PRIMARY HEALTH CARE WORKERS
TRAINING MANUAL

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Acknowledgement

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APPENDIX
DAY 1

MODULE 1: Course Overview and Introduction to the Training

LEARNING OBJECTIVES:
By the end of this Module, participants will be able to:
- Know more about the trainers and other training participants
- Understand the training agenda, objectives and “ground rules”

CONTENT:
Session 1.1: Welcome, Introductions, Agenda and Ground Rules
Session 1.2: Review of Training Objectives
Session 1.3: Pre-training Assessment

MATERIALS NEEDED:
Flip chart
Markers
Name tags
Pens and pencils (for each participant)
Copies of the GSP Work Book (for each participant)

SESSION 1.1: Welcome, Introductions, Agenda and Ground Rules
TRAINER INSTRUCTIONS

Step 1: Introduce yourself and the other trainers and welcome participants to the training. Lead an introductory activity so people can introduce themselves and get to know more about one another and the trainers. Adjust the activity depending on the size of the group.

| Ask participants to get in pairs with someone they do not know. Give the pairs five minutes to get to know each other (name, family members, current work place, hobbies…etc. After 5 minutes, bring the large group back together and ask each person to introduce their partner to the larger group. The trainers should also participate and introduce one another. |

Step 2: Pass around the attendance register and explain that participants will be required to record their name, organization, contact information daily for the five days of the training workshop.

Step 3: Introduce the Informed consent document for Health workers. Explain that one of the project aims is to determine the extent of knowledge retention among trained health workers. Therefore, the project team needs their consent to participate in baseline and follow up evaluations.

Step 4: Introduce the baseline Health Worker survey. Explain that this survey will be completed before the start of the training and at 6 months intervals after the training for a period of two years.

Step 5: Go over the training agenda that participants have in their workbook Highlighting logistics such as lunch, start and end times, payment of per diems and transport arrangements. Ask if there are questions about the agenda before moving on.

Step 6: Introduce the GSP work book and make sure each person has a copy. Explain that the Work Book contains the practical exercises key points for each Module and Practical exercises and can be used for note taking as well.

Step 7: Lead participants to set “ground rules” for the training. Record these rules on flip chart and encourage participation from the whole group. Examples include: turn off mobile phones, confidentiality, no judgmental attitudes, no question is a bad question, everyone should be respected when they have the floor, everyone should actively participate, come back from breaks and lunch on time, etc. Keep these “ground rules” posted throughout the training.
SESSION 1.2: Review of Training Objectives (15 minutes)

Training objectives

By the end of this basic training course (Modules 1-10), participants will be able to:

1. Initiate contact and build rapport with persons at risk for depression, screen for depression, differentiate between mild-moderate and severe depression and refer severe cases to mental health workers.
2. Demonstrate counseling skills and self-care strategies required to deliver group support psychotherapy.
3. Demonstrate ability to provide psycho-education, effective coping strategies and problem solving techniques for depression and HIV/AIDS.
4. Demonstrate ability to use the GSP manual to deliver group support psychotherapy.
5. Describe and use emotional self-care strategies.
MODULE 2: Introduction to Group Support Psychotherapy (GSP)

By the end of this Module, participants will be able to:

**LEARNING OBJECTIVES:**
- Understand why GSP was developed
- Describe the structure of GSP
- Describe the theoretical perspectives of GSP
- Describe how GSP leads to reduction in depression
- Describe the Group Therapy Process
- Describe the Roles and Responsibilities of GSP Facilitator

**CONTENT:**

- Session 2.1: Development and testing the Group Support Psychotherapy Model
- Session 2.2: The group therapy process
- Session 2.3: Roles and Responsibilities of Group Facilitators
- Session 2.4: Practicum on introduction to Group Support Psychotherapy, GSP session 1

**MATERIALS NEEDED:**

- Flip chart
- Markers
- Name tags
- Pens and pencils (for each participant)
- Copies of the GSP Work Book (for each participant)

**Session 2.1: Development and testing the Group Support Psychotherapy Model**
Why was Group Support Psychotherapy developed?

Conflict and post conflict settings often suffer the heavy burden of psychological effects associated with war but these are made even worse by the HIV/AIDS epidemic.

For example, HIV infection rates in post-conflict northern Uganda are estimated at 11% which is higher than the national HIV infection rate of 7%. Among war-affected individuals receiving care from trauma clinics in northern Uganda, HIV infection rates range from 10% among children to 15% among adults (Nakimuli-Mpungu et al., 2013).

Depression is the commonest mental health problem in Northern Uganda, a region that has been ravaged by war for two decades. War-related violence, chronic diseases such as HIV/AIDS and socio-economic disadvantage including poverty and low education make it more likely for one to develop depression. (Patel and Thornicroft, 2009).

Indeed, high prevalence rates of depression symptoms have been reported in the northern region of Uganda which suffered two decades of brutal civil wars, with estimates ranging from 45% to 70% (Roberts et al., 2008; Vinck et al., 2007).

For these reasons, there is urgent need of culturally appropriate interventions for depression especially in low resource settings.

The World Health Organization (World Health Organization, 2010) recommends treating depression with basic psychosocial support or psychotherapy, such as cognitive behavior therapy (CBT) as first line treatments for depression in poor resource settings. However, these treatments are limited in such settings e.g. northern Uganda (Patel et al., 2007).

Further, recent studies (Fournier et al., 2010; Kirsch et al., 2008; Khan et al., 2002) have found that antidepressants are superior to placebo only in cases of moderate-severe depression and may present no advantage over placebo in treatment of mild or moderate depression which is more common in low resource settings like northern Uganda (Nakimuli-Mpungu et al., 2013a, 2013b; Roberts et al., 2008).

Furthermore, existing psychological interventions are mostly individual counseling/psychotherapy models developed elsewhere which often fail to adequately address the mental health needs of this population. Therefore, there is need for culturally sensitive interventions developed within the region and with the local population. Out of that need, this culturally sensitive group support psychotherapeutic intervention was been developed.

Development process
The group support intervention was developed collaboratively and interactively over a one year period (June 2012–May 2013).

Initially, study investigators reviewed the literature on psychotherapeutic interventions for depression and found that more evidence exists for the effectiveness of CBT than for other psychotherapeutic interventions (Hofmann et al., 2012).

We also learned that in cultural adaptations of CBT for ethnic minorities which have been described in developed countries (Interian et al.; 2008), focus group discussions were used to obtain in-depth information about what it was about the therapy that worked in the “original” CBT.

However, in our target community, no one had the experience of participating in the “original” CBT sessions and no health worker had the experience of having facilitated these CBT sessions.

Through our work in the PCAF trauma clinics, we knew that depression exists in our target community and this community had specific ways of expressing their depression symptoms as well as indigenous ways of dealing with individuals with depression.

Also, our PCAF staff had experience in providing a group counseling intervention in which they actively listened to personal problems and trauma stories, conducted psych-education talks, taught positive coping skills and discussed negative coping skills.

These group counseling sessions appeared to be effective in reducing depression symptoms (Nakimuli-Mpungu et al., 2013a, 2013b) but, given the low uptake of this intervention, we were not certain as to whether this counseling was addressing all psychological and social issues that the community associates with depression and whether the mode of delivery of this group counseling was culturally appropriate and acceptable.

A decision was made to conduct focus group discussions to obtain information on the cultural understanding of depression symptoms, complications and treatment methods used in the local community to inform the further development of the counseling intervention that is provided to individuals attending PCAF trauma clinics in northern Uganda.

Lessons learned from qualitative interviews
The major themes that emerged from this qualitative study included community misperceptions of the precipitants, presentations and appropriate treatment options for depression in this community.

Although some participants identified war-related traumatic experiences as one of the precipitants of depression, many still attributed depression symptoms to ancestral spirits and witchcraft.

Indeed, studies in sub-Saharan African countries have shown that symptoms of depression are not regarded as mental health problems but rather social problems resulting from poverty, alcoholism, or poor marital relations, supernatural/spiritual attacks or “thinking too much” which traditional healers can

The participants were enthusiastic about a group format for the intervention. Through their observations of various group interventions that exist in their communities, they believed that a group participants’ social networks, thereby enhancing social support.

Further, they would be able to learn new skills from other group members that would not only help them to cope with stigma and stressful life events, but would also improve their livelihoods.

These findings support the inclusion of sessions on teaching positive coping skills, problem solving skills and basic livelihood skills in our intervention

Many participants desired that the facilitators of the groups to be respectable members of their community who could understand what the group participants have been through and to be able to empathize with them.

Participants emphasized that group facilitators do not always have to be health professionals but individuals with some knowledge of the problem at hand and with good community standing such as community elders, spiritual leaders, teachers, clan leaders and police men. They also thought that those who have experienced depression and have recovered could be trained to deliver the intervention. Group facilitators should not only build and earn the trust of group members but also ensure that confidentiality of sessions is preserved.

Participants emphasized the need for a community based group intervention that not only focused on treatment of their depression symptoms but also provided them with skills to improve their livelihoods.

