Facilitator Guide

Mental Health

Pehchan Training Curriculum
MSM, Transgender and Hijra
Community Systems Strengthening
Pehchan Consortium Partners

India HIV/AIDS Alliance (www.allianceindia.org)

Pehchan Focus: National coordination and grant oversight
Based in New Delhi, India HIV/AIDS Alliance (Alliance India) was founded in 1999 as a non-governmental organisation working in partnership with civil society and communities to support sustained responses to HIV in India. Complementing the Indian national program, Alliance India works through capacity building, technical support and advocacy to strengthen the delivery of effective, innovative, community-based interventions to key populations most vulnerable to HIV, including men who have sex with men (MSM), transgenders, hijras, people who use drugs (PWUD), sex workers, youth, and people living with HIV (PLHIV).

Alliance India Andhra Pradesh

Pehchan Focus: Andhra Pradesh
Alliance India supports a regional office in Hyderabad that leads implementation of Pehchan in Andhra Pradesh and serves as a State Lead Partner of the Bill & Melinda Gates Foundation.

The Humsafar Trust (www.humsafar.org)

Pehchan Focus: Maharashtra, Madhya Pradesh, Goa, Gujarat and Rajasthan
For nearly two decades, Humsafar Trust has worked with MSM and transgender communities in Mumbai, Maharashtra. It has successfully linked community advocacy and support activities to the development of effective HIV prevention and health services. It is one of the pioneers among MSM and transgender organisations in India and serves as the national secretariat of the Indian Network for Sexual Minorities (INFOSEM).

Pehchan North Region Office

Pehchan Focus: Punjab, Delhi, Uttar Pradesh and Bihar
Alliance India supports a regional implementing office based in Delhi that leads implementation of Pehchan in four states of North India.

Solidarity and Action Against The HIV Infection in India (SAATHII) (www.saathii.org)

Pehchan Focus: West Bengal, Manipur, Orissa and Jharkhand
With offices in five states and over 10 years of experience, SAATHI works with sexual minorities for HIV prevention. SAATHII works closely with the West Bengal's State AIDS Control Society (SACS) and the State Technical Support Unit and is the SACS-designated State Training and Resource Centre for MSM, transgender and hijra.

South India AIDS Action Programme (SIAAP) (www.siaapindia.org)

Pehchan Focus: Tamil Nadu
SIAAP brings more than 22 years of experience with community-driven and community development focussed programmes, counselling, advocacy for progressive policies, and training to address HIV and wider vulnerability issues for MSM, transgender and hijra community.

Sangama (www.sangama.org)

Pehchan Focus: Karnataka and Kerala
For more than 20 years, Sangama has been assisting MSM, transgender and hijra communities to live their lives with self-acceptance, self-respect and dignity. Sangama lobbies for changes in existing laws that discriminate against sexual minorities and for changing public opinion in their favour.
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About this Module

This module is designed to help training participants: 1) become familiar with basic concepts of counselling; 2) develop skills to form a support relationship with a programme client within an ethical framework; 3) increase awareness of common mental health concerns among men who have sex with men (MSM), transgenders and hijras; 4) build capacity to assess and provide basic psychosocial support; and 5) promote positive mental health. In the Pehchan programme, this module is used to introduce principles of family support to CBO Outreach Workers and Counsellors. This module is designed to help CBOs’ Counsellors and Outreach Workers to introduce the concept of Mental Health and the importance of psychosocial support.

About Pehchan

With financial support from the Global Fund, Pehchan is building the capacity of 200 community-based organisations (CBOs) for men who have sex with men (MSM), transgenders and hijras in 17 states in India to be more effective partners in the government’s HIV prevention programme. By supporting the development of strong CBOs, Pehchan addresses some of the capacity gaps that have often prevented CBOs from receiving government funding for much-needed HIV programming. Named Pehchan, which in Hindi means ‘identity’, ‘recognition’ or ‘acknowledgement,’ this programme will reach 453,750 MSM, transgenders and hijras by 2015. It is the Global Fund’s largest single-country grant to date, focused on the HIV response for vulnerable sexual minorities.

Training Curriculum Overview

In order to stimulate the development of strong and effective CBOs for MSM, transgender and hijra communities and to increase their impact in HIV prevention efforts, responsive and comprehensive capacity building is required. To build CBO capacity, Pehchan developed a robust training programme through a process of engagement with community leaders, trainers, technical experts, and academicians in a series of consultations that identified training priorities. Based on these priorities, smaller subgroups then developed specific thematic components for each curricular module.

Inputs from community consultations helped increase relevance and value of training modules. By engaging MSM, transgender and hijra (MTH) communities in the development process, there has been greater ownership of training and of the overall programme among supported CBOs. Technical experts worked on the development of thematic components for priority areas identified by community representatives. The process also helped fine-tune the overall training model and scale-up strategy. Thus, through a consultative, community-based process, Pehchan developed a training model responsive to the specific needs of the programme and reflecting key priorities and capacity gaps of MSM, transgender and hijra CBOs in India.
Preface

As I put pen to paper, a shiver goes down my spine. It is hard to believe that this day has come after almost five long years! For many of us, Pehchan is not merely a programme; it is a way of life. Facing a growing HIV epidemic among men who have sex with men (MSM), transgender, and hijra communities in India, a group of development and health activists began to push for a large-scale project for these populations that would be responsive to their specific needs and would show this country and the world that these interventions are not only urgently needed but feasible.

Pehchan was finally launched in 2010 after more than two years of planning and negotiation. As the programme has evolved, it has never stepped back from its core principle: Pehchan is by, for and of India’s MSM, transgender and hijra communities. Leveraging rich community expertise, the Global Fund’s generous support and our government’s unwavering collaboration, Pehchan has been meticulously planned and passionately executed. More than just the sum of good intentions, it has thrived due to hard work, excellent stakeholder support, and creative execution.

At the heart of Pehchan are community systems strengthening. Our approach to capacity building has been engineered to maximise community leadership and expertise. The community drives and energises Pehchan. Our task was to develop 200 strong community-based organisations (CBOs) in a vast and complex country to partner with state governments and provide services to MSM, transgender and hijra communities to increase the effectiveness of the HIV response for these populations and improve their health and wellbeing. To achieve necessary scale and sustain social change, strong CBOs would require responsive development of human capital.

Over and above consistent services throughout Pehchan, we wanted to ensure quality. To achieve this, we proposed a standard training package for all CBO staff. When we looked around, we found there really wasn’t an existing curriculum that we could use. Consequently, we decided to develop one not only for Pehchan but also for future efforts to build the capacity of community systems for sexual minorities. So began our journey to create this curriculum.

Building on the experience of Sashakt, a pilot programme supported by UNDP that tested the model that we’re scaling up in Pehchan, an involved process of consultations and workshops was undertaken. Ideas for each module came from discussions with a range of stakeholders from across India, including community leaders, activists, academics and institutional representatives from government and donors. The list of modules grew with each consultation. For example in Sashakt, we had a single training module on family support and mental health; in Pehchan, we decided that it would be valuable to split these and have one on each.

Eventually, we agreed on the framework for the modules and the thematic components, finding a balance between individual and organisational capacity. Overall, there are two main areas of capacity building: one that is directly related to the services and the other that is focused on building capable service providers. Then we began the actual writing of the curriculum, a process of drafting, commenting, correcting, tweaking and finalising that took over eight months.
Once the curriculum was ready to use, trainings-of-trainers were organised to develop a cadre of master trainers who would work directly with CBO staff. Working through Pehchan’s four Regional Training Centers, these trainers, mostly members of MSM, transgender and hijra communities, provided further in-service revisions and suggestions to the modules to make them succinct, clear and user-friendly. Our consortium partner SAATHII contributed particularly to these efforts, and the current training curriculum reflects their hard work.

In fact, the contributors to this work are many, and in the Acknowledgements section following this Preface, we have done our best to name them. They include staff from all our consortium partners, technical experts, advocates, donor representatives and government colleagues. The staff at India HIV/AIDS Alliance, notably the Pehchan team, worked beautifully to develop both process and content. That we have come so far is also a tribute to vision and support of our leaders, at Alliance India and in our consortium partners, Humsafar Trust, SAATHII, Sangama, and SIAAP, as well as in India’s National AIDS Control Organisation and at the Global Fund to Fight AIDS, Tuberculosis and Malaria in Geneva.

We would like to think of the Pehchan Training Curriculum as a game changer. While the modules reflect the specific context of India, we are confident that they will be useful to governments, civil society organisations and individuals around the world interested in developing community systems to support improved HIV and other health programming for sexual minorities and other vulnerable communities as well.

After two years of trial and testing, we now share this curriculum with the world. Our team members and master trainers have helped us refine them, and seeing the growth of the staff in the CBOs we have trained has increased our confidence in the value of this curriculum. The impact of these efforts is becoming apparent. As CBOs have been strengthened through Pehchan, we are already seeing MSM, transgender and hijra communities more empowered to take charge, not only to improve HIV prevention but also to lead more productive and healthy lives.

Sonal Mehta
Director: Policy & Programmes
India HIV/AIDS Alliance
New Delhi
March 2013
General Acknowledgements

The Pehchan Training Curriculum is the work of many people, including community members, technical experts and programme implementers. When we were not able to find training materials necessary to establish, support and monitor strong community-based organisations for MSM, transgenders and hijras in India, the Pehchan consortium collectively developed a curriculum designed to address these challenges through a series of community consultations and development workshops. This process drew on the best ideas of the communities and helped develop a responsive curriculum that will help sustain strong CBOs as key element of Pehchan.

We would like to take this opportunity to acknowledge the contributions of those who helped in taking this process forward, including (in alphabetical order): Ajai, Praxis; Usha Andewar, The Humsafar Trust; Sarita Barapanda, IWW-UK; Jhuma Basak, Consultant; Dr. V. Chakrapani, C-Sharp; Umesh Chawla, UNDP; Alpana Dange, Consultant; Brinelle D’Sourza, TISS; Firoz, Love Life Society; Prashanth G, Maan AIDS Foundation; Urmi Jadav, The Humsafar Trust; Jeeva, TRA; Harleen Kaur, Manas Foundation; Krishna, Suraksha; Monica Kumar, Manas Foundation; Muthu Kumar, Lotus Sangama; Sameer Kunta, Avahan; Agniva Lahiri, PLUS; Meera Limaya, Consultant; Veronica Magar, REACH; Magdalene, Center for Counselling; Sylvester Merchant, Lakshya; Amrita Nanda, Lawyers’ Collective; Nilanjana, SAFRG; Prabhakar, SIAAP; Priti Prabhughate, ICRW; Nagendra Prasad, Ashodaya Samithi; Revathi, Consultant; Rex, KHPT; Amitava Sarkar, SAATHII; Dr. Maninder Setia, Consultant; Chetan Sharma, SAFRG; Suneeeta Singh, Amaltas; Prabhakar Sinha, Heroes Project; Sreeram, Ashodaya Samithi; Suresh, KHPT; Sanjantia Veul, JHU; and Roy Wadia, Heroes Project.

Once curricular framework was finalised, a group of technical and community experts was formed to develop manuscripts and solicit additional inputs from community leaders. The curriculum was then standardised with support from Dr. E.M. Sreejit and streamlined with support from a team at SAATHII, led by Pawan Dhall. This process included inputs from Sudha Jha, Anupam Hazra, Somen Achrya, Shantanu Pyne, Moyazzam Hossain, Amitava Sarkar, and Debjyoti Ghosh Dhall from SAATHII; Cairo Araijo, Vaibhav Saria, Dr. E.M. Sreejit, Jhuma Basak, and Vahista Dastoor, Consultants; Olga Aaron from SIAAP; and Harjyot Khosa and Chaitanya Bhatt from India HIV/AIDS Alliance.

From the start, the Government of India’s National AIDS Control Organisation has been a key partner of Pehchan. In particular, Madam Aradhana Johri, Additional Secretary, NACO, has provided strong leadership and steady guidance to our work. The team from NACO’s Targeted Intervention (TI) Division has been a constant friend and resource to Pehchan, notably Dr. Neeraj Dhingra, Deputy Director General (TI); Manilal N. Raghvan, Programme Officer (TI); and Mridu, Technical Officer (TI). As the programme has moved from concept to scale-up, Pehchan has repeatedly benefitted from the encouragement and wisdom of NACO Directors General, past and present, including Madam Sujata Rao, Shri K. Chandramouli, and Shri Lov Verma.

Pehchan is implemented by a consortium of committed organisations that bring passion, experience, and vision to this work. The programme’s partners have been actively engaged in developing the training curriculum. We are grateful for the many contributions of Anupam Hazra and Pawan Dhall from SAATHII; Hemangi, Pallav Patnaik, Vivek Anand and Ashok Row Kavi from the Humsafar Trust; Olga Aaron and Indumati from SIAAP; Vijay Nair from Alliance India Andhra Pradesh; and Manohar from Sangama. Each contributed above and beyond the call of duty, helping to create a vibrant training programme while scaling up the programme across 17 states.
India HIV/AIDS Alliance’s Pehchan team has been untiring in its contributions to this curriculum, including Abhina Aher, Jonathan Ripley, Yadendra (Rahul) Singh, Simran Shaikh, Yashwinder Singh, Rohit Sarkar, Chaitanya Bhatt, Nunthuk Vunghoihkim, Ramesh Tiwari, Sarbeshwar Patnaik, Ankita Bhalla, Dr. Ravi Kanth, Sophia Lonappan, Rajan Mani, Shaleen Rakesh, and James Robertson. A special thank-you to Sonal Mehta and Harjyot Khosa for their hard work, patience and persistence in bringing this curriculum to life.

Through it all, the Global Fund to Fight AIDS, Tuberculosis and Malaria has provided us both funding and guidance, setting clear standards and giving us enough flexibility to ensure the programme’s successful evolution and growth. We are deeply grateful for this support.

Pehchan’s Training Curriculum is the result of more than two years of work by many stakeholders. If any names have been omitted, please accept our apologies. We are grateful to all who have helped us reach this milestone.

The Pehchan Training Curriculum is dedicated to MSM, transgender and hijra communities in India who for years, have been true examples of strength and leadership by affirming their pehchān.
Module Acknowledgments: Mental Health

Each component of the Pehchan Training Curriculum has a number of contributors who have provided specific inputs. For this component, the following are acknowledged:

**Primary Author**
Monika Kumar, Manas Foundation

**Compilation**
Dr. E. M. Sreejit, Consultant

**Technical Input**
Vahista Dastoor, C4D Consultant, Debjyoti Ghosh, SAATHII and Harjyot Khosa, India HIV/AIDS Alliance

**Coordination and Development**
Vahista Dastoor, C4D Consultant
Pawan Dhall, SAATHII

**References**

# About the Mental Health Module

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<th>No.</th>
<th>C3</th>
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<tbody>
<tr>
<td>Name</td>
<td>Mental Health</td>
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| Pehchan Trainees | • Project Managers  
• Counsellors  
• Outreach Workers (ORWs) |
| Pehchan CBO Type | TI Plus |
| Training Objectives | By the end of this module, the participants will:  
• Understand the basic concepts of mental health and be able to recognise symptoms of mental disorders;  
• Be able to articulate common mental health concerns in the MTH community and be able to respond appropriately to people experiencing symptoms of mental disorders; and  
• Understand the basic concepts of counselling and the role of Pehchan personnel in helping persons with psycho-social problems. |
| Total Duration | One and a half days. A day’s training typically covers 8 hours. |

## Module Reference Materials

All the reference material required to facilitate this module has been provided in this document and in relevant digital files provided with the Pehchan Training Curriculum. Please familiarise yourself with the content before the training session.

**Attention:** Please do **not** change the names of file or folders, or move files from one folder to another, as some of the files are linked to each other. If you rename files or change their location on your computer, the hyperlinks to these documents in the *Facilitator Guide* will not work correctly.

If you are reading this module on a computer screen, you can click the hyperlinks to open files. If you are reading a printed copy of this module, the following list will help you locate the files you need.
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<th>Audio-visual Support</th>
<th>PowerPoint presentation ‘Mental Health’.</th>
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<td>Annexures</td>
<td>Annexure 1: ‘Ramesh’s Story’.</td>
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<td>Annexure 2: ‘Definitions of Health and Mental Health’.</td>
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<td>Annexure 3: ‘Mental Disorders’.</td>
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<td>Annexure 4: ‘Difference between Poor Mental Health and Mental Disorders’.</td>
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<td>Annexure 5: ‘Mental Health: What’s Normal, What’s Not’.</td>
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<td>Annexure 8: ‘Model of Counselling’.</td>
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<td>Annexure 10: ‘Listening to the Client’s Story’.</td>
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<td>Annexure 11: ‘Helping Clients Explore Their Story’.</td>
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<td>Annexure 13: ‘Helping Clients Make a Plan’.</td>
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<td>Annexure 14: ‘Dealing with Suicide and Self-harm’.</td>
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# Activity Index

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<th>Activity Name</th>
<th>Time</th>
<th>Material¹</th>
<th>Audio-visual Resources</th>
<th>Take-home material</th>
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</table>
| 1   | Understanding Mental Health                       | 1 hour 30 minutes | Chart paper, markers | N/A                    | Annexure 1: ‘Ramesh’s Story’  
Annexure 2: ‘Definitions of Health and Mental Health’                               |
| 2   | Identifying Mental Health Problems and Disorders  | 1 hour 30 minutes | Refer to the slides titled  
‘Signs and Symptoms of Poor Mental Health to Some Common and Severe Disorders’ from the PowerPoint Presentation  
‘Mental Health’  
Annexure 3: ‘Mental Disorders’  
Annexure 4: ‘Difference between Poor Mental Health and Mental Disorders’  
Annexure 5: ‘Mental Health: What’s Normal, What’s Not’ | N/A                      | Annexure 3: ‘Mental Disorders’  
Annexure 4: ‘Difference between Poor Mental Health and Mental Disorders’  
Annexure 5: ‘Mental Health: What’s Normal, What’s Not’ |
| 3   | Mental Health and the MTH Community                | 1 hour          | Chart paper, markers | N/A                    | Annexure 6: ‘Changing Status of Homosexuality vis-à-vis Mental Health’           |
| 4   | Introduction to Counselling                        | 45 minutes      | N/A        | N/A                    | Annexure 7: ‘Counselling Cards’  
Annexure 8: ‘Model of Counselling’                                                   |
| 5   | Counselling Skills: Building a Foundation         | 1 hour          | N/A        | N/A                    | Annexure 9: ‘Building a Foundation’                                               |
| 6   | Counselling Skills: Listening to the Client’s Story | 1 hour          | N/A        | N/A                    | Annexure 10: ‘Listening to the Client’s Story’                                    |
| 7   | Counselling Skills: Helping Clients Explore their Stories | 1 hour           | N/A        | N/A                    | Annexure 11 on ‘Helping Clients Explore their Story’                             |
| 8   | Counselling Skills: Helping Clients Explore Options | 1 hour          | N/A        | N/A                    | Annexure 12 on ‘Helping Clients Explore Options and Self-help Strategies for Successful Coping’ |

¹ Overhead projector, laptop, sound system and whiteboard should be provided at every training.
<table>
<thead>
<tr>
<th></th>
<th>Topic</th>
<th>Duration</th>
<th>Notes</th>
<th>Resources</th>
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<tr>
<td>9</td>
<td>Counselling Skills: Helping Clients Make a Plan, Reviewing, and Terminating</td>
<td>1 hour</td>
<td>N/A</td>
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<td>10</td>
<td>Dealing with the Risk of Harm to Self or Others</td>
<td>30 minutes</td>
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<td>11</td>
<td>Wrap-up</td>
<td>30 minutes</td>
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Activity 1: Understanding Mental Health

<table>
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<tr>
<th>Time</th>
<th>1 hour 30 minutes</th>
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<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
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<td></td>
<td>• Define ‘mental health’ and understand its relation to overall health.</td>
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<tr>
<td>Materials</td>
<td>Chart papers and markers.</td>
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<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
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</table>
| Take-home Material | Annexure 1 on ‘Ramesh’s Story’.  
Annexure 2 on ‘Definitions of Health and Mental Health’. |

Methodology

Write the words ‘mental health’ on the whiteboard/flip-chart and gauge participants’ knowledge levels by asking the following questions:

• What is mental health?
• How do you identify a person who has poor mental health?

