INFORMATION GUIDE
FOR COMMUNITY PSS WORKERS

Community-based Mental Health and
Psychosocial Support in Sierra Leone

Contents

Section 1.1

Introduction

Sierra Leone has encountered several emergency situations in the past decades including conflict, disease outbreaks, and environmental disasters caused by extreme weather patterns. The Ebola outbreak that began in May 2014 and ended formally in March 2016 has had a direct impact on the psychosocial wellbeing of the people of Sierra Leone.

In light of this situation, Dr. Fiona Shanahan of University College Cork, in collaboration with Trócaire and national partner organisations Centre for Democracy and Human Rights, Access to Justice Law Centre and Justice and Peace Commission in Freetown, conducted a study on psycho-social interventions in the context of the Ebola outbreak. This participatory research highlighted that women, men, girls and boys affected by Ebola experienced multiple difficulties as a result of the crisis and that psychosocial distress was exacerbated by aspects of the humanitarian response. It also highlights key resources and coping strategies that individuals, families and communities used to respond to these difficulties.

Over the years, organisations throughout Sierra Leone have been using tools to respond to the people's psychosocial needs, and this has not been limited only to the armed conflict or the Ebola response. To assist frontline psychosocial workers at community level, this guide and the accompanying toolkit are aimed at restoring and strengthening access to existing family and community support.

In July 2015, the PSS Toolkit Working Group was formed to develop a Psychosocial Support Toolkit for practical use by psychosocial support (PSS) workers in Sierra Leone. Grounded in the local context, the Toolkit makes use of tools and exercises being used by organisations and agencies that have acquired expertise in PSS. Drawn from all regions of Sierra Leone, this culturally appropriate toolkit is intended for practical use, both in the post-Ebola recovery process as well as for more general application in the country.

This Information Guide accompanies the practical Toolkit, providing information that will enable PSS workers to understand the technical sections of the Toolkit in more detail. The Information Guide will also support local organisations working on PSS to provide technical guidance to community workers for using the Toolkit and to further promote psychosocial wellbeing and heightened resilience in Sierra Leone.

Section 1.2

Definition and Core Principles

Psychosocial support refers to any type of local or outside support that aims to protect or promote psychosocial wellbeing people, including their mental health (IASC, 2007). This manual focusses on community psychosocial support, which is aimed at fostering resilience, empowerment, and strength in the face of difficult circumstances. Treating mental disorders is something that goes beyond the scope of this manual and Toolkit.
The term '**psychosocial**' refers to the close relationship between an individual and their social environment and interactions.

- The '**psychological**' effects are caused by a range of experiences that affect an individual's emotions, behaviour, thoughts, memory and learning capacity.
- The 'social' effects are the shared experiences of disruptive events that affect the relations between people. Such events can include death, separation and a sense of loss. The social effects can also be economic or political in nature, such as health disasters or armed conflicts.

For the purposes of this manual and the Toolkit, **mental health** is viewed as a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.

Six core principles guide all mental health and psychosocial support (MHPSS) activities in Sierra Leone, as outlined in the Government of Sierra Leone MHPSS Strategy (2015-2018) and international guidelines (IASC, 2007):

1. **Human rights and equity** as a means to maximise fairness in the availability and accessibility of MHPSS services across gender, age, language groups, ethnic groups and based on identified/assessed needs.
2. **Participation** of the person(s) affected and receiving treatment and their rights to receive or refuse certain forms of assistance.
3. **Do No Harm** by ensuring interventions are established from sufficient information, open to scrutiny and evaluation, culturally and age-appropriate and based on recent evidence.
4. **Building on available resources and capacities**, including utilisation of local supports, self-help, and strengthening the internal and external competencies of those receiving care.
5. **Integrated support systems** that ensure MHPSS service packages are linked to wider systems, support mechanisms and other services which are sustainable for long-term support if required.
6. **Multi-layered support** that includes providing for the basic services and security of those in crisis, connection with their community and family supports, providing of non-specialised care and/or specialised services where required.

Section 1.3

Confidentiality

Confidentiality is very important to creating a safe space for individuals to receive psychosocial support. As a general rule, the information relating to individuals participating in PSS must not be disclosed to others and should not be discussed outside the safe space.

There are three important aspects of confidentiality

1. **Protect**: This means protecting the person's information from others.
2. **Inform**: This means communicating with the person how any information collected will be used.
3. **Provide choice**: This means discussing with patients under what circumstances confidentiality must be broken.

The cases in which confidentiality must be broken are i) in the case where there is a threat to the life of the individual or to the life of another person or a threat of serious bodily harm, ii) in cases where child protection issues arise, and iii) in cases where there is a threat of a serious crime (including but not exclusive to murder, rape and child abuse). In this case, the information regarding the cases can be discussed with others (for example, a Mental Health Nurse) on a need-to-know basis, when the person in question can have a positive effect on the outcome of the case.

In the case of i) it is the duty of the PSS worker to assess the individual's intent and ability to carry out this harm and act on this if there is a clear and present immediate danger. Frontline PSS workers should always know who to refer these kinds of cases to if they arise. In Sierra Leone, referrals can be made to the District Mental Health Nurse or a Family Support Unit (FSU). It is important to discuss referrals with the individual and create confidence in that individual that their information will be further protected and why this referral is needed.

Section 1.4

Structure of Implementation for PSS Workers

The toolkit was developed in line with the Government of Sierra Leone Mental Health and Psychosocial Support Strategy 2015 – 2018, the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support (2007) and the Sphere Standards, particularly standard 2.5 on Mental Health (2011). Mental health and psychosocial support for those affected by humanitarian emergencies should focus on resources and strengths, build on local existing capacities and be delivered through existing structures and services. From the onset of an emergency, linked, multi-level supports should be made available, as illustrated in the IASC MHPSS guidelines intervention pyramid (see Figure 1).