Theoretical Framework
The theoretical perspectives that informed the development of GSP were based on the principles of cognitive behavior theory (Beck, 2011) social learning theory (Bandura, 1989) and the sustainable livelihoods framework (Carney, 2003). The cognitive behavior theory holds that the way we think about our reality is central to how we react to that reality. The social learning theory stems from the idea that behavior is learned from the environment by observation, in which the person being observed is referred to as the model. The sustainable livelihoods framework posits that, the absence of skills to adapt to adverse situations (positive coping skills), the lack of social networks or connections (social support), and inability to work and support an income or to have land (functioning), constrains livelihood opportunities.

We hypothesized that when depressed PLWH agree to participate in GSP sessions and receive the optimal dose of the intervention (at least 6 sessions), they acquire knowledge and skills that enhance their social connections and support and help them cope better with adverse situations and stigma. These changes lead to a reduction in depression symptoms. The absence of depression improves ability to work and obtain savings and other livelihood assets. The pursuit of livelihoods helps restore the dignity and independence of PLWH, thereby leading to a further reduction in stigma that, in turn, sustains a reduction in depression and improvement in functioning.

**Group Exercise**
Summary of the structure

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Testing the Group Support Psychotherapy Model
Overview of the trial

This was an open-label randomized controlled trial that included men and women with HIV, aged 19 years or older from an urban HIV care centre in Kitgum district, northern Uganda, who met the Mini International Neuropsychiatric Interview criteria for major depression. Participants were randomly assigned to receive eight weekly sessions of either GSP (n=57) or GHE (n=52). Randomization was achieved by allowing men and women separately to pick pieces of paper containing the intervention allocation code from a basket (1:1 allocation ratio). The intervention sessions were provided in gender-specific groups. Participants were followed up immediately after the intervention and again 6 months after the end of treatment. The primary outcomes were change in depressive symptom scores (measured with the Self-Reporting Questionnaire) and in functioning scores (measured with a locally developed method). The data were analyzed following an intention to treat approach using cluster-adjusted t tests and permutation tests.

This trial was registered with The Pan African Clinical Trials Registry, number PACTR201402000742370. The study was submitted to and approved by both the Makerere University College of Health Sciences Research Ethics Committee and the Uganda National Council of Science and Technology. All study participants provided written informed consent. Light refreshments were served during all group sessions in both treatment groups and every participant received an equivalent of US$2–5 to defray transport costs. Full details of the trial are described elsewhere (Nakimuli-Mpungu et al., 2015)
Session 2.2: The Group Therapy process

Starting a Group: Five Key issues to remember

Starting group therapy is almost always a very anxiety-provoking experience for the client. Despite reasonable efforts at preparation, many uncertainties remain. Often, due to anxiety or preoccupation, the client is only partially listening to or absorbing verbally conveyed information; thus, there is a need for written materials.

For the client, the structure and framework of the group should be crystal clear. This means being informed about such items as the location of the group, the time and day that it meets, the duration of sessions (generally two hours), the duration of the group, if time-limited, and the size of the group (generally seven to ten participants).

Policies concerning eating or drinking during the group, notifying the group if an absence is anticipated, and leaving the group should also be clear. Clients often have mistaken conceptions about these concrete and essential practical factors.

Clients can also benefit from the group facilitator reviewing expectations concerning the facilitator behavior in the group. This may range from practical issues such as the placement of chairs and number of chairs in the event of a client’s absence or departure from the group to technical issues concerning therapeutic interventions.

Clients pay close attention to the group facilitator, particularly at the beginning of a group. The facilitator’s behavior should be consistent with the client’s expectations and with his or her own. Specifying the therapist guidelines in written form is an easy way to keep them in the forefront. For many current short-term group therapies, therapy manuals are available for this purpose (e.g., McCallum et al, 1995; Piper et al., 1995).
Table 1. The Therapeutic Factors (Yalom and Leszcz, 2005) Therapeutic Factors

<table>
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<tr>
<th>Therapeutic Factors</th>
<th>Definition</th>
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<tr>
<td>Universality</td>
<td>Members recognize that other members share similar feelings, thoughts and problems</td>
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<td>Altruism</td>
<td>Members gain a boost to self concept through extending help to other group members</td>
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<td>Instillation of hope</td>
<td>Member recognizes that other members’ success can be helpful and they develop optimism for their own improvement</td>
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<td>Imparting information</td>
<td>Education or advice provided by the therapist or group members</td>
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<td>Corrective recapitulation of primary family experience</td>
<td>Opportunity to reenact critical family dynamics with group members in a corrective manner</td>
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<td>Development of socializing techniques</td>
<td>The group provides members with an environment that fosters adaptive and effective communication</td>
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<td>Imitative behavior</td>
<td>Members expand their personal knowledge and skills through the observation of Group members’ self-exploration, working through and personal development</td>
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<tr>
<td>Cohesiveness</td>
<td>Feelings of trust, belonging and togetherness experienced by the group members</td>
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<tr>
<td>Existential factors</td>
<td>Members accept responsibility for life decisions</td>
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<tr>
<td>Catharsis</td>
<td>Members release of strong feelings about past or present experiences</td>
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<tr>
<td>Interpersonal learning-input</td>
<td>Members gain personal insight about their interpersonal impact through feedback provided from other members</td>
</tr>
<tr>
<td>Interpersonal learning-output</td>
<td>Members provide an environment that allows members to interact in a more adaptive manner</td>
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<tr>
<td>Self-understanding</td>
<td>Members gain insight into psychological motivation underlying behavior and emotional reactions</td>
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GROUP DEVELOPMENT

Why is it important to understand stages of group development?

Like all groups, therapeutic groups change and evolve over time (Arrow et al., 2004; Worchel & Coutant, 2001). Knowledge of group development can help the group therapist discern if member behaviors reflect personal and individual or group developmental issues. Furthermore, an appreciation of how members cope in the face of group developmental issues can aid the therapist in formulating specific interventions that are specific to the developmental stage of the group.

Developmental Stages.

Despite variation in the number and naming of stages put forward by the various models of group development, commonalities can be discerned (Wheelan et al., 2003). A general description of a five-stage sequence follows, with reference to the models of Tuckman (1965), Garland et al., (1973), and Wheelan et al., (2003).

1. At the outset of its life, the group is in a “forming” (Tuckman, 1965) or “preaffiliation” (Garland et al., 1973) stage. The focus is on issues of “dependency and inclusion” (Wheelan et al., 2003). The members will experience anxiety, seek guidance from the group leader(s) on appropriate behaviors, and engage in tentative self-disclosures and sharing.

2. Once established, the group will enter a stage characterized by “counter dependency and flight” (Wheelan et al., 2003), or a “storming” stage (Tuckman, 1965) defined by struggles around the issues of “power and control” (Garland et al., 1973). Competition and conflict among the members, anxiety about the safety of the group and the authority of the leader are common concerns at this stage. Confrontations of the leader reinforce member solidarity and openness. Many theories of group development hold that these struggles over authority and status are essential for the emergence of genuine cohesion and cooperation.

3. In a third stage of “norming” (Tuckman, 1965) or “intimacy” (Garland et al., 1973), a consensus on the group tasks and a working process emerge. The group begins to demonstrate “trust and structure” (Wheelan 2005), cohesion and openness.

4. A fourth stage of “performing” (Tuckman, 1965), “differentiation” (Garland et al., 1973), or “work” (Wheelan et al., 2003) is characterized by a mature and productive group process and the expression of individual differences. The group has the capacity for focusing on the task of therapeutic work and the members engage in an open exchange of feedback. If the group has a time-limited format or certain members prepare to “graduate” during this stage, elements of disillusionment and disappointment can emerge.
5. The final stage concerns the issue of termination, whether of individual members or the group as a whole. Concerns associated with “adjourning” (Tuckman, 1965) and “separation” (Garland et al., 1973) prompt the emergence of painful affects and oscillations between conflict and defensiveness and mature work. The members’ appreciation for each other and the group experience, along with efforts at preparing for a future independent of group participation, also characterize termination sessions.

Summary

There is strong consensus for a five-stage model of group development.

1. The first or forming stage addresses issue of dependency and inclusion. The leader aims to educate the members (group purpose, norms, and roles of participants), invite trust and highlight commonalities.

2. The second or storming stage is concerned with issues of power or status and the resolution of the associated conflicts. The leader aims to promote a safe and successful resolution of conflict, encourage group cohesion, and facilitate interpersonal learning.

3. The third or norming stage reflects the establishment of trust and a functional group structure (norms). The leader aims to facilitate an early working process; interventions reflect a balance of support and confrontation.

4. The fourth or performing stage is characterized by a mature, productive group process and the expression of individual differences. The leader’s aim is to allow the group to function at an optimally productive level, and to highlight the individuality of the members.

