MANUAL
for promoting mental health of affected children
WITH ACCENT ON REFUGEES’ / MIGRANTS’ CHILDREN

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CONTENTS

INTRODUCTION 5

PART I
RELEVANT CONCEPTS ABOUT THE MENTAL HEALTH OF MIGRANTS/REFUGEES 7
Mental health ................................................................. 9
Mental health in the migrant/refugee context ......................... 9
Migration ......................................................................... 10
Definition of the terms: migrant and refugee .......................... 10
Migrant ........................................................................ 10
Refugee ....................................................................... 11
Usual types of reactions which occur regarding exposure to traumatic events ........................................ 12
Stress ........................................................................... 12
Trauma .......................................................................... 12
Grief ............................................................................ 12
Health processes of overcoming exposure to traumatic events ...... 13
Resilience ..................................................................... 13
Coping .......................................................................... 13
Psychosocial support ....................................................... 14
Intervention model for mental health and psychosocial support in emergencies ................................. 14

PART II
HELPING THE HELPERS 21
Being a helper .................................................................. 23
Organisation of helpers in terms of space, time and networking .... 25
Awareness about the working space .................................... 25
Time awareness/time management ...................................... 26
Network of helpers in the relief assistance facility .................. 28
Self-help of helpers ........................................................ 29
Systematic approach toward psychosocial intervention .......... 32
Improvement of the psychosocial intervention approach .......... 33
Nine steps to develop a treatment plan ................................. 34
PART III
LOOKING AFTER THE MENTAL HEALTH OF AFFECTED CHILDREN 43
Helping affected children from a different culture .........................45
Helping affected children from different age groups .....................46
How to recognize the mental health problems of children ...............48
Typical stress reactions related to different age groups .................48
How to conduct interview with a child
after experiencing traumatic event .............................................. 54
Loss ......................................................................................... 55
Practical advice for helpers in terms of
supportive communication with children ........................................58
Psychological workshops for children and adolescents ..................60

PART IV
PARENTING/CAREGIVING IN RELIEF ASSISTANCE FACILITIES 65
Differences in family structure ....................................................67
Individuality and integrity of parents
(mother/father) and caregivers ....................................................69
Supporting parents and caregivers .............................................. 70
Fathers (male caregivers) ............................................................71
Mothers (female caregivers) .........................................................71
Supporting mothers of infants who need special help .....................72
Supporting the parent/caregiver to stimulate infants
(0-2 years) ...................................................................................73
Supporting the parent/caregiver to stimulate preschool children
(2-6 years) ...................................................................................74
Supporting the parent/caregiver to stimulate children of school age
(6-12 years) ...................................................................................75
Supporting the parent/caregiver to stimulate young people
(12-18 years) ................................................................................76

References 78
Appendix 83
Introduction

This manual is aimed at promoting the mental health of children under risk and providing psychosocial care in facilities accommodating persons under risk. It was developed from the project entitled: “Capacity building for providing psychological interventions and resilience of professional staff in Transit Centres to refugees and migrant children.” The project was funded and supported by the United Nations Children’s Fund (“UNICEF”) and implemented by the Chamber of Psychologists of the Republic of Macedonia. The main objective of the project was: “to equip front line workers, including psychologists and social workers working in Transit Centres, with tools and skills how to provide targeted psychological interventions through group and/or individual work”.

This manual is intended to serve as a guide for psychologists and/or psychotherapists engaged as helpers who (will) work with affected people¹ in relief assistance facilities. The manual can also be useful for social workers, teachers and health workers.

This manual is only a handy reference tool and cannot be taken as replacement of formal education and other non-formal training and expertise. The same can be used as complementary to the formal education, for educational purposes and expertise strengthening.

This Manual contains the following parts:

► Part I: Relevant concepts about the mental health of affected people,
► Part II: Helping helpers and mental health providers,
► Part III: Mental health of emergency affected children, and the last part,
► Part IV: Parenting/caregiving in relief assistance facilities.

The Appendix has several proposed instruments that should be introduced for the promotion of mental health in relief assistance facilities.

Professionalism, critical thinking and ethical/moral reasoning is required for the users of this manual!

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¹ Affected people are people who are adversely affected by a crisis or a disaster and who are in need of urgent humanitarian assistance (http://www.who.int/hac/about/definitions/en/).
RELEVANT CONCEPTS ABOUT THE MENTAL HEALTH OF MIGRANTS/REFUGEES
Mental health

Mental health is defined as a state of well-being in which every individual realizes his/her own potential, can cope with the normal stress of life, can work productively and fruitfully, and is able to make a contribution to his/her community.

The positive dimension of mental health is stressed in the World Health Organization's (WHO) definition of health as contained in its constitution:

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."²

Mental health in the migrant/refugee context

War and disasters have the greatest impact on mental health and psychosocial well-being.³

Experiences of conflict-related violence and concerns about the situation of countries affected by war are compounded by the war traumatic events, daily stressors of displacement, including: poverty, lack of basic needs and services, on-going risks of violence and exploitation, isolation and discrimination, loss of family and community supports, and uncertainty about the future. Recognizing and appropriately treating mental health problems among migrants and refugees poses a challenge because of differences in language and culture and because of specific stressors associated with migration and resettlement (Hassan, G. et al, 2015).

² http://www.who.int/features/factfiles/mental_health/en/

Professional interpreters should be used to facilitate and improve communication and increase disclosure of psychological symptoms among migrants/refugees and can also be used when delivering psychosocial interventions. However, working effectively with interpreters involves a collaborative process and requires specific skills (Kyrmaer et al, 2011). For more information on how to include interpreters in psychosocial interventions see Appendix I.

**Migration**

Migration is the process of social change whereby an individual moves from one cultural setting to another for the purposes of settling down either permanently or for a prolonged period. Such a shift can be for any number of reasons, war, and economic, political or educational betterment. The process is inevitably stressful and stress can lead to mental illness. However, not all migrants go through the same experiences and/or settle in similar social contexts. The process of migration and subsequent cultural and social adjustment also plays a key role in the mental health of the individual (Bhugra & Jones, 2001).

**Definition of the terms: migrant and refugee**

The terms ‘refugee’ and ‘migrant’ are frequently used interchangeably in media and public discourse. However, there is a difference between them and for individual governments, this distinction is important. Countries deal with migrants under their own immigration laws and processes. Countries deal with refugees through norms of refugee protection and asylum that are defined in both national legislation and international law.

**Migrant**

UNHCR definition of a migrant:

“Migrants choose to move not because of a direct threat of persecution or death, but mainly to improve their lives by finding work, or in some cases for education, family reunion, or other reasons. Unlike refugees who cannot safely return home, migrants face no

such impediment to return. If they choose to return home, they will continue to receive the protection of their government.”

**Refugee**

UNHCR definition of a refugee: “A refugee is someone who has been forced to flee from his/her country because of persecution, war, or violence. A refugee has a well-founded fear of persecution for reasons of race, religion, nationality, political opinion or membership in a particular social group. Most likely, they cannot return home or are afraid to do so. War and ethnic, tribal and religious violence are leading causes of refugees fleeing their countries.”

In a refugee situation the roles of adults and parents become very different. Adults can remember the past, their own childhood and life before the move. Refugee children may have spent their whole lives as refugees. They may have seen their parents only as refugees and may have few memories of how they were before. Men lose their means of earning and providing for their families. Women lose their traditional ways of caring for their families and their children. Normal roles, cultural life and daily routines are lost, which leaves people precarious, frustrated and depressed.

In general, refugees have the following feelings: uselessness, helplessness, loneliness, lost self-confidence, depression, loss of social roles, strong social insecurity, social isolation, being left to themselves, disintegration (Kirmayer et al. 2011).

There is always insecurity about the future and living “from today to tomorrow”. Planning is difficult, so reality is unclear (there is no clear focus on the reality, they (the migrants/refugees) do not live in “here and now”, but in “there and then”).

Among adults there is a feeling of social and personal incompetence, especially regarding parenting. Families face deterioration of the relationships parent-child, husband-wife. Those relations are “sutured” with bad feelings so migrants cannot find solution.

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5 http://www.unhcr.org/news/latest/2016/7/55df0e556/unhcr-viewpoint-refugee-migrant-right.html

6 http://www.unrefugees.org/what-is-a-refugee/.
Usual types of reactions which occur regarding exposure to traumatic events

Stress

Stress is a normal response to a physical or emotional challenge and occurs when demands are out of balance with resources for coping. Stress is simply a reaction to a stimulus that disturbs our physical or mental equilibrium. A stressful event can trigger the “fight-or-flight” response, causing hormones such as adrenaline and cortisol to surge through the body. A little bit of stress, known as “acute stress,” can be exciting – it keeps us active and alert. However, long-term, or “chronic stress,” can have detrimental effects on health.7

Trauma

The American Psychological Association defines trauma as an emotional response to a terrible event such as an accident, rape or natural disaster. Immediately after the event, shock and denial are typical. Longer-term reactions include unpredictable emotions, flashbacks, strained relationships and even physical symptoms, such as headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.8

Survivors of traumatic events need reconnection of fragments, reconstruction of history, and to make meaning of their present symptoms in the light of past events (Herman, 1992).

Grief

Grief is a natural process that’s painful, personal, and normal. Grief allows a person to come to terms with a significant loss, and make sense of their new reality without a loved one. In most cases, grief will resolve itself with the passage of time, and psychotherapy is unnecessary. Other times, grief can become complicated and fail to be resolved.9

8 http://www.apa.org/topics/trauma/.
According to the Kübler-Ross model, the 5 stages of grief and loss are:

1. Denial and isolation;
2. Anger;
3. Bargaining;
4. Depression; and
5. Acceptance.

People who are grieving do not necessarily go through the stages in the same order or experience all of them.¹⁰

**Health processes of overcoming exposure to traumatic events**

**Resilience**

Resilience is the process of adapting well in case of trauma, tragedy, threats or significant sources of stress – such as family and relationship problems, serious health problems or workplace and financial stressors. Being resilient does not mean that a person doesn’t experience difficulty or distress. Emotional pain and sadness are common in people who have suffered major adversity or trauma in their lives. In fact, the road to resilience is likely to involve considerable emotional distress.

Resilience is not a trait that people either have or do not have. It involves behaviours, thoughts and actions that can be learned and developed in anyone.¹¹

**Coping**

Coping skills are methods a person uses to deal with stressful situations. Obtaining and maintaining good coping skills takes practice. Coping is a way to prevent, delay, avoid or manage stress.¹²

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¹⁰ see website: http://www.ekrfoundation.org/international/ for further information
Psychosocial support

Psychosocial support refers to the actions that address both the psychological and the social needs of individuals. It helps individuals and communities heal the psychological wounds and rebuild social structures after an emergency or a critical event. It can help change people into active survivors, rather than passive victims.\(^\text{13}\)

The concept of psychosocial support reflects the dynamic relationship and interaction between psychological and social issues. Emergency produces wide range of problems at different levels: individual, interpersonal (family, friends, partners), community and society. At each of these levels, the events erode protective supporting mechanisms, increasing the risk of various problems and tending to amplify pre-existing problems at the level of social injustice and inequality. Psychological and social problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature (International Federation Reference Centre for Psychosocial Support, 2009).

In emergencies like a migrant/refugee crisis, people are affected in different ways and require different kinds of support. One of the key principles in ensuring the availability of complementary support is MHPSS (mental health and psychosocial support systems), which require a layered system of complementary support that meets the needs of different groups. All layers are important and should ideally be implemented concurrently (IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 2010).

**Intervention model for mental health and psychosocial support in emergencies**

There has been a wide range of approaches and activities named ‘psychosocial support’. The IASC (Inter-Agency Standing Committee) model for mental health and psychosocial support enabled shared understanding between mental health and psychosocial approaches.

This model illustrates a layered system of complementary support in the form of a pyramid. The layers represent the different kinds of support people may need, whether at times of crisis, at an early stage of reconstruction, or in the ongoing situations of

\(^\text{13}\) (see: http://www.ifrc.org/en/what-we-do/health/psychosocial-support/).
distress experienced by people over many years (International Federation Reference Centre for Psychosocial Support, 2009).

The model has four levels of intervention (Inter-Agency Standing Committee, 2008):

The first layer, **basic services and security**, represents the emergency response required to protect the psychosocial health of the entire population. They can be: social, educational, vocational, recreational activities and focused non-specialized activities. The well-being should be protected through the (re)establishment of security, adequate governance and services that address **basic physical needs**.

A mental health and psychosocial response to the need for basic services and security may include:

- advocating that these services are put in place with responsible actors;
- documenting their impact on mental health and psychosocial well-being;
- influencing humanitarian actors to deliver them in safe, dignified, socio-culturally appropriate ways that promote mental health and psychosocial well-being;
A smaller subset of the population affected by the crisis will be able to maintain their psychosocial well-being if they receive help in accessing **community and family support**, the pyramid's second layer, which is often disrupted by crises or emergencies. This support might include family tracing and reunification, memorials, parenting groups and the activation of social networks, such as women groups and youth clubs. The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing family support and community support.

This layer includes:

- family tracing and reunification;
- assisted mourning and communal healing ceremonies;
- mass communication on constructive coping methods;
- supportive parenting programmes;
- formal and non-formal educational activities;
- livelihood activities and the activation of social networks, such as women groups and youth clubs;
- various social/recreational activities to activate social networks and strengthen community system and
- non-structured activities with different groups of affected people.