Divide participants into five groups and give them a chart paper and marker. Ask each group to divide their chart paper into three columns, ‘physical’, ‘mental’ and ‘social/relationships’.

Read aloud the first section from Annexure 1 on ‘Ramesh’s Story’. Ask the participants to trace the significant events of Ramesh’s life and comment on the impact such events may have had on Ramesh physically, mentally and socially.

Help identify some of the events to give cue to the participants, such as Ramesh’s wet dream, his mother scolding him, falling in love with Raj, self-education on sexuality, falling in love with Aziz, being beaten by Aziz’s brother, marriage, going to the city, meeting Piyal, meeting up with Piyal’s friends, and getting syphilis. Give them about 30 minutes to do this activity.

Read out the remaining section of the case study, and ask the participants to fill up the columns with their responses. Now draw four columns on the whiteboard/flip-chart with the following titles for the columns: events, physical, mental and social. Ask each group to share their inputs and write the keywords from their responses on the whiteboard/flip-chart.

Using the participant responses on the whiteboard/flip-chart, ask the participants to consider looking at each column vertically, wherein one can observe the ups and downs in his physical, mental, and social life and relationships.

Now study the table horizontally, one can see that positive states of being, whether they be physical, mental or social/relationships, seem to occur at the same time as the negative states seem to occur. Ask the participants why they think this is so. Spend some time on allowing them to come to the conclusion that the physical, mental and social/relational aspects of a human being cannot be segregated as easily as has been done in the lists in the columns as each aspect is closely integrated with the other, and a negative effect in one can have a domino effect on the other aspects. Give examples.

• Losing one’s job could isolate one from others (social/relationship aspect), could make one feel helpless and depressed (mental), and could lead to a loss of appetite (physical) and subsequently, make one feel weak.
• On the other hand, getting a much-wanted job could raise one’s spirits (mental),
put one in touch with others (social/relationship) and because of the elated feeling of well-being, it can improve one's appetite.

At this juncture, explain the concept of health as the (World Health Organization, 2003) has defined it: ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’. While physical and mental well-being should be clear to the participants, spend some time discussing the concept of social well-being, which essentially refers to how people experience their connections with others and the strength of those relationships. Social well-being also includes connections with family members, friends, neighbourhood, community, and workplace.

Using some of the responses from the whiteboard/flip-chart, ask the participants to identify the sequence of impact on the three aspects of Ramesh’s being – physical, mental and social/relationships. They should be able to make the conclusions that follow.

- In some cases, a clear-cut sequence of events can be identified.
- In other cases, the sequence of causality may not be so clear.
- In some cases, an adverse event caused mental disturbance, which resulted in negative reactions being manifested in his physical and social self.
- In others, an adverse event caused Ramesh to develop positive coping skills which had an impact on his physical, mental and social well-being.

Ask the participants that if each of them were to be in Ramesh’s position, would the impact on their physical, mental and social well being be identical? If yes, ask why they think it would be. If not, then ask why not? It is important that the participants reach the conclusions that follow.

- While events may negatively impact health, health is dependent on many other factors, such as genetics, income, social status, education, literacy, etc.
- More importantly, each person is a unique human being and is a product of a unique physiology, state of mind, life experiences and learnings, both good and bad. People live through the most adverse of life circumstances and yet can lead healthy, happy lives.

Ask participants to consider Ramesh’s case and answer how would they conclude whether a person is mentally healthy or not. Allow them to brainstorm for a while, listing their responses on the whiteboard/flip-chart. If you feel it is necessary, ask them to work in their groups to develop a definition of mental health.

After they have shared their responses, read out the World Health Organization definition (2003) of mental health: ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.

Discuss the different sections of the definition in relation to Ramesh’s case.

- Does Ramesh realise his own abilities?
- Can Ramesh cope with the normal stresses of life?
- Does Ramesh work productively and fruitfully?
- Is Ramesh able to make a contribution to his community?

Draw the participant’s attention to the fact that for every person mental health is not an absolute state but has its ups and downs. This can clearly be seen in Ramesh’s story.
Background Information

(World Health Organization, 2011)

The Determinants of Health

Many factors combined together affect the health of individuals and communities. Circumstances and environment determine the health of a person. To a large extent, factors such as where we live, the state of our environment, genetics, our income, education level, and our relationships with friends and family all have considerable impact on our health; whereas the more commonly considered factors, such as access and use of healthcare services, often have less of an impact.

Determinants of health include:

- Social and economic environment;
- Physical environment; and
- Person’s individual characteristics and behaviours.

The context of people’s lives determines their health. Individuals are unlikely to be able to directly control many of the determinants of their health. These determinants – things that make people healthy or not – include the above factors, and many others, which are available in detail in Annexure 2 on ‘Definitions of Health and Mental Health’.
Activity 2: Identifying Mental Health Problems and Disorders

**Time**  | **1 hour 30 minutes**
---|---
**Learning Outcomes** | By the end of this activity, participants will be able to:
- Identify the signs and symptoms of poor mental health; and
- Understand the distinction between the terms ‘normal’ and ‘abnormal’ in the context of mental health.

**Materials** | Chart paper and markers.

**Audio-visual Support** | Refer to the slides titled ‘Signs and Symptoms of Poor Mental Health’ from the PowerPoint Presentation ‘Mental Health’.

**Take-home Material** | Annexure 3: ‘Mental Disorders’.
| Annexure 4: ‘Difference between Poor Mental Health and Mental Disorders’.
| Annexure 5: ‘Mental Health: What’s Normal, What’s Not’.

**Methodology**

**Part I: Signs and Symptoms of Poor Mental Health**
Ask the participants how they would recognise a person with poor mental health. After allowing them to brainstorm for a while, use the PowerPoint slides titled ‘Signs and Symptoms of Poor Mental Health’ to discuss the following:

- Different physical and mental reactions in a person that may occur due to poor mental health – use the pictures on the slides to discuss whether Ramesh could have manifested similar reactions; and if so, during which phase of life he would exhibited the same.
- The terms ‘signs’ and ‘symptoms’ and the difference between subjective indication of disease and objective evidence.

After the discussion, explain to the participants what is meant by a ‘sign’: an indication of the existence of something; any objective evidence of a disease that is perceptible to a physician, as opposed to the subjective sensations. Explain that a ‘symptom’ is subjective evidence of disease or of a person’s condition; it is the evidence as perceived by the person, indicative of some bodily or mental state.

Further, ask participants to think of the following questions in relation to the PowerPoint presentation used in the module:

- What could cause a sign/symptom?
- What could the person be thinking at this time?
- What could the person be feeling at this time?
- What was the person doing or what he or she may have done after experiencing the distress? (Behaviour)

Form the participants into smaller groups, giving each group chart paper and a marker. Ask them to divide the chart paper into four columns, labelling the columns ‘events’, ‘thoughts’, ‘feelings’ and ‘actions’, and ask the participants to write down what they think Ramesh would have thought, felt and did at the time of the various events in his life.
Ask the participants to share their responses and write them down on a flip-chart. Once you have sufficient responses, stick the flip-chart in a prominent place on the wall for ready reference during later activities. Conclude the session by pointing that:

- All persons are unique, and that a person’s facial expressions, outer appearance and behaviour are only indicative of what the person is really thinking and feeling. Responsible professionals, helpers and caregivers must explore, through counselling and other means, what the person is actually thinking or feeling and should not intervene on the basis of external behaviour and appearance only.

**Part II: Brief Overview of Mental Disorders**

Discuss the difference between poor mental health (or mental ill-health) and mental illness (or mental disorders).

Using the Power Point slides titled ‘Some Common and Severe Disorders’ introduce participants to some mental disorders and also to the two major classification reference guides of mental disorders: the Internal Classification of Diseases (ICD) and the Diagnostic and Statistical Manual (DSM).

**Background Information**

*(University of Melbourne, 2009)*

**Mental ill-health**

This term refers to the kind of general mental health problems we can all experience in certain stressful circumstances; for example, work pressures can cause us to experience poor concentration, mood swings and sleep disturbance. Such problems are usually of temporary nature, are relative to the demands a particular situation makes on us, and are generally responded to with support and reassurance.

**Mental disorders (or mental illness)**

These can be defined as the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired.

Some form of professional medical help is usually needed for recovery/management of both poor mental health and mental disorders. This help may take the form of counselling or psychotherapy, drug treatment, and/or lifestyle change.
Classification of Mental Disorders

Severe Mental Disorders
People with severe mental disorders usually experience a mixture of physical, emotional, mental and behavioural symptoms, as well as imagined symptoms.

Severe mental disorders are rare and usually involve noticeable behavioural problems and the expression of strange or unusual ideas, often called psychosis. Psychosis is sometimes described as ‘losing touch with reality’.

People with severe mental disorders are more easily identified as having a mental health problem than those with common mental disorders, because they seem more obviously different from others in the way they think and behave. Most people in psychiatric hospitals suffer from severe mental disorders. Refer to Annexure 3 on ‘Mental Disorders’.

Part III: Determining What is Normal and What is Abnormal
Ask the participants to list factors that they believe affect mental health. Write their responses on a flip-chart in three separate columns under the following heads:

- Social and economic environment
- Physical environment
- Individual characteristics and behaviours

It is important to discuss that while genetics and an individual’s physical and mental make-up plays a role in mental disorders, external factors too have a significant role to play, and labelling people who have poor mental health or have mental disorders as people who ‘should pull themselves together’, who are weak-minded, weak-willed, crazy, abnormal, etc. is irresponsible.

Discuss the dangers of labelling people as ‘normal’ or ‘abnormal’. While there are a numerous pitfalls in using the labels ‘normal’ and ‘abnormal’, from the mental health/mental disorders point of view, it becomes necessary to distinguish between these to understand whether a person’s mental state has deviated from what is considered a state of ideal mental health.

In this context, you can again remind participants of the WHO definition of ideal mental health as being: ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.
Introduce participants to the criteria of ‘Failure to Function Adequately’ (see box), which they can use as a ‘checklist’ to determine whether a person’s mental state has deviated from the norm. Using this set of criteria, behaviour of an individual may be defined as abnormal if it harms the individual or other people. Use Ramesh’s case study to elaborate on each of the above criteria.

- Was Ramesh in distress when he realised that he was unable to have sex with his wife without thinking about Aziz?
- Was his behaviour irrational and unconventional when he started showing uncontrolled sexual behaviour in the city?

Discuss the grey areas in the criteria titled ‘Observer discomfort’ and ‘Violation of moral standards’: Who are the observers and who set the moral standards?

Remind participants of the various factors that affect mental health, that what may be considered ‘normal’ in one society may be considered ‘abnormal’ in another, and that the concept of norms also changes over time. Evolving norms related to homosexuality are a case in point; this is discussed in more depth in the following activity.

Also point out that, as professionals, when one speaks of a person who is in poor mental health, it is the thoughts, feelings and behaviour that are evaluated as normal or abnormal, not the person. When one speaks of the person as abnormal, it amounts to stigmatising the person. For more information on this, please refer to Annexure 5 on ‘Mental Health: What’s Normal, What’s Not’.

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**Criteria for Failure to Function Adequately**

- **Distress**: the person is upset or depressed.
- **Maladaptive behaviour**: behaviour that prevents someone from coping with everyday situations.
- **Irrationality**: belief or behaviour not connected with reality.
- **Unpredictability**: reacting to a situation in a way that could not be predicted or reasonably expected.
- **Unconventional behaviour or statistically rare behaviour**.
- **Observer discomfort**: behaviour that makes other people feel uncomfortable.
- **Violation of moral standards**: breaking laws, taboos, etc.

**Strengths of this Technique**

- It provides a practical checklist.
- It takes into account the social/cultural context.

**Weaknesses of this Technique**

- Sometimes it is normal to be distressed (e.g. grieving).
- Some people may be abnormal (e.g. a psychopath) and yet show no signs of distress.
- Some of the criteria are subjective; who judges what is ‘unpredictable’?

(Rosenhan & Seligman, 1989)
Activity 3: Mental Health and the MTH Community

### Learning Outcomes
By the end of this activity, the participants will be able to:

- Understand the historical background of homosexuality vis-à-vis mental health;
- Identify the common mental health issues faced by the MTH community and understand the role that stigma plays in determining mental health; and
- Identify the scope of mental health interventions in Pehchan and understand their roles in the same.

### Materials
N/A

### Audio-visual Support
N/A

### Take-home Material
Annexure 6: ‘Changing Status of Homosexuality vis-à-vis Mental Health’.

### Methodology
Discuss how homosexuality has been considered a mental illness and give the timeline of events of the last forty years that have changed that perception (as mentioned below). Point out the impact of activism in changing norms of society and medical establishment.

Refer to the decriminalisation of Section 377 of the Indian Penal Code as another normative change – this time in the legal establishment – and the implications of the change in legal status on the mental health of those who were previously affected by the law.

Discuss how despite legalising homosexuality, social acceptance remains poor, leading to stigma (both external and self-stigma) and discrimination. Point out that there is a popular but unfounded perception that homosexual people have more mental health problems. However, stigma is a major cause of mental health problems in lesbian/gay/transgender (TG) people, not homosexuality. Also point out about the double marginalisation faced by the community: people with mental illnesses are also socially stigmatised in a number of countries, including India, and MTH people with mental illnesses are therefore doubly marginalised.

Ask the participants to share their experiences with mental health problems in the MTH community. Ensure that the terms they use and their articulation of these problems are not vague but reflect the learnings of the day’s activities.

Using Ramesh’s case study, ask the participants the following questions:

- Can we link the instances of homophobia in Ramesh’s life with his later high-risk behaviour?
- When Ramesh went to the city and met his new friends, was his social life actually growing? Or was he merely experiencing freedom for the first time, which he expressed sexually?
- In his experience of freedom, was he displaying responsible behaviour?
- What roles does Ramesh’s family expectations play in his overall mental state, especially in his high-risk behaviour?
• When Ramesh started having sex with Piyal and his friends without any protection, he felt very happy and did not experience any distress. Would you call that healthy behaviour?
• Do you think Ramesh was driven into this lifestyle because of his sexual orientation?
• What role did non-acceptance of Ramesh's sexual orientation by his family play in his life? Would his life have been different had he been accepted the way he was?

Help participants identify the factors that play a detrimental role in the mental health of the community in general and explore whether there are differences in mental health issues among the three identities: MSM, transgender and hijra.

Briefly discuss the role of Pehchan programme and its component of internal capacity building of MSM, transgender and hijra communities to help them deal better with stigma and discrimination that affects their physical and mental health.

Discuss the role and scope of Pehchan personnel in dealing with the mental health issues of the MTH community. Use Ramesh's case study an example to identify when and how Pehchan personnel could have intervened to help Ramesh.

• What do you think should have been done to Ramesh by the hospital/doctor/medical advisor at the following stages:
  • When he was first taken to the hospital after being a victim of a violent homophobic attack by Aziz's brother?
  • When he was diagnosed with syphilis?
  • When he, along with his wife, was diagnosed with HIV?

• What could the personnel of Pehchan programme have done had they been linked with the various medical service providers Ramesh interacted with in the course of his life?
Activity 4: Introduction to Counselling

Time 45 minutes

Learning Outcomes
By the end of the activity, the participants will be able to:
• Define the term counselling and understand the difference between counselling and other helping relationships;
• Articulate the physical, temporal, and relational boundaries of a counselling relationship; and
• Be able to articulate the steps in counselling.

Materials N/A

Audio-visual Support N/A

Take-home Material
Annexure 7: ‘Counselling Cards’.
Annexure 8: ‘Model of Counselling’.

Methodology

Part I: Introduction to Counselling

Ask the participants what they think counselling is and write key responses on a flip-chart. Tell the group that when people experience difficulties in their lives, they sometimes turn to another person for help. This could be a trusted friend, a family member or a religious leader. They could also meet with a person who has been trained to effectively help them. In simple terms, a counsellor is trained to listen and respond to people in emotional distress and to empower them to deal with their difficulties.