5. The final or termination stage involves a focus on separation issues, a review of the group experience, and preparation for the ending of the group. The leader aims to encourage the expression of feelings associated with saying goodbye, and to facilitate attention to unfinished business in the group.
Session 2.3: Roles and Responsibilities of GSP Facilitator

1. The coordination and regulation of the boundaries of the group
2. The group facilitator should convey care directly and also models caring for the group members.
3. The group facilitator plays an important role in activating emotion within the group. The activation of emotion is ideally followed by the attribution of meaning to the group member's personal experience. These actions contribute to the client's learning and acquisition of insight.
4. The judicious use of self-disclosure by the group facilitator can have substantial therapeutic impact.

Session 2.4: Practicum on introduction to Group Support Psychotherapy: Session 1

Divide participants into small groups and give each a flip chart or flip chart sheet. Their task is to plan how they would conduct the introductory session of group support psychotherapy with a group of 8-10 individuals with HIV and depression. After 15 minutes of discussion a group should elect 2 persons to demonstrate how to facilitate the introductory session of group support psychotherapy.
MODULE 3: Depression and HIV/AIDS

LEARNING OBJECTIVES:
By the end of this Module, participants will be able to:
Differentiate between sadness and depression
Correct misperceptions about depression
Describe the situations that are likely to cause depression
Describe the signs and symptoms of depression
Use a screening measure for depression and recognize an individual with significant depression symptoms
Differentiate between mild, moderate and severe depression
Describe the treatment options for mild, moderate and severe depression
Describe the complications of untreated depression
Describe the common mental health problems that co-occur with depression

CONTENT:
Session 3.1: Myths, definitions, categories s and causes of depression
Session 3.2: How to diagnose depression
Session 3.3: mental health problems comorbid with depression
Session 3.4: complications of untreated depression
Session 3.5: The relationship between depression and HIV
Session 3.6: Practicum on psycho education, GSP, session 2

MATERIALS NEEDED:
Flip chart
Markers
Name tags
Pens and pencils (for each participant)
Copies of the GSP Work Book (for each participant)
Session 3.1: Myths, definitions, categories and causes of depression

What is mental illness?

Mental illness is brain dysfunction, affecting our feelings (emotions), thoughts, behavior and the way we experience the world with our senses (perception).

a. Emotions – All human beings experience a variety of moods (e.g., depression, anxiety, mania) and mood changes. Mental illness can emerge when symptoms cause significant distress over time and impair one’s ability to function in daily life.

b. Thinking – Thoughts may occur very quickly/slowly, may be poorly organized, confusing, illogical, irrational, etc.

c. Behavior – People’s behavior may be quite bizarre and confusing for those who do not understand mental illness (e.g., someone with PTSD hiding in the closet when he/she hears helicopters; an individual with obsessive-compulsive disorder checking the stove 20 times before leaving the house; a depressed individual lying in bed for days at a time)

d. Perception (the way we experience the world with our senses)

– People may experience the world with their senses (vision, smell, taste, touch, hearing) in unusual and/or strange ways (e.g., hearing voices, seeing things that others do not see).

What is Sadness?

Sadness is something we all experience; it’s a normal, human emotion. We experience it when we experience something unpleasant in life—a loss, a disappointment, and so on. Sadness is what happens when you get a divorce. Sadness is what happens when you’re stood up for a date. Sadness is what happens when normal events occur in ways that are hurtful. Sadness can occur at very regular intervals in our everyday lives.
What is depression?

Everyone feels depressed or down at times; however, major depression is more than just feeling the “blues” every once in a while. Each person’s experience of depression is unique.

Discussion Questions:

What are some symptoms of depression?

Which are most difficult for you to cope with?

1. Feeling sad, blue, or down
2. Losing interest in previously enjoyed activities
3. Experiencing a change in appetite or weight
4. Having a change in sleep patterns
5. Feeling tired and fatigued OR feeling restless
6. Feeling worthless or guilty
7. Having trouble concentrating, thinking, or making decisions
8. Having thoughts of death or suicide

The difference between sadness and depression?

However, sadness is not constant. Sadness is not an every-moment-of-every-day thing like depression is.

Sadness relents, depression doesn’t. Sadness is interrupted by periods of laughter; depression often can’t be budged by even the most talented comedian.

Sadness may usher in negative thoughts but it does not propel a person into a place of suicidal ideation.

Sadness may reduce our ability to enjoy life but it doesn’t destroy it all together.
Sadness may last for what feels like a long period of time, but it does not remain constant for weeks or months.

Sadness doesn’t produce significant weight changes or prolonged periods of sleep changes.

Sadness doesn’t include **psychosis**.

In short, depression is so far beyond sadness that comparing the two is almost laughable.

Sadness is painful and it sucks, but it is normal and it does pass. Depression is beyond painful. It’s life-altering, it is *not* normal, and often does not resolve itself without medical intervention.

**Categories of depression**

*Begin by saying,* many different categories of depression exist, but some common categories include:

*Draw on board/ Flip Chart (and very briefly define each disorder): Ask participants to fit the disorders below in the two categories*

- Acute stress reactions
- Adjustment disorder with depressed mood
- Bereavement
- Major depressive disorder
- Bipolar disorder/manic-depressive disorder
- Alcohol induced depression
- Post partum depression
- Depression secondary to General medical condition e.g. HIV/AIDS, Cancer

<table>
<thead>
<tr>
<th>Common categories of depression</th>
<th>Not so common categories of depression</th>
</tr>
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<td></td>
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</table>
Causes of depression

*Begin with a discussion question:* What are some commonly held beliefs about the causes of depression

**Examples:**
1. Mental illness does not exist.
2. Mental illness is a normal response to a sick society.
3. Mental illness is caused by the devil, demons, or turning away from God.
4. Mental illness is caused by poor parenting.
5. Mental illness is caused by being lazy and weak.
6. Mental illness is caused by poor family communication

*Then say*

Over the years, different theories have been proposed regarding the causes of depression

*Myths such as these develop because people need an explanation for confusing behaviors.*

*The myths can be transmitted down through many generations without being checked for accuracy.*

*Sometimes myths are a means of denial or of avoiding responsibility for mental illness in a family.*

**B. What science does know:**

*Distribute Handout: Biopsychosocial Model and Vulnerability-Stress Model*

1. Biopsychosocial model: Mental illnesses have several dimensions that are helpful to review.

*Write on board: Bio, Psych, Social*

*Explain that each area can contribute to an individual's level of risk for developing a mental illness.*

**BIO:** biology – Refers to the structure of the brain, chemicals in the brain, genes inherited from parents, diseases affecting the brain etc. Science is gaining more knowledge about the large influence of biology on the risk for acquiring a mental illness.

**PSYCH:** psychology – Refers to personality, personal beliefs, thoughts, experiences, etc.

**SOCIAL:** sociology – Refers to environmental stress (e.g., trauma of war,
assault), cultural factors, discrimination, etc. severe childhood physical or sexual abuse, childhood emotional and physical neglect, and severe life stress are probably all risk factors. Losing a parent early in life.

**Therefore** … Treatment needs to be aimed at all three of these areas:

**BIO:** medication, nutrition, general physical health

**PSYCH:** education (GSP Program), psychotherapy, coping skills

**SOCIAL:** environmental management, stigma of mental illness, advocacy

2. Vulnerability-stress model

a. One can inherit a predisposition or increased vulnerability (diathesis) to a certain illness (or class of illnesses). The importance of family history with some medical problems (e.g., cancer) is well known. Investigating family history with mental illness can similarly provide very valuable information. Having a family history of a mental illness does not mean you will necessarily get the illness, but you do have an increased risk.

**Example:** depression:

How do we know that genes play a role in causing depression? Scientists look at patterns of illness in families to estimate their “heritability,” or roughly what percentage of their cause is due to genes

| 20-25% prevalence in general population |
| 12% if a first degree relative (parent, sibling) has the disorder |
| Fraternal twins: 10-15% incidence rate |
| Identical twins: 40-50% incidence rate |

*This could mean that in most cases of depression, around 50% of the cause is genetic, and around 50% is unrelated to genes (psychological or physical factors).

**Discussion Questions:**

Do you have any questions about either model?

Do you have questions about the causes of any specific category of depression?
Session 3.2: How to diagnose depression

Steps in screening for depression

The following is a suggested procedure for screening a group of community members for Depression or any other emotional need. Screening should occur before official mental health testing. Participation is always, of course, optional.

Step 1: Introduce yourself to the people to be screened and give health talk on depression emphasizing the importance of screening

Step 2: Hand out screening test to those who would like to be screened.

Step 3: Look at the score, and assess level of functioning, and make referrals;

Step 4: Review in private the concerns with each individual who took the test.

Step 5: If there are no signs of severe depression e.g. suicide attempt, psychosis offer treatment with group support psychotherapy. If there are signs of severe depression refer to mental health worker at closest health center.

There are various screening instruments for depression but we shall teach you one simple screening instrument for depression which we would like you to use in your day today care of individuals in the community. This screening instrument is called the Self-Reporting Questionnaire.

In previous research with PLWH in southern Uganda, a score of 6 or more had 84% sensitivity and 93% specificity for current depression, and 75% sensitivity and 90% specificity for any depressive disorder.