The third layer represents the support necessary for the yet smaller number of people who additionally require more focused
individual, family or group interventions by trained and supervised psychologists (but who have had training in emergencies). Counselling, targeted support groups require extensive training on specific topics.

This layer refers to:
- individual psychological support;
- group psycho-social support (psycho-social workshops with children and adults) and
- family psycho-social support.

The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the support already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric support for people with severe mental disorders whenever their needs exceed the capacities of primary/general health services.

Mental health intervention requires mental health background for psychological and psychiatric services to be delivered.

Global expert guidance indicates that 10%-15% of affected people will require specialized services, the pyramid’s final layer, such as professional psychological or psychiatric support (Shanahan and Cheilleachair, 2015).
Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies (Inter-Agency Standing Committee 2008).

For illustration of the implementation of Intervention pyramid for mental health and psychosocial support in the Republic of Macedonia during the period of 2015-2017 see Appendix II.
Being a helper

To provide support and treatment to affected people with emotional difficulties a helper\(^{14}\) should achieve helping skills. The first step in becoming an effective helper is to understand oneself better. The better understanding of oneself can start with simple questions like the following:

- What is my motivation to help affected people?
- What do I get from helping others?
- What knowledge, characteristics and skills do I have to provide assistance to affected people?
- Do I know how to use my skills?
- What additional knowledge and skills do I need?
- Am I aware of the capacity of my personality to be exposed to stressful events?

Here is a list of some personal characteristics of an effective helper\(^ {15}\):

- Caring
- Supportive
- Optimism
- Tolerance
- Common sense
- Critical thinking
- Honesty
- Empathy
- Non-judgemental attitude
- Self-confidence
- Self-awareness
- Patience
- Positive attitude to life
- Respect for others
- Warmth
- Flexibility
- Openness
- Sense of humour

\(^{14}\) In this manual the meaning of the term helper will refer to a person who provides psychosocial help to affected people.

\(^{15}\) These personal characteristics were obtained regarding the focus group research conducted with field workers in the framework of the UNICEF project for capacity building of frontline workers, November 2016.
Useful instructions for helpers:

You must fully respect the persons you are trying to help, regardless of values and beliefs!

There has to be a boundary* between yourself and the person you are helping!

Respect the differences!

Do not judge the other person’s life; rather, think of yourself as an invited guest.

You have been asked to help, not to take over people’s lives!

You should try to empathize with the persons you wish to help. This means trying the best you can to imagine yourself in that person’s position and trying to understand how that person sees the world!

Ask yourself: How does this person feel about his or her life? How does this person see the world? What is best for this person to do?

Do not assume that you know the way another person feels because of the way you would feel! Each person has a unique life history and a particular set of values, needs, desires and beliefs!

* Establishing boundaries

One of the most vital components in creating a relationship with the affected people to whom a helper is providing help is to set boundaries. Also, it is relevant to establish boundaries with the co-workers/coordinators. Simply said, boundaries are what sets the space between “where you end” and “where the other person begins”. Just as setting the boundaries in relation between the helper and the person in need is important, setting the boundaries between the co-workers and the coordinator is much more important for their well-being. Setting the boundaries can help both the helper and the affected person. A helper can prevent professional burn out and the affected person will get a space for personal growth.
Here are some basic steps that helpers should know in the process of setting boundaries:

► Recognize and accept your feelings;
► Recognize the feelings of the other;
► Do not mix your feelings (thoughts) with the feelings and thoughts of others;
► Recognize how the other is “crossing” your boundaries;
► Be aware about yourself, are you crossing the boundaries of another person by asking too many questions just to satisfy your curiosity (asking traumatized persons for the sake of asking only can cause secondary trauma);
► Set up boundaries with people to whom you are providing help, with your co-workers and your coordinators. Verbalize clearly what you accept and what you do not accept.

Organisation of helpers in terms of space, time and networking

Awareness about the working space and the feeling of safety in and/or outside the working space

Helpers and affected people for some amount of time share the almost same space in the relief assistance facilities. There are two types of space: the real physical space and the personal subjective space (perception of the space).

It is important for helpers to be aware of the similarity or difference between subjective perceptions of the physical working space and real physical working space.

So, the question that helpers have to ask themselves is: What is my perception of the place where I help affected people?
The easiest way to become aware of the subjective perception is through symbolic presentation of the relief assistance facilities, actually through drawings. It is useful to work on these issues in group settings. This can be done in peer group sessions. Each helper draws a map of the camp with the elements which he/she thinks that really exist. Then it is very useful to see what mental map of the place the others have. This drawing should be followed by questions like: Where are the safe and non-safe places for affected people? Where do I feel safe? Am I comfortable with the entire space that the relief assistance facilities cover? Where is my place in the relief assistance facilities? Am I isolated?

<table>
<thead>
<tr>
<th>Do</th>
<th>Don't</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trust your perception: what do I see, what do I feel, what do I think?</td>
<td>Do not be influenced by the rumors or stories!</td>
</tr>
<tr>
<td>Think critically!</td>
<td>Criticism (which is not same with critical thinking) is not helping the ones who need help.</td>
</tr>
</tbody>
</table>

**Time awareness/time management**

It is very useful for the helpers to think about their perception, awareness and management of time: they have to be fully aware of their **personal time** (their activities in the working place with migrants), the **time of their organization** (the activities of their organization which has the “power” to control helper’s activities and duties), the **time of the affected people** (the activities during their stay in the relief assistance facilities). This is a highly desirable helpers’ skill, which can provide successful planning and fully professional treatment implementation.
There are some practical tips on how to manage one’s own time and how to manage the time planned for expert’s activities, which also means managing the time of the affected people. The easiest way to become aware is through symbolic presentation of the tree types of time awareness. It is useful to work on these issues in group settings. Each helper draws three separate, but parallel columns of time, and then each of them writes every single activity during one working day. Then, it is very useful to see the overlapping of activities in the parallel columns. This drawing should be followed by questions such as: “Does my time match the time of the organization and the time of my colleague?”, “Does my time fit with the time of the organization and that of my colleague?”, “Does my time match the time of affected people?”, “Does my time fit the time of affected people?”

**Example: Time table**

<table>
<thead>
<tr>
<th>Time Periods</th>
<th>My Time (activities that I perform during the day)</th>
<th>Time of My Organization (activities that my organization performs during the day)</th>
<th>Time of the Affected People(^\text{16}) (activities that migrants perform during the day)</th>
</tr>
</thead>
<tbody>
<tr>
<td>00h - 01h</td>
<td>Sleeping</td>
<td>Night shift</td>
<td>Sleeping</td>
</tr>
<tr>
<td>01h - 02h</td>
<td>Sleeping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14h - 15h</td>
<td>Preparing the Workshop</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15h - 16h</td>
<td>Psychological Workshop</td>
<td>Educational activities</td>
<td>Rest time</td>
</tr>
<tr>
<td>23h - 24h</td>
<td>.....</td>
<td>.....</td>
<td>.....</td>
</tr>
</tbody>
</table>

\(^{16}\) The helper should also be aware of any differences in time organization regarding age and gender. Maybe the time of a female has different time structure than that of a male. Maybe children have different time structure than their parents.
A network of helpers in the relief assistance facility should be established as soon as possible. Sometimes, if there are many organizations involved in providing mental help for affected people, there can be lack of coordination, support and trust between organizations. If the functional network is not established, there might be overlapping of the psychosocial intervention provided from different organizations, which is unprofessional and does not lead to the desired mental health improvements.

Do

Try to organize your activities regarding the time of the affected people, your colleagues, or other field workers in the relief assistance facility.

Be present in the “here and now”. When you are in the relief assistance facility be there not only with your body, but also with your emotions and thoughts.

Don’t

Do not overlap your activities with your organization and other organization colleague’s activities.

When you are outside (at home, with friends) the relief assistance facilities do not bring it with you — it is too heavy.

Network of helpers in the relief assistance facility
Real illustration of one example of intervention regarding the symptom of night urination

Several organizations provided psychosocial intervention in one facility (Organization A, B, C and D in the picture), giving some type of professional help to a child who manifested symptoms of night-time urination. As these interventions were not systematized, they did not bring about the wanted improvements.

Self-help of helpers

Each helper experiences a unique combination of rewards from this kind of work, such as:

► Feeling of personal growth and self-awareness;
► A sense of emotional connection with survivors and the community.

These rewards are source of self-care. A helper should be aware of the rewards and satisfactions he or she receives from this work – and be aware when the signs of caring too much start to outweigh those rewards.

The awareness about the symptoms of professional burn out is the most important issue in this context of self-help.

Here is the list of some symptoms regarding different aspects of personal life:
**EMOTIONS**
- Anxiety • Powerlessness • Insecurity • Sadness
- Helplessness • Depression • Mood swings • Anger
- Fear • Disappointment • Pity

**HEALTH**
- Headaches • Fatigue or exhaustion
- Susceptibility to illness • Muscular aches

**BEHAVIOIRS**
- Sleep changes (insomnia or over sleeping) • Irritability
- Hypervigilance • Appetite changes/ Loss of weight/gain
- Substance use

**WORKPLACE**
- Avoidance • Slowness • Absenteeism
- Lack of motivation or initiative
- Decreasing of creativity

**RELATIONSHIPS**
- Withdrawal/Isolation
- Avoidance of social interaction and communication
- Decreased intimacy • Mistrust • Misplaced anger • Over-protectiveness

**THOUGHTS**
- Disorientation • Perfectionism • Problems with concentration
- Thoughts of harm • Rigidity
- Intrusive thoughts • Confusion

**SPIRITUALITY**
- Loss of purpose • Anger with your God • Loss of faith
- Questioning meaning/ purpose of life and beliefs
Concerning the symptoms provided here, it can be said that helpers who have some of these symptoms manifest signs of professional “burnout”. This should be prevented in terms of the following points:

1. Preparing clear and real working day plan: what activities should be done in what time during one working day and flexibility to make new rearrangement of the activities concerning the real situation in relief assistance facility (“in the here and now”);
2. Efficient time management, travelling, working hours, working days, free time;
3. Establishing groups for support based on trust;
4. Motivation for self-care and improvement of personal mental and physical health;
5. Gaining tools for specific professional psycho-social intervention.

(see Appendix III for level of professional stress)

The following table contains some strategies that are often recommended and can be practiced. The most important point is to know what works for you, and when you’re stressed, remember to do it or do more of it!

<table>
<thead>
<tr>
<th>Get Sufficient Sleep</th>
<th>Have Some Time Alone Utilize the Self-Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exercise</td>
<td>Eat a Balanced Diet</td>
</tr>
<tr>
<td>Practice a Sport</td>
<td>Pray or Follow Your Other Usual Spiritual Practices</td>
</tr>
<tr>
<td>Connect with Others</td>
<td></td>
</tr>
</tbody>
</table>
And remember:

Caring for yourself while helping others does not make you selfish or needy. The care that field workers provide to others can only be as good as the care they provide to themselves!

Systematic approach toward psychosocial intervention

Beside the usage of self-support strategies, helpers should be part of the system, which includes the following elements:

1. **Peer support groups.** It is necessary to organise groups for support facilitated by experienced psychotherapists. The facilitator controls the discussions and provides support. This type of sharing can prevent professional “burnout”. If group support is not sufficient in some cases, individual psychotherapy should be suggested to the helper.
2. **Supervision.** Helpers should, on a regular basis, go to supervision sessions with an experienced psychotherapist. Supervision sessions can be group or individual ones.

3. **Coaching on field.** Coaching on field can have influence on supporting professional self-confidence of helpers. Coaching should be done by the senior psychotherapist. Coaching on field has multifunctional benefits for the helpers: providing learning through doing, providing professional and personal support etc. (see Appendix IV – How to write a report regarding coaching on field).

4. **Continuous training.** Continuous training can provide ongoing efficiency in providing psychosocial intervention.

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**FIELD WORK**

- Debriefing, Individual or Group Psychotherapy
- On Field Coaching and Continuous Training
- Peer Groups for Support (Daily)
- Supervision

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It will be useful to include external evaluation and monitoring regarding mental health issues in relief assistance facilities (see Appendix V for further information).

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**Improvement of the psychosocial intervention approach**

The approach for improvement of the psychosocial intervention (beside support at the personal level, such as: establishing contact-withdrawal boundary, self-support, self-confidence, stimulation of creativity and critical thinking) can be grouped in several categories:
1. Gain knowledge about the affected people’s (migrants’/refugees’) culture (and language);
2. Theoretical knowledge about developmental psychology and different therapeutic approaches;
3. Training for practical skills and tools for specific intervention in limited circumstances and development coping strategies.

Treatment plan preparation. Nine steps to develop a treatment plan

(This part of the manual is mostly based on the UNHCR and WHO manual for mental health of the refugees, 1996)

The nine steps of a treatment plan refer to:
1. Arrange a safe, quiet and private helping environment. Provide comfort and support;
2. Build a helping relationship based on trust;
3. Listen effectively;
4. Probe for information;
5. Provide comfort and support;
6. Encourage self-sufficiency;
7. Assess the problems;
8. Develop a plan of action with the person you want to help;
9. Write a report at the end of the implemented activity;

Life in relief assistance facilities is always connected with the loss of privacy. People have the need to protect their privacy, and do not want to be talked about by others. Being an affected person in relief assistance facilities can affect personal self-respect. Whenever it is possible, helpers should respect affected person’s dignity and find a way for them to regain that dignity.
**Practical advice**

The helper should try to find a way how to communicate with the affected person (migrant/refugee) when translation is needed in a direction to protect his/her privacy. The helper should work on the expressed emotions and behaviour, but not dig in the content (to ask information irrelevant for the mental health intervention).

