor have better understanding about possible recovery paths and empower her across a difficult process. Referrals are NOT a substitute for the basic care you offer a survivor.

What to do if you think a survivor is at acute risk for suicide:[7]

Ensure the survivor is out of immediate danger – i.e. have she taken any medications or suffered serious injury needing immediate medical treatment? She should not be left alone;

[7] Adapted from ***Where There is No Psychiatrist: A mental health care manual.*** Vikram Patel © The Royal College of Psychiatrists, 2003. Pages 63-69

ask a family member or friend to spend time with her – especially if she has attempted suicide and you think she is at risk for harming herself again.

If the family is not interested in the survivor's well-being, try to contact more distant family members or friends for support. If this fails, consider any women's groups, etc. that could provide support. If one of these groups can offer accommodation, it may be appropriate for the survivor to seek temporary shelter.

Once the immediate risk is gone, involve the survivor in regular psychological support until she feels more in control of her problems. If she is depressed, try to make a referral to a specialist. If no specialist is accessible/available, consider antidepressant medications (see below). However, be aware that treatment takes 3-4 weeks to show effects and support during this time is essential.

The survivor should also be referred to the nearest hospital if the suicide attempt was serious and life-threatening; thoughts of suicide persist despite support; there is a serious mental illness (like psychosis): and/or there is a repeated suicide attempt.

Medications[8] - only for use for severe psychological reactions!

Only treat psychological symptoms with medications if absolutely necessary – in MOST cases, survivors will NOT require medication!

When should you consider medication? And which medications?

If a survivor exhibits severe acute psychological symptoms – i.e. SYMPTOMS ARE LIMITING BASIC FUNCTIONING (such as not being able to talk to people, for at least 24 hours):

1. Make sure the survivor is physically stable.
2. Diazepam 5-10mg tablets – 1 tablet at night time up to 3 days' maximum.
3. Refer the survivor to a mental health professional, if possible.
4. If no referrals available, re-evaluate the survivor daily – adjusting the regimen appropriately.
5. Do not use diazepam with the aim to reduce anxiety, although it may be indicated for sleeping problems for a few days. **Be very cautious: benzodiazepine use may quickly lead to dependence, especially among very distressed survivors.**

If a survivor complains of severe, sustained distress lasting at least 2 weeks AND the incident occurred within the last 2-3 months AND the survivor is asking for more intense treatment **AND you cannot refer her**:

1. Consider trial of imipramine, amitriptyline or similar antidepressant medicine. Dose 75-150mg at bedtime (starting with 25mg dosing and adjust if necessary).
2. Watch out for side-effects, such as a dry mouth, blurred vision, irregular heartbeat, and light-headedness or dizziness, especially when the survivor gets out of bed in the morning.
3. Duration of treatment will vary with response.

[8] Adapted from ***Steps 6 & 7 from Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons – Revised ed.*** © World Health Organization / United Nations High Commissioner for Refugees, 2004.

If the incident occurred more than 2-3 months ago AND psychological support is not reducing highly distressing or disabling trauma-induced symptoms, such as depression, nightmares, or constant fear AND no referrals are possible:

1. Consider a trial of an antidepressant (see medications listed above – imipramine, etc.).

If a patient is suffering from psychological symptoms/illness - regardless of the type of symptoms, diagnosis or treatment given - follow-up is critical. Even if you refer a survivor to a mental health professional, it is important to also follow-up on the survivor's symptoms yourself[9].

Hand out 5.4. Support and treatment of more severe mental health problems[10]

Helping with more severe mental health problems

Assessment of mental status

You assess mental status at the same time that you do the general health examination. Assessing mental status begins with observing and listening closely. Take note of the following:

Appearance and behaviour	Does she take care of her appearance? Are her clothing and hair cared for or in disarray? Is she distracted or agitated? Is she restless, or is she calm? Are there any signs of intoxication ormisuse of drugs?
Mood, both what you observe and what she reports	Is she calm, crying, angry, anxious, very sad, without expression?
Speech	Is she silent? How does she speak (clearly or with difficulty)? Too fast/too slow? Is she confused?
Thoughts	Does she have thoughts about hurting herself? Are there bad thoughts or memories that keep coming back? Is she seeing the event over and over in her mind?