The SRQ-20 appears to be a reliable and valid screening measure for depression among rural HIV-positive individuals.
<table>
<thead>
<tr>
<th>NO.</th>
<th>ITEM</th>
<th>FEMALES IMAGE</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you often have headaches?</td>
<td></td>
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<td>2.</td>
<td>Is your appetite poor?</td>
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<td>3.</td>
<td>Do you sleep badly?</td>
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<td>4.</td>
<td>Are you easily frightened?</td>
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<td>5.</td>
<td>Do your hands shake?</td>
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<td>6.</td>
<td>Do you feel nervous, tense or worried?</td>
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<tr>
<td>7.</td>
<td>Is your digestion poor?</td>
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<tr>
<td>8.</td>
<td>Do you have trouble thinking clearly?</td>
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<td>9.</td>
<td>Do you feel unhappy?</td>
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<td></td>
<td>Question</td>
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<tr>
<td>10.</td>
<td>Do you cry more than usual?</td>
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<td>11.</td>
<td>Do you find it difficult to enjoy your daily activities?</td>
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<tr>
<td>12.</td>
<td>Do you find it difficult to make decisions</td>
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<tr>
<td>13.</td>
<td>Is your daily work suffering</td>
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<tr>
<td>14.</td>
<td>Are you unable to play a useful part in your life?</td>
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<tr>
<td>15.</td>
<td>Have you lost interest in things</td>
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<tr>
<td>16.</td>
<td>Do you feel like you are a worthless person?</td>
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<tr>
<td>17.</td>
<td>Has the thought of ending your life been on your mind</td>
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<tr>
<td>18.</td>
<td>Do you feel tired all the time?</td>
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<tr>
<td>19.</td>
<td>Do you have uncomfortable feelings in your stomach?</td>
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<tr>
<td>20.</td>
<td>Are you easily tired?</td>
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</table>
Session 3.3: Complications of untreated depression

The impact of depression on relationships

1. Depression affects a person’s behavior and style of communication (less eye contact, slower and softer speech, negative thinking, reduced problem-solving abilities).
2. Depression is often accompanied by an increase in marital tension and arguments.
3. Depressed people have greater difficulty interacting with others. Therefore, the social life of the couple/family may be altered.
4. Some depressed people are unable to work. Therefore, other family members may have to get a job for the first time or work two jobs to compensate for the reduced income.
5. Family members often become frustrated with the depressed person’s behavior, thinking the consumer should just “get over it” or “cheer up.”
6. Depressed people often have decreased interest in physical intimacy and sexual activity. Partners often worry that the consumer is no longer physically attracted to them, which can increase the tension in the relationship.

Suicidal behaviors

1. Individuals with mental illness commit suicide at a rate that is considerably higher than that of the general population.
2. One third (33%) of all clinically depressed people attempt suicide.
3. Men are four to five times more likely to complete suicide than women. Women are three times more likely to attempt (but not complete) suicide than men.
**Why do people consider and attempt suicide?**

1. Some make a decision to end their lives – they are very unhappy with their lives and feel hopeless that the situation will improve.
2. Some engage in reckless behavior because they don’t think they will die (e.g., jump off a tall building believing they are super-human). Their judgment is impaired, and they may not understand the consequences of their behavior.
3. Some hear voices telling them to harm themselves.
4. Some do not know how to ask for help directly but kill themselves unintentionally (e.g., take too much pain medicine; cut wrists, etc.)

**Warning signs for suicidal behavior**

1. Has previously attempted suicide or has a history of being impulsive
2. Has a specific plan for how to kill him/herself
3. Has access to lethal means (such as weapons, pills, etc.)
4. Talks about having done an unforgivable behavior
5. Hears voices saying to harm him/herself (psychosis)
6. Begins to get his/her affairs in order (e.g., writes a will, gives things away, systematically contacts old friends or relatives)
7. Lives with chronic medical illness and/or chronic pain
8. Talks about killing him/herself (e.g., “Everyone would be better off without me”)
9. Increases use of alcohol or other drugs. These substances may increase the level of depression AND may lower inhibitions, both of which are dangerous with suicidal people.
10. Worsening of depression symptoms

**Suicide Risk Assessment**

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Session 3.4: Mental health problems co-morbid with depression

**Posttraumatic stress disorder (PTSD): What is it and who is at risk?**

- Combat, sexual assault, and surviving a natural disaster or an attack are examples of traumatic psychological events that can cause PTSD.
- These severely traumatic events often have a direct physical impact on a person’s safety. Individuals who have been injured in combat are at high risk for PTSD because they have sustained a direct injury in a violent setting.
- Survivors of rape have experienced physical and emotional trauma which is associated with very high rates of posttraumatic responses. These events can be a single occurrence in a person’s lifetime or occur repeatedly, such as ongoing physical abuse or an extended or repeated tour of duty in a war zone.
- The severity of traumatic events and duration of exposure are critical risk factors for the risk of developing PTSD.

**How is PTSD diagnosed?**

<table>
<thead>
<tr>
<th>The DSM –V criteria for identifying PTSD requires that symptoms must be active for more than one month after the trauma and associated with a decline in social, occupational or other important area of functioning. The three broad symptom clusters can be summarized as follows:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Persistent Re-experiencing.</strong> A person experiences one or more of the following: recurrent nightmares or flashbacks, recurrent images or memories of the event, intense distress at reminders of trauma, or physical reactions to triggers that symbolize or resemble the event.</td>
</tr>
<tr>
<td><strong>2. Avoidant/Numbness Responses.</strong> A person experiences three or more of the following: efforts to avoid feelings or triggers associated with the trauma; avoidance of activities, places or people that remind the person of the trauma; inability to recall an important aspect of the trauma; feelings of detachment or estrangement from others; restricted range of feelings; or difficulty thinking about the long-term future.</td>
</tr>
<tr>
<td><strong>3. Increased Arousal.</strong> A person experiences two or more of the following: difficulty falling asleep or staying asleep, outbursts of anger/irritability, difficulty concentrating, increased vigilance that may be maladaptive, or exaggerated startle responses</td>
</tr>
</tbody>
</table>
**What are the treatment options for coping with PTSD and achieving recovery?**

<table>
<thead>
<tr>
<th>Treatment strategies should be customized to the individual’s needs and references. The stage of recovery is important because interventions that are useful immediately after a trauma may not be appropriate years later.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological first aid includes support and compassion and is critical immediately after the traumatic event.</td>
</tr>
<tr>
<td>Medications can play a role in reducing symptom intensity but are usually not enough alone.</td>
</tr>
<tr>
<td>Avoidance of use of substances to attempt to moderate the experience is important.</td>
</tr>
<tr>
<td>Psychotherapy that includes structured interventions and is very supportive seems to work best for people with PTSD: Cognitive behavior therapy (CBT) employs tailored exposure to the traumatic event by increasing tolerance and gradually reducing anxiety and symptoms.</td>
</tr>
<tr>
<td>Group therapy with other survivors of trauma is supportive and uplifting.</td>
</tr>
</tbody>
</table>
Alcohol and Depression share a complex, mutually reinforcing relationship with excessive alcohol consumption. This means regardless of whether heavy alcohol consumption or depression came first, having one condition makes it significantly more likely the other will develop. In both cases however, the risk increases with greater consumption of alcohol: excessive drinking increases the chance of developing depression, and drinking while depressed both exacerbates depressive symptoms and makes recovery more difficult.

**What does alcohol do to the brain?**

A number of clinical research studies have found that regularly drinking alcohol disrupts the brain’s chemistry, altering the way it operates. Lowering the level of serotonin in the brain – the chemical responsible for regulating people’s mood – and disrupting other chemicals, may lead to the development of depressive-like symptoms.

**What’s the link between Alcohol and Depression**

Depression is found in heavy drinkers at a significantly higher rate than in the general population and suffering from depression increases the likelihood of excessive alcohol consumption and dependence in the future.

Alcohol dependence is roughly three times more likely amongst those experiencing depression, compared with non-depressive populations. A complex & mutually reinforcing relationship exists between the two. Alcohol’s effect on the human body (especially excessive alcohol consumption over a long period of time) has been shown to cause depressive symptoms.
‘Self-medicating’

Many people suffering from depression and experiencing acute feelings of sadness and anxiety may drink alcohol in an attempt to relieve those symptoms, this is known as ‘self-medicating’.

Temporarily, the effect alcohol has on the body may relieve some of them – by depressing the central nervous system, alcohol helps ‘numb’ emotions to avoid dealing with difficult issues. However, ‘self-medicating’ has been shown to be one of the least effective methods of dealing with depression.

Suffering from depression is often experienced before the development of problematic drinking, particularly in women, which suggests that people attempting to self-medicate accounts for a substantial amount of the number of concurrent alcohol problems in depressed people. Ultimately, self-medicating with alcohol not only fails to reduce depressive symptoms, but can exacerbate them and contribute to the development of problematic drinking in its own right.
Session 3.5: The relationship between depression and HIV

HIV and Clinical Depression

Why is clinical depression a concern for those who are HIV +

Mood disorders, particularly depression, are the most common psychiatric complication associated with HIV disease.