- The helper should find a quiet place where to talk. It will be a good thing for the helper to ask the affected person to find a place where they can talk.
- The affected person should not be exposed to being interviewed many times about his or her traumatic experiences by different helpers. This approach can cause secondary victimization.

---

**Step:**

**2**  
*Build a helping relationship based on trust!*

A person’s trust can only be earned through behaviour. Being a helper does not automatically mean that he or she is a trustful person. Over time, when trust is established, then the person can open himself/herself for traumatic experiences.

- The best way to earn trust is to be honest and to treat others as you want to be treated by others.

---

**Step:**

**3**  
*Listen effectively!*

Talking to somebody can make him/her feel better. Somebody might want to talk about a traumatic event over and over again, but it does not mean that he or she is in contact with the emotions provoked by the traumatic event. Others can hardly speak about anything regarding a traumatic experience.
**Practical advice**

- The helper should be aware about how he/she feels when listening to them talking about the traumatic experiences. The helper should keep this feelings/thoughts in his/her mind and share them after the session with peer helpers, supervisor or psychotherapist.
- He/she can share how he/she is touched by listening, but not to replace the focus of the conversation on himself/herself; he/she should be aware that he/she is there for the migrant/refugee and not at a session about her/his own emotional needs.
- Respond to how the person feels, not to how you feel.
- Ensure that your concern does not cause the person feel uncomfortable and therefore stop the flow of emotions.
- Many times a person will feel tremendous relief after speaking openly and knowing that someone listens and cares.

**How to listen**

- Sit facing the person;
- Make eye contact;
- Give your full attention.
- Do not let yourself be distracted;
- Nod your head or say something like “I see”, so the person knows you are listening.

**Listening has many levels:**

- Person's words;
- Sound of a person's voice;
- Listen by observing how a person's body moves as he or she speaks;
- Listen to the silence and note what the person does not say;
- The meaning that the words have for the person who is speaking;
- We can listen for person’s feelings.

*Never assume that you know how a person feels. Listen to what the person has to say.*
► Ask questions calmly and slowly, but don’t insist. Avoid sounding like an interrogator.

► Be thoughtful about what you ask. Think about how the person may feel while answering to you.

► Let people talk at their own pace.

► Everyone has their own behaviour, thoughts and feelings. To help someone with an emotional problem it is necessary to understand how their behaviour, thoughts and feelings contribute to the problem. Probing, questioning and leading can be used to get information about all three areas.

► Many people ask for help by talking about a problem of behaviour: for example, “I have a headache”.

► It is easiest for the person to begin by describing one’s behaviour. To fully understand the behaviour, ask the person to describe the problem exactly.

► Ask what the person thinks about the problem. What thoughts are really going on inside the person’s mind?

► It is very important to try to understand people’s feelings. This is often difficult, because many cultures discourage expression of feelings and people believe they must always appear confident and strong.

► If you provide a safe environment, appear caring and listen closely, most people will eventually open up about their feelings. Once they realize that expressing feelings is permitted, the feelings often come out like a flood. Encourage the flow but be careful not to overdo it.

► It can be stressful for the field worker to listen to a person expressing emotions in this way.

► Stay calm and resist the impulse to try to make the person feel better at once. First, the feelings must be expressed. This is not the time to make a plan for improvement or to give advice; it is the time to listen and probe for information. It is no use being too logical; feelings are not usually based on logic.
Use a kind and gentle voice.
Your body can show your interest and caring. Sit close, but not too close, and lean towards the person. If appropriate, touch the person’s arm to show concern.
Offer a tissue for the person’s eyes or a glass of water.
Show concern in your facial expression.

The helper should show that he/she has confidence in the affected person’s capacity for self-help. Many people feel uncomfortable if they are in need of help.

**Practical advice**

The helper should support the affected person’s potential for coping with life difficulties. The helper should stimulate knowledge and skills (for example, playing some musical instrument, knowledge of some handcrafts...).

Before the helper can develop a plan of action he/she needs to assess the problems.
**Practical advice**

- It is good to spend some time thinking about what the person said. Often the problems presented initially are not the only issues to be considered.
- Consider the person’s behaviour, thoughts and feelings and how each contributes to the problem.
- Consider the person’s life situation and the practical difficulties to be faced in making the change that is needed.
- Consider the person’s family and community. What impact do other people have on the person?

**Step:**

**Develop a plan of action with the person you want to help!**

The helper should:

1. Formulate the problem clearly, in one sentence. If there is more than one problem, all of them should be clearly written. Use one sentence for one problem;
2. Make a decision which problem is the most urgent one. Make a rank list of the problems;
3. Make a plan what should be achieved and which approach will be the most useful regarding the age, cultural background, level of trust, societal circumstances, etc.

Write the plan. It is often useful to write down the plan of action.
**Sample plan of action**

**PROBLEMS**

**CHILD BEHAVES AGGRESSIVELY TOWARDS OTHER CHILDREN**

![Question Mark]

**GOALS**

**IMPROVE BEHAVIOUR**

![Target with Arrow]

**IMPROVEMENT PLAN**

**WATCH** child at play with other children.

**SHOW** her/him other ways to behave when she/he becomes upset.

The physical activity can be the following one (give idea for a game which needs physical activity, give pillow to hit as much as he/she needs, use drawings).
Practical advice

The helper should be aware of the outcome of the intervention. What was useful and what was not (Why?). What else can he/she do? What will the plan be for the next session? How did he/she feel during the intervention? All these questions can help the helper to improve the treatment.
LOOKING AFTER THE MENTAL HEALTH OF AFFECTED CHILDREN
Children become part of affected population when they seek safety with their parents or are sent for safety outside their own country. They often find themselves in a culture different from their own. Many children have traumatic life events, but not all have mental health problems. Although only a small proportion of people need mental health care, *people who work with affected children and their families should be able to recognize signs of mental disorder or emotional distress in children and know how to help.* As far as possible, *affected children* should be cared for within their families and communities. Helpers must seek the help of traditional health, religious and social systems to treat children in ways that are appropriate to their culture (NSW Refugee Health Service Working with Refugees, 2004).

From a psychological point of view, affected children, especially if they are unaccompanied migrants/refugees, are a particularly vulnerable group. Many of them have suffered multiple traumas – the horrors of war, violence, bereavement. Traumatic experiences may create recurring memories that haunt these children to the point where their emotional, cognitive and social development is impacted. These children may sometimes reveal their distress in their drawings, depicting anguish and loss (Centre for Multicultural Youth).

**Helping affected children from a different culture**

If the helper is working with affected children who are not from the same culture, it is crucial to gain information about the children’s culture. When talking to the community, the helper might ask how people care for their children, what rituals and celebrations they have, and what hopes they have for the future, also about the roles of different family members to find out how the community cares for children without families. Here are samples of some useful questions (WHO, UNHCR, 1996):
Helping affected children from different age groups

Working with affected children means high level of knowledge about aspects of normal development from infancy to adolescence. The summarized aspects are presented in the following table (Gormly and Brodzinski, 1990):

- Does the immediate family (mother, father, sisters and brothers) care for infants? Or is there an extended family system where grandparents, aunts and uncles care for children?

- Who disciplines children and how do they do it?

- Are certain kinds of behaviour accepted until the child reaches a certain age? Is the child then expected to mature and behave differently?

- Are children from large families often sent to live with other family members? If so, what is the children’s role in their new family groups?

- What do parents expect of their children at different ages? What work do parents expect a child of a certain age to do in the home? How much is a child of a certain age expected to look after brothers and sisters? At what age would children normally start school and how long would their education last? When would they learn a trade? When would they leave home?

- What is the traditional way of caring for children without relatives?

- What does the community think about foster care (taking responsibility for someone else’s child?)
<table>
<thead>
<tr>
<th>Personality</th>
<th>Language</th>
<th>Cognitive</th>
<th>Social/Emotional</th>
<th>Sensory/Motor</th>
<th>Physical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-awareness begins; sees self as separate from others; oral anal stages; trust develops.</td>
<td>One and two word sentences are produced; vocabulary increases.</td>
<td>Sensor motor understanding emerges; early memory skills develop.</td>
<td>Establishes attachments to caregivers; imitates others; temperamental reactions; separation distress; stranger anxiety.</td>
<td>Prehension and locomotion; depth and face perception develop.</td>
<td>Rapid increases in weight and height; head to toe and inner to outer directed growth.</td>
</tr>
<tr>
<td>Premoral view gives way to moral realism; good is what is rewarded.</td>
<td>Mastery of grammar and large increase in vocabulary.</td>
<td>Preoperational thought; use of symbols.</td>
<td>Gender roles, prosocial behaviors emerge.</td>
<td>Gross motor skills emerge before fine motor skills; handedness is established.</td>
<td>Brain approaches adult size; growth or size continues, but slows down.</td>
</tr>
<tr>
<td>Self-awareness becomes psychological in nature; body and self-esteem are formed; the crisis of industry versus inferiority is resolved. Introspective self emerges.</td>
<td>Able to construct complex sentences; vocabulary increases; able to appreciate puns or play of words.</td>
<td>Appearance of concrete operational thought; attention span increases with strategies; cognitive styles emerge.</td>
<td>Peer relationships develop; gender roles are practiced; friendships become important; reactions to stress are influenced by social support; fears become more realistic.</td>
<td>Fine and gross motor coordination improves with practice.</td>
<td>Children grow leaner and taller at a slower, more uniform rate; physical strength increases; brain development approaches maturity; physical fitness begins.</td>
</tr>
<tr>
<td>Self-concept affected by timing of sexual maturity; egocentric view of self is enhanced by personal fame and belief in an imaginary audience; racial and ethnic identity established.</td>
<td>Vocabulary includes more abstraction; mastery of communication skills reached.</td>
<td>Formal operational thought emerges for some adolescents; able to consider hypothetical and ideational situations.</td>
<td>Peer group membership is important, prompting conformity; increase in risk taking related to unrealistic assessment of morality and vulnerability.</td>
<td>Period of large growth spurt; sexual maturity is reached; females reach menarche; males able to produce sperm; increase in height, weight and muscle mass; sex organs reach maturity.</td>
<td>Uneven growth in early adolescence of body parts produced some awkwardness; coordination emerges in late adolescence.</td>
</tr>
</tbody>
</table>
How to recognize the mental health problems of children

Below is a list of some common reactions recognized among children in transit centres in Macedonia, and are typical for any affected children population.

- Aggression (physical)
- Aggression (verbal)
- Night-time urination
- Lack of concentration
- Destruction
- Isolation
- Intolerance
- Anxiety
- Insomnia
- Fear
- Sadness
- Anger
- Insecurity
- Need for a way out
- Stuttering
- Hyperactivity
- Manipulation
- Bullying
- Animal abuse
- Tics
- Problematic behaviour
- Lack of parents
- Avoiding to talk
- Sexuality
- Nightmares
- Poor health
- Fear of making mistakes
- Poor education
- Need for attention
- Possessiveness
- Crying
- Avoiding talking about what has happened
- Playing or drawing and re-acting elements of traumatic events
- Asking a lot of questions about the future

Typical stress reactions related to different age groups

**Birth to 2 years (infancy):**

Even though small children do not have words to describe the event or their feelings, they can retain memories of particular sights, sounds or smells. They may cry more than usual, be clingy, ir-
ritable, passive or emotional. Possible reactions to stress: increased crying, biting, thumb-sucking, overall agitation, more frequent startle responses, a tendency to throw objects out of cribs, beds, or play areas, and occasional attempts to throw those objects at others. Children who are already toilet-trained or are close to that goal may have setbacks (Levin, 2001).

2 to 6 years (early childhood):

Pre-school children often feel helpless and powerless after a crisis. They typically fear being separated from parents and return to earlier behaviour like thumb-sucking, bedwetting or fear of darkness. Play activities may involve aspects of the event that has been experienced, where the child enacts the event over and over again. When these methods fail, young children turn to denial and withdrawal. They may become silent (mute) or avoid playmates and adults, seeking comfort through illness or tiredness. Children at this age may also exhibit anxious attachment behaviours toward their caregivers, physically holding onto adults and not wanting to sleep alone. They also may become withdrawn and may manifest short “sadness spans” that suddenly appear and disappear throughout the day. They may also regress in their physical independence, refusing to dress, feed, or wash themselves. Many children of this age will experience sleep disturbances; nightmares will be common (Levin, 2001).

6 to 12 years (middle childhood):

The years during which children are normally at school are important for their development. Their view of the world and what happens in it changes dramatically during this time.

The school-age child is able to understand more complicated issues. This can result in a wide range of reactions, such as guilt,
feelings of failure or anger that the event was not prevented, or fantasies of playing rescuer. Their behaviour may appear moody as they attempt to deal with increasing feelings of inadequacy and the need to establish control. Some children want to talk about the event continually. School-age children usually show a decline in performance in school and work tasks, or they become perfectionists, trying harder and harder to be perfect in order to avoid the previous consequences.

Common at this age is the child’s fantasy that he/she will become the “saviour” who is able to rescue family, friends, and society from disaster. Also, expect the child to be less trustful of adults and less confident in the perceived safety of his/her environment. At the same time, expect the child to become more tentative in moving toward independence from parents. Headaches, stomach-aches, and other physical ailments become common stress reactions at this age.