You can also gather information by asking general questions:

- "How do you feel?"
- "How have things changed for you?"
- "Are you having any problems?"
- "Are you having any difficulties coping with daily life?"

[9] Full text on medications updated from Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan. Participant Handbook.Ministry of Public Health and WHO. Afghanistan 2015.

- [10] This chapter has been adapted from Clinical Handbook on Health care for women subjected to intimate partner violence or sexual violence. WHO, UN Women, UNFPA 2014.

If your general assessment identifies problems with mood, thoughts or behaviour and she is unable to function in her daily life, she may have more severe mental health problems.

Details on the assessment and management of all the problems mentioned below and other common mental health problems can be found in the mhGAP intervention guide and its annex on conditions specifically related to stress. http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

Imminent risk of suicide and self-harm

Some health care workers fear that asking about suicide may provoke the woman to commit it. On the contrary, talking about suicide often reduces the woman's anxiety around suicidal thoughts and helps her feel understood.

If she has:

• current thoughts or plan to commit suicide or to harm herself,

OR

• a history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and she is now extremely agitated, violent, distressed or uncommunicative,

then**there is immediate risk of self-harm or suicide, and she should not be left alone.**

Refer her immediately to a specialist or emergency healthfacility.

Moderate-severe depressive disorder

Women who have suffered intimate partner violence or sexual assault may feel extreme emotions of continuing fear, guilt, shame, grief for what they have lost, and hopelessness. These emotions, however overwhelming, are usually temporary and are normal reactions to recent difficulties.

When a woman is unable to find a way to cope and these symptoms persist, then she may be suffering from mental disorders such as depressive disorder.

People develop depressive disorder even when not facing extreme life events. Any community will have people with pre-existing depressive disorder. If a woman has suffered from such depressive disorder before experiencing violence, she will be much more vulnerable to having it again.

Note: The decision to treat for moderate-severe depressive disorder should be made only if the woman has persistent symptoms over at least 2 weeks and cannot carry out her normal activities.

Typical presenting complaints of depressive Disorder

• Low energy, fatigue, sleep problems
• Multiple physical symptoms with no clear cause (for example, aches and pains)
• Persistent sadness or depressed mood; anxiety
• Little interest in or pleasure from activities

Assessment of moderate-severe depressive disorder

1. Does the woman have moderate-severe depressive disorder?Assess for the following:

   A. *The woman has had at least 2 of the following core depression symptomsfor at least 2 weeks.*
      - Depressed mood (most of the day, almost every day), (for children and adolescents: either irritability or depressed mood)
      - Loss of interest or pleasure in activities that are normally pleasurable
      - Decreased energy or easily fatigued

   B. *The woman has had* at least 3 other features of depression*during the last 2 weeks:*
      - Reduced concentration and attention
      - Reduced self-esteem and self-confidence
      - Ideas of guilt and unworthiness
      - Bleak and pessimistic view of the future
      - Ideas or acts of self-harm or suicide
      - Disturbed sleep
      - Diminished appetite

   C. *The woman has considerable difficulty functioning in personal, family, social, occupational, or other important areas of life.*

Ask about different aspects of daily life, such as work, school, domestic or social activities.

If A, Band C – all 3 – are present for at least 2 weeks, then moderate-severe depressive disorder is likely.

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2. Are there other possible explanations for the symptoms (other than moderate severe depressive disorder)?

   A. Rule out any physical conditions that can resemble depressive disorder.

   B. Rule out or treat anaemia, malnutrition, hypothyroidism, stroke and medication side-effects (for example, mood changes from steroids).

   C. Rule out a history of manic episode(s). Assess if she has had a period in the past when several of the following symptoms occurred at the same time:
      - Decreased need for sleep
      - Euphoric (intensely happy), expansive, or irritable mood
      - Racing thoughts; being easily distracted
      - Increased activity, feeling of increased energy, or rapid speech
      - Impulsive or reckless behaviours such as excessive gambling or spending, making important decisions without adequate planning
      - Unrealistically inflated self-esteem.

The woman is likely to have had a manic episode if several of the above five symptoms were present for longer than 1 week and the symptoms significantly interfered with daily functioning or were a danger to herself or others. If so, then the depression islikely part of another disorder called ***bipolar disorder*** and sherequires different management. Consult a specialist.