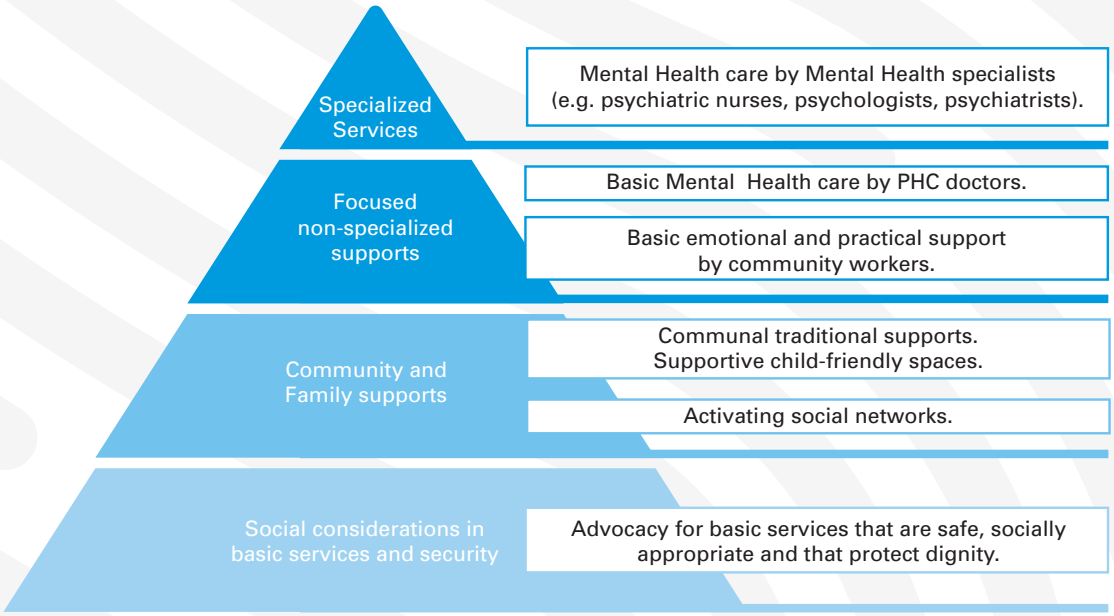

Figure 1. Mental Health and Psychosocial Support in Emergencies Intervention Pyramid Source: Inter-Agency Standing Committee Reference Group on Mental Health and Psychosocial Support, 2010.

In Sierra Leone, the Government's policy is that the first two layers of the pyramid are provided to all people affected by a crisis, with additional support added from package 3. community-based focused, non-specialized support and package 4. specialized support if needed. This process is outlined in the following flow chart. If someone requires more focused support, you should also continue to offer them basic supports – all the levels work together.

Mental Health and Psychosocial Support (MHPSS) Services Packages are intended for all persons affected by crisis, with a particular focus on children. MHPSS refers to any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder

All MHPSS Services Packages are grounded in the core principles of:
Human rights and equality - Participation - Do No Harm - Building on available resources and capacities - Integrated support systems - Muti-layered supports

All crisis-affected persons:

Minimum MHPSS Services Package 1:
Safe and dignified provision of basic needs and security

Minimum MHPSS Services Package 2:
Community-based wellbeing support

If indicated

Minimum MHPSS Services Package 3:
Community-based, focused, and non-specialized support

If indicated

Minimum MHPSS Services Package 4:
Specialized support

Section 1.4.1

Service Package 1

Safe and Dignified Provision of Basic Needs and Security

This aspect focuses on the protection of the well-being of all people through (re)establishing of security, adequate governance and services that address basic physical needs. It may include advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in safe, dignified, socio-culturally appropriate ways that promote mental health and psychosocial well-being.

Minimum MHPSS Services Package 1: Safe and Dignified Provision of Basic Needs and Security

WHO NEEDS IT?	EXAMPLES OF WHO MIGHT PROVIDE IT	WHEN IS IT PROVIDED?	EXAMPLES OF ACTIVITIES
All crisis affected person(s)	• Government; • Community-based organisations; • Religious services and groups; • Community-based groups., clubs, associations; • Individuals (parents, friends, family, caregivers); • UN agencies; • (I)NGOs; • Schools.	Basic needs are provided **as soon as safely possible**	• Non-food item distributions; • Food distributions; • Shelter programmes; • Water and sanitation programmes; • Advocacy programmes to support community access to services; • Assessment of compliance with humanitarian standards (e.g. child protection mainstreaming guidelines[1], Sphere standards[2]); • Livelihood activities, including agricultural activities and/or operating small businesses.

[1] Minimum standards for child protection in humanitarian action. Child Protection Working Group (CPWG) (2012). [2] The Sphere Project (2011). Humanitarian charter and minimum standards in humanitarian response, 3rd Ed., The Sphere Project, UK.

Section 1.4.2

Service Package 2

Community-Based Wellbeing Support [1]

This is 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 accessing community and family support. Useful responses in this layer include:

- 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 through women's groups and youth clubs).

Minimum MHPSS Services Package 1: Safe and Dignified Provision of Basic Needs and Security

WHO NEEDS IT?	EXAMPLES OF WHO MIGHT PROVIDE IT	WHEN IS IT PROVIDED?	EXAMPLES OF ACTIVITIES
All crisis affected person(s)	• Government; • Community-based organisations; • Religious services and groups; • Community-based groups., clubs, associations; • Individuals (parents, friends, family, caregivers);	Based on identified needs, **as soon as it is safely possible** to implement community-based support programmes.	• Community planning activities • Participation in community and peer group activities. For example, community-run clubs or groups, religious practices; • Education, including life-skills programmes; • Participatory learning approaches; • Children's play programmes; • Recreational activities; • Stress reduction, calming techniques, or relaxation programmes; • Resilience programmes, including those that support positive coping strategies; • Traditional ceremonial activities (e.g. burial, purification rituals, religious practices, and/or healing rituals); • Income generation (or livelihood) programmes that integrate psychosocial support approaches.

Section 1.4.3

Service Package 3

Community-Based, Focused and Non-Specialised Support

A smaller proportion of people will be able to regain their psychosocial well-being with some **one-to-one support** from trained, non-specialised staff or volunteers. Community workers and primary health workers can provide more focused individual, family or group interventions with training and supervision. For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. Psychosocial First Aid (PFA) and basic mental health care in primary health care settings also fall into this category. fall into this category.

Minimum MHPSS Services Package 3: Community-Based, Focused and Non-Specialised Support

WHO NEEDS IT?	EXAMPLES OF WHO MIGHT PROVIDE IT	WHEN IS IT PROVIDED?	EXAMPLES OF ACTIVITIES [3]
• Person(s) whose MHPSS needs cause **persistent distress or functional impairment** (after their basic needs, and security have been met and community/ family supports restored); • Person(s) with **common mental health problems** (e.g. depression, anxiety, stress, trauma-responses) • These services are **not intended** for individuals showing signs or symptoms of **severe mental disorder** (e.g. catatonia, psychosis)	• Local religious and/or community leaders; • Lay counsellors; • Primary health care workers; • Case managers; • Child protection workers; • Social workers; • Community health care workers*; • Nurses* / Psychiatric nurses*. * Some health care workers operating in a formalised health care system may be able to offer individuals a combination of advanced psychosocial interventions and medication, however this must be supervised by a qualified medical professional.	• **After** a person(s) **basic needs** and security have been assured and they have had adequate opportunities to receive familial/ community support; and • When a person(s) levels of **distress interfere with daily functioning** over an extended period of time and/or **functional impairment** cause substantial suffering.	• **Activities**, such as those outlined in Services Package 2, but where the intervention is addressing identified and assessed **psychosocial problems that require specific attention;** • **Behavioural activation**, including problem-solving and stress management; • **Cognitive behavioural therapy;** • Cognitive behavioural therapy with a trauma focus; • **Interpersonal psychotherapy** (individual or group; particularly for depression); • **Case management support** for monitoring of general protection and wellbeing indicators.