Ask the participants to think about a time when they sought help from someone when they were in a difficult problem and felt supported. Ask them to think about the experience and what were their feelings and the state of mind:
• Before they approached the person?
• During their interaction/s with the person?
• After speaking to the person?

Ask a few participants to talk about their experiences of being helped. Encourage them to focus their feedback on the questions asked above and on the feelings generated, not on the problem. Participants may have difficulty in articulating a range of feelings; encourage them by prompting but do not put words in their mouths. List key words from their responses on a flip-chart under the three columns titled ‘Before’, ‘During’ and ‘After’.

Probe whether the helpers gave them advice and solutions, or heard them out and allowed them to find their own solutions. Link their feedback to the process of counselling and discuss the pros and cons of giving advice as opposed to allowing a person find their own solution.

Describe counselling as a process based on a relationship that is built on empathy, acceptance, and trust. Within this relationship, the counsellor focuses on the client’s feelings, thoughts and actions, and then empowers clients to:
• Cope with their lives;
• Explore options;
• Make their own decisions; and
• Take responsibility for those decisions.
Part II: Understanding the Framework of Counselling

Summarise the discussions by telling participants that the main aim of counselling is to create an emotionally safe space and an accepting, caring relationship in which the client can explore, discover and clarify ways of living a more satisfying and resourceful life.

Introduce the concept of boundaries in counselling by conducting an interactive discussion on the possible disadvantages of having a close personal relationship (e.g. friend, family member) with someone seeking help. You could also discuss the power dynamics between a person seeking help and a helper, and how important it is to ensure that the relationship remains one of equality.

Explain how the following help in creating a ‘safe space’ necessary for counselling:

- The physical frame (location and arrangement of counselling setting).
- The time frame (length and number of sessions).
- The ethical frame (respecting the dignity, individuality and rights of the counselee)
- The counselling frame (being in the client’s frame of mind, creating a safe space, limited self-disclosure and physical contact, permission for taking notes or tape recording, only if necessary).

Part III: Overview of Counselling Process

Ask for five volunteers and hand each volunteer one of the placards containing the elements of the Model of Counselling (Refer to Annexure 7 on ‘Counselling Cards’). Tell the volunteers they have two minutes to stand in a sequence they believe is correct for the process of counselling. They should arrange themselves in such a manner that they face the other participants in the correct order.

When two minutes are up, or if they have already arranged themselves in a sequence, ask the other participants to comment on the correctness of the sequence. If they suggest changes, ask them why they are suggesting a change. If they feel that the arrangement is correct, ask them to explain why they feel this sequence is logical.

Once volunteers are in the correct sequence, ask participants why the ‘Help Client Make a Plan’ is not a rectangle like the other placards. Then re-arrange the placards vertically so that it looks like a house, where the ‘Help Client Make a Plan’ placard becomes the roof of the house. Point out that the ‘Build a Foundation’ placard is right at the bottom, just like the foundation of a house. If possible, stick these placards in this manner in a prominent place so that participants can refer to this during the following sessions.

Use the following scenario from Ramesh’s story:

‘For many months, Aziz and I kept on catching up with each other in the afternoons before I went off home. No one used to be there at his place – his elder brother was in college, his father at work, and his mother passed away. One day, his brother came back early and, unknown to us, was watching us undress each other. He suddenly burst in with a cricket bat and started beating me mercilessly. I must have passed out, for the next thing I remember I was in a hospital with my anxious parents staring at me.’

Ask the participants to imagine that the doctor treating Ramesh refers him for counselling. Assuming Ramesh has come for counselling; hypothesize what each of the elements in the Model of Counselling would entail. Allow participants to guess what might be happening at each stage and clarify their responses wherever necessary.

Tell participants that this is only a model – there are variations to the approach; however, keeping this in mind will help them give direction in their counselling process. Also remind them that a client does not show improvement in a neat, linear manner and will often progress, regress and even digress. The counsellor needs to be prepared for this to
happen and move at the pace of the client. Moreover, it is to be noted that these steps could be achieved with some clients in one or two sessions, and for others, this process may take many sessions.

End the session leaving participants with the following visual imagery: remind them of the counselling framework and its four frames and ask them to visualise the Counselling Model as a house with the counselling framework around it like a protective fence.

Emphasise that:
- Throughout the counselling process, the responsibility for growth and change remains with the client; and
- Essentially, counselling is about helping others to help themselves, and helping them grow in a way they choose.

**Background Information**

**A Model of Counselling**

(Kustner, 2011)

![Counselling Model Diagram]

**Principles of the Model**

‘Building the house’ means building the counselling relationship to help the client deal with his/her problems. As the counselling process moves forward, a trustful working relationship is built between the counsellor and the client.

Clients have different needs with regard to counselling. Some clients just need help in telling their story in order to help them to continue with the ‘house building’ on their own. The client is responsible for building his/her house and counselling can end at any stage in the ‘house building’ process. The counsellor is only a facilitator of the process.
Listening to and exploring the client’s story helps to build trust and understanding, which then allows the client and the counsellor to move into exploring solutions and making a plan. Reviewing the counselling process is done by summarising and is helpful to re-focus the client and counsellor on what has been achieved in the counselling process. The client’s family, friends and community resources are included in this helping process.

‘Building the house’ is also a collaborative effort of the client, the counsellor and external support structures, and follows a flexible process.

The Counselling Framework
(Kustner, 2011)

Physical Frame
The counselling room should be comfortable, quiet and private. Even if you do not have access to a proper counselling office, consider the following while setting up the space:

- Positioning of chairs;
- Minimal wall decorations;
- Box of tissues handy;
- Culture-friendly ornaments; and
- Small, visible clock.

Other physical contexts: Counselling can take place in other contexts (e.g. a hospital room, under a tree, a waiting room, a formal counselling space, a police station, a clinic), and sometimes counsellors have to be creative in finding ways to ensure privacy and facilitate communication.

Timeframe
Sessions should ideally last 45-50 minutes as shorter sessions may provide too little time to explore, and longer sessions can tire the client and the counsellor. (In trauma cases, sessions may take longer than 50 minutes). How often the client should come (frequency) and how many sessions are allocated (duration) depends on the needs of the client and availability of the counsellor. This is discussed in the initial session. Sessions should be regular (usually weekly) and consistent.

In some cases, the counsellor may only have one or two sessions with the client and will have to do his/her best within these limitations. (There is research suggesting that just unburdening in a first session can help individuals/families to move forward.)

Ethical Framework

- Respect the dignity, individuality and rights of the counselee.
- Respect the autonomy of the counselee.
- Take informed consent.
- Provide confidentiality, including confidentiality of records.
- Avoid doing any harm.
Counselling Relationship Frame
As counsellors, one must maintain physical, emotional and social boundaries when dealing with clients.

As counsellors, one should not touch their clients, reveal personal details, give advice or pass judgements, and engage in multiple relationships with the clients. It is not appropriate to be a friend and a counsellor to a client at the same time.

As a counsellor one should not get emotionally attached to the clients, share their own problems, make false promises, get angry, or cry in front of clients.

These are avoided so as to maintain clear relationship as one of ethical counselling and not everyday socialising.

This framework makes the client feel safe and comfortable to explore his/her problem, and it protects the counsellor from getting emotionally involved.
Activity 5: Counselling Skills: Building a Foundation

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<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will understand:</td>
</tr>
<tr>
<td></td>
<td>• What constitutes a counselling relationship and the skills needed to build the relationship; and</td>
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<tr>
<td></td>
<td>• The concepts of ‘empathy’, ‘trust’, ‘non-directive’, and ‘here and now’ and their role in facilitating counselling.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Annexure 9 on ‘Building a Foundation’.</td>
</tr>
</tbody>
</table>

Methodology

Part I: Understanding ‘Building a Foundation’
Refer to the base of the model of counselling ‘Building a Foundation’ and ask participants what they think this would constitute. After eliciting their responses, conclude that building the foundation constitutes:

• Self-preparation: being aware of how one is feeling before the session and putting aside one’s own thoughts and feelings to focus completely on the client.
• Preparation of context: preparing the physical space in which counselling is to take place and mentally preparing oneself to act within the framework of counselling.
• Welcoming and contracting: point out how important first impressions are, and how important it is for the client to feel comfortable and safe when s/he comes into the counselling space. Establishing the boundaries of the counselling relationship also gives the counselee a clear idea of what s/he can expect and what is expected of her/him.

Part II: Skills-building
Ask for two volunteers, one to act as Ramesh and the other as the counsellor. Ask them to do a small role-play where Ramesh visits a counsellor for the first time. In this role-play, Ramesh has a minimal role to play; the focus is on the counsellor and how s/he demonstrates foundation building skills. Stop the role-play when the counsellor finishes establishing the boundaries of the relationship.

Ask Ramesh how comfortable or uncomfortable he felt with the counsellor and why he felt that way. Ask the other participants to give feedback on the counsellor’s role-play. Ensure that the feedback is given in a constructive manner. Remind participants to think of themselves as counsellors when giving feedback – they should be empathic, non-judgemental, non-directive, and responsive to the needs of the role-player. Encourage more participants to play the role of the counsellor.
Part III: Pillars of Counselling

Start the next session with visual imagery: tell the participants to close their eyes and visualise the ‘House’ model of counselling again, but this time in 3-D. They should visualise the house as a 3-D rectangle, with four pillars at the four corners, reaching from the floor to the ceiling. These four pillars are named:

- Empathy
- Trust
- Non-directive
- Here and now

Brainstorm with the participants about the concept behind each of these pillars. Discuss the concept of ‘empathy’ as opposed to ‘sympathy’. Discuss why being non-judgemental is one of the most important facilitators in counselling.

Discuss the concept of non-directive; remind participants that the goal of counselling is to restore/awaken the client’s own resources, and being directive would be akin to taking away choice from the client.

Discuss the concept of being in the ‘here and now’: the counselee brings up problems that affect him or her in the current session and the counsellor responds accordingly. Events reported by the client are not as important as the thoughts and feelings (and events) being reported in the current session.

Tell participants that apart from these four pillars or principles of counselling, there are a number of others, for more information refer them to Annexure 9.
Activity 6: Counselling Skills: Listening to the Client’s Story

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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</table>
| Learning Outcomes | By the end of this activity, the participants will:  
• Understand what is meant by listening and attending skills. |
| Materials    | N/A        |
| Audio-visual Support | N/A |
| Take-home Material | Annexure 10: ‘Listening to the Client’s Story’. |

Methodology

Part I: Introduction to Listening and Attending
Tell participants that listening and attending are the two skills required to help clients tell their story, and practicing the principles of SOLER MAP (see the adjacent box) will help them in listening and attending.

Skill-builder: SOLER
Ask for two volunteers to play the role of Ramesh and a counsellor and allow them to get comfortable in their chairs. Ask Ramesh to start talking about a problem scenario, and ask the group to observe the counsellor.

Now ask the participants to point out whether the posture of the counsellor was appropriate and to explain the reason behind their opinion. After some discussion, introduce the concept of SOLER and allow various participants to practice it.

Elaborate on the concept of listening, and ensure that participants understand that listening is more than just hearing; it includes the following:
• Listening with your ears to the words being said and hearing what people are saying;
• Noticing the way people look when they’re talking (non-verbal);
• Grasping the meaning behind people’s words; and
• Observing your reactions to what you hear, so you can respond in a non-judgemental and empathic way.

Skill-builder: Responding Using the Principles of MAP
Responding is a key element in listening – it conveys to the speaker that the other person has heard. Facilitate small role plays in which the counsellor responds with minimal encouragers such as ‘mmm’, ‘uh’ ‘huh’, and ‘I see’ that could be accompanied by nods of the head.

Ask the participants to conduct a role-play in which the counsellor keeps interrupting Ramesh, and discuss how interrupting or saying things before Ramesh does cannot be called effective listening.

SOLER MAP
Sit squarely, facing the other person
Open, non-defensive body posture
Lean slightly toward the client
Eye contact
Be relaxed and comfortable
Minimal encouragers
Attentive silence
Presentation

For more details refer to Annexure 10 on ‘Listening to the Client’s Story’.
Part II: Silence in the Counselling Space: What Does it Mean?

Discuss silence in the counselling space: what does it mean when a client is silent, and how can a counsellor use silence effectively. Highlight the use of silences in allowing the client space to collect his/her thoughts and regain composure, especially when clients are crying or thinking.

Being silent in an interaction is often uncomfortable and avoided. People are tempted to fill the gap in a conversation. However, in counselling, sitting with a person in silence often communicates a deep, empathic understanding.

Clients are encouraged to explore feelings in counselling, and often crying, shouting or looking away are ways in which these feelings are expressed. The counsellor should respect and allow for free expression of feelings by giving the client space and by appropriately reflecting his/her feelings.

Through practice, a counsellor will learn the difference between ‘stuck silence’ and ‘reflective silence’. If you are unsure about the silence, it is OK to ask the person to clarify. Otherwise, respect the silence and stay with it.

Background Information

Listening to the Client’s Story

(Kustner, 2011)

Listening

Listening is integral to building trust in the counselling relationship, and it gives the client space to open up. It also prepares the client and counsellor to reach a level where it is emotionally safe in the relationship to help the client explore options and make a plan. We listen for and observe:

- Our own feelings – self-awareness;
- The client’s experiences – what happened to them (content);
- The client’s behaviour – what they did or did not do (non-verbal);
- The client’s feelings – that arise in relation to their experiences and behaviour; and
- The client’s mood, appearance, and speech patterns.

Attending

Attending means being physically, intellectually and emotionally ‘present’ in a counselling session.

These skills indicate to the client that the counsellor is listening, is aware and is ready to interact. They show in a non-verbal way that the counsellor is attentive and available.

For more details on these skills refer to Annexure 10 on ‘Listening to the Client’s Story’.
Activity 7: Counselling Skills: Helping Clients Explore their Stories

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Understand the importance of helping clients explore their stories; and</td>
</tr>
<tr>
<td></td>
<td>• Demonstrate the skills of reflection, paraphrasing, clarifying, and summarising.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Annexure 11: ‘Helping the Client Explore their Story’.</td>
</tr>
</tbody>
</table>

Methodology

Part I: Why ‘Explore’ the Client’s Story

Ask the participant’s why exploring the client’s story is necessary – can a counsellor not just listen to the problem and give a solution?

Elicit their responses, and remind them that counselling is a process of empowerment, not solution-giving by the counsellor. In exploring their own stories, counsellees begin to untangle the various threads of their own lives, explore their own strengths, weaknesses, and options. More importantly, having someone listen empathetically and non-judgmentally to one’s thoughts and feelings is a critical part of the healing process.

Draw the following processes on a flip-chart, briefly elaborating on each step, and on how exploring the client’s story plays a critical role in the cycle of moving towards resolution and healing.

Also point out that exploring does not mean only focusing on ‘problems’, but also means focusing on ‘solutions’. It is a process in which:

• The counsellor asks what the client wants to change and how;
• Opens the space for possibilities – looks at exceptions and resources;
• Most importantly, assumes that the client is competent, resilient and resourceful; and
• Gives preference to the client’s voice and expertise and builds on the clients ideas.

Left: Problem Cycle. Right: Problem Treatment Cycle

Source: Basic Counselling Skills Participant Manual (Community Counsellor Training Kit)
Part II: Skill-building in Reflection, Paraphrasing, Clarifying and Summarising

The nervousness of a novice counsellor is usually generated by the thought ‘What do I say to the client’. Assure the participants that the main skill of the counsellor is listening and responding to what the client says, and this responding essentially mirrors what the client is saying.

- Point out that if they mirror the client’s responses, they will not fall into the trap of responding in a judgemental manner.
- Skilful use of reflection is the key to conveying empathy; by mirroring what the client says (or, as in advanced skills, does not say), the client feels understood by the counsellor.
- Introduce the skill of reflection, and get participants to reflect on content and feeling. Ensure that participants are not parroting the client’s statement, but go beyond to correctly reflect thinking, feeling and process.
- Also introduce participants to the idea of paraphrasing and clarifying process.

Now ask the participants to do small role-plays demonstrating the skill of paraphrasing and clarifying.

- Explain the concept of summarising and facilitate role-plays in which participant can practice the skills of summarising.

Part III: Skill-building in Questioning

Discuss the techniques of exploring through questioning, and point out that:

- Almost every novice counsellor tends to overuse questions. Caution participants of the drawbacks of this.
- Before asking a question, remind participants to ask themselves, ‘What is the need for me to ask this question?’ Questions should serve a purpose and help the client to think about the problem in a different way.
- Probing is a way of getting a more accurate understanding of the client and their problem. It must be used sparingly and must not be used to satisfy the counsellor’s curiosity.

Introduce participants to open-ended and close-ended questions and to the importance of open ended questioning in facilitating the process of counselling.

Background Information

Helping the Client Explore Their Story
(Kustner 2011)

Reflection

When somebody takes the time to tell us their story, it is important that we respond in a way which respects what they have said and shows them we have grasped what they are trying to say. Reflecting skills are those skills which allow the counsellor to respond directly to what a client has said to take the conversation further in a useful direction. They also show that the counsellor has been listening or, if the response misses the mark, gives permission to the client to put the counsellor back on track.

It is always important to begin a response with a qualifier such as, ‘It seems to me …’ or ‘It appears that …’ and to use a tone of voice which conveys tentativeness. This is not because the counsellor wishes to appear uncertain but to show respect for the client’s right to be the final judge of the ‘truth’ of their words, thoughts and feelings.
Paraphrasing
A paraphrase is a brief, tentative, statement which reflects the essence of what the person has just said. A good paraphrase:

- Captures the essence of what the person said. It leaves out the details;
- Conveys the same meaning, but uses different words;
- Is brief. Your paraphrase should be shorter than what the person just said;
- Is clear and concise. Your paraphrase should help clarify things, not confuse them; and
- Is tentative. We want the client to feel comfortable with disagreeing with or correcting the paraphrase.