In sub-Saharan Africa, research has shown that 1 in 3 persons with HIV receiving HIV care services has significant depression symptoms which interfere with motivation to take antiretroviral treatments.

Untreated depression increases HIV transmission risk behaviors (Musisi et al., 2014), reduces adherence to ART (Mayston et al., 2012), decreases immune status (Schuster et al., 2011), and increases mortality (Leserman et al., 2007).

These concerns are even more prominent in post-conflict settings where challenges of poverty, starvation and limited access to psychological care abound (Patel et al., 2014).

Who is at risk for depression?

HIV+ individuals who:

- Have not disclosed their seropositive status,
- Have lost loved ones to HIV,
- Have advanced stage of the illness
- Have treatment failure,
Does HIV cause depression?

Many health care professionals believe that an HIV+ diagnosis will naturally result in depression. Although the diagnosis will certainly trigger anxiety and distress—sometimes so severe it impairs functioning and may even lead to suicide—this kind of situation-specific emotional response is not the same as depression.

A person distressed by an HIV diagnosis may indeed need treatment, most likely for an adjustment reaction, but the distress will respond to supportive and other types of psychotherapy rather than medications.

HIV can damage subcortical areas of the brain and produce HIV dementia, resulting in states that are mistaken for clinical depression.

HIV+ patients can also experience other medical and endocrine abnormalities that can create mood disturbances. Systemic illnesses secondary to HIV infection—such as hepatitis, *pneumocystis carinii* pneumonia and endocrinopathes can all look like depression. Malnourishment, specifically with deficiencies in vitamins B6 and B12, also mimics depression.

A number of HIV medications can also have side-effects that can cause depression and other psychological symptoms, as outlined in the table below.

<table>
<thead>
<tr>
<th>HIV Medication</th>
<th>May trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interleukin</td>
<td>Depression, disorientation, confusion and coma</td>
</tr>
<tr>
<td>Steroids</td>
<td>Mania or depression</td>
</tr>
<tr>
<td>Efavirenz (Sustiva)</td>
<td>Decreased concentration, depression, nervousness, nightmares</td>
</tr>
<tr>
<td>Stavudine (Zerit, d4T)</td>
<td>Depression or mania, asthenia</td>
</tr>
<tr>
<td>Zidovudine (Retrovir, AZT)</td>
<td>Mania, depression</td>
</tr>
<tr>
<td>Interferon</td>
<td>Neurasthenia fatigue syndrome, depression</td>
</tr>
<tr>
<td>Zalcitabine (Hivid)</td>
<td>Depression, cognitive impairment</td>
</tr>
<tr>
<td>Vinblastine</td>
<td>Depression, cognitive impairment</td>
</tr>
</tbody>
</table>
How can a clinician differentiate depression from other complications of HIV?

Symptoms of true clinical depression come in two categories: affective and somatic.

**Affective symptoms** include depressed mood, loss of interest in normally pleasurable activities, feelings of guilt or worthlessness, hopelessness or suicidal ideation.

**Somatic symptoms** include loss of weight or appetite, sleep disturbances, agitation/retardation, fatigue and loss of concentration.

Some symptoms of clinical depression (e.g., fatigue) can be “explained away” as the effects of HIV and the medications used to treat it. But the fatigue that accompanies depression will include a true loss of interest (as opposed to simply loss of ability) in formerly enjoyable activities.

It’s challenging to differentiate clinical depression from the effects of HIV, the side-effects of treatment and even other illnesses, all of which can affect mood. The surest way to finding the difference is in how someone responds to depression treatment. Conditions that are not actually depression will respond poorly to antidepressant treatment.

What kind of treatment is appropriate for an HIV+ person suffering from clinical depression?

**First line treatments:** Basic support, psychological first AID, Psychotherapy

**Second line treatments:** Psychotherapy and Medications

The same treatments used with depression in the general population are effective in treating depression in HIV+ people.
Session 3.6: Practicum on psycho education, GSP, session 2

Divide participants into small groups and give each a flip chart or flip chart sheet. Their task is to plan how they would conduct psych-education on depression to a group of 8-10 individuals with HIV and depression. After 15 minutes of discussion a group should elect 2 persons to demonstrate how to conduct psych education on depression and HIV.
Module 4: Counseling and Communication skills

Learning Objectives

By the end of this Module, participants will be able to:
- Describe the key counseling skills required to deliver GSP
- Avoid the common errors made by group counselors
- Describe various types of communication
- Demonstrate good communication skills
- Understand the impact of the group facilitator's attitudes and values on the counseling process

TIME: 100 minutes (1hr 40minutes)

Content

Session 4.1: Introduction to Counseling
Session 4.2: Key counseling skills for group facilitators
Session 4.3: Common errors made by group facilitators
Session 4.4: Communication in counseling
Session 4.5: Sharing personal problems
Session 4.6: Group facilitator's attitudes and values
Session 4.6: Practicum on counseling skills required for GSP session 3 and 4

PREPARATIONS/ MATERIALS

- Flip chart paper
- Flip chart stand
- Markers
- Masking tape

Session 4.1: Key counseling skills for group facilitators

Step 1: Introduce “Counseling” (30 minutes)
Say the following

I welcome you all to this learning session on counseling. Through the steps in this session I will work with you to improve on your understanding of counseling. The following topics will be covered:

- Counseling; its definition
- The factors that influence the efficacy of counseling
- The basic principles of counseling
- The issues that can be addressed through counseling
- The modes of counseling

Ask the large group the following question: What is the meaning of the word counseling?

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. Then say: I will summarize counseling as follows: a process in which specific methods are used by a trained person (counselor) to guide individuals (clients) in seeking and finding their own solutions to the dilemmas they face.

**Definition of “Counseling”**

Counseling is a process in which a trained counselor guides clients in seeking their own solutions to the problems they face.

*Explain by saying:*

To explain more;

- Counseling is a process that involves guiding people to make needed changes in their ways of thinking, feeling and behaving in order to improve their ways of living.
- It is a goal-based collaborative process involving a non-judgmental, supportive counselor who works with the client(s) to overcome, or cope with, distress.

*Add by saying:* It is important to note that counseling is NOT advice giving. The counselor should not give advice to clients in the name of counseling. In counseling people are helped to
identify their own issues and solve these issues on their own, while advice is telling your clients what you think is best for them. Advice is the counselor’s opinion.

**Step2. The Basic Principles of counseling (20 minutes)**

Say: In the counseling relationship, the clients’ helplessness exposes them to exploitation by the counselor whether knowingly or unknowingly. To protects the client, the counselor must know and follow the following principles:

- Each client must be accepted as an individual and dealt with as such (the counselor does not necessarily approve of all behavior, but still accepts the client as a person).
- The client has permission to say what they want without being judged by the counselor.
- Counseling emphasizes thinking *with* not *for* the client; don’t give advice to clients.
- All decision-making rests with the clients.
- Counseling is centered on the client’s problems.
- Counseling is a learning situation aimed at behavioral change.
- The counseling relationship is confidential.

Summarize the above step by calling for some questions and answering them. Say: I would like to end this section by answering your questions, if any.

**Step3. The Factors that Influence the effectiveness of counseling (40 minutes)**

Form group of 3 participants each. Give a flip chart and marker to each group of participants and ask:

There are several factors that influence counseling and make it a productive time for the clients & counselor. Using the flip chart provided, write down these factors and one member from each group will present to the larger group.

Facilitate each group to present their work to the larger participants’ group through one representative. At the end of the group presentations, summarize the factors by saying:
The factors that influence counseling and make it a productive time for the clients & counselor can be summarized as follows:

- Structure; clarity of counseling goals, objectives and process, for both clients and counselor, influences the level and quality of change in the life of the clients as well as counselor.
- Client Qualities; for instance trusting versus suspicious, oriented versus disoriented, motivated versus demotivated, etc.
- Good Counselor Qualities; e.g.:
  - Empathy, which is the ability of the counselor to understand what is taking place emotionally in the life of the client and to communicate your understanding of that to your client.
  - Commitment to working with clients.
  - Open mindedness/ openness to new experiences presented by clients.
  - Being non judgmental to clients’ issues.
  - High sense of responsibility for the clients’ well being.
  - Being a patient active listener.
  - Tolerance
  - Attentiveness to the clients’ process
  - Awareness of own culture, attitudes and values as well as personal history,
  - Capability to be present in the present moment

I. Physical setting for counseling; Counseling needs to happen in a place where there is;

- Privacy,
Confidentiality, extremely important aspect of the counseling relationship.
- Quietness and
- Comfort

Conclude the above step by calling for some questions and answering them. Say:

We would like to end this section by answering your questions, if any. Otherwise, thank you very much for your active participation.

Step 4. The types of counseling (10 minutes)

Say: The main counseling types include the following:

- Individual counseling: one client with counselor(s)
- Group support counseling: 6 – 8 or more clients with counselor(s)
- Family counseling: family with counselor(s)
- Couple counseling: two partners with counselor(s)

Note: During this training we shall mainly focus on and use group counseling, specifically Group support psychotherapy.