[3] Age-appropriate approaches must be used for children, such as using play as a medium for therapeutic intervention. All community-based, focused, and non-specialised support services personnel who are actively providing individual and/or group advanced psychosocial support interventions must be routinely supervised with cases reviewed regularly for improvement.

Section 1.4.4

Service package 4

Specialised Support

Additional support is required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have **significant difficulties in basic daily functioning**.
This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of primary health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers.

Minimum MHPSS Services Package 4: Specialised support

WHO NEEDS IT?	EXAMPLES OF WHO MIGHT PROVIDE IT	WHEN IS IT PROVIDED?	EXAMPLES OF ACTIVITIES
Individuals showing signs or symptoms of **severe mental disorder** and/or **distress** and/or **functional impairment**	• Providers of specialised support may include: • Psychiatrist; • Psychologist; • Clinical/ mental health social worker; • Psychiatric nurse; • Trained primary health care worker; • Medical doctor.	**As promptly as possible** after a person has shown **persistent signs** of **severe** mental disorder.	• Behavioural activation, including problem-solving and stress management; • Cognitive behavioural therapy; • Cognitive behavioural therapy with a trauma focus; • Interpersonal psychotherapy (individual or group; particularly for depression); • Case management support for monitoring of general protection and wellbeing indicators; • Contingency management therapy (for alcohol and drug use disorders); • Family counselling or therapy, including negotiated problem solving and crisis management (for psychosis and/or alcohol and drug use disorders); • Motivational enhancement therapy (for alcohol and drug use disorders); • Eye movement desensitisation and reprocessing (EMDR; for Posttraumatic Stress Disorder); • Pharmacological treatments. • Contingency management therapy (for alcohol and drug use disorders); • Family counselling or therapy, including negotiated problem solving and crisis management (for psychosis and/or alcohol and drug use disorders); • Motivational enhancement therapy (for alcohol and drug use disorders); • Eye movement desensitisation and reprocessing (EMDR; for Posttraumatic Stress Disorder); • Pharmacological treatments.

Section 2.1

Important Information for PSS Workers about Referral

What is Referral?

Referral means the act of **recommending that a person should speak to a professional** who is more competent to handle the difficulties and complexities of his or her needs. Try to refer to professionals or organisations with whom your organisation has cooperation or contact. **You should know in detail what has been done by your organisation** regarding cooperation and collaboration with others and maintain regular contact with other services through coordination mechanisms. Always refer in consultation with your supervisor.

Know your limits

There may be situations when someone needs much more advanced support than you can provide. Know your limits and get help from others, such as medical personnel, counsellors, your colleagues or other people in the area, local authorities, or community and religious leaders.

Section 2.1.1

When to Refer

Referrals should be made under the following circumstances:

- When you realise the problem is beyond your capability, level of training, and the purpose of the psychological support programmeme.
- When you have difficulty maintaining real contact with the person.
- When a person hints or talks openly of suicide.
- When a person hints or talks openly about harming others.
- When a person presents imaginary ideas or details of persecution. Be aware though that it might be the truth.
- When you become aware of child abuse or any criminal activity.
- When you see persistent physical symptoms developing.
- When a person is so upset that they cannot care for themselves or their children.
- When you become aware of dependency on alcohol or drugs.
- When you see the person engaging in risky behaviour (showing carelessness towards one self/others).
- When you yourself become restless, confused and/or have recurring bad thoughts or dreams about the case.

Section 2.1.2

How to Refer

What to do	Helpful Tips
As a rule, inform the person concerned about your intentions.	Let him/her know that you care for him/her and then explain the reasons for the referral.
If you have the option, you should present different possibilities of referral to the person concerned.	Discuss matters such as fees, location, accessibility, etc.
Assure the person that you will continue your support until the referral is complete.	You might even suggest accompanying him/her to the first visit with the professional.

Consent

The PSS worker may encounter situations where an individual does not give consent for referral. In most cases, this wish should be respected, particularly if the individual is not yet emotionally ready to engage in this process or prefers one referral option over another.

However, there are cases where the PSS worker has no choice but to refer. These would be cases where there is a threat to the life of the individual, such as suicidal thoughts, or to the life of another person or a threat of serious bodily harm. In Sierra Leone, referrals can be made to the District Mental Health Nurse or a Family Support Unit (FSU).

Section 2.2

Assessments

What are Assessments?

Assessments are processes carried out to understand the views, issues and needs of an individual or different people in order to identify actions that respond to them.

MHPSS workers use mental health and psychosocial needs assessments in two broadly different ways:

1. Needs assessments[4]: When starting work with a community it is important to **assess what the needs are** to inform what programmemes and activities might be appropriate. This can be done through:
   - A **review** of existing assessments and a desk review of written information;
   - Key **informant interviews**;
   - **Participatory interviews** with community members and affected people.

2. Individual/Family assessment and referral: When starting work with a new person or family, MHPSS workers work with them to **identify what kind of support** might be useful.

[4] There are a number of excellent tools available to assist you in planning and conducting needs assessments, in particular the WHO/UNHCR assessing MHPSS in humanitarian situations and the IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. The tools included in the PSS Toolkit are based on this guidance and adapted for use in Sierra Leone.

Section 2.2.1

Basic Information on Assessments

Assessments are conducted in three main ways:

- Home visits,
- Interviews,
- Through group discussions, activities, and/or consultations.

- **Home visits** can include visiting families in the areas they have been affected or in the case of displaced families in the areas that they have been relocated to. It's often a **less formal way** to start building rapport and later trust with members of the affected communities. These visits are often sensitive because families are allowing you to become part of their experience. One way to improve the success at entry is to **partner with a reputable local organisation** and include members of the provider team who are either part of the community, and/or who speak the language of the community members.

- **Interviews** can be structured or unstructured meetings with key stakeholders in government, leading communities, or organisations who operate in the affected areas. In order to get complete information, it is important to ensure that there is a balance in the number of people being interviewed across gender, age, culture/tribal groups, and income status.

- **Group discussions and activities** are necessary when collecting information from a large number of children and adults who have experienced an emergency together, most likely in one community.

Facilitating group discussions and activities should be done in conjunction with local NGOs or people from within the community, particularly if the assessor is not familiar with the culture or does not know the language.

Tips

1. Be clear on your role as counsellor – be professional, clarify roles and responsibilities and deliver those. Follow core principles.
2. Ensure that the people you work with understand what mental health psychosocial support (MHPSS) is.
3. Avoid carrying out assessments without following up with treatment – don't raise false expectations.