D. Rule out **normal reactions** to the violence. The reaction is more likely a normal reaction if:
    - There is marked improvement over time without clinical intervention
    - There is no previous history of moderate-severe depressive disorder or manic episode, and
    - Symptoms do not impair daily functioning significantly.

Management of moderate-severe depressive disorder

1. Offer psychoeducation

Key messages for the woman (and caregiver if appropriate):

1. Depression is a very common condition that can happen to anybody.
2. The occurrence of depression does not mean that she is weak or lazy.
3. The negative attitudes of others (e.g. "you should be stronger", “pull yourself together”) may relate to the fact that depression is not a visible condition (unlike a fracture or a scar) and the false idea that people can easily control their depression by sheer force of will.
4. People with depression tend to have negative opinions about themselves, their lives and their future. Their current situation may be very difficult, but depression can causeunjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression is managed.
5. It usually takes a few weeks before the treatment starts working.
6. Even if it is difficult, she should try to do as many of the following as possible. They will all help to improve her low mood:
    - Try to continue activities that were previously pleasurable.
    - Try to maintain regular sleeping and waking times.
    - Try to be as physically active as possible.
    - Try to eat regularly despite changes in appetite.
    - Try to spend time with trusted friends and trusted family.
    - Try to participate in community and other social activities, as much as possible.
7. Be aware of thoughts of self-harm or suicide. If you notice these thoughts, do not act on them. Tell a trusted person and come back for help immediately.

2. Strengthen social support and teach stress management

3. If trained and supervised therapists are available, consider referral for brief psychological treatments for depression *whenever these are available:*

- Problem-solving counselling
- Interpersonal therapy
- Cognitive behavioural therapy
- Behavioural activation

4. Consider antidepressants

Prescribe antidepressants only if you have been trained in their use.

Details on the assessment and management of moderate severe depressive disorder, including prescription of antidepressants can be found in the mhGAP intervention guide: http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

5. Consult a specialist when:

- She is not able to receive either interpersonal therapy, cognitive behavioural therapy or antidepressants.
  OR
- She is at imminent risk of suicide/self-harm.

6. Follow-up

- **Offer regular follow-up**. Schedule the second appointment within one week and subsequent appointments depending on the course of the disorder.
- **Monitor her symptoms.** Consider referral if there is no improvement.

Post-traumatic stress disorder

Immediately after a potentially traumatic experience such as sexual assault, most women experience psychological distress. For many women these are passing reactions that do not require clinical management. However, when a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after theevent, she may have developed post-traumatic stress disorder(PTSD).

It should be noted that despite its name, PTSD is not necessarily the only or even the main condition that occurs after violence. As mentioned above, such events can also trigger development of many other mental health conditions, such as depressive disorder and alcohol use disorder.

Typical presenting complaints of PTSD

Women with PTSD may be hard to distinguish from women suffering from other problems because they may initially present with non-specific symptoms such as:

- Sleep problems (e.g. lack of sleep)
- Irritability, persistent anxious or depressed mood
- Multiple persistent physical symptoms with no clear physical cause (e.g. headaches. pounding heart).

However, on further questioning they may reveal that they are suffering from characteristic PTSD symptoms.

Assessment for PTSD

If the violence occurred more than 1 month ago, assess the woman for post-traumatic stress disorder (PTSD).

Assess for:

A. **Re-experiencing symptoms –** repeated and unwanted recollections of the violence, as though it is occurring in the here-and-now (for example, frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror).

B. **Avoidance symptoms –** deliberate avoidance of thoughts, memories, activities or situations that remind the woman of the violence. For example, avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened.

C. **Symptoms related to a heightened sense of current threat,** such as excessive concern and alertness to danger orreacting strongly to unexpected sudden movements (e.g.being "jumpy" or "on edge").

D. **Difficulties in day-to-day functioning. If *all* of the above are present approximately 1 month after the violence, then PTSD is likely.** Check also if she has any other medical conditions, moderate-severedepressive disorder, suicidal thinking or alcohol and druguse problems.

Management of PTSD

1. Educate her about PTSD

Explain that:

a. Many people recover from PTSD over time without treatment. However, treatment will speed up recovery.
b. People with PTSD often feel that they are still in danger, and they may feel very tense. They are easily startled ("jumpy") or constantly on the watch for danger.
c. People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they had when the event was actually happening. They may also have frightening dreams.
d. People with PTSD try to avoid any reminders of the event. Such avoidance can cause problems in their lives.
e. (If applicable) people with PTSD may have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.