Conclusion (10 minutes)

Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session two. Review their information intake by asking them to name the main themes discussed during session two.
**KEY POINTS OF THIS MODULE INCLUDE:**

- Counseling is a process in which specific methods are used by a trained person to guide individuals in seeking and finding solutions to their problems.
- Counseling is not advice giving.

**The do’s**

- Respond to clients’ thoughts, feelings and behavior
- Self disclose
- Focus on the issue
- Ask appropriate questions
- Paraphrase and clarify

**The don’ts**

- Do not be judgmental.
- Do not preach or moralize
- Do not dismiss client’s feelings
- Do not give unrealistic assurance
- Do not lecture
Session 4.2: Key counseling skills for group facilitators

Step 1. Describe the key Counseling Skills for Group Counselors/ therapists (30 minutes)

Say the following: A group counselor needs a number of skills in order to facilitate the group counseling sessions effectively, for instance:

I. Leading: this requires that you as counselor, you are aware of how you are leading the group every moment of the session. Further, as a counselor, you are working on the clients’ issues, not your issues.

II. Responding: The counselor responds to clients’ issues in the counseling processes using different responding styles such as:

- Affective Responding; focusing on clients’ feelings.
- Behavioral Responding; focusing on actions and behaviors of the clients.
- Cognitive Responding; focusing on thoughts of the clients.
- As the counselor, you will balance those throughout the session with clients.

III. Self disclosure: requires that the counselor reveals some information about him/herself to the group, e.g. when the counselor realizes that it is necessary to cause a positive effect to the group process. (The details of self disclosure will be covered in module 5).

IV. Confrontation: It is an attempt by the counselor to gently bring about awareness in the clients of something that they may have overlooked or avoided. It can also be used to highlight contradictions that clients have previously been unaware of.

In the counseling process, there are four common contradictions which the clients often display; they can be between:

- Thoughts and feelings
- Thoughts and actions
- Feelings and actions or
- A combination of thoughts, feelings and actions.
V. Excellent communication: it is the capacity of the counselor to communicate with clients in clear and simple terms that the clients are able to understand. It is verbal and non-verbal.

VI. Focusing: it is the capacity of the counselor to guide the clients to adequately address a particular issue at a time without wandering away, especially from painful experiences.

VII. Appropriate questioning: it is the capacity of the counselor to ask purposeful questions that facilitate a progressive and coherent narrative of the clients’ issues in the counseling process.

VIII. Paraphrasing: the skill of saying what the clients have said in other words in order to check understanding.

IX. Clarifying: the skill of asking relevant questions to help clients clarify their ideas.

X. Linking: the ability of helping clients to understand links between their thoughts, feelings and actions and between causes and consequences.

XI. Modeling: the capacity to behave in a way that helps clients to learn that they can cope with the issues of discussion at a moment in the session.

XII. Blocking: the ability to regulate clients’ expression of issues in order to remain focused to the theme of the moment in the session.

XIII. Summarizing: the ability to say a long story of the client in fewer words to check understanding.

XIV. Structuring and prioritizing (of the group issues and processes): the ability to help clients to formulate strategies and to develop positive coping mechanisms in a focused manner.

Conclude step 1 by calling the participants to ask questions and make contributions to anything about the presentation on the key good counseling skills of group counselor. Facilitation a plenary discussion of the matters arising and answer the questions, if any.
Session 4.2: Common errors made by group facilitators

Step 2. Common Errors Committed by Group Counselors/therapists (20 minutes)

Say: When the counselor uses inappropriate facilitation methods and when s/he makes errors with the clients during the counseling process, counseling can be harmful to clients. The common errors some counselors make include the following:

1. Directing and leading group toward counselor’s own unspoken goals.
2. Being judgmental and evaluating what the clients are discussing using your own mind set of things.
3. Moralizing, preaching and patronizing the group aiming at making the group do things as you want.
4. Reassurance even when you know that what you are promising might not be achieved.
5. Not accepting the clients’ feelings or dismissing clients’ feelings as uncalled for.
6. Interrogating clients (in a manner that offends them or that leads to personal findings other than helping the clients to discover unconscious aspects of their lives blocking well being).
7. Encouraging dependencies of clients on you, the counselor.
8. Pushing and manipulating the group, and making rules for it.
9. Counselor whose own problems are so great and so pressing that s/he centers the group on himself, and is not available to, nor deeply aware of, the group members.
10. Frequently giving interpretations of motives or causes of behavior in members of the group.
11. Counselor withholding himself from personal emotional participation in the group and holds himself aloof as the expert, able to analyse the group process and the members' reactions through his superior knowledge.
12. Lecturing to the group members about their feelings and dynamics.
13. Excessive Questioning of the group members.
14. Storytelling instead of helping group members to move on in the counseling process.
15. Asking the “‘Why?’” question.
Conclude step 2 by calling the participants to ask questions and make contributions to anything about the presentation on the key counseling skills of the group counselor. Facilitation a plenary discussion of the matters arising and answer the questions, if any.

**Conclusion (10 minutes)**

Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session one. Review their information intake by asking them to name the main themes discussed during session one.

Say: You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

Conclude the session by naming the themes as covered in each step of the session. Say:

We have covered:

- Key good counseling skills of group counselor
- Common errors committed by group counselors/therapists

Thank you so much.
Session 4.3: Communication in counseling groups

Step 1: Introduce “Communication” (15 minutes)

Say the following

We welcome you all to this learning session on communication in counseling. Through the
steps in this session you will work to broaden your understanding of communication in
counseling. The following topics will be covered:

- Communication in counseling
- The types of communication
- Good communication skills in counseling
- Active listening skills in counseling

Ask the large participants group the following question: What is your understanding of the term
communication?

Listen to a number of responses from the group. Then write the responses on a flip chart and
summarize their ideas as you review each point. Then thank the participants for the contributions,
conclude by summarizing their understanding of communication.

Then say:

There are several meanings of the term communication that have been suggested and generally
agreed on. We will however take one that seems to be simpler than all the others; so we will
take this as our definition of communication in counseling.

<table>
<thead>
<tr>
<th>Definition of “Communication”</th>
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</table>
| Communication is the purposeful activity of information exchange between two or
  more participants in order to convey or receive the intended meanings through a
  shared system of signs. |

Explain saying: Communication is complete only when feedback is given.
Step 2. Types of communication in counseling [5 minutes]
Say: There are two types of communication in counseling, namely:

- Non-verbal communication; applies to all messages that are feelings, beliefs or thoughts that the clients unconsciously or consciously send during the counseling without spoken or written words.
- Verbal communication; applies to all messages that clients send through spoken or written words.

Step 3. Good Communication Skills in Counseling [30 minutes]
Facilitate a plenary brainstorming about Good Communication Skills in Counseling. Call for answers by show of hands and ask one of the participants to write down the answers on a flip chart. Review the answers with the group and agree on what is, and what is not, applicable.
Congratulate the participants on their contributions.
Then say the following without repeating those that have been written down:

Counseling work requires the counselor to have and use a number of good communication skills for example:

- Listen first; you need to understand before you respond.
- Show interest in the people you are communicating with.
- Be relaxed and warm.
- Use eye contact (be culture appropriate).
- Ask purposeful questions (that shows your interest).
- Show that you trust and respect the other person.
- Be nonjudgmental to the views of the other person; find out their reasons for their views.
- Be assertive, honest and genuine.
- When you are speaking, be enthusiastic and appropriate.
- Use self-disclosure appropriately.
- Avoid imposing your opinions onto the other person.
- Give appropriate information to help the other person.
- Be patient; don’t rush the other person.
- Avoid being distracted other stimuli, e.g. phones, etc.
- Use active listening skills

Conclude step 2 by thanking the participants for their active participation in this section. Call for any matters arising and answer any questions, if any.

**Step 4. Active Listening Skills in Counseling (20 minutes)**

Facilitate a plenary brainstorming about active listening skills in counseling. Call for answers by show of hands and ask one of the participants to write down the answers on a flip chart. Review the answers with the group and agree on what is, and what is not, applicable. Congratulate the participants on their contributions. Then say the following without repeating those that have been written down:

Active listening skills include the following in addition to those we have written down:

- Maintaining eye contact (be culturally appropriate)
- Using clarifying questions and summarizing statements
- Avoiding giving opinions or arguing with clients.
- Avoid being distracted, e.g by telephones.
- Focus on what the person is saying, rather than guessing, or preparing what you yourself will say next.
- Using your own body language to show your attention to the clients.
- Using words like ‘yes,’ and ‘hm,’ and ‘go on’
- Using appropriate facial expressions
- Keeping your posture relaxed and open
- Being awake and attentive – maintain high energy levels
- Allowing time for silence and thoughts
Conclusion (10 minutes)

Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session four. Review their information intake by asking them to name the main themes discussed during session one.