Section 2.2.2

Ethics of MHPSS Needs Assessments

Proper assessments require participation and asking the right questions to people in line with their culture and beliefs. There is a risk of carrying out healing activities without know the background of a context, and caution must be taken to avoid worsening a situation through an assessment or intervention.

Some of the ethical principles underpinning MHPSS assessments are as follows:

- **Participation** of relevant **stakeholders** (e.g. governments, NGO's, community and religious organisations, local research and university capacities, affected populations) in design, implementation, interpretation of results, and translation of results into recommendations. Participation of women, girls and other **at-risk groups** is essential to ensure that protection risks are assessed effectively.
- **Inclusiveness** of different sections of the affected population, including attention to children, youth, women, men, older people, people with mental health problems, people with disabilities and different cultural, religious, and socio-economic groups.
- **Relevant data collection** with a **focus on action** rather than purely collecting information. Collecting too much data (i.e. so much data that not all can be analysed) or data that is unlikely to guide or translate into action is a waste of resources[5].
- **Attention to conflict**, including maintaining impartiality, independence, and being considerate of possible tensions and power structures.
- **Protection** of people and groups providing data by taking into consideration protection threats and putting people at risk by asking questions, or inappropriately storing and/or sharing data.
- **Cultural appropriateness** of assessment methodology, terminology and the behaviour and attitudes of assessment team members.
- **Ethical principles**, including respecting privacy, confidentiality, voluntary participation, informed consent, and the best interest of the interviewee. Assessors should take care to avoid raising expectations and make sure that **assessments are linked to action** and tangible benefits where possible.
- **Assessment teams** trained in ethical principles (including confidentiality principles), possessing basic interviewing skills, supportive when encountering people in distress (e.g. basic principles of **psychological first aid**), knowledgeable about the local context, and balanced in terms of gender. Some of the team members should be members of (or intimately familiar with) the local context.
- **Data collection methods** should adopt **multi-method** approaches including review of relevant literature, agency reports and policy documents, qualitative and quantitative data collection methods (e.g. key informant interviews, focus group discussions, surveys), observation, and site visits.
- **Dynamism and timeliness**. The guidelines describe assessment as a dynamic phased process. Assessments can take place in phases, with more detailed assessment taking place in later phases. Guiding Principles (cf. IASC, 2007)

[5] Psychiatric epidemiological surveys - assessing the prevalence, distribution and correlates of mental disorders - can be of academic and advocacy value but are outside the scope of the IASC (2007) MHPSS Guidelines and the current document.[5] Guiding Principles (cf. IASC, 2007)

Section 2.2.3

Notes of Caution for Interviews

Before conducting interviews, it is important to take the following into consideration:

1. **Interviews should be conducted in the participants' mother tongue** where possible, rather than Krio where Krio is not the mother tongue, to allow them to fully express themselves.

2. **Introduce yourself.** Clearly state how long you have been working in the community and what services you provide.

3. **Tell people they can choose whether to participate or not.** When you are conducting general needs assessments, clearly tell participants that there is no link between them participating in the assessment and accessing services, and that the person can access your organisation's services without participating in the assessment. Do not pressure anyone to participate in an assessment.

4. **Interviews and data collected must be kept confidential**. All participants should be made aware that whatever information they share will not be shared with anyone else, and that their personal identity will not be attached to any of the data collected.

5. **Choose questions selectively**. Do not use all questions from these tools. Assessors should choose those questions that are of relevance to their setting.

6. **Avoid lengthy interviews.** Remember that the most common mistake in assessments is to ask too many questions that are not subsequently analysed, reported or otherwise used. Do not ask more questions than needed. **Interview length should be no more than 1 hour.** If interview takes more than 1 hour, then it is advised to make a second appointment at another time for a follow-up interview.

7. **Be careful.** Highly sensitive questions that put people (interviewee, interviewer, or other people) in danger should not be asked. Questions that are not sensitive can be asked during group interviews. Depending on the context, sensitive questions may be asked during individual interviews.

8. **Adapt to your setting.** Questions may be adapted for use in a group or individual setting.

9. **Use probes only when necessary.** Some questions contain probes; these should only be asked if necessary (i.e. when the respondent cannot think of a response after some time). It is not necessary to use each probe one-by-one; they are meant as examples to stimulate a more elaborate response.

10. **Remember to debrief after the interview.** Offer the participant a referral to psychosocial support if they experience discomfort or distress. Tell them how they can give feedback or make a complaint about your organisation.

Section 3.1

Avoiding Stigma

PSS workers need to understand the dynamics of the use of words relating to the field of psychosocial support. Failing to do so can result in oversimplifications, the incorrect usage of words, and/or stigma.

Below are lists of recommended terms for PSS workers, as well as terms that are not recommended.

Examples of recommended terms	Examples of terms that are not recommended to be used outside clinical settings
- "Distress", "anguish", "torment", "overwhelm" - "Distress" or "stress" - "Psychosocial" and "social" "effects of emergencies"	- "Trauma" - "Post traumatic stress disorder"
- "Terrifying", "life-threatening" or "horrific" events	- "Traumatic events"
- "Distressed" (children or adults) (children with normal reactions to the emergency) - "Severely distressed" (children or adults with extreme/severe reactions to the emergency)	- "Traumatised" (children or adults)
- "Reactions" to "difficult situations" - "Signs of distress" - "Psychosocial wellbeing" or "Mental health"	- "Symptoms" - "Wellbeing" (this is not specific enough) - "Good mental health" - Mental illness - Psychosis
- "Structured activities"	- "Therapy"

Note: Terms like "Trauma" and "Post-Traumatic Stress Disorder (PTSD)" should only ever be used in cases where the person being referred to has already received a diagnosis from a clinical psychologist, psychiatrist or psychiatric nurse. These terms are potentially stigmatising and international guidelines would caution very strongly against using them to describe people in distress more generally (IASC reference group, 2011; Sierra Leone Ministry of Social Welfare, Gender and Children's Affairs, 2015).