Clarifying
Clarifying is a way of getting more information from the client by asking them to make clearer what they have just said. As noted above, the simple act of paraphrasing what the client has said may bring clarity because in their response to the paraphrase they will automatically expand on their words and ideas.

Sometimes, however, you are not sure what they mean by something and it is necessary to ask a question and probe. Probing is a real art and is an advanced skill which gets better with practice. Clarifying is a form of gentle probing because it does not introduce anything into the counselling which is not already there – that is, it starts from what the client has already said.

Exploring Through Questioning
In any communication with a client in which the ultimate aim is to understand the client, convey information, and promote emotional wellness, the counsellor will have to go beyond reflecting what has been heard to explore what is not clear and to deepen understanding on both sides. The counsellor should use exploring skills after the initial phases of the encounter have been completed (meeting, contracting, and hearing the initial concerns, facts and feelings).

Summarising
Summaries are essentially a series of paraphrases of issues from a client. A summary provides order and focus and sorts out relevant material to explore in an encounter. Good summaries act as natural ‘stopping and reflecting’ points in a conversation and can also be used to start sessions and bring them to a close. To effectively summarise, the counsellor has to really listen and attend to what the client is saying and how they are saying it.

For more details on these skills, refer to Annexure 11 on ‘Helping Client Explore their Story’.
Activity 8: Counselling Skills: Helping Client Explore Options

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
</tr>
</thead>
</table>
| Learning Outcomes | By the end of this activity, the participants will be able to:  
  • Explore options and understand self-help strategies. |
| Materials       | N/A    |
| Audio-visual Support | N/A |
| Take-home Material | Annexure 12: ‘Helping the Client Explore Option and Self-help Strategies for Successful Coping’. |

Methodology

Part I: Why explore options?
Remind participants that the goal of counselling is to empower the client, and point out that, in the problem treatment cycle, the client moves from exploring their problems towards finding solutions.

Point out that in exploring solutions, the client needs to discover their own inner resources and coping skills. Introduce the concept of examining one’s own strengths and weaknesses by conducting an interactive discussion using Ramesh’s life as a case to explore his possible strengths and weaknesses, and their implications in moving towards a solution.

Ask participants what kind of external support could be used by the client to bolster his/her quest for empowerment. While clients need to look at their inner resources, a part of the exploratory process is also looking at the allies (drawn from family, friends and community) and the emotional and practical sustenance that the client can draw from them. However, stress that external support should not become a prop for the clients; otherwise, they neglect developing their inner resources, and depend only on external support.

Discuss the following options which counsellors can encourage clients to explore:
  • Self-help treatments and coping strategies (Refer to Annexure 12 on Helping the Client Explore Option and Self-help Strategies for Successful Coping);
  • Professional counselling, psychiatric and general health practitioners;
  • Other service providers. (Remind the participants that they will be discussing referrals in the D4 module on Friendly Services); and
  • Drawing support from family, friends, and community.

Skill-builder 1: Encourage Self-help Treatments
Refer to the earlier sessions on Mental Health Disorders, and ask participants which disorders could respond to self-help. Explore their answers through role-plays.

Discuss the kind of self-help treatments and self-care methods that can be recommended for common mental disorders. If you have the time, lead the participants through a guided relaxation exercise. Tell them that it is a practical tool they can use in counselling clients, and that clients can also practice relaxation exercises when alone.
Skill-builder 2: Giving Reassurance and Information
Discuss with examples the difference between giving reassurance and giving false hope. Ask participants why giving false hope or false reassurances are detrimental to the helping process, and facilitate role-plays in which realistic reassurance is demonstrated.
Discuss the importance of giving correct information and facilitate role-plays which demonstrate how a counsellor/helper should respond if s/he does not have correct or complete information.

Skill-builder 3: Giving Information about Psychiatric Treatment
Although prescribing drugs and other forms of treatment are strictly beyond the scope of the helper, participants need to be aware of there are different types of drugs that are used to treat mental health disorders. Elaborate that only a certified psychiatric can prescribe it, while taking care of issues of drug compliance, side-effects etc.
Describe the importance of consulting a professional psychiatrist before taking any medication, and facilitate role-plays in which helpers deal with clients’ reservations about taking drugs.

Skill-builder 4: Encourage the Person to Get Appropriate Professional Help
Tell participants that as responsible helpers they need to know the limitations of their helping skills and that referring clients to the appropriate referral services is a part of their skill-set. Discuss the various services that persons with mental health problems may need, and facilitate some role-plays in which the helper directs Ramesh to an appropriate service provider.
Discuss or demonstrate how a person reluctant to see another service provider, say, a psychiatrist, can be encouraged to do so (through reassurance and information giving).
Activity 9: Counselling Skills: Helping Clients Make a Plan, Reviewing, and Terminating

<table>
<thead>
<tr>
<th>Time</th>
<th>1 hour</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Be able to demonstrate the skills of problem-solving and planning and understand the process of assessing and reviewing change.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Annexure 13: ‘Helping Clients Make a Plan’.</td>
</tr>
</tbody>
</table>

Methodology

Part I: Problem-solving and Planning
Ask participants how Ramesh, or any other client, should choose amongst a number of available options. Discuss the role of information in problem-solving – what kind of information would Ramesh need in order to decide on a particular course of action?

Using Ramesh’s case, conduct an interactive discussion on the pros and cons for him to select a particular course of action – for instance, moving to the city.

Discuss the role of the counsellor in providing information to the client, and conduct an interactive discussion on the kind of information-giving that would be appropriate within the ambit of Pehchan programme. The counsellor should have information on the following:

• HIV/AIDS and sexually transmitted infections (STIs)
• Identity, gender and sexuality
• Referral services available
• Legal and human rights
• How to report human rights violations
• Community support services.

Part II: Understanding, Assessing and Reviewing Change
Ask participants about what they think will change for a client as she/he moves towards empowerment/healing/resolution.

• Is it the external circumstances that change?
• Or does the client change? If the latter, then what changes in the client?

Remind participants of the exercise where they categorised happenings in Ramesh’s life into thoughts, feelings and behaviour, and point out that through counselling, it is possible for the client to bring about changes in his own thoughts, feelings and behaviour to be able to cope better with external circumstances.
Drawing the following stick-figures in a sequence on a flip-chart, discuss the slow and difficult process of behaviour change.

Ask participants how a counsellor can support a client in putting a choice into action and evaluate the results.

Discuss the cyclical nature of counselling, in which both the client and counsellor assess progress towards the client’s goals, and continually re-explore experiences, options and solutions, and take steps towards the client’s goals.

**Background Information**

(Kustner, 2011)

**Problem-solving: The ‘Traffic Light Model: Stop, Think, Do’**

The traffic-light problem-solving model is a useful way to approach problematic situations. Sometimes people rush into ‘solving’ problems without thinking of the pros and cons of their actions. This model encourages people to stop, think and then act, thereby they make informed and well thought-out decisions in solving their problems.

**Process of Change**
STOP

Define the Problem
This is the most important step in the problem-solving model, and often requires the most time in counselling. This step involves gathering information and clarifying. It also involves breaking what seems to be a huge problem into its various parts or sub-problems (sometimes called partialising).

THINK

Explore All Options
This step involves exploring all possible options to solve the problem (or, to start with, just one part of the problem, perhaps something that is reasonably achievable). Encourage the client to brainstorm as many solutions as they can to their problem, even if they seem silly. Continue until all ideas are exhausted. It is important that you as a counsellor do not have a preconceived idea on what the solution should be.

Look at alternatives and consider the consequences of each idea generated from the above brainstorm. Ask clients to look at the pros and cons of each solution. Usually the best solution is the one with the more advantages than disadvantages.

DO

Select an Option, Make a Plan, and Take Action
Encourage the client to select the most effective option, based on whether or not it is practical, appropriate, and realistic. Be patient and gently support the client to make their choice.

Develop a Plan
Ask the client to think about how they can put their choice into action. Ask questions such as who, what, when, and how to make the plan as specific, achievable, and realistic as possible so that it can be implemented within a time-frame. It is sometimes helpful if the client writes their plan down.

Take Action
Acknowledge that this step is usually the most difficult for people. To help build the client’s confidence, it can be helpful to start with an action where the client has a relatively good chance of succeeding. Using role-play to ‘practise’ what the client will do and say and to anticipate possible reactions can also be helpful. Reassure the client that you will explore the outcome in the next session.

Evaluate
This is an important opportunity to see what worked, what did not work and why. Reassure clients that if they do not succeed, to try and try again till they succeed!
Activity 10: Dealing with the Risk of Harm to Self or Others

<table>
<thead>
<tr>
<th>Time</th>
<th>30 minutes</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will learn how to deal with:</td>
</tr>
<tr>
<td></td>
<td>• The possibility of harm to self or others; and</td>
</tr>
<tr>
<td></td>
<td>• The issue of confidentiality in such cases.</td>
</tr>
<tr>
<td>Materials</td>
<td>N/A</td>
</tr>
<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>Annexure 14 on ‘Dealing with Suicide and Self-harm’.</td>
</tr>
</tbody>
</table>

Methodology

Read out the following case scenario:

‘I went back to the city, wracked with guilt and shame. I started neglecting my work, stopped interacting with my so-called friends, and started drinking heavily. I used to cry myself to sleep every night. It was entirely my fault – I am nothing short of a murderer, I thought – and one day, I realised that I had no right to live. So I decided I would throw myself off a moving train. That would end everything. No one needed to know who I was and where to send my body, for I no longer have any home or any family’.

Ask the participants to imagine that at this stage, on the train, a peer educator from their CBO bumps into him. What do you think the peer educator can do? Was there any other stage in his entire life that someone could have approached him with help? Brainstorm whether a timely intervention earlier in Ramesh’s life could have helped Ramesh lead a healthier and a more satisfying life.

Ask whether a counsellor or any helper should directly refer to suicide, such as asking ‘Do you sometimes feel that life is not worth living?’ Conclude the discussion by elaborating that counsellor needs to be sensitive towards the client while addressing the issues of suicide. Ask them to refer to the following steps while addressing self-harm and suicidal thoughts:

- Risk-assessment involving intent and planning (where, how, when) and history of previous attempt.
- Making a contract.
- Exploration of confidentiality – exclusion.
- Ensuring security – suicide watch, hospitalisation.
- Attending to any emergency.
- Working at close intervals with client to ensure that client moves away from suicidal ideation towards hope.

When the client fears violence2 from someone, ask the client to:

- Avoid negotiating with the abuser.
- Make security arrangements.
- Be assured that it is not the client’s fault.
- Have courage to take charge of his/her life and not feel like a victim.

Note to Facilitator

If you believe the person is at risk of harming him/herself, then:

- Don’t leave the person alone;
- Seek immediate help from someone who knows about mental disorders;
- Try to remove the person from access to the means of taking their own life; and
- Try to stop the person from using alcohol or drugs.

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2 Violence is discussed in detail in Module D4: Trauma & Violence
If the client is threatening/behaving violently to others:

- Warn about breaking confidentiality.
- Assess risk, and if necessary, warn the potential victim (if possible); if necessary, escalate the warning and report to police or other restraining authorities.

**Basic Elements in Helping**

(University of Melbourne, 2009)

**Assess the Risk of Suicide or Harm to Self or Others**

People with mental disorders sometimes feel so overwhelmed and helpless about their lives, as they perceive their future to be hopeless. Engage the person in conversation about how they are feeling and let them describe why they are feeling this way. Ask the person if they are having thoughts of suicide. If they are, find out if they have a plan for suicide. This is not a bad question to ask someone who is mentally unwell. It is important to find out if he/she is having these thoughts in order to refer him/her for help.

**Encourage the Person to Get Appropriate Professional Help**

You can encourage the person to consult with a doctor who knows about mental disorders, and who is able to prescribe medication, if necessary. Then you can follow up by giving ongoing support to the person and their family. If the person is very unwell, i.e. you think they are suicidal or psychotic, and he/she is refusing to take any help from a doctor, encourage the family to consult with the doctor so that they can explain the situation and get professional support.

For more details, refer to Annexure 14 on ‘Dealing with Suicide and Self-harm’
Activity 11: Wrap-up

<table>
<thead>
<tr>
<th>Time</th>
<th>30 minutes</th>
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</thead>
<tbody>
<tr>
<td>Learning Outcomes</td>
<td>By the end of this activity, the participants will:</td>
</tr>
<tr>
<td></td>
<td>• Review the module’s learnings.</td>
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<tr>
<td>Materials</td>
<td>N/A</td>
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<tr>
<td>Audio-visual Support</td>
<td>N/A</td>
</tr>
<tr>
<td>Take-home Material</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Methodology

Ask the participants to:

• Review the definition of mental health and summarise how the counselling process helps in mental health;
• Explain why counselling is different from other forms of helping;
• Outline the aims of counselling and the role of Pehchan personnel in the mental health of the MTH community;
• Warn against diagnosing mental disorders and labelling people as mentally ill, or mentally disturbed, as doing so is beyond their purview; and
• Describe the scope of Pehchan front-line workers and their scope.

Remind the participants that learning counselling is a lengthy process – however, to aid them in their daily work, the annexures provided in previous sessions should be read thoroughly and kept handy at all times by all members of the CBO.
Annexure 1: Ramesh’s Story

Section I

Hi, I am Ramesh – and this is my story.

I was born in a village. I lived with my parents and my elder brother. Everyone thought I was a blessing from God, for I was born over 10 years after my brother.

I was a child when I first saw anyone having sex. It was my elder brother and the neighbour’s daughter. He was 16 and I was five. At first I thought he was beating her – she kept on moaning and crying out loudly. My brother, luckily, never caught me looking. It took me about six more years to start understanding what was going on.

Yet, while I started understanding what was going on, I did not understand what my brother found attractive in that girl – or any girl for that matter.

In a year’s time, the movie ‘Qayamat se Qayamat tak’ came to our village cinema. I adored Amir Khan. He was so good looking! At the time, I did not realise what I was feeling – till one morning I woke up to a wet stain in my shorts after a night filled with songs from the film and Amir Khan – and the stain was definitely not urine.

I rushed to my mother to tell her, thinking I had got some kind of disease. All she told me was that I must have had ‘dirty thoughts’ in my head for something like this to happen, and that if it kept on happening then she would tell my father. I was afraid of my father. I decided that I would only concentrate on my studies, and keep thoughts of Amir Khan out of my head. From that day on till the time I finished school, I never came second in class. I avoided my friends in case they realised that I must have had ‘dirty thoughts’. I could not tell them that Amir Khan was really cute, could I?

Yet, as hard I would try, I kept on getting wet dreams. I never touched myself down there, thinking that it was a perversion – after all, my mother had told me to keep dirty thoughts at bay. Touching yourself is dirty, isn’t it?

The year I was about to finish school, I met Raj. He and I became best friends – we even taught each other. I taught him maths, and he taught me history. However, that did not last long – for one day, over a history lesson, his hand touched me, and then started our love-making. We were no longer friends, we were lovers. Yet, every time we would make love, when I went home, I would cry in shame and disgust at myself for feeling such feelings for another boy – my mother could not be wrong!

We finished school, and Raj and I had to part ways, for he got admitted to a different college in a different state. We promised to remain in touch, but seldom did. The last I heard, he got married and even had two children.

I moved on, got admitted into college with a full scholarship, thanks to my academic track record. I started reading more and learning more about sex, sexuality and gender – and I realised I was not heterosexual – beyond that I could not articulate at that point. As I realised, my mother was wrong – about the ‘dirty thoughts’, about my wet dreams, about everything! I burned with anger at having let myself be misled by her – of having had years of guilt about touching myself sexually, about touching Raj sexually. Yet I realised that at that point I could have done nothing. I started channelising my anger at the college gym – I ran for miles at times just to get her words out of my head. Once or twice, I even got drunk, but my body revolted so badly, I decided never to do it again.
In my class, there was a boy, Aziz. His skin was like snow, his lips were cherry red, and he used to spend hours staring at me. I felt a familiar stir inside me, and decided to befriend him. We became really good friends over a short period of time. We used to go to the college gym together, sometimes even go running together. He seemed to get the fact that I was trying to get my mother's words out of my head – even though I had not told him anything. Aziz went out of his way to introduce me to all his friends and family members as his best friend, without whom he felt incomplete.

One day, while at his place to exchange notes, Aziz playfully came and sat on my lap and said that that was the way my girlfriend must be sitting on my lap. Then suddenly, our eyes locked, and we let our emotions take over. From then on, there was no looking back – my mother's words were driven out from my mind and for the first time I felt love for myself.

For many months, Aziz and I kept on catching up with each other in the afternoons before I went off home. No one used to be there at his place – his elder brother was in college, his father at work, and his mother no more.

Yet one day, his brother came back early, and unknown to us, was watching us undress each other. He suddenly burst in with a cricket bat, and started beating me mercilessly. I must have passed out, for the next thing I remember I was in a hospital with my anxious parents staring at me.

Aziz's brother had told my father about the situation he had found the both of us in. My father decided that enough was enough, a good girl would settle everything. And thus, I was married to a shy young girl from a village.

In the beginning everything was fine – the festivities kept everyone occupied. I was very happy with all the attention that I was getting, but this happiness was short-lived. Everytime I would try to have sex with my wife, Aziz's face would float into my mind. There were times when I would suddenly stop everything, and rush out of the room, to my wife's utmost amazement.

I decided that I would move to the city in search of a job and stay away from my wife as much as possible.

My parents were very happy that at least one of their sons was going to live in the city. Little did they realise why.

I reached the city, and put up with my relatives there. In about a week's time, I got a job as a newspaper sales agent. I would have to go from door-to-door selling newspaper subscriptions.

One day, on such a round, I met Piyal. When Piyal opened the door the first time, he was standing there in his underwear. He invited me in, and excused himself and went to put on some clothes. He came back and sat next to me while I explained the details of the subscription.

Piyal readily agreed to buy one, and asked for my phone number for further details. I was very flattered – till then no one in the big city had asked for my number.

In a couple of days, Piyal called me and asked me to go over to his place because he wanted to talk about further subscriptions. I went over in a great hurry, and saw him seated there with a couple of others.