Children of school age (6-12 years) in need of special attention for stimulation may have some of the following symptoms:

- The child may always be crying;
- The child may tremble or appear frightened;
- The child may indulge in self-stimulation such as rocking back and forth or banging the head;
- The child may have sleep disorders, nightmares or sleeplessness, or may sleepeexcessively;
- The child may wet the bed;
- The child may have eating disorders;
- There may be physical illnesses or problems, such as headaches, dizziness, back aches, or stomach upsets with no apparent cause;
- The child may be physically aggressive or very loud and rough during play;
- The child may be extremely withdrawn, quiet and well-behaved, never expressing feelings or desires, or depressed and unresponsive;
- The child may start acting like a much younger child (for example, there may be loss of bladder control);
- There may be restlessness and inability to complete a task;
- The child may be unable to concentrate or remember things in school;
The child may be irritable towards others or unable to work with others;

The child may be frightened of others and unable to trust them;

The child may always be thinking that bad things will happen in the future (WHO, UNHCR 1996).

12 to 18 years (adolescence):

Adolescents may show responses similar to those of adults. Isolation, irritation, rejection of rules and aggressive behaviour is common. Some teenagers may become involved in dangerous, risk-taking behaviour, such as reckless driving, alcohol or drug abuse, self-harm and may develop eating disorders. Others become fearful.

Some reactions characteristic for pre-teens: 12-13 years old pre-teens become particularly cognizant of the lack of safety in the world, and may exhibit considerable anger without a clearly defined target. They may feel more threatened, may feel the future is more uncertain, and may feel a sense of meaninglessness or purposelessness. Pre-teens may also become more withdrawn as they try to stuff their feelings deep inside. Psychosomatic illnesses become quite common at this stage. Please note that psychosomatic symptoms are real physical symptoms precipitated by psychological stress. Typically, the part of the body that is the weakest or most prone to illness – i.e., the stomach, back, or head – may be the most likely site of increased pain or disability.

Some characteristic 13-18 year old's possible reactions: anger, increased rebelliousness, sleeplessness, nightmares, attempts to establish control over their environment, increased judgmental behaviour toward themselves and others, being suspicious of others, exhibiting eating disorders (either an increase or decrease in food consumption compared to previous patterns), depression, anxiety, possibility of substance abuse, and psychosomatic illnesses. In many ways, teenagers are the most vulnerable of these age groups.
because their minds and bodies are in so much developmental flux, and because they are painfully aware of the realities and implications of tragedy. They are less likely to be or to feel protected from the assaults of the outside world, and they have limited capability to forge solutions on their own to make things better.

The main problems of people in this age group relate to their separating from their families and becoming independent. It is important for their development that they are able to practise skills with other young people of the same age.

They also need to copy adult behaviour as they gradually take on adult roles in their community and society. The passage from childhood to adulthood is vital to healthy development.

Symptoms of distress in young people include:

► Withdrawal from others; failure to form relationships;
► Identifying too much with others; being dependent on others for direction;
► Aggressive behaviour, attitude or actions;
► Agitation, restlessness or inability to remain still or concentrate;
► Extreme depression; unresponsiveness to the extent that they are immobile (catatonic);
► Moodiness or changes of mood and behaviour from one extreme to another in a short time;
► Functional or physical complaints (such as frequent headaches, stomach upsets) caused by stress;
► Sleeping disorder;
► Hallucinations; seeing or hearing things that do not exist;
► Paranoia or inability to trust others; feeling that others are threatening to do harm;
► Suicide attempts.

The refugee situation can make matters worse because:

► Young people are prematurely separated from family because of forced movements or poverty;
► Young people’s roles in the community and the community itself may change;
► Family needs may force young people into adult roles earlier than normal (WHO, UNHCR, 1996).

(see Appendix VI for instruments)
How to help children of different age, practical advice (Levin, 2001 and WHO, UNHCR, 1996)

<table>
<thead>
<tr>
<th>BIRTH TO 2 YEARS</th>
<th>2 TO 6 YEARS</th>
<th>6-12 YEARS</th>
<th>12-13 YEARS</th>
<th>13-18 YEARS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Provide comfort, lots of physical contact (cuddling, rocking)</strong></td>
<td><strong>Maintain the daily routine</strong></td>
<td><strong>Answer their questions in an age-appropriate way</strong></td>
<td><strong>Supportive behavior as extra degree of attention and support</strong></td>
<td><strong>Provide opportunities for community involvement (volunteering, tutoring, etc. to help foster feelings of accomplishment and contribution)</strong></td>
</tr>
<tr>
<td><strong>Encourage drawing, painting, dramatic play, playing with clay, and playing with super-hero toys to help elicit or ventilate feelings</strong></td>
<td><strong>Assure them that it is acceptable to be scared or sad, but also assure the child that other adults will protect him or her</strong></td>
<td><strong>Temporarily lower expectations of performance</strong></td>
<td><strong>Encourage conversations with family and friends</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Provide as much of a routine and schedule as possible</strong></td>
<td><strong>Encourage the verbal expression of thoughts and feelings, provide additional attention, hugging</strong></td>
<td><strong>Encourage the pre-adolescent to connect with same-age group activities</strong></td>
<td><strong>Encourage young people to connect with same-age group activities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Allow some back-sliding in maturation (do not criticize child for regression)</strong></td>
<td><strong>Encourage the use of art, drama, and music to help ventilate and facilitate the expression of feelings</strong></td>
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</table>
How to conduct interview with a child after experiencing traumatic event

Interviewing a child who has experienced trauma can be difficult for the child and also for the field worker trying to assist the child. Only an experienced helper and trained in child psychotherapy can conduct an interview with a traumatized child! There is one format for an interview in three stages:

Stage: OPENING

Opening permits the child first to express the trauma through play, fantasy and metaphor by use of projective free drawing and storytelling. Younger children (under 4 year) may play while they draw, but they can be encouraged to “make up story”.

The most important segment in helping children is to provide continuity in the educational process!!!
Trauma: therapeutic exploration. In this stage there is a move from the child's drawing and story to explicit discussion of the event. At this point the child becomes very emotional and it is very important that the child feels that the field worker is supportive and will protect the child from becoming overwhelmed by his emotional reactions. The field worker needs to be prepared to share and to provide comfort for the child. It is relevant to bring the child to the point of the experience where he is not too frightened by his emotional responses.

Closure: assist children in their current life concern.

It is helpful to get the child to participate in reviewing and summarizing the session. Children should be supported that their feelings are understandable, universal and realistic. This will help the child to feel less alone and more ready to accept further support. Child self-esteem should be encouraged. It is important to ask the child to describe what was helpful or difficult during the interview. This will help him gain control back over what is happening to him (Husain, Holcomb, 1993).

Loss

The death of someone close is one of the hardest things, especially for refugee/migrant children. They have already lost their home, so family and relatives are the only stable support system for them during their migrant life. A child's understanding of loss
depends on their age, gender, stage of development, family background, personality and previous experience. Violent death of someone close to the child, especially if he or she was parent or guardian, and additionally if the child witnessed the death can cause serious depressive reactions.

The helpers, even if they can do anything, they can’t protect a child from the pain that follows bereavement, but there are things she or he can do to help the child cope with his/her loss. Talking about death can be difficult for helpers in two ways: first because they want to protect the child and second they will have to cope with their loss (if they have experienced loss of a close person). Here are some useful suggestions what not to do and what to do when communicating to children after the loss of someone close to them.

Be careful with the following explanations:

“Grandmother will sleep in peace forever.”

► This explanation may result in a child becoming frightened of going to bed or to sleep.

“Father has gone away for a while, but will come back soon.”

► Eventually the child will realize that father is not coming back and might get anxious and wonder why.

“God took auntie because she was such a good person.”

► The child might worry that other good people will also be taken away.

“This happened because it was God’s will.”

► The child might wonder why God wants bad things to happen.

“This was a punishment from God.”

► The child might fear God and be overly anxious every time he/she does something wrong.

“Sister died because she was sick and went to the hospital.”

► The child may be worried every time someone gets sick, especially if someone has to be taken to the hospital.
Useful practical advice how to talk with children who have lost somebody:

- First, come in contact with your own feelings of loss,
- Try to be fully present with your thoughts while talking to the child, so the child can feel that he or she is not alone,
- Try to avoid telling the child not to worry or be sad. It’s healthy to express feelings. Anger and sadness usually appear together. Child can feel anger as he or she is now without the important one. Ensure them that it is ok to be angry. The child has no reason to blame himself/herself for feeling anger,
- Be sure to give the child plenty of reassurance. Let them know they are loved and that there are still people who will be there for them. A cuddle can make a big difference and make them feel cared for. It’s also a good idea to stick to a routine, as much as it is possible. This can help the child feel more secure,
- Be honest. Children need to know what happened to the person that died. If you know what happened try to explain in clear, simple language that’s right for their age and level of experience,
- Encourage the child to ask you questions. Children are curious and when they are upset they can ask the same questions over and over,
- Ask children to tell their story, use playing techniques, drawings, physical expression,
- Ask them to tell their story. Asking children to tell their story of the death and experience of grief will let them know they are important and that their relationship with the person who died has been recognised. It can help you understand what they know about what happened and correct anything that’s not quite accurate. It can also help children discover that the way they see things changes with time\textsuperscript{17}.

Usage of Memory box

Memory boxes help children remember in a positive way someone who has died. Having a memory box can prevent the child from feeling afraid that he or she will forget the person who died. Things that once belonged to that person, e.g. letters, photos, can be put in the memory box. Tell the child that sometimes remembrance is painful. The memory box can be put away after a time, but should be available when needed. Adolescents may also like to use memory boxes or other means of remembrance.18

Practical advice for helpers in terms of supportive communication with children

Be positive!

<table>
<thead>
<tr>
<th><strong>DO</strong></th>
<th><strong>DO NOT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>use positive supportive phrasing such as: “You are good at many different things...”, “I can see you have done your best...”</td>
<td>use negative phrasing such as: “You are not good at...”, “You always fail at...”</td>
</tr>
</tbody>
</table>

Give clear and positive instructions!

<table>
<thead>
<tr>
<th><strong>DO</strong></th>
<th><strong>DO NOT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>use ‘do...’ a lot more, and explain things simply and carefully to enable realistic expectations of both you and the child.</td>
<td>use ‘do not...’ all the time. DO NOT expect children to know how to do things on their own!</td>
</tr>
</tbody>
</table>

## Do's and don'ts of helping children who have been abused

### DO
- **Encourage and support the child’s efforts**, speak respectfully as you do to others — say ‘please’ and ‘thank you’.
- **Listen to the child attentively and look at the child when he or she is talking and pay attention**.
- **Ask general, open-ended questions**: “Do you want to tell me about that?”
- **State observations**: “I see you have bruises on your legs.”
- **Validate feelings**: “I see that you are upset.”
- **Express concern**: “I need to know that you are safe; let’s try to get some help.”

### DO NOT
- Don’t **put a child down verbally, shout or verbally abuse a child**.
- Don’t **assume you know a child’s opinion**.
- Don’t **underestimate a child’s intelligence**.

### Show respect!

<table>
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<td></td>
</tr>
</tbody>
</table>
Psychological workshops for children and adolescents

Psychological workshops are part of the psychosocial intervention programmes for mental health promotion. Psychological workshops are highly structured group activities on a certain topic, using different modalities of expression within three parts of session: introductory part, main part – the topic of the workshop – and closure. There is an already given topic around which the contact with the personal experiences and emotions of a child develops in order to articulate and integrate new experiences. This is done symbolically, through various ways of expression chosen by the child receiving the meaning of the transitive object through which the topic is elaborated.

Psychological workshops can be used in relief assistance facilities when affected people are not in transition. Whenever there is settlement longer than a month, this approach is very useful for children’s mental health.

The main goal of the psychological workshop is stimulation of the coping strategies, resilience and psychosocial development through structured playful activities such as: voice, movement, painting, drawing, song, sound.

When abuse is suspected or disclosed, we must ACT

A: Acknowledge the child’s situation and feelings; Access support and help; report.
C: Carefully listen to what the child says; Comfort the child; Ensure the child is safe.
T: Take notes; document what the child says and what is observed.

► Groups should meet once or twice a week and meetings should last about an hour.
► Groups should always meet at the same time and do what has been agreed.
► Everybody sits in a circle (sitting in circle enables equidistance of every member of group).
► Every group creates its own rules, but there are some general rules: everybody has to be heard, everybody should be respected, insulting is not allowed.
► Children groups should be well structured and stable.
► There should normally be no more than 12 participants.
► Children should be allowed privacy and confidentiality.
► Groups should meet in a calm, private place without others who do not participate.
► Group leaders should be prepared to discuss with the parent and child, in a separate meeting, about what happened in the group.
► Groups should create an atmosphere of security, trust and safety, so that children can express their needs, thoughts and/or emotions. If someone does not want to share with the group he or she must not be forced to do so.
► Psychological workshops can be used for children 5 years and up, with adaptation according to the age of the children.

Steps (Judson, 1983)

1. In the first place is the affirmation of the group members (there are a lot of “put downs” in the everyday life of migrants which has its own reflection on their mental health): affirming somebody is acknowledging and appreciating the good and admirable qualities in him or her.

2. Group confidence, cooperation, communication (a supportive group atmosphere allows people to work together on problems and provides ongoing confidence. In this atmosphere it is assumed that everyone is an equal member of the group (community) and everyone has something to contribute.

3. Sharing of feelings, information, experience (sharing with others breaks down the sense of isolation which keeps people
from empathizing with others in conflict situations (when there is some optimal level of affirmation and positive group dynamic is established, then sharing can take place).