Advise her to:

a. Continue normal daily routines as much as possible.
b. Talk to people she trusts about what happened and how she feels, but only when she is ready to do so.
c. Engage in relaxing activities to reduce anxiety and tension.
d. Avoid using alcohol or drugs to cope with PTSD symptoms.

2. Strengthen social support and teach stress management

3. If trained and supervised therapists are available,consider referring for:

- Individual or group cognitive behavioural therapy with atrauma focus (CBT-T)
- Eye movement desensitization and reprocessing (EMDR)

4. Consult a specialist (if available)

- If she is not able to receive either cognitive behavioural therapy or EMDR

OR

- she is at imminent risk of suicide/self-harm.

5. Follow-up

Schedule a second appointment within 2 to 4 weeks and later appointments depending on the course of the disorder.

Handout 5.5.Sample techniques for main symptoms and consequences

Relaxation and Grounding Exercise

1. Simple relaxation exercise

Introduction:

"Tension and anxiety are common when experiencing violence. Unfortunately, they can make it more difficult to cope with what you went through. There is no easy solution to cope with what you went through, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have more energy. Here is a basic breathing exercise that may help":

For Adults:

- Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
- Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one; one-thousand two; one-thousand three) through your mouth and comfortably empty your lungs all the way down to your stomach.
- Silently and gently say to yourself, "My body is releasing the tension."
- Repeat five times slowly and comfortably.
- Do this as many times a day as needed.

For Children:

- "Let's practice a different way of breathing that can help calm our bodies down.
- Put one hand on your stomach, like this [demonstrate].
- Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this [demonstrate].
- Then, we will breathe out through our mouths. When we breathe out, our stomachs are going to suck in and up like this [demonstrate].
- We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe out really slowly.
- Let's try it together. Great job!"

2. Grounding

Introduction:

"After an experiencing violence, you can sometimes find yourself overwhelmed with emotions or unable to stop thinking about or imagining what happened. You can use a method called 'grounding' to feel less overwhelmed. Grounding works by turning your attention from your thoughts back to the outside world. Here's what you do...."

For adults:

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five non-distressing objects that you can see. For example, you could say, "I see the floor, I see a shoe, I see a table, I see a chair, I see a person."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing sounds you can hear. For example: "I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing things you can feel. For example: "I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed together."
- Breathe in and out slowly and deeply.

For children:

You might have children name colours that they see around them. For example, say to the child, "Can you name five colours that you can see from where you are sitting. Can you see something blue? Something yellow?Something green?" If none of these interventions aids in emotional stabilization, consult with medical or mental health professionals, as medication may be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

Stress Reduction Exercises

1. Slow breathing technique

- Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed or anxious or cannot sleep.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

2. Progressive muscle relaxation technique

- In this exercise you tighten and then relax muscles in your body. Begin with your toes.
- Curl your toes and hold the muscles tightly. This may hurt a little. Breathe deeply and count to 3 while holding your toe muscles tight. Then, relax your toes and let out your breath. Breathe normally and feel the relaxation in your toes.
- Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count to 3, and then relax and breathe out slowly.
  - Hold your leg and thigh muscles tight…
  - Hold your belly tight…
  - Make fists with your hands…

- Bend your arms at the elbows and hold your arms tight…
- Squeeze your shoulder blades together…
- Shrug your shoulders as high as you can…
- Tighten all the muscles in your face….

➢ Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this 3 times. Now, go the other way…inhale to the left and back, exhale to the right and down. Do this 3 times.

➢ Now bring your head up to the centre. Notice how calm you feel.

Annex:

Risk Assessment and Safety Planning

INCIDENT CODE	REGISTER NUMBER	PERSONNEL CODE

CONFIDENTIAL

Family Violence

a) Risk assessment with survivors of family violence:

Note to the health care provider:
Consider only the steps/questions that respond to the survivor's individual situation.