He asked me to sit down, and we started chatting. He offered everyone drinks – but I refused. I started getting a little impatient – what about my subscriptions? His friends immediately took out the money and told me to sign them on – but they had a condition: I would have to get intimate with them.
I knew it from the moment I saw Piyal for the first time – yet why didn’t I stop myself? I went ahead and started making out with everyone. I don’t remember whether there were any condoms or not, but I experienced anal sex for the first time there.

Over a period of time, my visits to Piyal’s place started growing. Everytime I would go there, we would have sex – either with him, or with his friends. My world was growing at a fast pace. I seldom thought about my wife sitting at home – I was finally being able to live my life the way I wanted to – I was doing well at work, thanks to Piyal and his friends helping me out, and they became my support group – even though all we did was meet up for sex.

However, one day, I went down with a very high fever. When I went to the doctor, I was told that I had syphilis. I had ignored the slight sore patch near my penis – and apparently that had been the first sign of it. I started having sleepless nights, thinking of everything else that might have happened to me. These bouts of insomnia kept on even after I recovered. I could barely concentrate at work and I felt afraid to have sex again.

I went and met Piyal and told him about it – he said that these things happen, and it is no big deal. I felt reassured. That evening was a celebration at his place for my recovery, and I met all my other friends at the party – and once again, I was back to my normal way of things.

Section II

One day, after a lot of cajoling by my mother, I had to go visit my parents. When back in the village, I saw that my wife was under tremendous pressure to have a child. I did what I considered to be my duty, much to my chagrin.

After I went back to the city, in a month I got the news that my wife was pregnant. I felt relieved. At least now I would not be required to have sex with her. I felt sorry for her at times – after all she had nothing to do with this situation.

Over the next few months, her visits to the doctors became very frequent. I thought that there would be nothing to worry about – after all a child born in the village is far healthier than one born in the city!

One day she called me up and told me that her delivery date was in a week’s time, and that she wanted me to be there. I took leave and went off to my village. The child was delivered. It was a boy, but a very ill boy. My wife was also extremely unwell. The doctors did multiple tests, and then asked me to give blood for a test too.

In a few hours, I was told that we were both HIV positive and that they would start the necessary treatment on the child.

My entire world came crashing down. I knew why it had happened – why hadn’t I listened to myself?

That evening I went to a local bar, and drank till I fell down unconscious. Later when I came around, I saw myself lying outside my parents’ home’s door. Someone must have dragged me there and left me there.

I entered, and saw that everyone was looking at me in a very cold way. I thought, the doctor must have told them. But I ignored them and rushed off inside to wash my face and lie down. I felt helpless and I did not know what to do. Then in the morning I realised why they were so silent the previous night – the child had died, and so had my wife.
Suddenly everything in my world changed. After I completed the funeral rites, my father called me to his room, and told me that I must leave the village forever, for he knew and nearly the entire village knew that my wife had died of HIV complications. I felt lost and trapped. I had a job in the city, yes, but I had no one there! Just the few friends with whom I would meet up to have sex! I had no family!

I knew that none of my relatives would speak with me if my father told them not to – and that is exactly what happened.

Wracked with guilt and shame, I went back to the city. I started neglecting my work, stopped interacting with my so-called friends and started drinking heavily. I used to cry myself to sleep every night. It was all my fault – I am nothing short of a murderer, I thought – and one day, I realised that I had no right to live. So I decided – I would throw myself off a moving train on the way back from work. That would end everything. No one would know who I am, where to send my body, for I no longer had any home or any family.
Annexure 2: Definitions of Health and Mental Health

Source: World Health Organization

The World Health Organization (WHO) defined health in its broader sense in 1946 as, ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’.

The World Health Organization defines mental health as ‘a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community’.

The Determinants of Health

Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of healthcare services often have less of an impact.

The determinants of health include:

- Social and economic environment;
- Physical environment; and
- Person’s individual characteristics and behaviour.

The context of people’s lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants – or things that make people healthy or not – include the above factors, and many others:

- Income and social status. Higher income and social status are linked to better health. The greater the gap between the rich and poor, the greater the differences in health.
- Education. Low education levels are linked with poor health, more stress and lower self-confidence.
- Physical environment. Safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health.
- Employment and working conditions. People in employment are healthier, particularly those who have more control over their working conditions.
- Social support networks. Greater support from families, friends and communities is linked to better health.
- Culture. Customs and traditions, and the beliefs of the family and community all affect health.
- Genetics. Inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses.
- Personal behaviour and coping skills. Balanced eating, keeping active, how we deal with life’s stresses and challenges all affect health. Coping skills also include smoking and drinking which may help one cope, but have a negative effect on
mental and physical health in the long run.

- Health services. Access and use of services that prevent and treat disease influences health.
- Gender. Due to gender differences individuals suffer from different types of diseases at different ages.
Annexure 3: Mental Disorders

1. Symptoms of Mental Disorders

<table>
<thead>
<tr>
<th>Physical</th>
<th>Feeling</th>
<th>Thinking</th>
<th>Behaviour</th>
<th>Imagining</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiredness</td>
<td>Sadness</td>
<td>Excessive worry</td>
<td>Crying</td>
<td>False beliefs</td>
</tr>
<tr>
<td>Aches &amp; pains</td>
<td>Anxiety</td>
<td>Self blame and criticism</td>
<td>Social withdrawal</td>
<td>Hearing voices</td>
</tr>
<tr>
<td>Weight loss</td>
<td>Guilt</td>
<td>Unable to make decisions</td>
<td>Talking to him/herself</td>
<td>Seeing things not there</td>
</tr>
<tr>
<td>Pounding heart</td>
<td>Helplessness</td>
<td>Poor concentration</td>
<td>Aggression</td>
<td>Smelling things not there</td>
</tr>
<tr>
<td>Sleep disturbance</td>
<td>Loss of emotion</td>
<td>Thoughts of death and suicide</td>
<td>Poor personal hygiene</td>
<td>Tasting things not there</td>
</tr>
<tr>
<td>Stomach ache</td>
<td>Mood swings</td>
<td>Rapid thinking</td>
<td>Avoidance behaviour</td>
<td>Feeling things not there</td>
</tr>
<tr>
<td>Feeling short of breath</td>
<td>Hoplessness</td>
<td>Poor judgement</td>
<td>Rapid speaking</td>
<td></td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Low self-esteem</td>
<td>Not making sense to others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Excessive fear</td>
<td></td>
<td>Attempting suicide</td>
<td></td>
</tr>
<tr>
<td>Lack of energy</td>
<td>Loss of motivation</td>
<td></td>
<td>Irritability</td>
<td></td>
</tr>
</tbody>
</table>

2. What You Can Do For a Person Who Needs Help

Source: University of Melbourne, 2009

2.1 Assess the Risk of Suicide or Harm to Self or Others

People with mental disorders sometimes feel so helpless about their life that future seems hopeless to them. Engage the person in conversation about how they are feeling and let them describe why they are feeling this way.

Ask the person if they are having thoughts of self-harm or suicide. If they are, find out if they have a plan for suicide. This is not a bad question to ask someone who is mentally unwell. It is important to find out if she/he is having these thoughts in order to refer her/him for help.

2.2 Listen without Judgment

Listen to what the person describes without being critical or thinking they are weak. Don’t give advice such as ‘just cheer up’ or ‘pull yourself together’. Avoid getting into an argument with the person.
2.3 Give Reassurance and Information
Provide hope to the person. Tell the person that she/he has an illness that can be treated, and it doesn’t mean that she/he is a bad person. Let she/he know that you want to help.

2.4 Encourage the Person to get Appropriate Professional Help
You can encourage the person to consult a doctor who knows about mental disorders, and who is able to prescribe medication if necessary. Then you can follow-up by giving ongoing support to the person and her/his family. If the person is very unwell, i.e. you think they are suicidal or psychotic, and she/he is refusing to get any help from a doctor, encourage the family to consult the doctor so that they can explain the situation and get professional support.

2.5 Encourage Self-help Treatments
Suggest actions that the person can perform herself/himself to help relieve the symptoms of mental disorder such as:
• Getting enough sleep;
• Eating a healthy diet;
• Regular exercise;
• Relaxation and breathing exercises, e.g. yoga;
• Avoiding alcohol; and
• Joining support groups for women, men or youth.

3. How You Can Respond to a Person With Unexplained Physical Complaints

3.1 Assess the Risk of Harm to Self or Others
Make sure that the person is not suffering from any physical illness. If you have doubts that the symptoms may be caused by a physical illness, refer the person to a doctor.

3.2 Listen without Judgment
Spend some time talking with the person to find out the type of complaints she/he has. It is helpful to use general questions – such as, ‘have you been worried about anything lately?’ – to find out if the person is having problems that may be contributing to physical illness.

3.3 Give Reassurance and Information
Stress and worry often contribute to unexplained physical illness. If the person is able to reduce these two, it will help improve the physical condition.

3.4 Encourage the Person to Get Appropriate Help
Explain that emotional stress often leads to physical illness, which in turn can make condition worse. Treatment is needed to help the underlying problem and not just the symptoms, for example stress caused by money problems may contribute to headaches and body aches, and finding a solution to the money problems will help treat the same. Vitamins and pain killers will not help unless there is evidence of malnutrition or a painful physical illness.
3.5 Encourage Self-help Treatments
Relaxation exercises such as slow breathing may help the person manage stress and worry. Encourage the person to involve herself/himself in interesting and pleasurable activities or to join support groups. Follow up with the person regularly and refer to the local doctor if further treatment for mental or physical disorders is required.

4. How You Can Respond to a Person Experiencing Excess Worry and Panic

4.1 Assess the Risk of Harm to Self or Others
If you are unsure if the person is having a panic attack or a life-threatening condition such as a heart attack or asthma attack call for a doctor immediately. If possible move the person to a quiet, safe place. Stay with the person until she/he has recovered.

4.2 Listen without Judgment
Stay calm yourself and help the person relax by encouraging slow breathing to match your own breathing (Elaborate that they need to breathe in for three seconds through your nose and pause for three seconds before breathing out for three seconds then repeat).

4.3 Give Reassurance and Information
Explain that the attack will soon stop and she/he will feel better. Reassure the person that their symptoms are not a sign of serious physical illness. Explain that worry and fear are triggering the symptoms.

4.4 Encourage Self-help Treatments
Explain that if the person can stop worrying, it will help break the cycle of worry which then leads to panic which is a precursor for further worry. Teach a relaxation technique that can be used at times of stress (see below).

Relaxation techniques are helpful for controlling stress and worry. Many people with stress often breathe shallowly. The following technique introduces a better way of breathing that can be used when feeling anxious, and can help the person to feel calmer.

Find a comfortable position either lying flat on your back or sitting comfortably in a chair.

- Place your hands on your stomach.
- Breathe as you normally would and notice whether your hands on your stomach rise or your chest rises as you breathe.
- To breathe properly your stomach should rise (as this expands your diaphragm).
- Begin by slowly breathing in through your nose for five counts. Watch your hands to help you see if your stomach is rising when you breathe in.
- Gently hold your breath and count till five. When learning you may only be able to count to three but after practice you can increase to five.
- Slowly breathe out through your mouth for a count of five while gently pushing down on your stomach.
- Repeat this process for three to five minutes.
5. How You Can Respond to a Person Feeling Unusually Sad or Thinking About Suicide

5.1 Assess the Risk of Suicide and Harm to Self or Others
Ask the person if she/he has thoughts of ending her/his life. If the person is thinking so, it is important to seek professional help as soon as possible.

5.2 Listen without Judgment
Treat the person with respect and dignity. Don’t be critical of the person or belittle her/his feelings. Do not interrupt if the person is speaking more slowly and less clearly than usual. Remain patient even if the person is more repetitive than usual. Encourage the person to talk to you since ‘a problem shared is a problem halved’. Talking about feelings usually makes things better. Let the person know you are concerned about her/him and would like to help. It is more important to be ‘genuinely caring’ than to say all the ‘right things’. Supporting a person who is feeling unusually sad and hopeless requires patience, persistence and encouragement, and takes genuine kindness and attention. Offer some practical assistance with tasks that may seem overwhelming for the person such as fetching water or cleaning the house. Give reassurance and information that:

- They are not alone in facing their problems;
- They are not to blame for feeling sad and hopeless;
- They are not weak or a failure because have these feelings; and
- With time and treatment they will feel better.

If a person has thoughts of suicide you can help them identify reasons to continue living, such as being with friends and family.

5.3 Encourage the Person to Get Appropriate Help
If the person is very depressed she/he should be seen by a doctor who understands about mental disorders and will be able to diagnose the problem and offer treatment and care. If the person has been feeling sad and hopeless for weeks and it is affecting their functioning in daily life, the doctor may prescribe anti-depressant medication. A doctor may decide to refer the person to a specialist for further counselling.

5.4 Encourage Self-help Treatments
- Help the person to think positively about their situation.
- Help the person to identify their negative thoughts and how they make them feel. For example: ‘I will always feel miserable, nothing will change in my life’.
- Suggest some positive ways of looking at the same situation. For example: ‘These feelings are temporary, I feel this way because I am not well, talking to the health worker, taking my medicine and trying to solve my problems will make me feel better’. Encourage the person to frequently challenge negative thoughts in this way.
- Involve the family.
  - If there is conflict or violence in the family you may need to think of alternative support networks such as women’s groups, friends or a religious leader.
  - Families often need help to understand the person’s problems and manage their own stress related to the situation.
  - Families also need help to understand the importance of not being too critical or over protective of the depressed person.
If a person is thinking of committing suicide:

- Remove access to all dangerous items such as knives and poison;
- Ensure the person is not left alone—enlist help from family and friends to keep the person company if necessary;
- Seek professional help as soon as possible;
- If the person is consuming alcohol, try to stop him/her from consuming anymore;
- Listen non-judgmentally, do not give advice or contradict the person;
- Let the person know that you and others care about him/her;
- Let the person know that even though the situation seems hopeless at present, things are likely to improve—feeling bad is only temporary; and
- If the person has already harmed him/herself e.g. swallowed poison, emergency medical treatment is required.

6. How You Can Respond to a Person Who is Tired all the Time

6.1 Assess the Risk of Harm to Self or Others
Make sure the person is not suffering from any physical illness by referring them to see a doctor.

6.2 Listen without Judgment
Recognise that chronic tiredness is a symptom of a problem rather than laziness. It is important to identify the possible reasons why a person feels tired. Once the problem is identified it will be possible to work out a solution to help overcome feelings of being tired.

6.3 Give Reassurance and Information
If having poor sleep is the problem, refer to the handout on ‘How you can respond to a person with a sleeping problem’.
Encourage the person to gradually increase activity levels.
Regular contact with friends and relatives can help. There is no specific medication that by itself will cure tiredness; taking tonics or vitamins is not helpful for people who do not have anaemia or malnutrition.

6.4 Encourage the Person to get Appropriate Help
Refer the person to a doctor if you suspect tiredness is due to a physical illness. Refer the person to a doctor if she/he might be depressed.

6.5 Encourage Self-help Treatments
Lifestyle changes can help a person to regain and maintain mental balance without having to resort to medications or a therapy.
7. How You Can Respond to a Person Who is Hearing Voices, Suspicious of Others or Expressing Unusual Beliefs

7.1 Assess the Risk of Suicide and Harm to Self or Others
- Try to determine if there is any risk of self-harm or any threat of harm to others.
- A person who is hearing voices may be frightened and suspicious and needs to be approached in a very unthreatening way.
- If the person is suicidal, respond as outlined in the handout on ‘How you can respond to a person who is feeling unusually sad or thinking about suicide’.
- If the person threatens violence to others try to restore calm and safety – this is covered in the hand-out on ‘How you can respond to a person who is threatening violence’.

7.2 Listen without Judgment
- Speak calmly, clearly and in short sentences.
- Introduce yourself and let her/him know that you want to help.
- Don’t be critical of the person.
- Avoid confrontation and arguments.
- Don’t tell her/him that there are no voices or that her/his beliefs are wrong.
- Don’t pretend that you can hear the voices or agree with false beliefs.
- Give reassurance and information.
- Try to talk to the person when she/he is calm and thinking clearly.
- Be honest and try to win the person’s trust.
- Do not make promises you cannot keep and do not lie to the person.
- Explain to the person and her/his family that hearing voices is a symptom of a mental disorder (or a problem in the brain) and treatment is available.

7.3 Encourage the Person to Get Appropriate Help
Encourage the person to see a doctor to be assessed for antipsychotic medication, which is usually the best treatment for this disorder.

7.4 Encourage Self-help Treatments
- Visit the person regularly once she/he has started to recover.
- Assist the person to reintegrate into the social life of the community and into employment or other family duties.

8. How You Can Respond to a Person Who is Engaging in Harmful Use of Alcohol

8.1 Assess the Risk of Suicide or Harm to Self or Others
Urgent medical help may be required if the person is suffering from:
- Intoxication or overdose of alcohol;
- Severe withdrawal reaction; and
- Serious infection or injuries from alcohol use.
8.2 Listen without Judgment
Do not be critical of the person, as stopping alcohol use is not easy for those who are dependent.

8.3 Give Reassurance and Information
- Harmful use of alcohol is a common problem.
- Often other problems such as depression or anxiety underlie an alcohol problem and there are effective treatments for the underlying problems.
- There are three stages to overcoming an alcohol problem.
  - Admitting there is a problem.
  - Stopping or reducing the harmful use of alcohol.
  - Remaining sober.
- Provide the person with information of the harm caused by using too much alcohol.

8.4 Encourage Self-help Treatments
- Refer the person to a community support-group that helps people who drink too much alcohol, e.g. Alcoholics Anonymous, or facilitate the formation of similar support groups.
- Advise:
  - Have two or three days a week free from alcohol; and
  - Eat before you have your first drink.