**And the most important element: Enjoying life: joy is a part of life and we should celebrate life no matter where we are!**

Important points for the leaders of psychological workshop (Nada Ignjatovic-Savic, 1993, Tunde Kovac-Cerovic, 1993)

The child experiences the world and himself/herself through adults, so adults should help the child grow by protecting him/her from contents and events which he/she cannot understand. Leaders as a model for identification support tolerance, stimulate self-confidence and always stimulate creative expression and humour (but not mockery).

► There are no already prepared solutions, or correct answers.
► Adults and children participate equally in workshop activities.
► Leaders respect the expression of negative feelings, giving them time to be expressed, not interrupted with comments like: “do not cry, it is not worth crying”.
► Leader helps children to understand what he or she is feeling. For example: “How do you feel now...is it anger...or maybe you are sad” etc.
► Leaders support constructive expression of tension. This can be done through physical activity (for example, games with running, jumping, throwing etc.) or by drawings, or by games with voice (loud, very quiet, then again loud singing or screaming or saying the child’s name).
► Leaders express support and happiness when children succeed in something (it is very useful for every psychological workshop to find something to support in every child. This should not be “giving support just to give it”; it should be based on real behaviour of the child).
► Materials which are produced should be treated with respect. Every produced material (for example, drawings) should be respected as they are expression of the children’s feelings, needs and thoughts (there should be some place where the group can keep their materials). They can be used as an ex-
Leader selects an activity. When selecting the activity it is important to ask yourself the following questions (Judson, 1983): What do I want to accomplish in this group? How is this activity helpful? Is this activity suitable for the level of trust in the group? Is there a need to adapt the activity to the age group? And the most important one: Do I feel comfortable with this activity?

Sample of psychological workshop

<table>
<thead>
<tr>
<th>NAME OF THE PSYCHOLOGICAL WORKSHOP:</th>
<th>Tips: It is possible to find such qualities in every human being. Therefore, each person can be affirmed!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self awareness</td>
<td></td>
</tr>
<tr>
<td>GOAL OF THE WORKSHOP:</td>
<td></td>
</tr>
<tr>
<td>Affirmation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FIRST PART</th>
<th>GAMES WITH NAMES</th>
<th>TAKE CARE ABOUT THE MOMENT OF LIKE AND DISLIKE OF HER/HIS OWN NAME. ALLOW HIM OR HER TO USE A NAME WHICH HE/SHE LIKES.</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAIN PART</td>
<td>DRAWING SELF-PORTRAIT</td>
<td>THERE CAN BE COMPLAINS SUCH AS: “I DO NOT KNOW HOW TO DRAW”. ASSURE THEM THAT NOBODY WILL JUDGE THEIR ARTISTIC PERFORMANCES. MAYBE SOME CHILD WOULD LIKE TO DRAW SOMETHING ELSE, ALLOW HIM OR HER TO DRAW WHATEVER COMES TO THEM TO DRAW!</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLOSURE</th>
<th>GROUP PORTRAIT</th>
<th>PUT ALL DRAWINGS ON ONE WALL AS A BIG PICTURE OF THE GROUP. THIS HELPS IN ACHIEVING POSITIVE GROUP DYNAMICS!</th>
</tr>
</thead>
</table>

(See Appendix VII for monitoring and evaluation of psychological workshops)
Part IV

PARENTING/CAREGIVING IN RELIEF ASSISTANCE FACILITIES
Parenting plays the most important role in helping children to understand and manage emotions, develop resilience and foster positive relationships.

The way parents care for their children during displacement plays a key role in children’s emotional and behavioural outcomes. The process of parenting can be affected during life in relief assistance facilities. For the mental health of the affected children, parents are most important, as they are their guardians. The role of being a “shield” between the traumatic events and the protection of their own children is very exhausting for parents.

**Differences in family structure**

Helpers should be aware of the differences in family structures. Family structure can be recognized through three aspects:

1. *Relationship parent – child, attitudes toward raising children*;
2. *Relationship husband – wife*;

Main aspects of **traditional family** attitudes are included in the following table:

<table>
<thead>
<tr>
<th>RELATION PARENT – CHILD</th>
<th>CHILDREN SHOULD OBEY THEIR PARENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>RELATION HUSBAND – WIFE</td>
<td>WIVES SHOULD OBEY THEIR HUSBANDS; MEN WHO DO NOT CONTRIBUTE FOR THEIR FAMILY SHOULD SEE THEMSELVES AS UNSUCCESSFUL HUSBANDS AND FATHERS</td>
</tr>
<tr>
<td>RESPONSIBILITIES OF MALES</td>
<td>PROTECT FAMILY DISCIPLINE CHILDREN FIX THINGS REGARDING HOUSEHOLD PROVIDE SUPPLIES FOR THE FAMILY (MONEY, FOOD ETC.)</td>
</tr>
<tr>
<td>RESPONSIBILITIES OF FEMALES</td>
<td>CAREGIVER STAY HOME AND LOOK AFTER CHILDREN</td>
</tr>
</tbody>
</table>
**Case from the 2015-2017 crisis in Macedonia**

Here are some specific aspects of detected behaviour among parents in the relief assistance facilities in Macedonia (research with focus groups – 2016) regarding their gender which determines migrant’s family structure as a traditional one. Also, regarding the traumatic experiences the parents' mental health is affected and this has reflection on their role as parents.

The perception of the helper is that:
- **Women**
  - There is a lack of motivation for life in general and for parenting.
  - Maternal depression. Child neglect.
  - If they have older daughters, they transfer all the obligations to them.
  - If not, then they do all the activities relevant for family life.
- **Men**
  - The perception of the helpers is that: there is no “father role”, they are not involved in the process of parenting. Aggression and depression are dominant.
  - Boredom and lack of activities, not having much to do during the day.
  - They need to do something, to work which will make them busy and useful.
  - Inability to provide for themselves and their families.

Women with no husband or relatives are at higher risk, but those with husbands or family can be exposed to family violence. They feel exhausted physically and psychologically.

The helpers should recognize the nature of the family structure and adjust their psychosocial support to the family members (children, mother, father, relatives etc.).

**Tips for the helpers:**

- Respect the established family structure. This structure is something that gives support to the family members, it is like their pillar!
- Be aware of the cultural differences in the family system structure!
- Comparison of the systems (those which you are used to practice in your culture, in your family) will not help parents in the improvement of their parental role!
- Try not to blame parents on how irresponsible they seem to you!
- Mental health prevention and intervention does not mean transformation of the family structure!
Individuality and integrity of parents (mother/father) and caregivers

It is very important to give support to the parent/caregiver as a person, not only as a parent/caregiver. It is important for children that parents and caregivers look after themselves.

General manifestation of adult’s reactions (parents, caregivers) in migrant/refugee camps is presented in the table below.

<table>
<thead>
<tr>
<th>Depression</th>
<th>Communication problems</th>
<th>Emotional indulgence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of interest</td>
<td>Sadness</td>
<td>Traditionalism</td>
</tr>
<tr>
<td>Health problems</td>
<td>Indifference</td>
<td>„Freezing“</td>
</tr>
<tr>
<td>Aggression</td>
<td>Suicide intentions and self-harm</td>
<td>Psychosomatic disease</td>
</tr>
<tr>
<td>Intolerance</td>
<td>Need of way out, feeling of “no way out”</td>
<td>Limited ability and motivation for day-to-day tasks (many people give up on cleaning their living space and on personal hygiene)</td>
</tr>
<tr>
<td>Irritability</td>
<td>Fear</td>
<td>Anger, frustration, shouting, acting out</td>
</tr>
<tr>
<td>Irresponsibility</td>
<td>Child neglect</td>
<td>Sleep disturbance</td>
</tr>
<tr>
<td>Avoidance</td>
<td>Hysteria</td>
<td>Uncertainty about the future</td>
</tr>
<tr>
<td>Family violence</td>
<td>Child abuse</td>
<td></td>
</tr>
</tbody>
</table>

(see Appendix VIII for identification of disorders and evaluation of psychotherapeutic process)

All conditions presented can prevent parents from taking adequate care about their children.
Supporting parents and caregivers

When parents and caregivers are supported to look after themselves they are more likely to feel good and helpers can stimulate their self-support. By supporting their right to take care of themselves, parents/caregivers will be more able to provide their children with the best care possible. Being healthy helps parents promote positive mental health and well-being in children (WHO, UNHCR, 1996).

How to support parents and caregivers to look after themselves?

► Establish group of mothers (fathers)/caregivers in which, through practical activities, they will be stimulated to build and maintain positive relationships (ex. with friends, family or helpers). Establishing support in-between affected people in relief assistance facilities is especially helpful during challenging times. Established supporting groups can be helpful for psychological education where they can recognise symptoms of stress, understand what is causing them and learn some coping strategies (see Appendix IX).

► It is very important to stimulate affected people in relief assistance facilities to develop or maintain or share with others their personal interests (ex. reading, drawing, singing, some handcraft skills etc.).

Parent/caregiver as educator

The stimulation of a child’s development and education is the most important aspect for children!

Parents/caregivers should be supported to be teachers to their children!
Fathers (male caregivers)

Fathers are the hardest segment of the family to be supported. According to the traditional role of the father in the family, fathers should take care and provide supplies for all members in their family. In the relief assistance facilities, this is very hard to achieve, so they may feel that they are failures.

Tips for helpers on how to support fathers:

- Appreciate their efforts about what they did and are doing to protect their families in very hard life circumstances.
- Try not to judge them, but to show respect and understanding.
- Respect the family hierarchy, when providing help for the family, consult with the father about the well-being of his family.

Mothers (female caregivers)

In relation to the traditional family system mothers are caregivers, they are usually at home taking care of the children, the cooking, cleaning and washing. These activities are very hard in relief assistance facilities, where they do not have basic household supplies.
Supporting mothers of infants who need special help

If a mother is exhausted or depressed by her situation, helpers can decide that it is necessary to arrange for more support.

Here are some ways on how to offer support:

► Arrange home visits to make sure that the mother and child have lots of support to begin with. As the mother gets better, visits can be decreased gradually;

► It may be possible to get relatives, neighbours or other women who are alone to help in the day-to-day care of the mother and child;

► Later, a group of home visitors of this kind should be trained to keep an eye on the mother and child;

► In very extreme cases, it may be necessary to move the child and mother to a place where they can be cared for. Mother and child must not be separated. (WHO, UNHCR, 1996)

Tips for helpers on how to support mothers:

Appreciate their efforts in providing basic conditions for, as much as it is possible, the normal life of their family.

Organize group for mothers to provide support and information on how to stimulate child’s psycho-physical and social development.

Organize group of women where issues of gender regarding human rights specific to women and girls will be discussed and where the role of women will be strengthened.
Supporting the parent/caregiver to stimulate infants (0-2 years)

The most important aspect for infant development is stimulation of sensor-motor system. The aim of stimulation is to maintain the infant’s development or to help the infant come as close as possible to the normal level of development. This is important for two reasons. First, stimulation motivates the baby physically. Second, it encourages the baby to make contact with the mother/father or caregiver. Mother and child respond to this attention. Their relationship becomes stronger. She can see the immediate positive result in the baby. The mother is pleased, so the baby wants to do more. This attachment to the parent/caregiver is one of the most important steps in the child’s development. From this early experience of trust and love, children learn communication skills that they will use.

“Stimulation” means actively encouraging infants to use:

- their senses (sight, hearing, etc.) – for example: the parent/caregiver can play with their infants with safe objects which produce different sounds, which infants can also use;
- their motor abilities (their skills when moving) – for example: catch some objects, put objects from one to another position;
- their ability to learn and solve problems – for example: put different objects in different holes to understand the concept of shape and size;
- their ability to communicate with others.

Ways to stimulate speech

The parent/caregiver can do the following to help stimulate speech:

- Talk to the infant while breast-feeding or spoon-feeding. Make eye contact and talk or sing to the infant while nursing.
- Put the infant on her lap or hold it in front of her as she talks. Talk about the surroundings or what she is doing. Tell the child where she is going (WHO manual).
Help the family construct or find a few simple playthings and encourage mother and child to play together for short periods every day.

Get older children or relatives to play with or stimulate the baby using the toys at hand.

Make toys from local materials. Making toys can be another way to involve parents in caring for the child.

Folk stories and songs should always be part of activities with children.

Search for items an infant would play with under normal circumstances.

Supporting the parent/caregiver to stimulate preschool children (2-6 years)

Preschool children understand that language and words are for communicating what they want. During the preschool years they spend a lot of energy practising and perfecting words and learning how to use them. This is a period when children can very easily learn new languages.

It is most important to support the parent/caregiver to continue to set aside special time to talk to the children face to face and listen to them, even if for only a few minutes a day. Daily routine activities can be excused for the parent/caregiver, but these daily routines can be helpful for maintaining and strengthening the bond parent/caregiver-child.

The helpers can support the parent/caregiver to talk to his/her children while doing their everyday activities, they can support them to sing some traditional songs, to tell stories etc.
Space is something which is not sufficient in relief assistance facilities, and during this period (from 3-6 years) the physical activity is the most important. So the parents/caregivers should be supported to spend some time with their children in the yard of the camp where they feel safe. Older sibling can be encouraged to play with younger children.

Parents/caregivers can be encouraged to make toys for their children (toys can be made from paper, wood, canvas...).

Symbolic games are very important for the psycho-social and sexual development for this age group. The most important suggestion for helpers is to play as much as possible with the children. Use every material which can cause no harm to make toys, for example you can use water to produce sounds to make balloons full of water during summer time etc.