Section 3.2

Key Concepts for Effective Communication

Here are some helpful definitions for communicating effectively with people who have been affected by a crisis:

Empathy	A helper must communicate an **ability to see and feel from the affected person's point of view.** This usually includes a quality of personal warmth, as opposed to someone who is aloof, mechanical, or all business.
Respect	A helper must communicate sincere respect for the dignity and worth of the affected persons.
Genuineness	This is about more than factual honesty or sincerity. In working with people who may find it difficult to trust others, the helper must be a very **genuine person who can earn trust** under difficult conditions. This means **saying what you mean and meaning what you say**. Anything less can lead to a sense of betrayal.
Positive Regard	A helper must demonstrate a sincere **regard for the welfare and worthiness of the affected person**. Such people may struggle with a sense of being unworthy and flawed. The helper's positive regard for them is often the seed of a renewed sense of self-esteem.
Non-judgemental Stance	People are often concerned that they will be judged by others to be at fault for the crises that befall them. A good helper can relieve this tension by carefully **avoiding judging** the affected persons. Otherwise, empathy, respect, and positive regard may be undermined.
Empowering	A helper is temporarily in the affected person's life. Therefore, it is crucial that you **leave the person feeling more resilient** and resourceful than when you met him/her.
Practical	Being practical about **what can and cannot be accomplished** for a person in crisis is necessary, if we are to succeed in leaving behind a strengthened and functionally whole person even after support is withdrawn.
Confidentiality	This refers to the helper's duty to keep private those things that are shared by a client. However, **certain information must be shared** on a need-to-know basis when the good of doing so outweighs the bad and the people who receive the information can positively influence the matter. Information, such as knowledge about child abuse, requires socially responsible action by the helper to protect others, and should lead to the helper disclosing the information.
	Ethical codes of conduct vary from context to context. They also, however, have certain principles in common; -Do no harm; -Be trustworthy and follow through on your words with appropriate deeds; -Never exploit your relationship; -Respect a person's right to make his/her own decisions; -Never exaggerate your skills or competence; -Be aware of your own biases and prejudices.

Tips:

- A common mistake that PSS workers can make when adopting an empathetic approach is to say, "I know what you are going through." However, it is important to note that every person is different, as are their experiences and life stories. Therefore, no one can ever truly understand exactly what another person is going through.
- PSS workers should be careful not to fall into the trap of describing their own life stories and challenges. The PSS worker is there to listen and help others through their difficulties, not the other way around.

Section 3.3

Good Communication Skills

Here are some tips on communicating well with the person(s) you are helping. This section draws on Commit and Act training materials used with practitioners in Southern Sierra Leone.

- Keep an **appropriate distance**: proximity reflects interest, but may also communicate intimacy, informality or pushiness. Judge an appropriate distance so as not to invade someone's personal space. This can usually be arm's length. **Sit face to face** if culturally appropriate. Keeping an appropriate distance is an important strategy to guarantee the physical and emotional safety of both the person being helped, as well as the PSS worker.

- Find a **quiet place** where the person feels free to talk. If working with children, children should never be isolated with adults. Likewise, it is not recommended for a PSS worker to be completely isolated with another adult of the opposite sex.

- Nod or use **facial expressions** or **gestures** to encourage the person to say more or to let them know you understand. You can even use ideophones – culturally appropriate sounds such as "Uhum!" or "Eneh!".

- Notice the person's **body posture**. If they are very tight and rigid, they might not be at ease. If they are slumped over or hunched, they might be feeling sad or lacking in self-esteem.

- Notice the **facial expression** of the person, looking for signs of emotion, whether that is positive or negative. Also, be sure to keep your own facial expression measured, relaxed, kind, and approachable. Avoid showing negative emotions or reactions such as anger or disgust.

- Look for **what is not said** as well as what is said – try not to make assumptions.

- Find the **real feelings** behind the story and body language.

This sections draw on Red Cross Psychosocial Centre training materials.

Section 4.1

Coping

Here is a breakdown of the **stages of assisted coping**.

Develop mutual comfort (rapport)	This is where a sense of trust and understanding are formed, which are crucially important elements for making progress.
Clarify issues of importance	Gather necessary information (problems and concerns) about the person's situation and set the stage for identifying needed changes.
Examine alternatives	Most people in a crisis can see many fewer options than they would normally. You can help them to regain their ability to consider a number of possible solutions and/or options for positive change, thus increasing their coping capacity.
Identify potentially successful methods	Agree on decisions for making hopeful changes. By encouraging people to evaluate their own potential, you are empowering them to regain a sense of control and self-determination.
Clarify potential costs of each method	It is important to recognise that any solution will have some degree of cost and uncertainty. By supporting this process of considering the costs you can help keep the person realistically connected to the situation and to his/her own limits.
Select and implement the best plan of action	This is often the most difficult step for a person in crisis because it is the point at which he is most vulnerable to new disappointments. He/she may require substantial support from you or from his/her support network during this transition.
Evaluate the outcome of the action and lessons learned	This phase brings a sense of closure by allowing the person to reflect on the decision-making process and the outcome achieved. It is important at this stage to reinforce people's sense of ownership over the process and the outcome so that they do not come away feeling helpless or dependent. The goal has always been for them to regain their sense of confidence in making their own decisions.
Follow up	This step is somewhat idealistic because it is mostly never done. Nevertheless, it allows for evaluation of the process. Whether the follow-up interval is a day or a year, it sends a validating message to people that they are still important and allows the volunteer to draw important lessons about the effectiveness of his/her work.

Section 4.2

Problem Solving

In your work as a PSS Helper, you will likely encounter people who are struggling. This section is designed to give you resources for helping people to think through their challenges.

Section 4.2.1

What is Problem Solving?

Problem solving is a proactive approach coping. In the context of PSS support designed to help people who have been in a crisis, it can include:

- Social support,
- Self-help activities,
- Self-advocacy (standing up for oneself),
- Resilience building, confidence building or empowerment activities,
- Skill building,
- And other activities that tangibly alter the distressing circumstances.

Section 4.2.2

What Should I Keep in Mind While Helping to Problem Solve?

Be careful not to settle too quickly on a coping solution. **The best help you can give is not necessarily the quickest answer.**

Remember, people are slow to learn new ways of coping, so **subtle variations** on familiar ways often work best.

Avoid the tendency to consider only individual solutions. **Collective or social solutions** have the great advantage of supporting helpful group relationships among members of the same family or community in ways that may endure long after your intervention.

Section 4.2.2 continued

What Should I Keep in Mind While Helping to Problem Solve?

Of course, **not all problems can be directly solved or changed**. In these cases it can be helpful to **focus on the long-term emotional adaptation** of the affected person.

- For instance, if thinking about particular losses in the past keeps leading to painful emotions, the person may benefit by avoiding those thoughts and instead thinking about more hopeful prospects in the present.
- Similarly, if a person has adopted a perspective that locks them in a cycle of painful emotions, it may help them to **focus on positive lessons** they have gained from a painful situation.
- However it is done, **it must be done sincerely** and with the intent of helping the person to accept certain losses so that he or she may again move forward. This is sometimes called moving from **the victim role to the survivor role.**

Section 4.2.3

More Guidelines for Helping Others to Problem Solve

A. Help the person to **define the problem**.
   - Try to keep it **limited and manageable**.

B. Help the person to formulate **multiple solutions**.
   - Consider the **benefits and costs** of each solution realistically.
   - **Do not over-help**, so that people have a chance to regain their decision-making abilities.
   - Eliminate impractical solutions, but **understand** if people need to consider some **miraculous (i.e. impractical) solutions**. They may not yet be able to accept their predicament.
   - Be realistic in the support you can offer. You may have the best intention and want to do more, but you may ultimately be limited in terms of time and resources. Try not to overcommit yourself or offer empty promises. Be honest with what you can actually help with.