9. How You Can Respond to a Person Who is Threatening Violence

9.1 The best way to help is by starting to restore calm and safety.
- Do not get involved physically to stop violence.
- Never put yourself at risk; if you are frightened, seek outside assistance immediately.
- Remove any weapons, or items which could be used as weapons, from the immediate environment.
- Stay calm and keep the atmosphere as non-threatening as possible; talk quietly, firmly and simply, avoid making any abrupt movements.
- Do not raise your voice or talk too quickly.
- Do not threaten the person, as this will increase their fear and may trigger an aggressive reaction.
- Give the person enough space so that they don’t feel trapped.
- Try to get the person to sit down; it is best if you are both seated side by side rather than facing each other.
- Do not ask a lot of questions as these can cause the person to become defensive, agitated or angry.
- If the person’s behaviour appears to be getting out of control, you must remove yourself from the situation and immediately call for other people to help.
10. How You Can Respond to a Person Who is a Victim of Domestic Violence

10.1 Assess the Risk of Suicide or Harm to Self or Others
Urgent psychological or psychiatric help may be required if the person is suffering from trauma due to domestic violence.

10.2 Listen without Judgment and Do Not be Critical of the Person
Fighting against domestic violence is often not easy given Indian social circumstances and considering the fact that most victims of domestic violence are marginalised people – women, children, people belonging to sexual minorities.

10.3 Give Reassurance and Information
Also, encourage the person to get appropriate help from the police, local clubs and lawyers if necessary.

10.4 Encourage Self-help Treatments
Refer the person to a community support-group or legal-aid societies where he/she can get advice on how to deal with different types of domestic violence from a legal standpoint.

11. How You Can Respond to a Person Who is in a Crisis Situation
1. Assess the situation and the risk.
2. Involve the family and friends of the client in managing the crisis if the family of the client is approachable.
3. Support the client on three levels.
   • The primary level – where the support shall be given by the peer educators, associated field workers and other officers of your community-based organisation (CBO) closest to the client.
   • The secondary level – where all other officers of your CBO shall step in as and when required.
   • The referral level – where friendly services associated with your CBO shall be mobilised to deal with the crisis as and when necessary – local police station, local politicians, local clubs, lawyers, doctors, etc.
4. Follow up with the client to see whether the crisis has been managed effectively or not.
5. If the crisis still continues, continue giving support and look for alternative solutions depending on the situation – remember the client needs to be kept out of harm’s way.
12. How You Can Respond to a Person Who is Experiencing Stress

12.1 Assess the Risk of Harm to Self or Others
Make sure that the person is not suffering from any physical illness, if you have any concern that the symptoms may be caused by a physical illness, refer the person to a doctor.

12.2 Listen without Judgment
Spend some time talking with the person to find out the type of complaints. It is helpful to use general questions such as ‘have you been worried about anything lately?’, to find out if the person is having problems that may be contributing to their symptoms, which might be varying in nature – from sleeplessness to acute body aches.

12.3 Give Reassurance and Information
Stress and worry often contribute to unexplained physical symptoms and if the person is able to reduce stress and worry this will help improve the physical symptoms.

12.4 Encourage the Person to Get Appropriate Help
Explain that emotional stress often leads to physical symptoms, which in turn can make emotional stress worse. Treatment is needed to help the underlying problem and not just the symptoms, for example stress caused by money problems may contribute to headaches and body aches, finding a solution to the money problems will help treat the headaches and body aches. Vitamins and pain killers will not help unless there is evidence of malnutrition or a painful physical illness.

12.5 Encourage Self-help Treatments
Relaxation exercises such as slow breathing may help the person manage stress and worry. Encourage the person to become involved in interesting and pleasurable activities or to join support groups. It has been seen that building a hobby often channelises stress and turns it into creative energy.

Review the person regularly and refer to the local doctor if further treatment for mental or physical disorders is required.
Annexure 4: Difference Between Poor Mental Health and Mental Disorders

Source: Mental Health Ireland, 2010

Poor mental health (or mental ill health) refers to the kind of general mental health problems we can all experience in certain stressful circumstances; for example, work pressures can cause us to experience poor concentration, mood swings and sleep disturbance.

Such problems are usually of temporary nature, are relative to the demands a particular situation, and generally respond to support and reassurance.

All of us suffer from mental health problems at times, and such temporary problems do not necessarily lead to mental illness. However, being mentally unhealthy limits our potential as human beings and may lead to more serious problems.

Mental disorders (or mental illness) can be defined as the experiencing of severe and distressing psychological symptoms to the extent that normal functioning is seriously impaired.

Some form of professional medical help is usually needed for recovery/management of both poor mental health and mental disorders. This help may take the form of counselling or psychotherapy, drug treatment and/or lifestyle change.
Classification of Mental Disorders

Source: University of Melbourne, 2009

Severe Mental Disorders

People with Severe Mental Disorders usually experience a mixture of physical, emotional, thought and behavioural symptoms, as well as imagining symptoms.

Severe Mental Disorders are rare and usually involve noticeable behavioural problems and the expression of strange or unusual ideas, often called psychosis. Psychosis is sometimes described as ‘losing touch with reality’.

People with Severe Mental Disorders are more easily identified as having a mental health problem than those with Common Mental Disorders, because they seem more obviously different from others in the way they think and behave. Most people in psychiatric hospitals suffer from Severe Mental Disorders.

The main types of Severe Mental Disorders are as given below.

<table>
<thead>
<tr>
<th>Psychotic Episode</th>
</tr>
</thead>
<tbody>
<tr>
<td>The person displays severe behavioural problems and expresses strange or unusual ideas. It is caused by a combination of factors including genetics, brain chemistry, stress and other factors such as the use of drugs or intense depression.</td>
</tr>
<tr>
<td>Psychotic episodes usually start suddenly and do not last for a long time.</td>
</tr>
<tr>
<td>A psychotic episode may eventually become a more serious psychotic illness such as schizophrenia, or it may only occur once in a person’s lifetime.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Schizophrenia</th>
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</thead>
<tbody>
<tr>
<td>Mainly affects young people before 30 years of age. Both men and women are affected equally by schizophrenia, and symptoms may develop rapidly over several weeks or more slowly over several months. Many people mistakenly believe that schizophrenia is the same as split-personality but this is not correct.</td>
</tr>
<tr>
<td>Symptoms of schizophrenia include:</td>
</tr>
<tr>
<td>- False beliefs e.g. thinking others are trying to harm her/him, or believing that her/his mind is being controlled by others.</td>
</tr>
<tr>
<td>- False perceptions – seeing, smelling or tasting things that are not there, and most commonly hearing voices that are not there.</td>
</tr>
<tr>
<td>- Strange behaviours e.g. talking to herself/himself.</td>
</tr>
<tr>
<td>- Poor concentration and inability to think clearly.</td>
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<tr>
<td>- Lack of motivation to do things.</td>
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<tr>
<td>- Inappropriate emotions e.g. laughing at something sad.</td>
</tr>
<tr>
<td>- Loss of social skills and social withdrawal.</td>
</tr>
<tr>
<td>- Restlessness, walking up and down.</td>
</tr>
<tr>
<td>- Poor personal hygiene.</td>
</tr>
<tr>
<td>- Saying things that do not make sense to others.</td>
</tr>
<tr>
<td>- Aggression.</td>
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</tbody>
</table>
### Bipolar Disorder

The person experiences extreme mood swings between low mood (depression), high mood (mania) and normal mood. The symptoms of the depressed stage of the illness are much the same as depression (described later), and the symptoms of the manic stage of the illness include:

- A very happy mood.
- Unrealistic plans or ideas.
- Inappropriate sexual behavior.
- Spending a lot of money.
- Not sleeping.
- Irritability.
- Rapid talking.
- Unable to be still and relax.
- Beliefs that she/he is special or superhuman.
- Limited understanding that she/he is behaving in an unusual way.
- Both men and women can be affected, usually in early adulthood.

### Common Mental Disorders

People with Common Mental Disorders usually experience physical, emotional, thinking and behavior symptoms, but not imagining symptoms. Some people may get treatment for physical problems associated with their illness (like poor sleep or appetite), but neglect the cause of these physical problems such as underlying depression or anxiety. People with Common Mental Disorders are often not treated because it is more difficult for family members and health workers to recognize that they are suffering from a mental disorder.

The main Common Mental Disorders are:

#### Depression

Unusually sad mood that does not go away. Depression is a mental disorder when the symptoms last for at least two weeks and they affect the person’s ability to carry out her/his work or have satisfying personal relationships. Everyone can feel sad when bad things happen, occasional sadness is not depression.

Events that contribute to the development of an unusually sad mood include:

- Distressing events that the person cannot do anything to control like the death of a loved one or the breakdown of a relationship.
- Stressful events such as ongoing family conflict.
- Chronic medical conditions like diabetes or stroke.
- Sometimes women can become depressed after they give birth.

The symptoms of depression include unusually sad mood, and all or some of the following.

- Loss of interest and enjoyment in activities.
- Tiredness and lack of energy.
- Loss of self-confidence.
- Feelings of hopelessness and helplessness.
- Wishing they were dead.
- Difficulties in concentrating.
- Sleeping problems.
- Loss of interest in food and loss of weight.
- Experiencing a range of physical complaints that have no apparent medical cause e.g. weakness, aches and pains.
- Not every person who is depressed has all these symptoms, and the severity of depression is different for different people.
Anxiety

Excessive fear, nervousness and worry (anxiety) is a mental disorder that is more severe and long lasting than everyday worries. It interferes with a person’s ability to carry out his/ her work or have satisfying personal relationships.

There are many types of anxiety disorders ranging from mild uneasiness to panic attacks.

**Generalised Anxiety Disorder** – when the person worries excessively about things, and experiences multiple physical and psychological symptoms that occur nearly every day for at least six months.

**Panic Disorder** – when the person experiences a sudden and severe anxiety attack. They feel intense fear or terror that is inappropriate for the setting.

The symptoms are often physical and include dizziness, shaking, sweating, feeling of choking, rapid breathing, and rapid heartbeat.

**Phobias** – when a person feels very scared in particular situations e.g. when in closed spaces, crowded places like markets, or near lizards etc. The person generally avoids the fearful situation.

**Obsessive-Compulsive Disorder (OCD)** – a condition where the person has repeated thoughts (obsessions) or does things repeatedly (compulsions) and is unable to stop the behaviour or the thoughts e.g. hand washing to the point where the skin is damaged.

<table>
<thead>
<tr>
<th>Symptoms include unrealistic or excessive fear and worry, and one or all of the following.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Irritability.</td>
</tr>
<tr>
<td>• Worrying a lot about things</td>
</tr>
<tr>
<td>• Feeling that something terrible is going to happen.</td>
</tr>
<tr>
<td>• Feeling scared (butterflies in the stomach).</td>
</tr>
<tr>
<td>• Avoiding certain situations e.g. social events.</td>
</tr>
<tr>
<td>• Disturbed sleep.</td>
</tr>
<tr>
<td>• Muscle tension.</td>
</tr>
<tr>
<td>• Restlessness.</td>
</tr>
<tr>
<td>• Physical symptoms like rapid heartbeat, dizziness and trembling.</td>
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</tbody>
</table>

Excessive Use of Alcohol and Other Drugs (Substance Abuse)

This is one of the most common mental disorders. Using alcohol or drugs does not mean that a person has a mental disorder, but it does become a disorder when the alcohol or drug use harms the person’s physical, mental or social health. Excessive use can result in.

- Dependence on alcohol or drugs, which makes it difficult for people to stop using the alcohol or drugs;
- Problems at work, school or home or legal problems due to use of alcohol or drugs; and
- Damage to physical or mental health secondary to the use of alcohol or drugs.

People with alcohol and drug problems often have other underlying mental health problems and use alcohol or drugs as a type of self medication for feelings of excessive worry or sadness.
Annexure 5: Mental Health: What’s Normal, What’s Not

Source: Mayo Foundation for Medical Education and Research, 2011

What is the difference between mental health and mental illness? Sometimes the answer seems clear. For instance, a person who hears voices in his or her head could have schizophrenia. A person who goes on a frenzied shopping spree or starts an ambitious project, such as remodelling the bathroom, without any plans might be having a manic episode caused by bipolar disorder.

In some cases, however, the distinction between mental health and mental illness is not so obvious. If you are afraid of giving a speech in public, does it mean you have a mental health condition or a run-of-the-mill case of nerves? If you feel sad and discouraged, do you have the blues, or is it full-fledged depression?

It is often difficult to distinguish normal mental health from mental illness because there is no easy test to show if something is wrong. Mental health conditions are diagnosed and treated based on signs and symptoms as well as on how much the condition affects your daily life.

Mental health conditions are identified by looking for signs and symptoms that affect our behaviour, feelings and thinking.

Behaviour

For instance, obsessive hand-washing is a sign of a mental health condition, as is not following daily self-care routines such as bathing, brushing one’s teeth and hair, or changing clothes regularly. Drinking too much alcohol might be the sign of a mental health condition.

Feelings

Sometimes a mental health condition is characterized by a deep or ongoing sadness, euphoria or anger.

Thinking

For instance, delusions, such as thinking that the television is controlling your mind, or thoughts of suicide, might be symptoms of a mental health condition.

Abnormality: What Is It?

While on the face of it, ‘abnormality’ sounds like an easy thing to define, there are many different techniques used by psychologists to classify behaviour, or mental health, as ‘abnormal’. All of these have their strengths and weaknesses; there is no one ‘right’ way to define abnormality. Some of the most common ways are given below.
Statistical Abnormality

In some cases it is possible to gather data in a numeric form and derive a mean average value. We can then say that the majority of values which are nearest to the mean are ‘normal’, and the minority of values farthest from the mean are ‘abnormal’. For example, if the average height of a set of people is five foot eight, with most values falling in the range four feet to six foot six, then a height of less than three foot or more than eight foot would probably be considered ‘abnormal’.

One problem with the statistical approach is that the decision of where to start the ‘abnormal’ classification is arbitrary. Typically, abnormal values are considered to be anything with a standard deviation of greater than two. Applying this measure to values of IQ, which have a bell-curve distribution around a mean of 100, values of lower than 70 or greater than 130 are classified as ‘abnormal’.

An important consideration of statistically ‘abnormal’ values is that ‘abnormal’ doesn’t necessarily mean undesirable. For example, someone with an IQ of 131 is statistically abnormal, but may well be regarded as gifted.

Another problem with this method is that behaviour which is undesirable may be statistically frequent. For example, depression is regarded as undesirable, yet it is not uncommon enough to be classified as abnormal in the statistical sense.

Deviation from Social Norm

A social norm is an unwritten rule which governs behaviour in a given social context (see Conformity). Using this definition, behaviour which breaks these rules is regarded as abnormal.

Strengths of this technique

- It takes into account the social dimension, which is important because the same behaviour that might be considered ‘abnormal’ in one context could be ‘normal’ in another. For example, wandering around naked in the town centre is not normal but wandering around naked on a naturist beach is.
- It takes cultural relativism (the way that social norms change over time and between cultures) into account.
- It tries to avoid ethnocentrism, which is the tendency to regard one’s own culture as ‘normal’ and consequently see different cultures as ‘abnormal’.

Problems With this Technique

- It is difficult to define what a ‘cultural context’ is because cultures have subcultures within them. One way to overcome this is to use laws as a reference point, e.g. if a society has a law against murder, then that is considered a ‘social norm’. However, evidence shows that many, if not most, people will admit to breaking the law, and so by this measure, they are all ‘abnormal’.
- It does not provide an objective definition of abnormality.
- It makes non-conformity undesirable. For example, suffragettes might have been labelled ‘abnormal’ even though they achieved positive things (by current standards).
- It can lead to discrimination/abuse of ‘non-conformists’: for example, labelling people as mentally ill if they do not go along with the prevailing political system.

Szasz argued that ‘mental illness’ is a label that is used to justify forcing treatment on people. For example, drugs are prescribed to people to make them behave more like ‘normal’ people do.
Deviation from Ideal Mental Health

In this context, ‘normal’ can be taken to mean ‘mentally healthy’, while ‘abnormal’ describes an undesirable state which is somehow deficient from ‘mental health’. This approach therefore attempts to describe the characteristics that constitute ‘ideal’ mental health.

This approach is characteristic of humanistic psychologists such as Maslow, who defined his hierarchy of needs (e.g. physiological, safety, love, esteem, self-fulfilment, etc.) as a means of assessing where an individual was on their path to self-actualisation, which he regarded as the ideal state. However, a problem with this approach is that very few people would be considered ‘normal’ by this measure, because few people achieve self-actualisation as Maslow defines it.

In a slightly different approach, Jahoda defined six criteria by which mental health could be measured:

- Attitudes of an individual toward his/own self;
- Growth, development, or self-actualization;
- Personality integration;
- Autonomy;
- Perception of reality; and
- Environmental mastery.

According to this approach, the more of these criteria are satisfied, the healthier the individual is.

An advantage of this type of approach is that it does provide areas to target when treating depression, and it focuses on a positive approach to the problems. On the other hand, like Maslow’s criteria, very few people are likely to achieve all six of Jahoda’s objectives, and it is also hard to measure the extent to which an individual misses these criteria. Another criticism of Jahoda is that some of the criteria might be seen to be ethnocentric: for example, autonomy is seen in some cultures as an undesirable trait.

Failure to Function Adequately

Using this set of criteria, behaviour is defined as abnormal if it hurts the person or other people. Rosenhan & Seligman, 1989 listed seven criteria.

- Distress: the person is upset or depressed.
- Maladaptive behaviour: behaviour that prevents someone from coping with everyday situations.
- Irrationality: belief or behaviour not connected with reality.
- Unpredictability: reacting to a situation in a way that could not be predicted or reasonably expected.
- Unconventional behaviour or statistically rare behaviour.
- Observer discomfort: behaviour that makes other people feel uncomfortable.
- Violation of moral standards: breaking laws, taboos, etc.
Strengths of this Technique

- It provides a practical checklist.
- It takes into account the social/cultural context.
- It takes into account statistical influence.

Weaknesses of this Technique

- Sometimes it is normal to be distressed (e.g. grieving).
- Some people may be abnormal (e.g. a psychopath) and yet show no signs of distress.
- Some of the criteria are subjective; who judges what is ‘unpredictable’?
Annexure 6: The Changing Status of Homosexuality vis-à-vis Mental Health

Source: Hooker, 1957

Evelyn Hooker’s pioneering research debunked the popular myth that homosexuals are inherently less mentally healthy than heterosexuals, leading to significant changes in how psychology views and treats people who are gay.