Say:

You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

Conclude the session by naming the themes as covered in each step of the session. Say:

We have covered:

- Communication in counseling
- The types of communication
- Good communication skills in counseling
- Active listening skills in counseling

Thank you so much.
Session 4.4: Sharing personal problems

**Step 1. Introduce sharing personal problems “Venting” - 10 minutes**

*Say the following:*

You are all welcome to this learning session on venting in group settings. Through the steps in this session we will work with you to enhance your understanding of venting of personal issues in group settings. The following topics will be covered:

- Venting; its definition
- The benefits of venting in group settings
- The tasks of helping clients to vent their issues in group settings

*Ask the large group the following question:* What is the meaning of the word venting?

*Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. Then say:*

Thank you very much for all your contributions. I will now give you the meaning of “venting” as it has been used in health for a long time.

**Definition of “Venting”**

Venting can be defined as verbalizing one’s painful feelings to another person(s).

*Explain saying:*

Venting involves someone telling another person(s) about what s/he is feeling about certain things. Venting requires openness on the part of the person venting and requires respect on the part of the listener(s).

**Step 2. The benefits of venting in group settings**

*Facilitate a plenary discussion by asking the participants the following question: what are the benefits of venting in a group setting? Listen to a number of responses from the participants. Then write the responses on a flip chart and summarize their ideas as you review each point. Then say:*

...
Many clients who have gone through counseling report that it is generally better to let things out than withhold them. The opportunity and ability to vent is almost the same as problem-solving, in the moment at least. Therefore, venting one’s frustrations alleviates tension and stress; it leads to relief and a general feeling of wellbeing.

However, it is important to note that clients report that it is easier to vent in individual than in group settings though they report great benefits of venting in groups over individual counseling as follows:

- The group offers members the opportunity to receive feedback from many others’ ways of looking at the same problem. This gives an individual a diversity of options to address his/her problems.
- The group offers multiple relationships which act as models to assist the individual in growth and problem solving.
- The group exists to help individuals grow emotionally and solve personal problems. All utilize the power of the group, as well as the facilitator who leads it in this process.
- Universality of problems; hearing from others with similar issues helps you to see that you’re not alone in having challenges. This discovery helps many people experience a sense of relief.
- Instillation of hope from a larger counseling group.
- Catharsis; group members have the opportunity to experience the most painful emotions within a group of trustful members who offer a substantial amount of social support.

Conclude step 2 by thanking the participants for their active participation in this section.
Step 3. Tasks of helping clients to vent their issues in group settings [45 minutes]

Remember that it is not very easy for clients to vent within group settings. Therefore, guide the participants in understanding that.

Say: It is not very easy for clients to vent in group settings. Therefore, the process of helping clients to vent their emotions involves a number of tasks for the counselor including the following:

i) Encouraging clients to share their problems; explain to the group that it may be very painful and difficult to share some experiences at certain moments. Encourage them however that without sharing, they remain with their baggage alone and it is impossible for the group to help in any ways.

However, each one reserves the right and freedom to share only what they are able to share at a time without coercion.

ii) Asking “Moving On” Questions

This involves asking clients about their future. In helping the clients to vent, it is helpful that they discover that all events in their life are part of their whole life’s story. You should also ask some questions about the future. For those who are still suffering deeply and are stuck in the problems of past and present, it may be useful to help them look at the future.

One of the responsibilities of the group counselor and the rest of the group members is to help the current sharer to develop a clear plan for the future, to give him/her appropriate courage and hope that it can be possible for them to reach a desirable kind of life despite all the current suffering. Therefore, listen to the sharer’s story and look for some reference to the future.

You can intervene in this process with questions such as (engage the group here as well):

- “How often do you think that your future can be better than your past?”
• “When you leave here, what do you want to see yourself doing?”
• “How will your life be different after this?”
• “As you start to resolve this painful time in your life, what’s your next step?”
• “What will you need to do to rebuild your life?”

Conclude this point by saying:

These questions also imply that the clients/group are capable of resolving problems, managing emotions, and accomplishing goals. This can be very empowering, which is one of the primary goals of GSP.

III. Managing Strong Emotions

When clients talk about their experiences, they will often be overwhelmed with grief, anger, bitterness and remorse. Expressing emotions is normal and unavoidable; tears and shouting help (to some extent) to relieve inner tension.

There are several strategies for helping clients manage their emotions so that they still express the emotions without being overwhelming.

• Attend to basic needs: see that the client is warm enough or cool enough, is not hungry or thirsty, and feels safe.
• Listen, understand and validate: Reassure the clients that you are there for them all, to listen and provide support, and that each client’s feelings are acceptable. Speak soothingly.
• Focus the clients’ attention on solving problems: People feel better if they feel like they can accomplish something. If you can discuss solving a problem, even a small one, the clients will calm down while considering the options.
• Recommend deep, controlled breathing: Slow, deep breaths can reduce nervous energy. Many people benefit from it.
Conclude this point by saying:

Emotions associated with clients’ conditions tend to diminish over time but they never completely disappear. In fact, a certain amount of emotion is helpful to think clearly and to motivate people to move ahead. Therefore, it is not helpful to urge clients to stop crying; though it is often the commonest reaction of the people in the community and group.

IV. Creating Hope

Having a plan for the future is the surest sign that the client has hope. Having hope means having the will power and the energy to make life better. Plans may be simple and not very ambitious at first, but as small things are accomplished, bigger and more complex plans will begin to take shape.

Conclude this session by saying:

The GST therapist’s job is to help the clients to imagine a future and think of ways to make their life better. The clients must develop their own goals and then start working to achieve them. The GST therapist and the group members must give encouragement without doing things for each client in the group. It is important that each client takes pride in accomplishing his or her goals by him or herself.

Conclusion (10 minutes)

Say: You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

Conclude the session by naming the themes as covered in each step of the session
Session 4.5: Group facilitator’s attitudes and values

Say the following: In this session, the following topics will be covered:

- Attitude; its definition and,
- Values; its definition
- The impact of the counselor’s attitudes and values on the counseling process.

Ask the participants the following question: What is the meaning of the word Attitude?
Listen to a number of responses from the participants. Then write the responses on a flip chart and summarize their ideas as you review each point. Then ask participants the following question: What is the meaning of the word Values?
Listen to a number of responses from the participants. Then write the responses on a flip chart and summarize their ideas as you review each point. Then say:
There are several definitions of the words attitude and values but I we will take the most commonly agreed definitions for the purpose of this training and the counseling work using GSP.

<table>
<thead>
<tr>
<th>Definition of “Attitude”</th>
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<tbody>
<tr>
<td>Attitude can be defined as a tendency to respond positively or negatively towards a certain idea, object, person, or situation. Attitude influences an individual’s choice of action and responses to stimuli (challenges, incentives and rewards).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Definition of “Values”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Values are about the ways of thinking about how things ought to be, or people ought to behave, especially in terms of qualities such as honesty, integrity and openness.</td>
</tr>
</tbody>
</table>
Then explain as follows:

1. Counselors should have positive attitudes in order to generate trust among group members. Counselor’s positive attitudes include:
   
   - Careful attending and genuine listening
   - Empathy
   - Genuineness and self-disclosure
   - Respect
   - Caring confrontation

2. The counselor’s values have a great impact on the group counseling process and its efficacy. Therefore, in order to effectively facilitate a counseling group process, the counselor needs to be aware of the following points every moment of the counseling process:
   
   - Essential that you are aware of your values and how they influence what you think, say and do in the group.
   - The counseling group is not a forum for you to impose your values on group members.
   - The purpose of a counseling group is to assist members in examining options that are most congruent with their values, NOT with the counselor’s values.
   - Group members have the task of clarifying their own values and goals, making informed choices, and assuming responsibility for what they do.

Conclusion (10 minutes)

Say: You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

Conclude the session by naming the themes as covered in each step of the session.
**Session 4.6: Practicum on counseling skills required for GSP session 3 and 4**

Divide participants into pairs and have each person—practice skills learnt in this session while the partner acts as an individual who shares personal difficulties and problems.
Module 5: Essential coping strategies to overcome depression

LEARNING OBJECTIVES

- By the end of this Module, trainees will be able to:
  - Define Coping
  - Describe positive coping strategies
  - Describe Negative coping strategies
  - Demonstrate Positive realistic thinking
  - Demonstrate Coping strategies for excessive worry thinking

TIME: 100 minutes (1hr 40minutes)

CONTENT

Session 5.1: What is coping?

Session 5.2: Positive coping strategies

Session 5.3: Negative coping strategies

Session 5: Positive realistic thinking to overcome negative thinking

Session 5.3 : Coping with excessive worries

Session 5.5: Practicum on essential coping strategies to overcome depression, GSP

PREPARATIONS/ MATERIALS

- Flip chart paper
- Flip chart stand
- Markers
- Masking tape
Session 5.1: What is coping?