C. Formulate a **plan of action** and **implement** the solution.

D. **Reflect** upon the plan to evaluate its effectiveness and make appropriate adjustments.

IMPORTANT NOTE: This section should be consulted alongside the Toolkit, which offers many exercises to do with different groups of people.

MHPSS focuses primarily upon assisting people at the community level. Because of this, you will need to become comfortable and effective in working with various sizes of groups.

Section 5.1

Helpful Information on Getting Started

A good first step is to **define a target group** around an issue for which there is sufficient apparent interest to motivate significant participation. Psychological well-being often flows from experiences of community participation and cooperative effort.

People who feel a sense of belonging within an effective group derive a sense of **membership and worth**. What is more, these activities signal a return to a more normal state of affairs where people work together constructively to improve conditions for the members of their group.

Establishing a support group is inexpensive and relatively simple. The following factors are critical in this process:

- **Participation of women, girls and other at-risk groups** is essential to ensure that protection risks are assessed effectively, in particular GBV risks and child protection risks associated with the programmeme.

- In many contexts, **groups of the same sex and age** (e.g. women's group, girls' group, boys' group and men's group) will function best, particularly when it is culturally appropriate for people to socialise with others who share their sex and age.

- Ensure that group meetings are **held at safe locations**, that participants can safely access the group, and that they can safely travel to and from sessions. **Consider the financial costs** incurred and the need to make alternative arrangements such as childcare.

Section 5.2

More Tips on Starting Group Work

- **Work with parents/guardians** to ensure that they consent to and participate in activities that engage with girls and boys, target parents/ guardians for parallel programmeming where possible.
- **Seek out existing groups** and supports that people are already turning to and work with them.
- It is important to carry out **baselining** to **monitor interventions** with groups, using established tools to understand the situation of people prior to the intervention. Generally, the assessment phase tends to be very weak or overlooked.
- When working with groups (either new or existing groups), establish **regularly scheduled meetings at an accessible location**. Approaches should be tailored for different age groups (i.e. youth might want to meet at a place that is different from where adults would feel comfortable meeting).
- Try to find (or to be) good **facilitator** who is aware of the particular theme of the group, skilful in managing discussions, objective and in general has **good people skills**.
- Groups should be **based on community members' need** and desire for one, and group members must together:
- **Determine** what the goals of the group are.
- **Decide** what actions need to be taken to accomplish these goals.
- **Know** the criteria by which the group can tell when it has reached its goals.
- Every individual within the group must also be **aware of how his own behaviour can contribute** to the group's goals, and thus has the responsibility to take action to accomplish them.

Section 5.2.1

More Tips on Starting Group Work

The following is a sample step-by-step process for setting up a support group .The target group was teenage mothers. In these community contexts existing groups were not available for the target population, as youth groups were mainly targeting girls in school and young mothers were finding it difficult to access supports due to childcare issues and in some cases discrimination.

Step 1

Through participatory community assessment, identify issues and target groups that require support and where there is significant motivation among the target group to seek support (e.g. teenage mothers). **Identify the barriers** for teenage mothers in gaining the support they need (familial, social, educational, economic, political barriers) through interviews with key informants (service providers, religious leaders, chiefs), families of teenage mothers and teenage mothers themselves.

Step 2

Confidentially, **ask each interviewee to identify further participants** who might benefit from group support. Key informants (service providers, religious leaders, chiefs, and women leaders), teenage mothers themselves, and parents, partners and family members are all asked to identify girls who they know are particularly vulnerable and socially isolated. All potential participants are invited to a meeting in the community. It should be made known that they are invited to bring their children as well.

Step 3

At the community meeting, invite a small number of **local leaders**, women's leaders and service providers who are known to the young women (e.g. supportive health workers, or a supportive teacher from local secondary school). Introduce the idea of setting up a support group. State that the idea would be that this group will meet together to **make plans and strategies** to improve the situation of teenage mothers and their children. Each group will be composed of 15 to 30 members.

Step 4

In the case of mothers who are interested in joining the group, some further mediated discussions with them and their families might be useful as an initial step towards ensuring they are free to participate.

Step 5

Initial **12 week programmeme** followed by social action:

A. The programmeme starts by forming the group; getting to know each other; create a **safe space**; establish **ground rules**; understand hopes, fears and expectations; and carrying out exercises on communication skills. Give clear information about what will be possible during the project and a summary of previous projects in Sierra Leone.

B. Engage in **problem analysis**, power analysis, prioritising and ranking issues of importance (problems and concerns), generating multiple potential alternatives for positive change in response to the most pressing issues and concerns.

C. **Examine** options and **identify** methods with the highest **potential for success**. (Remember to use constructive communication: facilitate the group in making their own decisions, don't rush this process, bring in external experts to dialogue with the participants and answer their questions if needed.) For example, if developing an income generation proposal, bring someone who can show them how to do market analysis and support them in analysing the market over a number of weeks).

D. Clarify **potential costs** of each method.

E. Select and implement the best **plan of action**. This might involve multiple activities – for example:

- Developing a **community drama** on the experiences of teenage mothers to start a discussion with families and communities and reduce discrimination
- **Volunteering** in the community as a group, for example assisting elders.
- With permission from the chief and the landowner, **cleaning up an area** in the community so that all children have a safe place to play.
- Supporting each other to complete schooling through alternative education.
- Other communal work, like setting up communal businesses (e.g. mobile phone repair).

F. Evaluate the outcome of the action and lessons learnt

G. Follow up.

Section 5.3

Reflective Listening

Reflective listening is a communication strategy involving two key steps: seeking to understand a speaker's idea, then offering the idea back to the speaker, to confirm the idea has been understood correctly.

Examples of Reflective listening include the following:

A work situation:

"I hate working with M'balu, she's so dismissive of my ideas."

Reflecting content:

"It sounds like you're saying that M'balu can be dismissive of your contribution at work."

Reflecting feelings

"It sounds like you're frustrated with M'balu."

Reflecting content **AND** feelings.

"It sounds like you're frustrated and finding it difficult to work with M'balu because you don't feel that your ideas are valued." (In this case, "frustrated" is the feeling and "you don't feel your ideas are valued" is content.)