Findings

In the 1950’s, Dr. Evelyn Hooker studied 30 homosexual males and 30 heterosexual males recruited through community organizations. The two groups were matched for age, IQ, and education. None of the men were in therapy at the time of the study. Dr. Hooker administered three projective tests, which measure people’s patterns of thoughts, attitudes, and emotions – the Rorschach, in which people describe what they see in abstract ink blots, the Thematic Apperception Test [TAT] and the Make-A-Picture-Story [MAPS] Test, in which people tell stories about different pictures.

Unaware of each subject’s sexual orientation, two independent Rorschach experts evaluated the men’s overall adjustment using a 5-point scale. They classified two-thirds of the heterosexuals and two-thirds of the homosexuals in the three highest categories of adjustment. When asked to identify which Rorschach protocols were obtained from homosexuals, the experts could not distinguish respondents’ sexual orientation at a level better than chance.

A third expert used the TAT and MAPS protocols to evaluate the psychological adjustment of the men. As with the Rorschach responses, the adjustment ratings of the homosexual and heterosexuals did not differ significantly. Based on these findings, Dr. Hooker tentatively suggested that homosexuals were as psychologically normal as heterosexuals.

Significance

Hooker’s work was the first to empirically test the assumption that gay men were mentally unhealthy and maladjusted. The fact that no differences were found between gay and straight participants sparked more research in this area and began to dismantle the myth that homosexual men and women are inherently unhealthy.

Practical Application

In conjunction with other empirical results, this work led the American Psychiatric Association to remove homosexuality from the Diagnostic and Statistical Manual (DSM) in 1973 (it had been listed as a sociopathic personality disorder).

In 1975, the American Psychological Association publicly supported this move, stating that “homosexuality per se implies no impairment in judgment, reliability or general social and vocational capabilities… (and mental health professionals should) take the lead in removing the stigma of mental illness long associated with homosexual orientation.”

Although prejudice and stigma still exist in society, this research has helped millions of gay men and women gain acceptance in the mental health community.
Timeline of Events

(Adapted from American Psychological Association)

Significant Events

1973 - American Psychiatric Association removes homosexuality from list of mental disorders in its Diagnostic and Statistical Manual (DSM).

1975 - American Psychological Association follows suit.


2001 - Chinese Psychiatric Association delists homosexuality as a mental disorder.

2008 - Indian Council of Medical Research considers allowing LGBT people (same-sex couples) to become parents through artificial reproductive techniques, but this is still under debate. Proposed changes in adoption laws may debar this provision.

Transgender phenomenon (in medical jargon Gender Identity Disorder [GID]), is still classified as a mental disorder in the DSM IV and ICD. But even this is set to change. The new version of the DSM is likely to replace it with the term ‘gender dysphoria’, no longer call it a disorder, but a condition in which some persons may need psycho-social and medical support.

The change in the ICD is still being debated. Trans-activists the world around don’t just want a simplistic change by delisting GID, but also want that many hidden sub-clauses or sections in the ICD be addressed. In fact, simply delisting GID may remove some of the health benefits that transpersons do receive because they have a ‘disorder’. They don’t want to lose those relevant benefits till an alternate arrangement assures them of that.
Annexure 7: Counselling Cards

- Build a foundation
- Listen to a client’s story
- Help client explore story
- Help client explore options
- Help client make a plan
Annexure 8: Model of Counselling

Source: Kustner, 2011

Principles of the Model

‘Building the house’ means building counselling relationship, in helping the client deal with her/his problems. As the counselling process moves forward, a trusting working relationship is built between counsellor and client.

Clients have different needs with regard to counselling. Some clients just need help to tell their story, in order to help them to continue with the ‘house building’ on their own. The client is responsible for building her/his house and counselling can end at any stage in the ‘house building’ process. Counsellor is the facilitator for the process. Listening to, and exploring the client’s story helps to build trust and understanding, which then allows the client and counsellor to move into exploring solutions and making a plan. Reviewing the counselling process is done by using the summarising skill, and is helpful to re-focus the client and counsellor on what has been achieved in the counselling process. The client’s family, friends and community resources are included in this helping process.

‘Building the house’ is also a collaborative effort, between the client, counsellor and external support structures, which follows the following flexible process.

Building a Foundation

Preparation for counselling is important in building a solid foundation for effective counselling to take place. Firstly, the counsellor prepares her/himself through self-awareness and diversity. The counsellor ensures that she/he is aware of the basic principles of counselling—being respectful, real and responsive.

For preparation of counselling context or environment is also important. A safe, quiet and comfortable place is prepared. Setting up the initial agreement (contract) also forms the groundwork of a successful counseling relationship.
Listen to Client's Story

Listening is integral in building trust in the counselling relationship and gives the client space to open up. It also prepares the client and the counsellor to reach a level where it is emotionally safe in the relationship to help the client explore options and make a plan. We listen for and observe the following:

- Our own feelings – self-awareness.
- The client’s experiences – what happened to them (content).
- The client’s behaviour – what they did or didn’t do (non-verbal).
- The client’s feelings – that arise in relation to their experiences and behaviour.
- The client’s mood, appearance and speech patterns.

We show the client we are listening to them by monitoring our own non-verbal behaviour in counselling. We use the SOLER MAP technique – sit squarely, facing the client at a comfortable angle and distance; have an open posture; lean towards the client when suitable; make appropriate eye contact; be relaxed and use minimal encouragers and attentive silences and assess the client’s presentation.

Help Client Explore Story

Besides listening to the client, we can help them explore their story, by accurately reflecting their feelings and content. By doing this, we show the client that we are willing to understand their world as they experience it. This also helps to build trust and encourages self-reflection.

In helping the client explore their story, we attempt to gain a deeper understanding of their experience. We also do this to help the client make sense of her/his world by focusing their thoughts and exploring and identifying themes.

Help Client Explore Options

The goal of counselling is to empower the client, and through the problem treatment cycle the client moves from exploring problems to finding solutions. In exploring solutions, the client needs to discover their own inner resources and coping skills, as well as look at external sources of support such as:

- Self-help treatments and coping strategies;
- Professional counselling, psychiatric and general health practitioners;
- Other service providers. (Remind the participants that they will be discussing referrals in the module on Friendly Services); and
- Drawing support from family, friends and community.

Help Client Make a Plan

Many novice counsellors (and even some senior counsellors) think that this part of the counselling process is the most important. However, as we have seen, the most important part of counselling is building the counselling relationship between client and counsellor and ensuring that the client feels heard in terms of her/his feelings and experiences.

In problem solving, the counsellor is merely a guide, leaving the responsibility for decision-making to the client. As ethical counsellors we respect our client’s dignity in making their own choices.
As counsellors, we guide clients by helping them look at various options or solutions to their problems. We also assist clients to make a plan, by helping them weigh up the pros and cons of the options. Solution-focused questions may also assist clients in thinking about their problems differently.

**Reviewing**

Ending counselling (after the first session or at termination) involves reviewing where the counselling relationship has reached, and acknowledging the different goals that have been realised as a result of the counselling relationship.

Reviewing gives both counsellor and client a sense of closure. When reviewing, it is important to deal with the client’s feelings of ending counselling.

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**Important Note for Pehchan Staff**

Participating in this training module does not mean that you have become a counsellor. You must be clear about the fact that you are not trained in mental health, and therefore there are restrictions to the kind of assistance you can provide.

Yet, in a helping capacity, as frontline personnel of Pehchan, you have the scope of providing ‘mental health first-aid’ as it were, to persons who need psychological help and support.

While you are not trained in diagnosing mental health disorders, you can help recognise these disorders in a person.

While you may not be able to correctly distinguish between depression and bipolar illness, or between generalised anxiety and panic, you can train yourself to observe whether a person is in poor mental health, and be in a position to suggest measures to improve her/his health, as well as appropriately refer the person to a competent service provider.
Annexure 9: Building a Foundation

Source: Kustner, 2011

**Initial Contact**

A person comes for counselling in one of the two ways: another organisation or person usually refers them, or they make a decision to seek counselling on their own. It takes a lot of courage for clients to come for counselling, and some are more eager than others to start the process.

When a person phones or asks to see a counsellor, it is important that the counsellor or telephone receptionist maintains ethical behaviour, as well as an empathic attitude, to give the client the impression that it is an emotionally safe place. The person’s problem is not usually discussed when the person phones or asks for an appointment. If the person starts discussing their problem, it is useful to reflect the client’s feeling and reassure them that you will discuss it in your session e.g. ‘It sounds like you are keen to talk now. Could we talk more about this on Thursday?’

An appropriate time and location is agreed upon by both parties, as well as any fees and procedures for cancelling the session. This initial contact forms the first part of the counselling contract.
**Getting Started**

When the person arrives for counselling, greet them respectfully and introduce yourself. Remember that you are in the role of counsellor, and the person is likely to see you as an authority, or provider of help. It is important to let the person feel comfortable, without losing your role as counsellor. Being over-friendly or ‘prim and proper’ usually does not create a favourable beginning for counselling.

Once you are both seated, the counsellor usually begins by asking the person for a few personal details – name, age, address and contact number. Some counsellors prefer their clients to fill in a client detail form.

**Initial Agreements**

Before discussing the client’s reason for coming for counselling, it is helpful to reassure the client that confidentiality will be maintained. Briefly explain the limits of confidentiality as well. Some counsellors, have an informed consent form that explains the ethical duties of the counsellor and what the client can expect from counselling.

‘Before we start, I just want to reassure you that everything we discuss here today will be kept confidential. The only time I might have to tell someone about our sessions is if I feel you may do harm to yourself or others, but I will always let you know if I do.’

At this stage, it is also suitable to briefly discuss and negotiate the duration of counselling, frequency and length of sessions, as well as any fees or counselling administrative procedures. In this initial agreement, it also useful to explain the roles of the client and counsellor, and what the client expects from the counselling relationship. In India, where counselling is not well understood, it would also be helpful to discuss what the client understands counselling to be; whether they have been for counselling before, and what their experience of counselling was.

Note all aspects of this initial agreement or contract are not necessarily explored in full, in the first session – it is usually re-negotiated, clarified and refined throughout the counselling process. It should be flexible and realistic.

**How to Begin**

An open-ended question is usually helpful to get the counselling session started: ‘What brings you here today?’, or a non-verbal gesture, such a nod of the head.

Statements such as, ‘How can I help you?’ may set the context that you are going to be ‘the helper’ and that the client is not able to help himself. This is not necessarily wrong but be aware of the impact of your words. Give the client time to respond, and empathically reflect on any non-verbal behaviour you may observe e.g. ‘It seems like it’s difficult for you to talk about it’.
Annexure 10: Listening to the Client’s Story

Source: Kustner, 2011

Listening is integral in building trust in the counselling relationship and gives the client space to open up. It also prepares the client and counsellor to reach a level where it is emotionally safe in the relationship to help the client explore options and make a plan. We listen for and observe.

- Our own feelings – self-awareness;
- The client’s experiences – what happened to them (content);
- The client’s behaviour – what they did or didn’t do (non-verbal);
- The client’s feelings – that arise in relation to their experiences and behaviour; and
- The client’s mood, appearance and speech patterns.

We show the client we are listening to them by monitoring our own non-verbal behaviour in counselling.

Attending

Attending means being physically, intellectually and emotionally ‘present’ in a counselling session. These skills indicate to the client that the counsellor is listening, is aware and is ready to interact. They show in a non-verbal way that the counsellor is attentive and available. The acronym SOLER MAP is often used to summarise basic skills.
- **S** – stands for sitting squarely: this means facing the client so that they can see the counsellor and communicate openly. Sometimes a more ‘conversational’ sitting style is used where the counsellor and the client sit at right angles to each other while they talk.

- **O** – stands for open posture: this means not crossing arms or holding a folder/file in such a way that it indicates a closed body, and possibly a closed or ‘switched off’ mind. It can also refer to being careful not to have, or minimising, barriers between counsellor and client, such as a desk or bed.

- **L** – stands for leaning forward: this means leaning in towards the client at appropriate times to convey interest and concern. This should be used carefully so as not to intimidate a client too soon in an encounter. In addition, counsellors must be mindful of body space differences in people from different backgrounds. Good observational skills will soon pick up what is an appropriate space.

- **E** – stands for eye contact: this means keeping natural eye contact to show the client that the counsellor is listening to what is being said. Remember that for some people, too much eye contact may be experienced as threatening or disrespectful: good contextual knowledge will assist here.

- **R** – stands for relaxed posture: this means not fidgeting excessively or holding one’s body in a tense manner. It also does not mean adopting a slouched position. The counsellor should convey a calm sense of containment to the client and should be aware of excessive gesticulating, body movements, tapping feet, clicking pen, playing with hair, fiddling, etc.

- **M** – stands for minimal encouragers: these encourage the client to keep talking and show one is listening. These encouragers, such as ‘mmm, uh huh, I see’ could go along with nods of the head.

- **A** – stands for attentive silence: we are often tempted to interrupt a client to ask a question, make an observation, or to get clarity on a particular point. While these are not bad things to do, we should generally wait for an appropriate pause in the conversation to make a verbal response. If the client is talking easily then it is better to maintain an attentive silence which conveys interest and respect.

- **P** – stands for presentation: how does the client present themselves and how should the counsellor present themselves. Aspects to look out for include the following.
  - What is the client’s general mood: is she/he positive and upbeat, pessimistic and depressed, angry and confused, defensive and wary?
  - What kind of body language is the client using? The ideas expressed in SOLER (above) are useful to think about – is the client open, does the client use appropriate eye contact and physical distance, is the client tense and withdrawn?
  - Is the client neat and appropriate in dress and physical presentation? It is not the role of the counsellor to judge the client’s fashion sense or pass moral judgment on an outfit – rather the counsellor is assessing the client’s general mood and wellbeing. A depressed person may often neglect their personal appearance and this can be an important warning sign.
  - How does the client use language? Rate of speech, tone of speech and volume of speech can affect how we understand the client and can also suggest mood and mental state.
  - The counsellor should also be appropriately dressed in attire which is suitable for his or her profession and the context in which the counselling takes place. The counsellor should be neat and tidy and convey an attitude of professionalism.
The counsellor should develop an awareness of how she or he uses language and attempt to modify vocal skills to improve comprehension and communication. Awareness of vocal style can be gained through taping of one's voice and reviewing for clarity or by asking for feedback from others, including the client. The kinds of things to look out for include the following.

- Tone of speech and volume of voice: the tone can convey warmth and empathy or indicate a desire to bring formality into a particular encounter.
- Rate of speech: in general one should use a slower rate with a client unfamiliar with one's accent – but this should not become sing-song or patronising.
- Range of inflections: stressing certain words and varying emphasis will prevent boredom.
- Modifying accent/ pronunciation: it may be useful in some settings to adapt pronunciation of certain words to accommodate local style and usage, in order to improve comprehension.
- Rhythm of speech: the counsellor should try to modify their rhythm of speech to be clear and interesting.
- Appropriate words and language: the counsellor needs to understand the particular context in which the counselling is being given, and to choose those words and phrases that clients also use and understand.
Annexure 11: Helping the Client Explore Their Story

Source: Kustner, 2011

Reflection

When somebody takes the time to tell us their story, it is important that we respond in a way which respects what they have said and shows them we have grasped what they are trying to say.

Reflecting skills are those skills which allow the counsellor to respond directly to what a client has said to take the conversation further in a useful direction. They also show the counsellor has been listening or, if the response misses the mark, gives permission to the client to put the counsellor back on track.

It is always important to begin a response with a qualifier such as ‘It seems to me …’ or ‘It appears that …’ and to use a tone of voice which conveys tentativeness. This is not because the counsellor wishes to appear uncertain but to show respect for the client’s right to be the final judge of the ‘truth’ of their utterances, thoughts and feelings.

Key Reflecting Responses

Each technique will be illustrated using the following client statement: ‘So now my partner has left, and I’m alone to deal with the big house and all the chores. He helped me a lot. I don’t know if I’m going to cope now.’

Reflection of Content (Paraphrasing)

The facts of what the client is saying are reflected using a technique called paraphrasing. Paraphrases are short, clear response in which counsellor states the essential points of the client’s statements in the counsellor’s own words. Paraphrasing is not the same as simply repeating word for word what the client has said, but rather the counsellor uses...
his/her own words to restate the main points of the client’s statements.

An example:

‘So you’re saying that now that your partner has gone, you’ll have to take on more tasks, and you’re not sure you can manage.’

Reflection of Feeling

By accurately reflecting the feeling which a person is experiencing we provide a deeper understanding of how an event has affected the person and connect with the client at an emotional level, which can build trust and enhance rapport. Reflecting feelings accurately takes some practice.

In English, there are many ‘feeling words’ of various intensities, e.g. cross, angry, furious. Other South African languages, such as Sotho and Zulu, do not have many words to describe feeling states, and thus it takes a special skill to show that you understand what the client is feeling. Using metaphors can be useful in these instances e.g. ‘Your heart feels sore’ instead of ‘You feel depressed’.

An example:

‘It sounds like you’re feeling worried and overwhelmed.’ (With this response, we are still in the client’s frame of reference, and the client stays focused on his/her feelings and experience).

If the counsellor is not quite sure what the client is feeling, she or he can ask the client a feeling question: for instance, ‘How does it feel now that you’ve had to take on all of this on your own?’

Note that empathy is more quickly achieved if the right feeling can be identified and reflected by the counsellor, rather than it being elicited by a question.

Reflection of Meaning

Reflection of deeper empathy (sometimes called reflection of meaning) is achieved through linking the feeling to the content. Many counselling manuals and courses suggest that counsellors use the ‘you feel (the feeling, e.g. sad) because (the reason, e.g. your relationship broke down)…’ formula to reflect a combination of feeling and content. If used incorrectly and in a formulaic way this can immobilize the client and changes the client from being in a ‘feeling mode’ to a ‘thinking mode’, i.e. instead of feeling understood, the client is trying to work out whether the counsellor has got it right.