Supporting the parent/caregiver to stimulate children of school age (6-12 years)

Parents should support their children to spend more time with other children and let them play as much as possible. Play is a way of relaxing and interacting with other children for enjoyment. It requires very little involvement from adults. It is also a way of developing physical, mental, emotional and social skills. Fathers (or other males) can be stimulated to teach children how to play football or some other sport. Also, if they know how to play some instruments they can teach children, too.

Children can express their feelings through drawing, painting, making things or doing drama activities. It is important to support parents/caregivers to use stories to educate their children. Helpers can support parents/caregivers to tell the stories known in their culture and talk about the meaning of the story, the main heroes, what is good to learn as a life lesson.

Note: Helpers can use story-telling techniques to improve parent/caregiver-child relation. Story-telling through usage of metaphor can provide a way for children to talk about their feelings
and what has happened to them following a disturbing event. This special healing use of stories requires the help of someone skilled in working with children in this way.

**Supporting the parent/caregiver to stimulate young people from (12-18 years)**

The main problems of people in this age group relate to separating from their families and becoming independent. It is important for their development that they are able to practise skills with other young people of the same age.

They also need to copy adult behaviour as they gradually take on adult roles in their community and society. The passage from childhood to adulthood is vital to healthy development.

Young people at this age need to achieve a level of independence from their parents/caregivers. Experimenting in becoming independent sometimes means usage of some substances, smoking and maybe some problematic behaviour.

The refugee situation is not a simulative situation for development because:

- young people are prematurely separated from family, as a result of forced movements or poverty;
- young people’s roles in the community and the community itself may change;
- family needs may force young people into adult roles earlier than normal.

Parents/caregivers should be stimulated to:

- encourage young people to maintain conversations with family and friends;
- encourage young people to connect with same-age group activities;
- encourage young people to continue with their formal and non-formal education;
- be more tolerant, and give support to their children even in the case of manifesting undesirable social behaviour.
Helpers should stimulate young people to:

- organize groups, clubs where they can share new information, skills and interest in: sport, science, music etc.
- provide opportunities for community involvement (volunteering, tutoring, etc. to help foster feelings of accomplishment and contribution)
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APPENDIX I

Clinical approach to working with interpreters and culture brokers

**BEFORE THE INTERVIEW**

- Meet with the interpreter to explain the goals of the interview.
- Discuss whether the interpreter’s social position in the country of origin and local community could influence the relationship with the patient.
- Explain the need for especially close translation in the mental status examination (e.g., to ascertain thought disorder, emotional range and appropriateness, suicide risk).
- Ask the interpreter to indicate when a question or response is difficult to translate.
- Discuss any relevant etiquette and cultural expectations.
- Arrange seating in a triangle so that the clinician is facing the patient and the interpreter to one side.

**DURING THE INTERVIEW**

- Introduce yourself and the interpreter and explain your roles.
- Discuss confidentiality and ask for the patient’s consent to have the interpreter present.
- Look at and speak directly to the patient; use direct speech (e.g., “you” instead of “she” or “he”).
- Avoid jargon or complex sentence constructions; use clear statements in everyday language.
- Slow down your pace; speak in short units to allow the interpreter time to translate.
- Do not interrupt the interpreter; keep looking at the patient while the interpreter is speaking.
- Clarify ambiguous responses (verbal or nonverbal) and ask the patient for feedback to make certain that crucial information has been communicated clearly.
- Give the patient a chance to ask questions or express concerns that have not been addressed.

**AFTER THE INTERVIEW**

- Discuss the interview and ask the interpreter to assess the patient’s degree of openness or disclosure.
- Consider translation difficulties and misunderstandings and clarify any important communication that was not translated or was unclear, including nonverbal communication.
- Ask the interpreter if he or she had any emotional reactions or concerns of his or her own during the interview.
- Plan future interviews; whenever possible, work with the same interpreter or culture broker for the same patient.

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1 More detailed information and resources for locating interpreters and culture brokers can be found at www.mmhrc.ca.

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*Common mental health problems in immigrants and refugees: general approach in primary care*  
http://www.cmaj.ca/content/183/12/E959.full.pdf.
APPENDIX II

Four layers for mental health and psychosocial support regarding migrant/refuge situation in Macedonia implemented in Transit Centres in the Republic of Macedonia from 2015 until 2017

Regarding the data obtained from focus groups with helpers (psychologists and social workers in the framework of the UNICEF programme for capacity building of the helpers), four layers can be presented in the following manner:

<table>
<thead>
<tr>
<th>Four Layer for Mental Health and Psychosocial Support Regarding Migrant/Refuge Situation in Macedonia</th>
<th>Implemented Activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BASIC SERVICES AND SECURITY</strong> <em>(This was the situation when refugees/migrants reached and entered Macedonia)</em></td>
<td>• Migrant transit centres were established in Tabanovce and Gevgelija</td>
</tr>
<tr>
<td></td>
<td>• Distribution of various items: food, NFIs, etc.</td>
</tr>
<tr>
<td></td>
<td>• Health-care services</td>
</tr>
<tr>
<td></td>
<td>• Involvement of relevant actors in provision of basic needs</td>
</tr>
<tr>
<td><strong>COMMUNITY AND FAMILY SUPPORT</strong></td>
<td>• Support of formal and non-formal education</td>
</tr>
<tr>
<td></td>
<td>• Established groups for early child development (for pre-school children)</td>
</tr>
<tr>
<td></td>
<td>• Creative workshops with children and adults</td>
</tr>
<tr>
<td></td>
<td>• Various social recreation activities</td>
</tr>
<tr>
<td></td>
<td>• Workshops for handicrafts</td>
</tr>
<tr>
<td></td>
<td>• Family reunion</td>
</tr>
<tr>
<td></td>
<td>• Legal advice</td>
</tr>
<tr>
<td><strong>FOCUSED NON-SPECIALIZED SUPPORT</strong> <em>(After prolonged stay in Transit Centres need for specialized focused support arises)</em></td>
<td>• Individual, group and family psychological support for people in distress</td>
</tr>
<tr>
<td><strong>IN BETWEEN LEVEL ACTIVITIES: NEED FOR ORGANIZED AND SYSTEMATIZED PSYCHOSOCIAL WORKSHOPS WITH CHILDREN, ADOLESCENTS AND ADULTS.</strong></td>
<td>• There is lack of organized and systematized mental health intervention</td>
</tr>
</tbody>
</table>

The refuge/migrant situation in Macedonia experienced changes in the dynamics leading to appearance of different needs for psychosocial intervention. The first part of this process, when refugees and migrants were just transiting through the country, was focused on providing basic services and security. Following the borders closure, when it was clear that a number of migrants/refugees will stay in Macedonia for a longer time period, there was a need for establishing Transit Centres (two transit centres were established in Gevgelija and Tabanovce). This situation opened space for implementation of activities at the second layer (formal and non-formal education, creative workshops, etc.) and at the third layer (individual, group and family psychological support for people in distress). There was a lack for a systematically organized approach in structured psychosocial intervention programme, which could be settled between two layers (third and fourth). This approach had elements of psychotherapeutic intervention, but still it was in a framework of supporting health coping strategies and supporting and stimulating children's psycho-social development (for further information about psychosocial workshops, see part: “Looking after the mental health of migrant/refugee children”). Also, there was a lack of specialized support on a fourth level – mental health intervention (mental health specialists: psychologists and psychiatrists).
## APPENDIX III

### Professional Quality of Life Scale (ProQOL)

**Compassion Satisfaction and Compassion Fatigue (ProQOL) Version 5 (2009)**

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

<table>
<thead>
<tr>
<th></th>
<th>1=Never 2=Rarely 3=Sometimes 4=Often 5=Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I am happy.</td>
</tr>
<tr>
<td>2.</td>
<td>I am preoccupied with more than one person I [help].</td>
</tr>
<tr>
<td>3.</td>
<td>I get satisfaction from being able to [help] people.</td>
</tr>
<tr>
<td>4.</td>
<td>I feel connected to others.</td>
</tr>
<tr>
<td>5.</td>
<td>I jump or am startled by unexpected sounds.</td>
</tr>
<tr>
<td>6.</td>
<td>I feel invigorated after working with those I [help].</td>
</tr>
<tr>
<td>7.</td>
<td>I find it difficult to separate my personal life from my life as a [helper].</td>
</tr>
<tr>
<td>8.</td>
<td>I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].</td>
</tr>
<tr>
<td>9.</td>
<td>I think that I might have been affected by the traumatic stress of those I [help].</td>
</tr>
<tr>
<td>10.</td>
<td>I feel trapped by my job as a [helper].</td>
</tr>
<tr>
<td>11.</td>
<td>Because of my [helping], I have felt &quot;on edge&quot; about various things.</td>
</tr>
<tr>
<td>12.</td>
<td>I like my work as a [helper].</td>
</tr>
<tr>
<td>13.</td>
<td>I feel depressed because of the traumatic experiences of the people I [help].</td>
</tr>
<tr>
<td>14.</td>
<td>I feel as though I am experiencing the trauma of someone I have [helped].</td>
</tr>
<tr>
<td>15.</td>
<td>I have beliefs that sustain me.</td>
</tr>
<tr>
<td>16.</td>
<td>I am pleased with how I am able to keep up with [helping] techniques and protocols.</td>
</tr>
<tr>
<td>17.</td>
<td>I am the person I always wanted to be.</td>
</tr>
<tr>
<td>18.</td>
<td>My work makes me feel satisfied.</td>
</tr>
<tr>
<td>19.</td>
<td>I feel worn out because of my work as a [helper].</td>
</tr>
<tr>
<td>20.</td>
<td>I have happy thoughts and feelings about those I [help] and how I could help them.</td>
</tr>
<tr>
<td>22.</td>
<td>I believe I can make a difference through my work.</td>
</tr>
<tr>
<td>23.</td>
<td>I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].</td>
</tr>
<tr>
<td>24.</td>
<td>I am proud of what I can do to [help].</td>
</tr>
<tr>
<td>25.</td>
<td>As a result of my [helping], I have intrusive, frightening thoughts.</td>
</tr>
<tr>
<td>26.</td>
<td>I feel &quot;bogged down&quot; by the system.</td>
</tr>
<tr>
<td>27.</td>
<td>I have thoughts that I am a &quot;success&quot; as a [helper].</td>
</tr>
<tr>
<td>28.</td>
<td>I can't recall important parts of my work with trauma victims.</td>
</tr>
<tr>
<td>29.</td>
<td>I am a very caring person.</td>
</tr>
<tr>
<td>30.</td>
<td>I am happy that I chose to do this work.</td>
</tr>
</tbody>
</table>

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PROQOL SELF SCORING WORKSHEET

This worksheet helps you to get an estimate of your score on the ProQOL. To make it easy for you to use on your own, scores are grouped into high, average and low. If your score falls close to the border between categories, you may find that you fit into one group better than the other. The scores are estimates of your compassion satisfaction and fatigue. It is important that you use this information to assist you in understanding how your professional quality of life is, not to set you into one category or the other. The ProQOL is not a medical test and should not be used for diagnosis.

What is my score and what does it mean?

In this section, you will score your test and then you can compare your score to the interpretation below.

Scoring
1. Be certain you respond to all items.
2. Go to items 1, 4, 15, 17 and 29 and reverse your score. For example, if you scored the item 1, write a 5 beside it. We ask you to reverse these scores because we have learned that the test works better if you reverse these scores.

<table>
<thead>
<tr>
<th>You Wrote</th>
<th>Change to</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
</tr>
</tbody>
</table>

To find your score on **Compassion Satisfaction**, add your scores on questions 3, 6, 12, 16, 18, 20, 22, 24, 27, 30.

The sum of my Compassion Satisfaction questions was

<table>
<thead>
<tr>
<th>So My Score Equals</th>
<th>My Level of Compassion Satisfaction</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 or less</td>
<td>Low</td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>High</td>
</tr>
</tbody>
</table>

To find your score on **Burnout**, add your scores questions 1, 4, 8, 10, 15, 17, 19, 21, 26 and 29. Find your score on the table below.

The sum of my Burnout questions

<table>
<thead>
<tr>
<th>So My Score Equals</th>
<th>My Level of Burnout</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 or less</td>
<td>Low</td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>High</td>
</tr>
</tbody>
</table>

To find your score on **Secondary Traumatic Stress**, add your scores on questions 2, 5, 7, 9, 11, 13, 14, 23, 25, 28. Find your score on the table below.

The sum of my Secondary Traumatic Stress questions

<table>
<thead>
<tr>
<th>So My Score Equals</th>
<th>My Level of Secondary Traumatic Stress</th>
</tr>
</thead>
<tbody>
<tr>
<td>22 or less</td>
<td>Low</td>
</tr>
<tr>
<td>Between 23 and 41</td>
<td>Average</td>
</tr>
<tr>
<td>42 or more</td>
<td>High</td>
</tr>
</tbody>
</table>
YOUR SCORES ON THE PROQOL: PROFESSIONAL QUALITY OF LIFE SCALE

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

Compassion Satisfaction

Compassion satisfaction is about the pleasure you derive from being able to do your work well. For example, you may feel like it is a pleasure to help others through your work. You may feel positively about your colleagues or your ability to contribute to the work setting or even the greater good of society. Higher scores on this scale represent a greater satisfaction related to your ability to be an effective caregiver in your job.

The average score is 50 (SD 10; alpha scale reliability .88). About 25% of people score higher than 57 and about 25% of people score below 43. If you are in the higher range, you probably derive a good deal of professional satisfaction from your position. If your scores are below 40, you may either find problems with your job, or there may be some other reason — for example, you might derive your satisfaction from activities other than your job.