Benefits of reflective listening for the disputants in resolving conflict:

- Disputant knows their concerns and feelings have been heard and understood.
- Helps them to:

  - focus on self,

  - ventilate (or "vent"),

  - express emotions,

  - and sort out issues.
- To move to deeper levels of expression at their own pace;
- To think aloud and to arrive at their own solutions.

Naming the perceptions, concerns and feelings accurately:

- Don't go beyond what the person has said.
- Don't go above them – which inflates or over frames their reality.
- Don't go too deep – which psychoanalyses them.
- Use the discipline of not adding anything: it is best to fall a bit short.
- Use of correct feeling words – don't escalate!

  Example: "frustrated", not "furious".
- Be open minded in your response, so that the speaker feels comfortable in correcting you if you have misunderstood them.

Focus more on feelings at the beginning of the story. Listen carefully and pick up on any feeling words to draw out the emotional content.

Section 5.4

Sample Group Activities – Reflective Listening

The following activities can be carried out with groups of PSS workers or PSS workers in training to strengthen their listening skills.

Activity 1: Reflecting on Values

PURPOSE: Acknowledging the values of different people and accepting these differences. To understand how values differ from person to person, enabling participants to accept difference.

TIME:
20 Minutes

AGES:
12 years and older

GROUP SIZE:
Small groups of 3 or 4 people or can be done with a large group.

RESOURCES:
An open space

PROCESS:

STEP ONE: SET UP

- Participants sit in a circle or a square

STEP TWO:

Give out the sheets and explain the questions, which are:

- *When you help others, what do you value most?*
- *How do you like to be treated when looking for help for a problem?*
- *Do your values and hopes differ depending on if you give or receive help? If so, how?*
- *Which of the values listed are most important to you?*

STEP THREE: SMALL GROUPS

- Divide the participants into small groups and put them in areas to talk to each other.
- Ask participants to take a few minutes to look at each other's view on life in the small groups by discussing the questions on the sheet (listed above).

STEP FOUR: CLOSING

- Thank everyone for taking part and for trusting each other.
- Remind everyone of the confidentiality agreement made by the group.

Activity 2: Non-verbal Communication

PURPOSE: Understanding different types of non-verbal communication and/or body language

TIME:	AGES:	GROUP SIZE:
20 Minutes	18 years and older	2- 30

RESOURCES:
A drum to beat to signal that it is time to switch positions.

PROCESS:

STEP ONE: SET UP

- Participants sit in a circle or a square

STEP TWO: DELIVERY

- Put the participants in pairs (or ask them to put themselves into pairs). Each pair should have a "Person A" and a "Person B".
- Ask the participants to have a conversation with each other and tell them that whenever you shout 'change!' they should change their physical position. They should not plan in advance. They can stand, kneel, lie on the floor, lean against the wall, stand on a table, turn their back, check their fingernails, stand on tiptoes or do whatever they like.
- After a few minutes, beat the drum to stop the conversation and ask "Person A" to tell "Person B" the position in which "Person A" felt most comfortable speaking to them. The "Person A" should stay in that position. Once all the pairs are in their new positions, have them look around and observe each other's positions. Then repeat with "Person B" doing the same.
- Discuss with the group about which positions were best for easy communication.
- Discuss with the group if there were any differences for women and men. Were women more comfortable with certain positions? Were men more comfortable with certain positions?
- Discuss whether there were certain positions that participants felt uncomfortable with based on who was older or younger.
- Go around the circle asking each participant to say one thing about how they felt about the activity
    - *Did they feel listened to? Respected?*

STEP THREE: CLOSING

- Thank everyone for taking part and for trusting each other
- Remind everyone of the group confidentiality agreement
- Centering exercise

  Share the following words:
    - *Everyone stand the floor and close your eyes.*
    - *Breathe deeply to the count of four, or to a higher count if you can.*
    - *As you breathe in, empty your mind of all thoughts.*
    - *Feel your belly getting bigger with air and then slowly release your breath.*
    - *Breathe in again, slowly, and keep breathing, concentrating on your breath.*
    - *If you find your mind wandering or full with thoughts of what you have said or heard, let the thought come, acknowledge it and come back once more to concentrating on your breathing.*
    - *Continue for two minutes.*
    - *And now in a moment I will bang the drum. We will return to the room and go on with our time together. I hope that we can leave any thoughts that we have and what we have said and heard here in the room and then we can continue with the rest of our day.*

Activity 3: Deep Listening

PURPOSE: Developing deep listening skills to be used in practice.

TIME:	AGES:	GROUP SIZE:
30 Minutes	18 years and older	2 - 30

RESOURCES:
An open space

PROCESS:

STEP ONE: SET UP

- Participants sit in a circle or a square

STEP TWO: DELIVERY

- **Deep listening** is different to other kinds of active or reflective listening. When using deep listening, we sit with another person and just listen to what they have to say. We do not offer solutions, reframe their experiences, verbally contain and acknowledge their feelings, or any of the other methods we would usually use.
- In order to explore the use of deep listening, in this activity **the person listening will not say anything at all**. Although you may wish to encourage or respond to the speaker by making short sounds and responses such as "hmm", "uh huh", "yeah", "wow" or "ah", please try and refrain from saying any more than that.
- I would like each of you to think of a wound, hurt or struggle that you have experienced in your life, you can go as deep or not as you feel comfortable. You will be divided into pairs *(divide the group into pairs, while remaining in the circle)*. Take some time now to think of something you might feel able to discuss with another person. Nothing that is discussed here today will leave this room; confidentiality is very important and we all agree to keep the trust of our fellow participants. I will now give you a few minutes to think of something you feel comfortable discussing (3 minutes).
- Please move your chairs/seats now so that you are facing the other person, and decide who will begin. After ten minutes of one person talking and the other listening I will sound the chimes and we will debrief in the larger circle.
- One person talks about their experience of hurt, while the other listens (10 minutes.)

STEP THREE: DEBRIEF

- Go around the circle to each of the people speaking and ask them to share how they found the activity.
- Go around the circle to each of the people that were listening, and ask them to describe how they found the activity.
- Begin the activity again so each of the listeners becomes a speaker and shares their experience of hurt, while the other listens (10 minutes). Repeat the debriefing questions.

SAFETY:
Participants choose what experiences they want to discuss. They may choose an upsetting hurt or struggle or a very minor one, and so there may be a risk of causing emotional stress. If any participant appears stressed during the activity, follow up with that person and refer them for additional support if they feel this is needed.

Activity 4: Listening Circle

PURPOSE: Teaching and using active listening skills

TIME:	AGES:	GROUP SIZE:
2 hours	18 years and older	2 - 30

RESOURCES:
A bell or a chime

PROCESS:

STEP ONE: SET UP

- Arrange 2 circles of 6 seats, one on the outside of the other, so that the inner circle and outer circle are facing each other.
- Each pair of chairs (an outside seat and the inside seat opposite) has a card marked with one of the six kinds of listening.
- Ask everyone to find a chair.