If used well, linking feeling to content can enhance empathy because it starts to bring depth, meaning and texture to the counselling encounter. By associating the feeling with a situation or an event the counsellor is helping to tie up the threads of the conversation and to help the client see why, in a certain situation, they responded in a certain way.

Sometimes if the client has already identified a particular feeling, the counsellor can expand and explore that feeling by asking the client to say more about the feeling or to describe its impact. The counsellor can also simply repeat the feeling word in a tentative and a questioning way, encouraging the client to go deeper and further.

An example:

‘If I’ve heard correctly, you’re saying that you feel scared and overwhelmed, because it seems as if your partner has left you to cope on your own.’

‘So your partner’s departure has raised a lot of feelings in you; perhaps anxiety, fear, anger…’

Both these responses allow the client to confirm or disconfirm what the counsellor is saying.
Reflection of Process

Sometimes we reflect the client’s feelings related to counselling itself or towards the counsellor. This is called reflection of process (or immediacy).

An example:

‘You feel embarrassed talking to me about personal things,’ or ‘When you said your partner had left you I noticed tears came into your eyes – this feels very sad for you.’

Immediacy skills can reflect on the relationship between the counsellor and client (or the ‘process’ of what is happening between them). If, for example, the counsellor asks the client a question about her relationship with her partner (‘How are things between you and your partner?’) and the client becomes very angry, the counsellor may need to address the client’s response as soon as possible.

The counsellor could respond in a number of different ways:

‘Susan, I noticed you got angry or anxious when I asked you about your partner. What was going on for you in that moment?’

‘Susan, that seemed to be an awkward moment between you and me there. Perhaps we should talk about it?’

‘Susan, it seemed you got very angry or anxious then. Could you tell me what angered you or made you anxious?’

Susan’s angry response might have been because she felt humiliated about her troubled relationship or felt put in a spot by the counsellor too early in the counselling session. She could have sensed a pattern of challenging questions from the counsellor, or she could have been defensive because a previous counsellor had been quite judgemental about her partner.

Only by using the skill of immediacy will the counsellor get to the root of the issue and allow the air to be cleared. Once the issue is out in the open it can be addressed and the relationship between the counsellor and client put back on an amicable and workable footing.

Meta-communication (communicating about a communication) is also a reflection of process.

An example:

‘Your voice seems to get much lower when you talk about your sister...’

Reflection of a process is an advanced skill only to be used by an experienced counsellor and always after a good, trusting relationship has been developed.

Reflection Tips

- When a reflection is accurate the client feels encouraged to continue speaking and to share more personal information. Here are some tips to help you reflect feelings.

- Listen to words and metaphors the client uses as clues to feelings, e.g. (client) ‘Everything seemed to happen at once’ – (counsellor) ‘You felt overwhelmed.’

- Observe the person's non-verbal language, such as facial expressions, body movements, posture and gestures, e.g. tight fists could mean anger.

- Ask yourself how you might have felt if you experienced what the client describes (remember though, that people may react differently to events).

- If all else fails, ask the client how he/she feels (don’t ask too often!)
Paraphrasing

A paraphrase is a brief, tentative, statement which reflects the essence of what the person has just said. A good paraphrase:

- Captures the essence of what the person said. It leaves out the details;
- Conveys the same meaning, but uses different words;
- Is brief. Your paraphrase should be shorter than what the person just said;
- Is clear and concise. Your paraphrase should help clarify things, not confuse them; and
- Is tentative. We want the client to feel comfortable with disagreeing with or correcting the paraphrase.

We use a paraphrase:

- To check perceptions: do you understand what the person has said? When you paraphrase what you think the person has said, they can react to your paraphrase and tell you whether it is accurate or inaccurate. Be sure your paraphrases are tentative enough so that the client will feel comfortable correcting you if you’re wrong;
- To clarify what the person has said: hearing an accurate paraphrase of what they have just said helps the client to clarify for themselves what they are thinking and feeling. Often a paraphrase will bring up new thoughts and feelings, acting as a prompt to further discussion. A good paraphrase may lead to interesting new explorations because it gives the client an opportunity to reorder their thoughts; and
- To give accurate empathy: an accurate paraphrase demonstrates to the person that you are listening, and that you understand. In effect, a good paraphrase says, ‘I’m with you.’ Some standard openings are: ‘Let me see if I’ve got it right’; ‘Sounds like...’; ‘I think I hear you saying...’; and ‘So, in other words...’

Clarifying

Clarifying is a way of getting more information about something the client has said by asking them to make clearer what they have just said. As noted above, the simple act of paraphrasing what the client has said may bring clarity because in their response to the paraphrase they will automatically expand on their words and ideas. Sometimes, however, you are not sure what they mean by something and it is necessary to ask a question and to probe.

You can clarify what is not clear through asking questions for greater understanding or repeating client statements with a questioning inflection. For example if a client says: ‘I always take my heart pills because of the children,’ the counsellor could respond in at least two ways:

- By asking a clarifying question such as ‘When you said because of the children what did you mean?’; or
- By saying ‘because of the children?’ with a rising inflection to indicate a question.

Both methods prompt the client to expand further on the particular point and clarify for the counsellor what is meant. It is important that the counsellor comes across as genuinely interested in greater clarity, rather than curious and voyeuristic. It is helpful to present oneself as tentative, interested and intent on building a comprehensive picture of the client, their story, their needs and challenges.

Some standard openings of paraphrases are:

- ‘Let me see if I’ve got it right’;
- ‘Sounds like...’;
- ‘I think I hear you saying...’;
- ‘So, in other words...’
• It can be also helpful for the counsellor to position herself or himself as a ‘naive’ listener, keen to get to the heart of what the client is saying but assuming nothing. If the client really believes they are the experts on their own lives, they will be willing to tell you more about them so that you truly understand where they are coming from.

Exploring through Questioning

Asking questions in counselling is useful but should be kept minimum. Almost every beginner counsellor tends to overuse questions. The following tips are useful to remember when using this skill in counselling.

- Questions should serve a purpose – either clarifying or helping the client to think about the problem in a different way. Before asking a question, ask yourself: ‘Whose need is it for me to ask this question?’

- Clients might expect counselling to be conducted on a question-answer basis, because that is what a doctor or traditional healer consultation is like. After asking a question, use other counselling skills, like reflection of feelings and summarising to demonstrate that counselling is not primarily about asking and answering questions.

- Ask open-ended questions rather than closed questions. Continually asking closed questions has an immobilising impact in communication in counselling. Counselling should not feel like a talk show or interrogation session. An open-ended question has many potential answers, a closed one has only one or two possible answers.

- Asking hypothetical questions. These are usually open questions which prompt lateral thinking in clients. An example to a client could be ‘What will you do if your husband agrees to go to couple counselling?’

- Asking reflecting questions. These are questions which encourage clients to summarise or reflect on a particular discussion. This could be very effective in a session where a number of issues have come up. For example, the counsellor asks: ‘What, for you, are the main reasons why you and your partner don’t communicate well?’

- Asking evaluative questions. These are questions which take a specific issue and ‘evaluate’ a course of action. For example if a client wants to resign and start a small business from home the counsellor could ask: ‘How do you think this will work over the next six months?’

Some Pitfalls of Questioning

- Leading questions: This type of question presumes that the questioner knows the answer, and puts words in the other person's mouth. (‘That’s hard for you, isn’t it?’ ‘When will you tell your parents?’)

- Why questions: They can make people defensive, as they can imply that the person should know the answers. Such questions can sound critical, as though you are questioning their judgement. (‘Why isn’t this working for you?’ ‘Why do you not understand this?’)

- Intimate questions: Some questions are not appropriate to ask because they may not be relevant or may be too personal. Always try to ask questions that are valuable for advancing a specific conversation. Always be respectful and treat other people as you would want to be treated. Questions asked out of curiosity should be avoided. (‘Are you gay?’ ‘And then what did you do in bed?’)

- Poorly-timed questions. Questions that are poorly-timed interrupt the flow of a person relating their story. ‘How long has this been going on for?’—asked in the
midst of someone revealing that he is cheating on his girlfriend. ‘Well, what will you do?’—asked while someone is still relating the details of her personal crisis.

**Summarising**

Summaries are essentially a series of paraphrases of issues from a client. A summary provides order and focus and sorts out relevant material to explore in an encounter. Good summaries act as natural ‘stopping and reflecting’ points in a conversation and can also be used to start sessions and bring them to a close. To effectively summarise, the counsellor has to really listen and attend to what the client is saying and how they are saying it.

**Other uses of summaries include:**

- Giving direction to a counselling session;
- Preventing from getting stuck on a particular issue;
- Checking out if the counsellor has really understood what the client is trying to say;
- Linking different points and themes together;
- Helping the client gain some perspective of his/her situation;
- Helping the client see where they’ve been and where they are going; and
- Helping the client to identify possible areas to be explored further.

**Some tips for summarising**

- A good summary is brief and includes not only the facts and the words but also the feelings the client has expressed.
- Put the ideas and descriptions at least partly into your own words but the language should still be primarily in the words used by the client.

**When to use a summary**

- It is a good way to begin or end the session.
- It is a useful skill at a point where a person appears to be stuck.
- It is helpful at the point where the person has spoken for a long time in a confusing or rambling way.
- It is useful when shifting modes, i.e. after you have explored and defined the problem, it is useful to summarise and then move on to exploring options.
Annexure 12: Helping the Client Explore Options and Self-help Strategies for Successful Coping

Source: Kustner, 2011

The goal of counselling is to empower the client, and through the problem-treatment cycle the client moves from exploring problems to finding solutions. In exploring solutions, the client needs to discover their own inner resources and coping skills, as well as look at external sources of support such as:

- Self-help treatments and coping strategies;
- Professional counselling, psychiatric and general health practitioners;
- Other service providers; and
- Drawing support from family, friends and community.

Self-help Strategies and Successful Coping Responses

1. **Be Proactive**, instead of passively waiting for things to get better. This gives us an increased feeling of competence and self-esteem. Make a decision to do something about the situation you are in.

2. **Practice Relaxation Techniques**. Relaxation doesn’t just happen – it’s a skill you need to practice. Taking slow deep breaths helps you remain in control and get through the stress more efficiently.

3. **Positive Self-talk**. So often, if we really listen, we can hear the negative things we are telling ourselves: ‘She doesn’t like me’, ‘I’m going to mess this up’, ‘He’s funnier than I am’. By using positive self-talk, you can start to hear words of encouragement and support. You will be surprised at how different that feels. Try this with deep breathing and see how much better you feel.
4. **Physical Activity.** It does not have to be much. Even just a brisk walk for 15 to 20 minutes can help lessen stress reaction and promote a general sense of well-being. Physical activity causes endorphins to be released, which are the body’s feel-good hormones. Regular exercise can also improve your body’s ability to handle stress in general.

5. **Writing.** Can be an effective means of working through stress as well as gaining a better understanding of what is bothering you. Keeping stressful thoughts to oneself can cause them to grow, as well as creating a new stress from holding on to these upsetting feelings. Write until you feel done.

6. **Realistic Appraisals.** Coping effectively with life’s problems and failures requires realistic expectations. Psychologists call these expectations and judgments appraisals. Life events aren’t a problem unless we appraise them as such. If our appraisals are realistic, we’re better able to react to day-to-day life events with a sense of proportion. It is possible to put an alternative interpretation in the place of an irrational judgment. Suppose someone treats you rudely. You may be tempted to think that that person is horrible, or ‘Everyone dislikes me’. An alternative interpretation could be: ‘I wonder what’s happening with that person for them to behave so rudely?’ We have the choice how to frame our perceptions.

7. **Art.** Creative endeavours are a known means of self-expression. Grab a piece of paper and some markers, paints, or crayons. Fill the page with colour. It does not matter what it looks like. Just do what seems to come next. Grab some magazines, scissors, and glue – make a collage. Make a mobile. Sculpt a shape out of mud. Arrange leaves and branches in a jar of water. The key is not to focus on the end product, but the process.

8. **Meditation.** Meditation need not be a complex, structured process that you learn from years of practice. You do not even need to buy a book. Think of a place that you love. Focus on the details. Focus on how it feels to be there, what sounds you hear, what smells arise. Focus all of your attention on the image. You may even fall asleep. Try doing this while taking slow deep breaths and listening to your favourite relaxing music.

9. **Music.** Listening to music is a powerful tool in coping. Music has the power to take the listener along any number of emotional paths. Pick your music wisely. Choose music that allows you to feel in a safe way, but does not create additional stress. Listening to cheery love songs, for example, may not facilitate coping if you are feeling sad and alone. Sometimes your music should be in the background; sometimes it should fill the room. Know what works for you, and allow yourself to do it.

10. **Friends.** Turning to friends during times of stress can be an invaluable coping tool. Friends can validate who you are and how you feel. They can provide a caring ear, ready and willing to listen and support you. Be aware of who your friends are. Surround yourself with caring supportive people who are quick to jump to your defence and want to protect you from getting hurt – not people who tend to put you on the spot or make you feel defensive.

11. **Good Nutrition.** Eating a healthy and well-balanced diet is not only good for the body but also for the mind. There is ample research to suggest that certain foods improve mood, concentration and mental agility. In addition, the act of preparing nutritious meals for friends and family assists with isolation and loneliness.

12. **Smile.** Even if it’s forced. The physical action of smiling sends positive messages to your brain.
Annexure 13: Help Your Client Make a Plan

Source: Kustner, 2011

Problem-solving: The Traffic Light Model: Stop, Think, Go

The traffic-light problem-solving model is a useful way to approach problematic situations. Sometimes people rush into ‘solving’ problems without thinking of the pros and cons of their actions. This model encourages people to stop, think and then act; thereby they make informed and well thought-out decisions in solving their problems.

Stop
Define the Problem: This is the most important step in the problem-solving model, and often requires the most time in counselling. This step involves gathering information and clarifying. It also involved breaking what seems to be a huge problem into its various parts or sub-problems (sometimes called partialising).

Think
Explore all Options: This step involves exploring all possible options to solve the problem (or, to start with, just one part of the problem, perhaps something that is reasonably achievable). Encourage the client to brainstorm as many solutions to their problem as possible, even if they seem silly. Continue until all ideas are exhausted. It is important that you as counsellor do not have a preconceived idea on what the solution should be.
Look at alternatives and consider the consequences of each idea generated from the above brainstorming. Ask clients to look at the pros and cons of each solution. Usually the best solution is the one with the most advantages.

**Do**

**Select an Option, Make a Plan and Take Action:** Encourage the client to select the most effective option, according to whether it is practical, appropriate and realistic. Be patient and gently support the client to make their choice.

**Develop a Plan:** Ask the client to think about how they can put their choice into action. Ask who, what, when, how, and where questions so that the plan is specific, achievable, realistic and within a time-frame. It is sometimes helpful if the client writes their plan down.

**Take Action:** Acknowledge that this step is usually the most difficult for people. To help build the client’s confidence, it can be helpful to start with an action where the client has a relatively good chance of succeeding. Using role-play to ‘practice’ what the client will do and say and to anticipate possible reactions can also be helpful. Reassure the client that you will explore the outcome in the next session.

**Evaluate:** This is an important opportunity to see what worked, what didn’t work and why. Reassure clients that if they don’t succeed, to try, try again!

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**Information Every Counsellor Should Have**

To help the client evaluate options, you must have accurate and up-to-date information about:

- HIV/AIDS and STIs;
- Identity, gender and sexuality;
- Referral services available;
- Legal and human rights and an understanding of methods of redressing rights violations; and
- Community support services.
Annexure 14: Dealing with Suicide and Self-harm

Source: University of Melbourne, 2009

Assess the Risk of Suicide or Harm to Self or Others.

People with mental disorders sometimes feel so helpless about their life, that future appears hopeless to them.

Engage the person in conversation about how they are feeling and let them describe why they are feeling this way. Ask them if they are having thoughts of suicide.

If they are, find out if they have a plan for suicide. This is not a bad question to ask someone who is mentally unwell. It is important to find out if she/he is having these thoughts in order to refer her/him for help.

If you believe the person is at risk of harming herself or himself then:

• Don’t leave the person alone;
• Seek immediate help from someone who knows about mental disorders;
• Try to remove the person from access to the means of taking their own life; and
• Try to stop the person continuing to use alcohol or drugs, in case they have been using these.

Encourage the person to get appropriate professional help.

You can encourage the person to consult a doctor who knows about mental disorders, and who is able to prescribe medication if necessary. Then you can follow-up by giving ongoing support to the person and their family. If the person is very unwell, i.e. you think they are suicidal or psychotic, and she/he is refusing to get any help from a doctor, encourage the family to consult the doctor so that they can explain the situation and get professional support.
Annexure 15: PowerPoint Presentation – Mental Health

Training on Mental Health

Mental Health

Symptoms of Poor Mental Health
Fear

Sadness

Sleeplessness or Disturbed Sleep
Quickened Heartbeats

Muscular Tension

Stomach Pain
Feeling Hopeless

Mood Swings

Lack of Energy
Increased or Decreased Talking

Suicide Attempt

Thinking about Suicide
Poor Concentration

Seeing Imaginary Things

Poor Judgment
Aggression

Believing Others are Going to Harm You

Withdrawing from Friends and Family
Some Common and Severe Mental Disorders

Mental Disorders

Common Mental Disorders
- Depression
- Anxiety
- Excess use of Alcohol

Severe Mental Disorders
- Psychotic Disorder
- Schizophrenia
- Bipolar Disorder

Geneticized Anxiety
- Panic Disorder
- Phobia
- TC3

References

Notes
Pehchan Training Curriculum
MSM, Transgender and Hijra
Community Systems Strengthening

CG Curricula Guide

A1 Organisational Development
A2 Leadership and Governance
A3 Resource Mobilisation and Financial Management

B Basics of HIV Prevention and Outreach Planning (Pre-TI)

C1 Identity, Gender and Sexuality
C2 Family Support
C3 Mental Health
C4 MSM with Female Partners
C5 Transgender and Hijra Communities

D1 Human and Legal Rights
D2 Trauma and Violence
D3 Positive Living
D4 Community Friendly Services
D5 Community Preparedness for Sustainability
D6 Life Skills Education