When a woman answers "yes" to at least three of the following questions, she may be at especially high immediate risk of violence:

1. Are you in immediate danger? ☐ yes ☐ no
2. Has the physical violence happened more often or gotten worse over the past six months? ☐ yes ☐ no
3. Has he ever used a weapon or threatened you with a weapon? ☐ yes ☐ no
4. Do you believe he could kill you? ☐ yes ☐ no
5. Has he ever beaten you while you were pregnant? ☐ yes ☐ no
6. Is he violently and constantly jealous of you? ☐ yes ☐ no

If the survivor feels at risk, give her/him information about her/his rights and referral options.

- For safety: Provide concrete information about legal, protection and mediation services.
- For emotional safety: Provide information and motivate for mental health referral.
- Provide referral to secondary level of care. Sometimes a hospitalization can be proposed to ensure the survivors safety in order to find appropriate solution to guarantee her/his safety.

When the survivor, accepts the referral, ensure direct referral.

When the survivor does not accept the referral at the moment:

- Help her/him to make a safety plan
- Make an appointment for a follow-up consultation

b) Safety plan for survivors of family violence

Note to the health care provider:

Explain to the survivor that a she/he does not have control over the violent behaviour of her/his aggressor(s), but that she/he does have a choice about how she/he responds to the aggressor(s) and how to best get her/himself (and the children) to safety.

1. If you need to leave your home in a hurry, where could you go?

_____

_____

2. Would you go alone or take your children with you?

_____

_____

3. How will you get there?

_____

4. Do you need to take any documents, keys, money, clothes or other things with you when you leave? What is essential?

_____

5. Can you put together items in a safe place or leave them with someone, just in case?

_____

6. Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?

_____

7. Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

_____

INCIDENT CODE	REGISTER NUMBER	PERSONEL CODE

CONFIDENTIAL

Non-family violence

a) Risk assessment with survivors of non-family violence:

Note to the health care provider:
Consider only the steps/questions that respond to the survivor's individual situation.

1. Is there a possibility to meet the aggressor(s) again? ☐ yes ☐ no

If yes, explain: _____

2. What information, if any, does the aggressor have about where you live, work, go to school or about places you go to on a regular basis?

_____

3. Do you believe the aggressor could kill you? ☐ yes ☐ no
4. Has the aggressor contacted you since the incident? ☐ yes ☐ no
   If yes, explain:

_____

5. Does the aggressor have access to your housing? ☐ yes ☐ no
   If yes, explain:

_____

6. There anybody (own family, in-law family, neighbours, friends, community) who you that could talk to for advice or that could play a protective role? ☐ yes ☐ no
   If yes, explain:

_____

If the survivor feels at risk, give her/him information about her/his rights and referral options.

- For safety: Provide concrete information about legal, protection and mediation services.
- For emotional safety: Provide information and motivate for mental health referral.

- Provide referral to secondary level of care. Sometimes a hospitalization can be proposed to ensure the survivors safety in order to find appropriate solution to guarantee her/his safety.

When the survivor accepts the referral, ensure direct referral.

When the survivor does not accept the referral at the moment:

- Help her/him to make a safety plan
- Make an appointment for a follow-up consultation

b) Safety plan for survivors of non-family violence

Note to the health care provider:
Explain to the survivor that she/he does not have control over the violent behaviour of her/his aggressor(s), but that she/he does have a choice about how she/he responds to the aggressor(s) and how to best get her/himself to safety.

1. What places does the perpetrator frequent?

_____

Explain the survivor to be conscious about those places

2. Who can help and protect you (even without informing them)?

_____

3. What strategies can you use to improve the safety at home?

_____

4. Who can accompany you when you leave the house, when you go to school or to work?

_____

⇨ The experience of violence is usually exhausting and emotionally draining. Explain to the survivor that is important that she/he tries to conserve her/his emotional energy and resources and tries to avoid emotional difficult situations.

a. What are things that you might do if you came into contact with the aggressor?

_____

_____

b. What can say to yourself to give you strength whenever the aggressor is trying to put you down, control or abuse you?

_____

_____

c. Who can you contact for support?_____

_____

Safety Planning Elements

Safety Planning Elements	
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
	Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?

Referral Chart[11]

			Job aid
Referral chart			
What to refer for	**Where / who to refer to**	**Contact info**	**Responsibility for follow-up**
Shelter/housing			
Crisis centre			

[11]Please use the Model of Healthcare Sector Response to GBV developed by UNFPA Afghanistan as a reference.

Financial aid			
Legal aid			
Support groups			
Counselling			
Mental health care			
Primary care			
Child care			
Other			