Burnout

Most people have an intuitive idea of what burnout is. From the research perspective, burnout is one of the elements of compassion fatigue. It is associated with feelings of hopelessness and difficulties in dealing with work or in doing your job effectively. These negative feelings usually have a gradual onset. They can reflect the feeling that your efforts make no difference, or they can be associated with a very high workload or a nonsupportive work environment. Higher scores on this scale mean that you are at higher risk for burnout.

The average score on the burnout scale is 50 (SD 10; alpha scale reliability .75). About 25% of people score above 57 and about 25% of people score below 43. If your score is below 18, this probably reflects positive feelings about your ability to be effective in your work. If you score above 57 you may wish to think about what at work makes you feel like you are not effective in your position. Your score may reflect your mood; perhaps you were having a “bad day” or are in need of some time off. If the high score persists or if it is reflective of other worries, it may be a cause for concern.

Secondary Traumatic Stress

The second component of Compassion Fatigue (CF) is secondary traumatic stress (STS). It is about your work-related, secondary exposure to extremely or traumatically stressful events. Developing problems due to exposure to other’s trauma is somewhat rare but does happen to many people who care for those who have experienced extremely or traumatically stressful events. For example, you may repeatedly hear stories about the traumatic things that happen to other people, commonly called Vicarious Traumatization. You may see or provide treatment to people who have experienced horrific events. If your work puts you directly in the path of danger, for example due to your work as a emergency medical personnel, a disaster responder or as a medicine personnel, this is not secondary exposure; your exposure is primary. However, if you are exposed to others’ traumatic events as a result of your work, such as providing care to people who have sustained emotional or physical injuries, this is secondary exposure. The symptoms of STS are usually rapid in onset and associated with a particular event. They may include being afraid, having difficulty sleeping, having images of the upsetting event pop into your mind, or avoiding things that remind you of the event.

The average score on this scale is 50 (SD 10; alpha scale reliability .81). About 25% of people score below 43 and about 25% of people score above 57. If your score is above 57, you may want to take some time to think about what at work may be frightening to you or if there is some other reason for the elevated score. While higher scores do not mean that you do have a problem, they are an indication that you may want to examine how you feel about your work and your work environment. You may wish to discuss this with your supervisor, a colleague, or a health care professional.

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Form for monitoring and coaching helpers in provision of psychosocial intervention

This form should be completed by the senior psychotherapist who is providing continuous on-the-job mentoring and coaching to the helpers (psychologists) working in relief assistance facilities.

<table>
<thead>
<tr>
<th>Senior psychotherapist</th>
<th>Relief assistance facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>______________________</td>
<td>___________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TIME OF MONITORING AND COACHING (DATE AND DURATION)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TYPES OF INTERVENTION</strong></td>
</tr>
<tr>
<td>1. <strong>INDIVIDUAL SUPERVISION</strong></td>
</tr>
<tr>
<td>2. <strong>GROUP SUPERVISION</strong></td>
</tr>
<tr>
<td>3. <strong>INDIVIDUAL PSYCHOTHERAPEUTIC INTERVENTION WITH HELPERS</strong></td>
</tr>
<tr>
<td>4. <strong>GROUP PSYCHOTHERAPEUTIC INTERVENTION WITH HELPERS</strong></td>
</tr>
<tr>
<td>5. <strong>TRAINING IN PSYCHOSOCIAL INTERVENTION (GROUP WORKSHOP)</strong></td>
</tr>
<tr>
<td>6. <strong>PSYCHOTHERAPEUTIC INTERVENTION WITH AFFECTED PEOPLE</strong></td>
</tr>
<tr>
<td>7. <strong>SENIOR PSYCHOTHERAPIST IMPRESSIONS, EMOTIONS AND CONSIDERATIONS</strong></td>
</tr>
<tr>
<td>8. <strong>FOLLOW-UP ACTIVITIES</strong></td>
</tr>
</tbody>
</table>
APPENDIX V

Form for monitoring in relief assistance facilities

INSTRUCTIONS FOR COMPLETING THE FORM FOR MONITORING IN RELIEF ASSISTANCE FACILITIES

This form is for collecting data through an interview. The interview may be conducted by a trained person who is a psychologist or a social worker, and it is preferable that several persons are interviewed. The first part of this form specifies the categories of persons with whom it is desirable to conduct the interview. Obtained data should be used to improve the work of the helpers to promote the mental health of affected people and helpers. The second part of the form lists the topics that should be discussed with the interviewees to gain data needed for the monitoring. These data will serve for further planning of all activities in the context of prevention and preserving the mental health of affected people and also of helpers working in the relief assistance facilities.

I CATEGORIES OF PERSONS WITH WHOM IT IS DESIRABLE TO CONDUCT AN INTERVIEW, REGARDING THE SITUATION IN THE RELIEF ASSISTANCE FACILITY RELEVANT TO THE MENTAL HEALTH OF AFFECTED PEOPLE:

1. Psychologists and social workers;
2. Pedagogues, teachers;
3. Translators/interpreters;
4. Patronage nurses;
5. Ambulance: doctor, nurse;
6. Other institutions involved: IOM, UNHCR...;
7. Relief assistance facility administration.

II MONITORING TOPICS

1. What are the physical conditions?

   A) What is the space in the facility like?
   - What personal space is available to affected people?
   - Is there a common area where affected people gather? /Are there any differences in terms of age/gender structure of affected people in the common area?
   - Are there CHILD FRIENDLY SPACES?
   - Are the wider surroundings of the facility security factor?

   B) Time
   - Time organization (How are daily activities organized?)
   - Is there too much free time?

   C) How are basic living needs satisfied? (water, food, personal hygiene, clothing, living conditions, conditions in containers, hygiene in the facility, educational materials, books, coloring books, Internet access, etc...)

   D) What is the availability of mobile phones? What is the availability of information? (How much are affected people informed, do they have an opportunity to be informed of the situation of their families, their chance of staying or leaving the facility, etc.?)
2. **What are the structures and the quality of relationships among affected people in the camp?**
   How do networks of communication function?
   - Children with children;
   - Adults with adults;
   - Adults with children;
   - Helpers with children;
   - Helpers with adults.

3. **Safety conditions in the facility**
   - Where are the safe places in the facility? (Mapping of safe places and unsafe places in the facility)
   - Is the facility safe every day, 24 hours? (Mapping of the time when people feel safe)

4. **Education**
   - Are affected children involved in education, what is the involvement like, do adults have some kind of education?

5. **Mental health of children and young people (and their parents/caregivers)**
   - Whether and how helpers can recognize symptoms in children and adults?
   - Whether and how symptoms are treated?
   - Who provides the mental health care?
   - Are methods for improving the mental health of children applied?
   - Is use of drugs and alcohol observed?
   - Is violence towards women, men, children and youth observed?
   - What are the most common symptoms of mental health disorder among affected people?
   - Mental health of helpers (insomnia, headaches, anxiety, fear...)?
   - Is there a group of affected people that is inaccessible, so that psychological help could be provided?

6. **Coordination in the facility**
   - What is the structure of the activities of helpers in terms of time and space?
   - Is there overlapping of activities of helpers?
   - Is there intersectoral coordination?
   - Is there coordination with government, non-governmental institutions (Police, Army, Ministry of Justice...)?

Space for subjective experience of the person conducting the interview
APPENDIX VI 1

Child's behavior questionnaire

This questionnaire should be completed by helpers who provide assistance to children. This questionnaire can be completed by psychologists, social workers and/or teachers who knows the child and who have experience with the child. The questionnaire should be completed for the purpose of providing an appropriate psychosocial intervention.

What are the reasons for monitoring the child's behavior?
______________________________________________________________________________________

General data
Gender  M F
Age:     ________________
Child lives with: ________________
Helper:  __________________________________
Organization (from which organization is the helper completing this questionnaire)
________________________________________________________

Helper is working with the child (several answers are possible):
a) individually     c) in a family setting
b) in a group       d) other

Areas of work with the child (several answers are possible):
a) entertainment   d) art activities
b) studying (teaching) e) psychological workshops;
c) recreational activities  f) psychotherapy.

How long has the helper known the child?
______________________________________________________________________________________

How much time (during the week) does the helper spend with the child?
______________________________________________________________________________________

According to your observations about the child so far, make an assessment of the child's behavior or trait, where “1” means that the child, in comparison to other peers, does not show the specified behavior or trait at all, and “5” means that the child shows the above behavior or trait more than other peers)

GROUP BEHAVIOR

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unwillingly hangs out with children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child is not accepted by other children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child withdraws from social contacts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child is shy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child is destroys his/her own things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child is destroys other people's things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child tries to impose on others</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constantly seeks the attention of the helpers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does not respect the rules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starts a fight</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Starts arguments</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is beaten by other children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OTHER REMARKS ________________________________
### Behavior When Performing Tasks

<table>
<thead>
<tr>
<th>Behavior</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finds hard to complete started tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Refuses to complete tasks</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows lack of interest in several activities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily gets angry when failed in completing task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gives up easily, when he/she faces difficulties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Finds it difficult to understand instructions and rules</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a difficulty in remembering things</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has a difficulty to work independently</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Remarks

### Emotions/Mood and Child's Behavior

<table>
<thead>
<tr>
<th>Emotion</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Looks sad</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Looks angry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appears insecure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shows fear</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seem alone</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quickly changes emotions/mood</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The child looks thoughtful and absent</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The child is easily irritable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The child shows stubbornness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The child complains of psychosomatic discomfort</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(headache, abdominal pain...)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The child complains of fatigue, loss of energy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a change in appetite or weight loss</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changes in sleeping</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicidal ideas or attempts</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feeling of unworthiness or inappropriate guilt</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Remarks

### Special Interest or Talent of the Child:

A) Artistic abilities (singing, drawing, writing, acting...)
B) Sports
C) Strong interests in some school subjects
D) Hobby
E) Positive characteristics of the child (for example: diligent, sociable...)

APPENDIX VI 2

Monitoring children’s behavior - short form

This is a short form used for monitoring children's behavior. This form is for psychologists who have experience working with children and have knowledge to recognize symptoms of mental health disorders among children between 2 and 18 years. This form contains children's age and symptoms of mental health disorders regarding age. It can be filed by circling the numbers from “1” to “8” whereby “1” stands for the lowest level of expression of the stated symptom and “8” for the highest level of expressing the stated symptom.

<table>
<thead>
<tr>
<th>Age from 2 to 5 years</th>
<th>Monitored behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Anxious attachment</td>
</tr>
<tr>
<td></td>
<td>Separation anxiety</td>
</tr>
<tr>
<td></td>
<td>Regressive behavior</td>
</tr>
<tr>
<td></td>
<td>Regress by losing skills previously mastered</td>
</tr>
<tr>
<td></td>
<td>Nightmares</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age from 6 to 12 years</th>
<th>Monitored behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Insufficient concentration</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Learning problems</td>
</tr>
<tr>
<td></td>
<td>“Pain and sickness”</td>
</tr>
<tr>
<td></td>
<td>Aggression</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
</tr>
<tr>
<td></td>
<td>Regression</td>
</tr>
<tr>
<td></td>
<td>Sleeping disorder</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age from 13 to 18 years</th>
<th>Monitored behavior</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-destructive behavior</td>
</tr>
<tr>
<td></td>
<td>Risky behavior</td>
</tr>
<tr>
<td></td>
<td>Withdraw from social contacts</td>
</tr>
<tr>
<td></td>
<td>Psychosomatics disorders</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
</tr>
</tbody>
</table>
Useful guideline plan for assessing children therapy

This is a useful guideline which assesses children holistically, taking into account the various aspects of their holistic self. These aspects, however, show a close connection with the stages of the therapeutic process to which attention should be paid, in order to enhance children's awareness of their process. This guideline can be used during every play therapy session to assess the child's process in respect of the various main aspects and subcomponents. This guidance can also be used in a process of psychosocial intervention organized as psychological workshops. The same guidance can be a useful tool in psychosocial or psychotherapeutic approach with adolescents and adults.

### MAIN ASPECT | SUBCOMPONENTS
---|---
**THERAPEUTIC RELATIONSHIP** | • What is the child's level of trust with the therapist?  
• Does the child manifest relevant resistance, or does he or she appear confused?

**CONTACT AND CONTACT SKILLS** | • Does the child make good contact with the therapist and can he or she maintain contact?  
• Does the child withdraw relevantly at times?  
• How does the child use his or her contact skills?

**INTEREST** | • Does the child show involvement, interest and excitement?  
• Is his or her voice expressive or 'weak'?  
• How does the child use his or her breathing?  
• What is the child's energy level and when does he or she have more and less energy?

**BODY POSTURE** | • How does the child walk, sit and stand; is his or her body impaired or loose and flexible?  
• How is his or her posture?  
• Are his or her shoulders rounded?

**HUMOUR** | • Does the child respond relevantly to humour?  
• Does the child have a sense of humour?

**RESISTANCE** | • What is the child's level of resistance?  
• How does resistance manifest in the child?

**EMOTIONAL EXPRESSION** | • Does the child know what emotions are?  
• Can the child express basic emotions, such as happiness, sadness, anger and fear?  
• Can the child identify reasons for his or her emotions?  
• Is the child's emotional expression relevant?  
• Is the child able to express emotions?  
• How does the child handle his or her emotions towards the therapist, his or her family and friends?  
• How does the child handle his or her emotion of anger?  
• Does the child have old, unexpressed and unfinished emotions of grief or anger that should be addressed?