STEP TWO: EXPLAIN ACTIVE LISTENING

- ***If we do not hear*** *what the other people communicate* ***we cannot support*** *them.*
- *Active listening means not only listening to what someone is saying with words, but also to how they say it through their voice and body.*
- *Active listening also involves letting the speaker know that he or she has been heard. For example "What I heard you say is…" "So you mean that…"*
- *When we work with conflict, we start with the other's view or opinion.*
- *The view or opinion of another person must be accepted as being 'truth' for them.*
- *It may be that this truth might change if they have a more of an understanding around the situation, or if they hear someone else's view. Their view or opinion may turn out to be only one small part of a bigger picture.*

STEP THREE: GOOD AND BAD LISTENING HABITS

- Ask the group if anyone can give examples of poor listening habits.
- Explain that there are two types of active listening skills:
- Attending skills i.e.
  - Building rapport by allowing the person to feel comfortable and safe
  - Eye contact (intermittent not permanent)
  - Posture
  - Gestures
  - Non-distracting environment
- Responding Skills i.e.
  - Let person know you have understood their feelings and respect their message
  - Probes to help person consider their situation more deeply
  - Challenges to help person consider new perspectives
  - Summaries to help person bring their experiences together

Activity 4: Listening Circle (continued)

PROCESS:

STEP THREE: GOOD AND BAD LISTENING HABITS (CONTINUED)

- Effective listing requires empathy – empathy means understanding what someone else feels and why they feel it. We should also repeatedly check to make sure we are understanding their view and feelings.
- This activity will look at different ways of responding to a person describing a conflict from their view.
- Example of a problem statement: "That's it, I'm going to tell my son to move out. He totally lost it with me when I asked him why he was home late. He's a waster and he never listens to me."
    - Dialogue (That's terrible! I know how you feel. It was the same with my son…)
    - Advice giving (Maybe you should ask his father to talk to him).
    - Clarifying (Is this the first time this has happened?)
    - Validating (That must be so hard for you! You're doing really well coping with him.)
    - Reflective listening (It sounds like you're feeling a bit desperate and even considering asking him to move out. It sounds as though you were hurt by the way he spoke to you, and are concerned that he doesn't listen to you.)
    - Reframing (So what you're saying is you're frustrated with your son and are very concerned about him. It sounds as though you feel a bit desperate with the situation and wish he would listen to you. If he was listening now what is it that you would like to say to him?).

STEP FOUR: ACTIVITY

- The inside circle is made up of "listeners".
- The outside circle is made up of "speakers".
- Each pair of chairs will have a card showing a type of listening.
- When you are at that seat, the listener uses that type of listening.
- Say: "I would like all of you (including those who are currently listeners and those who are speakers) to think of a conflict, hurt or struggle that you are currently experiencing or have experienced in the past. Because you will be talking about it with many people, it may be best to pick something that isn't a very deep hurt."

Examples:

Something that annoys or frustrates you in your work.

A work or personal conflict you are having with another person.

Something you are finding difficult at the moment.

Or any other conflict or hurt that you feel comfortable talking about.

It can be the same conflict you discussed before in deep listening, or a different one. If you're finding it difficult, and want to switch issues at any point, you can.

Give a few minutes for everyone to think of something. (1-2 minutes)

Outside circle/"Speakers": You will talk about this issue for 7 minutes with the person opposite you until the bell chimes.

Inside circle/"Listeners": You will listen using the style of listening on the card.

Activity 4: Listening Circle (continued)

PROCESS:

STEP FOUR: ACTIVITY (CONTINUED)

For example: For 'clarifying', ask questions or make statements in the way you feel is best.

When the bell chimes, everyone in the inside circle should move to your right and everyone in the outside circle should move to your left and begin again, leaving your listening card in place.

Chime bell after seven minutes (x 6 times).

STEP FIVE: DEBRIEF

Go around the circle to each of the people that were listening, and ask them to describe how they found the activity.

Which listening tool or style were you most comfortable with?

Which were you least comfortable with?

Did you experience anything new or learn anything about using the different styles in different situations?

Which style would you like more practice or experience in using, if any?

In which chair did you feel you had the most power or control?

In which chair did you feel you had the least power or control?

Go around the circle to each of the people speaking and ask them to share how they experienced the activity.

Which listening tool or style were you most comfortable with?

Which were you least comfortable with?

In which chair did you feel you had the most power or control?

In which chair did you feel you had the least power or control?

- Begin the exercise again so that each of the listeners becomes a speaker and shares their experience of conflict, while the other listens.
- Repeat the debrief.

STEP SIX: LARGER GROUP DISCUSSION

- Reflect on the debriefing session.
- Ask if anyone has any questions or comments.
- Explain again that each style and tool is useful in different circumstances, and explore through discussion when each listening tool might be used when mediating different types of conflict situations.

STEP SEVEN: CLOSING

- Thank you all taking part and for trusting each other.
- We must all remember that nothing discussed here in your pairs will be repeated.

SAFETY:

Participants choose what experience to discuss. They are advised not to choose a deep hurt in their lives, so the risk of emotional stress is low. If any participant appears stressed during the activity, follow up with that person and refer them for additional support if they feel this is needed.

Activity 5: Listening to Children

PURPOSE: How to listen to children

TIME:	AGES:	GROUP SIZE:
20 minutes	18 years and older	2 - 30

RESOURCES:
Flipchart, markers

PROCESS:

STEP ONE: SETUP

Participants sit around in a circle or a square

STEP TWO: BRAINSTORM

- Ask the full group to brainstorm what they feel should be the difference in communicating with children and with adults.
- Ask participants to identify the differences and write them up on a flipchart (even if you don't agree with something they say). For example, "Children may not tell the truth," or "Children will say what you want to hear." Pay attention to cultural expectations of children, such as "Children should be seen and not heard."

STEP THREE: TONALITY

- Write the following phrase on a flipchart: **"Ah, Mohamed/Mary. You are here. Come in. I have been waiting for you."**
- Ask volunteers to say the phrase in as many different ways as possible. Then discuss how each person said it and what each way means: happy, menacing, sad, frightened, inquiring, etc. What does this tell us about tone of voice?

STEP THREE: ROLE-PLAY CHILD INTERVIEW

Ask two volunteers to role-play a perfect adult-child interview. The rest of the group should give feedback. When asking for feedback, encourage them to remember the tips for good listening skills.

STEP FOUR: CLOSING

Thank you all for your participation and trust in each other, and we all remember that nothing discussed here in your pairs will be repeated.

SAFETY:
If any participant appears stressed during the activity, follow up with that person and refer them for additional support if they feel this is needed.

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