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1 Regarding *The Handbook of Gestalt Play Therapy: Practical Guidelines for Child Therapists* by Rinda Blom, page 68
### Cognitive Aspects
- Can the child express his or her feelings and thoughts?
- How are the child's language skills?
- Can the child follow directions, play a game, make choices, solve problems and organize?
- Does the child have ideas and opinions of his or her own?
- Does what the child says make sense?
- Does the child use age-related abstractions and symbols?
- Does the child have a sense of right and wrong?

### Creativity
- Is the child capable of taking part openly and freely in creative techniques?
- Can the child test new things?
- Is the child withdrawn, restricted and defensive?

### Sense of Self
- Does the child have a degree of self-awareness and introspection?
- Does the child run himself or herself down?
- Is the child self-critical, uncertain of him- or herself and seeking acceptance?
- Can the child make statements about him- or herself?
- Can the child make choices?
- Is the child self-assertive or inhibited?
- Is the child capable of separating from his or her parents?
- Does the child reveal confluent behaviour?

### Social Skills
- How is the child's relationship with others in his or her life?
- Does the child have friends?
- Does the child show signs of independent thoughts and actions?
- Does the child have environmental support for his or her needs?
- How does the child satisfy his or her needs?
- Does the child have age-related egocentricity?

### Process
- How does the child present him- or herself to the world (quiet, noisy, aggressive, passive, 'very good', leader, follower, etc.)?
- How does the child act towards his or her parents, siblings, friends and teachers?
- What behaviour does the child reveal?
- In what ways does the child try to satisfy his or her needs and acquire a sense of self?
- Do the events in the therapy sessions and events outside correspond?
APPENDIX VII

Psychological workshop evaluation form

I GENERAL DATA:
1. Facility ___________________
2. Date ___________________
3. Duration time: from _____ to_____ hour
4. Group ___________________
5. Age of the group members: from _____ to _____ years
6. Number of members present ___________________
7. Team leading the psychological workshop (mark who fills in this form)
   A) Leader of the psychological workshop ___________________
   B) Assistant of the psychological workshop ___________________

II. DATA FOR THE PSYCHOLOGICAL WORKSHOP
1. No. of psychological workshop ___________________
2. Main topic of the psychological workshop ___________________
3. Other topics included in the psychological workshop: _______________________
   _______________________________________________________________________
4. Place where the psychological workshop was conducted (for example: classroom, container, etc.) ______________

III SPECIFIC DATA FOR THE PSYCHOLOGICAL WORKSHOP
1. Plan for the psychological workshop
   First Part: Introduction
   Second Part: Main activities
   Third Part: Closure
2. Questions for the team leading the psychological workshop:
   • What do I want to accomplish in this group?
   • Will selected activities achieve the planned goal?
   • Are the activities suitable for the age, culture and level of trust in the group at the present time?
   • Do I feel comfortable? Will I enjoy the activities and games?
3. Dynamics of the psychological workshop (short description of the workshop should follow)
4. In this table, the workshop team should note the following: specific reactions; behavior, emotions of the members of the group; the intervention of the leader and assistant, what can be done differently and what will the plan be for the next workshop

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<tr>
<th>NAME</th>
<th>CONDITION (EMOTIONS, BEHAVIOR)</th>
<th>WHEN EMOTIONS OR BEHAVIOR APPEARED?</th>
<th>WHAT DID I DO IN THESE CIRCUMSTANCES?</th>
<th>WHAT WOULD I DO DIFFERENTLY?</th>
<th>WHAT WILL BE THE PLAN FOR THE NEXT WORKSHOP?</th>
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5. Recommendation for next workshop topics:

6. Questions for the leader and the assistant of the psychological workshops
   • In general, how satisfied are you with this psychological workshop?
   • Shortly, what did you experience inside you during this workshop? For example: satisfaction, sadness, anger, fury etc?
   • What was the main idea of your activities in the group?
   • What events did you see as relevant during this workshop (among all members in this group, with some particular member, or something in your personal experience?)
   • Which intervention you will mark as a particularly important (for all group members or for some group members)
APPENDIX VIII

Outcome Questionnaire OQ® – 45.2

Instructions: Looking back over the last week, including today, help us understand how you have been feeling. Read each item carefully and mark the box under the category which best describes your current situation. For this questionnaire, work is defined as employment, school, housework, volunteer work, and so forth. Please do not make any marks in the shaded areas.

Name: _________________________    Age:____yrs.    Sex __________ M □ F □

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Developed by: Michael J. Laxton, Ph.D. and Gary H. Helzer, Ph.D.

For More Information Contact:
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Lakewood Ranch, FL 34202-2351
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Fax: 941-882-0084

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Outcome Questionnaire (OQ-45.2) Quick Guide

The OQ 45.2 is to be administered to clients 19 years and older. Administered during the first treatment session, every 3 months and last treatment session.

**Purpose**

The OQ is sensitive to short-term changes, making it a good instrument for evaluating client progress at any point during treatment.

Provides the clinician with a “snapshot” of the client’s current functioning across a wide variety of disorders.

Assesses personal and socially relevant characteristics that contribute to one’s quality of life.

The OQ contains risk assessment items for potential suicide, substance abuse and workplace violence.

**Administration**

The OQ is self-administered and requires no instructions beyond those printed on the answer sheet. Clients should be encouraged to answer every question as accurately as possible. The administrator should indicate to the client how true each statement is for him/her during the past week.

It should be mentioned that participants taking this test can be affected by the attitudes of those who are in charge of the administration. It is important for the test administrator to encourage the participant to fill out the scale in an honest and conscientious manner. Negative attitudes by clinicians or others who administer this test can severely impair its validity, as can personal reasons respondents may have for wanting to give a less-than-candid picture of themselves.

**Time**

Under usual circumstances, participants will complete the scale in about five minutes. Some especially careful individuals may require as much as 15 minutes, while others can complete the test in three to four minutes.

**Scoring**

- Please review answer sheet to ensure client has answered all items.
- Using the hand-scoring answer sheet, transfer the score for each item to the appropriate box in the far right-hand column.
- Add each column of numbers and write the total in the space provided at the bottom of the right-hand column. The three subtotals represent the three OQ subscale scores.
- Add all three subscale scores for the Total Score.
- Missing Data: Review the client’s OQ responses to ensure the client has answered each item. If a client leaves an item blank, total all answered items in the subscale, divide by the number answered, round to the nearest whole number, and insert this number for missing items.
- Critical Items: Clinician should review and follow-up with any critical items that were endorsed (e.g., Item 8: Suicide; Items 11, 26 & 32: Substance Abuse; Item 44: Violence)
### Subscale (Domain) | Clinical Cutpoint Score
---|---
Symptom Distress (SD) | 36
Interpersonal Relations (IR) | 15
Social Role (SR) | 12
Total Score | 63

**Total Score**
- Is calculated by adding the three subscales
- Scores ≥ 63 are significant and reflect increased distress related to experiencing a high number of symptoms, interpersonal difficulties, and decreased satisfaction and quality of life.

**Interpretation of Initial Scores**
To use the OQ clinically, the clinician should consider three elements: the participants’ answers to certain critical items, the total score (TOT) and the subscale scores.

**Item Evaluation**
The clinician should first consider client ratings on certain critical items. Item 8 is a screening item for potential suicide that should be investigated further if the participant gives any rating higher than 0 (never). Items 11, 26 and 32 refer to substance abuse items, and should be investigated further if ratings other than 0 (never) are given. Item 44 screens for violence at work; any rating other than 0 (never) should be investigated for the possibility of current and/or future work conflicts that lead to violent acts against fellow employees.
SCORING

The OQ-45 provides a total score and three subscores.

1. To score the OQ-45, simply write the numeric value (found next to each client response box) selected by the client in the corresponding scoring box found to the right of each item on the right side of the questionnaire. There is one scoring box for each item which will automatically place the score for any item into its specific subscale category. Please note that the numeric values for items 1, 12, 13, 20, 21, 24, 31, 37, 43 are in reverse.

2. When the score for each item has been written in the corresponding box, add up each vertical column of numbers, and write the total for each column in the space provided in the bottom right-hand corner of the sheet. This will leave 3 column totals, each representing one of the three subscales for the OQ.

3. When these three column totals are added together, a total score for the questionnaire will be obtained which should be written in the total box found at the bottom.

4. Missing data: If a client leaves an item blank, use the average score for the remaining subscale items rounded to the nearest whole number in place of the missing value.

INTERPRETING

There are three elements to consider when interpreting the OQ-45:

• The client’s answers to certain critical items
• The total score
• The subscale scores

I Critical items

Any critical item with an answer other than zero should be flagged for follow-up in the clinical interview:

• Item 8: Suicide
• Items 11, 32, 26: Substance abuse
• Item 44: Violence

II Total Score

Range: 0-180
Cut-off score: 63 or more – indicates symptoms of clinical significance
Reliable change: indicated when a client’s score changes by 14 points or more (useful if you give the OQ-45 at two different points in time).

This score is calculated by summing all 45 items. The higher the score, the more disturbed the client.

A high score suggests that the client is admitting to a large number of symptoms of distress (mainly anxiety, depression, somatic problems and stress) as well as difficulties in interpersonal relationships, social role (such as work or school), and in their general quality of life.

Important!

Additional information for OQ-45

This Questionnaire contains questions regarding work defined as: employment, school, housework, volunteer work etc. These questions are:

4, 12, 14, 21, 28, 32, 38, 39, 44.

Do not ask these questions if they are not applicable. For example, these questions should not be answered by a migrant/refugee who does not have any possibility to practice any type of work mentioned previously.
### III Subscales

#### Symptom Distress (SD) Score

**Range:** 0-100

**Clinical cut-off score:** 36 or more – indicates symptoms of clinical significance

**Reliable change:** indicated when a client's score changes by 10 points or more (useful if you give the OQ-45 at two different points in time).

Research suggests that the most common disorders are anxiety disorders, affective disorders, adjustment disorders and stress related illness. The SD subscale is composed of items that have been found to reflect the symptoms of these disorders. A high score indicates the client is bothered by these symptoms, while low scores indicate either absence or a denial of the symptoms. Symptom scores correlate highly with various measures of depression (e.g., the BDI) and anxiety (e.g., the State-Trait Anxiety Inventory).

#### Interpersonal Relations (IR) Score

**Range:** 0-44

**Clinical cut-off score:** 15 or more – indicates symptoms of clinical significance

**Reliable change:** indicated when a client's score changes by 8 points or more (useful if you give the OQ-45 at two different points in time).

IR items assess complaints such as loneliness, conflicts with others, family and marriage problems. High scores suggest difficulties in these areas, while low scores suggest both the absence of interpersonal problems as well as satisfaction with the quality of intimate relationships.

#### Social Role (SR) Score

**Range:** 0-36

**Clinical cut-off score:** 12 or more – indicates symptoms of clinical significance

**Reliable change:** indicated when a client's score changes by 7 points or more (useful if you give the OQ-45 at two different points in time).

SR items measure the extent to which difficulties in the social roles of worker, homemaker or student are present. Conflicts at work, overwork, distress and inefficiency in these roles are assessed. High scores indicate difficulty in social roles, while low scores indicate adequate social role adjustment.

Note: Additional attention should be given to low scores to determine whether they result from role satisfaction or from the client's unemployment (e.g., the client arbitrarily marking the items 0 for never or not applicable).

The above document is summarized from the *OQ-45 Administration and Scoring Manual*. In addition to scoring and interpretation instructions, the manual provides details about the development and norming of the OQ-45; reliability and validity; age, gender, and ethnicity differences; a factor analytic study of the OQ-45; references; and other miscellaneous material. See David Gilles-Thomas if you are interested in looking at the manual.
APPENDIX IX

Psychological workshops for adults

EXAMPLE

STRATEGY FOR ORGANIZATION

Working with adults can sometimes be very demanding, with many obstacles and cultural barriers.

Because of all that various social/recreational activities, formal and also non-formal educational activities can be a supporting background for psychosocial intervention programs. (In this example, an educational activity such as learning a foreign language will be supporting background for psychosocial intervention program).

Two leaders for psychological workshops for adults are needed: psychologist and one who will conduct educational activities (educator).

Workshop plan

Each psychological workshop for adults should start with a detailed plan for ongoing activities. The psychologist and the educator should work together on their goals, activities, responsibilities and materials for each psychological workshop.

THIS IS ONE SAMPLE PLAN FOR PSYCHOLOGICAL WORKSHOP WITH EDUCATIONAL ACTIVITY AS BACKGROUND

TYPE OF GROUP ACTIVITY: learning foreign language

TOPIC OF THE CLASS: learning names of colors, emotions and parts of the body

I PART OF THE CLASS: learning the names of colors

II PART (MAIN PART): connect the names of colors with emotions, preparing glossary of emotions.

Every participant should design their own glossary of emotions where every emotion has its own color as it has in the following sample of the glossary of emotions.

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After designing the glossary of emotions, the participants connect emotions with the parts of the body (The psychologist could ask: Where do you feel sadness? In what part of the body do you feel sadness?)
Participants can draw emotions, then on the already prepared body shape they can color that part of the body which is affected by emotions. Through the process of learning a foreign language group members will come in touch with their own emotions and how to express them.

III Part (closure): preparing mutual map of emotions, by making paper colored with emotions.

This workshop will cover the following aspects:
• Coming in contact with one’s own emotions in a very safe way – through metaphoric expression;
• Sharing with others;
• Strengthening group cohesion and trust.

Ideas for other workshops:
Handcraft activities: working with wood, for example, can be a good start to come in contact with one’s own home....