Step 1: Introduce “Coping” (30 minutes)

Say the following: We welcome you all to this learning session on coping strategy. Through the steps in this session we will work to improve on your understanding of coping strategies. The following topics will be covered:

- Definition of coping
- Positive coping strategies
- Negative coping strategies
- The coping strategies for depression specifically

Ask the large group the following question: **What is the meaning of the word coping?**

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of coping strategy, say:

<table>
<thead>
<tr>
<th>Definition of “Coping”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coping refers to the specific efforts, both behavioral and psychological that people employ to master, tolerate, reduce, or minimize stressful events.</td>
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</table>

Explain by saying: Coping strategies can be positive or negative.

Step 2. Positive coping strategies (40 minutes)

Facilitate a plenary brainstorming about the meaning and examples of positive coping strategies. Call for answers by show of hands. Then say the following:

**Positive Coping Strategies** are actions that you take which help you when feeling strong emotions such as anger, anxiety, or depression in the short and long run. They are activities
that are likely to help you avoid more stress or problems and they therefore help you to be more resilient and stress tolerant.

Here below is a list of positive coping strategies:

i. **Distractions;** they are those coping strategies that enable someone to stop thinking about the stress inducing situation. Distractions are not the final solution, but each one can be useful in the basic goal of remaining safe and peaceful. They are useful for a moment and the person using them has to move away from distraction to more active strategies that address the challenges, otherwise distractions become a way of avoidance. In using distraction, someone may:

- Write, draw, and or paint something that you enjoy.
- Play a music instrument, sing, dance, act
- Take a shower or a bath
- Go gardening; tend to flowers or fruit trees, etc.
- **Take a walk,** or a bike, or go for a drive, or go to the gym, or road work/jogging, etc.
- Watch television or a movie or listen to a radio program
- Play a game, e.g. draft, chase, mweso or a telephone game
- Go shopping in the market
- Clean or organize your environment, e.g. your house or compound
- Read a book, article in the newspapers or magazine.
- Take a break or vacation or a tour

ii. **Social/Interpersonal strategies;** involve interactions with others that someone trusts.

Social support can be useful for providing assistance in difficult times. Using this category of coping strategies, one can:

- Talk to a relative, friend or someone you trust
• Set boundaries and say "no" in a way that does not lead to conflicts and or additional stress.
• Write and send a message to someone you care about
• Be assertive: strive to clearly express yourself about the things you like and dislike.
• Use humor
• Spend time with friends and/or family
• Serve someone or encourage others in need, this leads also to self-fulfillment
• Care for or play with children or pets
• Role-play challenging situations with others who understand you

iii. Physical (cathartic) or Relaxation Strategies; involve acting on strong emotions in ways that are safe for oneself and others. Punching a pillow could be a way to release tensions in a safe way.

However, someone has to be careful with cathartic responses because they can become habit and may translate to real life situations, e.g. a child who practices punching a pillow may envision a person's face and end up actually punching that person's face when angry. Then add:

It is known that physical processes are directly tied to mental and emotional processes. For instance, it is known that a person's breathing rate can elicit a response from the sympathetic nervous system. Raising your voice can send signals to your brain that you are angry. Therefore, in the same way, acting calmly in the face of difficulty can help send signals to your brain that everything is okay. Using relaxation strategies, one can:

• Engage in routine physical exercises or sports
• Catharsis, e.g., yelling in the bathroom, punching a punching bag, i.e. act your emotions out in a non-destructive manner.
• Cry when you feel the need/ urge to cry
• Laugh when you feel you feel the need/ urge to laugh.
• Get enough sleep
• Eat enough healthy foods with lots of vegetables and fresh fruit
• Limit caffeine, alcohol and other drugs intake
• Practice deep/slow breathing exercises

iv. **Cognitive (of the Mind) Strategies;** are those actions that involve using the mind and thought to influence the way one feels and behaves. For example:

• Make a list of things for which you feel grateful about yourself and the world in general.
• Brainstorm solutions and identify workable ones
• Write a list of strengths that you possess
• Lower your expectations of the situation; be more realistic
• Accept challenges with a positive attitude aiming at identifying positive lessons for use in the future situations of challenge.
• Identify and keep an inspirational quote, proverb, slogan or a revolutionary song with you
• Be flexible; be willing to try a number of options
• Write a list of goals you want to achieve
• Act opposite of negative thoughts and feelings
• Write a list of pros and cons of every possible decision you can make
• Reward or pamper yourself when successful; this raises one’s spirits and a sense of self-worth

v. **Spiritual Strategies;** are aimed at satisfying the need to feel worthwhile, connected and at peace; they improve wellbeing at the core of a person. This influences one’s attitudes and actions and according to [Maslow’s hierarchy of needs](#), we all need to feel a sense of purpose. So one can:

• Pray or meditate
• Enjoy nature by taking a walk or watching nature.
• Get involved in a worthy cause, e.g. a community activity or advocacy for justice of the disadvantaged, etc. this enhances self-worth (self-esteem).

vi. **Set and maintain clear boundaries;** it is a preventive measure to protect oneself against overwhelming stress created by doing too much of something. Limits can be set for one's self or others. Using this strategy, one can:

• Drop some involvement in activities that seem to be stressing her/him.
• Prioritize important tasks
• Use assertive communication
• Schedule time for oneself

**Step 3. Negative coping strategies – 40 minutes**

*Facilitate a plenary brainstorming about the meaning and examples of positive coping strategies. Call for answers by show of hands. Then say the following:*

**Negative Coping Skills** are things you do that cause relief in the short term but will cost you in the long run. Negative coping strategies do more harm than good in most cases and can make life more stressful. Negative coping strategies may include the following:

i. **Distractions;** they are activities that turn the attention of the person away from immediately addressing the stressors; such as:

• Procrastination
• Using or abusing drugs or alcohol
• Wasting time on unimportant tasks, e.g. gambling, rumor mongering, etc.

ii. **Social/Interpersonal Coping Strategies, including:**

• Blaming
• Isolating/withdrawing
• Mean or hostile joking
• Gossiping
• Criticizing others
• Manipulating others
• Refusing help from others
• Lying to others
• Sabotaging plans
• Being late to appointments
• Provoking violence from others
• Enabling others to take advantage of you

iii. **Cognitive (of the Mind) Coping Strategies**, such as:

• Denying the obvious problem
• Stubbornness/inflexibility
• All or nothing/black or white thinking
• Catastrophizing, e.g. it’s the worst ever.
• Overgeneralizing, e.g. no one can ever manage this.

iv. **Physical (cathartic) or Relaxation Strategies**; such as:

• Throwing things at people
• Hitting people
• Yelling at others
• Destroying property
• Speeding or driving recklessly
• Suicide attempt and or completion
• Self harm, e.g. self-mutilation
- Developing illnesses or somatisation

v. **Intrapersonal coping strategies**, such as:

- Making fun of yourself
- Self-sabotaging behaviors
- Blaming yourself

vi. **Behavioral coping strategies**, such as:

- Spending too many resources at one time and regretting later.
- Gambling
- Eating too much and or binging
- Setting dangerous fires
- Continually crying

**Session 5: Positive realistic thinking to overcome negative thinking**

Depression is associated with negative thoughts. There are various ways of coping positively with negative thoughts and feelings associated with the stressful life events that we go through, so we are going to look at these.

- Our next discussion regards how to manage depressive thinking but first we must understand what it is: Negative thinking involves: Unrealistic negative thoughts about your situation, yourself and the future. Second, we must learn about some types of depressive thinking so that we can learn to identify them. Let us consider this example: **An HIV positive man/woman says “I cannot do anything now. I am just a cripple, there is really no point. Nothing I do seems worthwhile. I am going to die anyway.”**

How to identify depressive thoughts: Let us identify the different negative thoughts in this statement:
I cannot do anything now

**All or nothing thinking**
You see the world in extremes eg. entirely healthy or totally ill. Gradual improvement is not enough.

I am just a cripple

**Labeling**
Labeling involves talking to yourself harshly and calling yourself insulting names.

There is really no point. Nothing I do seems worthwhile

**Over generalizing**
You may think that if you fail the first time, you’ll fail every time.

I am going to die anyway.”

**Fortune-telling**
You feel as though you know what the future will bring, and it’s negative.
**Depressive Thinking** can affect the way you feel, your physical state and actions as illustrated below:

Our minds generate depressive thinking in stressful situations.

Take the following steps to manage depressive thoughts during stressful situations:

**Step 1:** Remind oneself that they are caused by the difficult situation you are going through.

**Step 2:** Replacing depressive thoughts with realistic thoughts by asking oneself some reality questions

- Can I get more evidence by asking someone else about this situation?
- What is a more encouraging and useful way of thinking?

**Step 3:** Repeat this realistic thinking over and over until it becomes automatic.

**Step 4:** Talk back to depressive thinking. For example if a thought comes: I am a cripple.
Talk back I am not a cripple.
Every time you talk back you make depressive thinking weaker and the realistic thinking stronger.
Session 5.3 : Coping with excessive worries

Having a chronic health condition such as HIV/AIDS leads to various problems that may cause you to worry. You may worry whether the condition will become worse, whether you will be able to keep working and look after your family and whether the pain or discomfort will intensify. When worry becomes too much, it will cause more harm than good.

Let me explain more using this diagram

*(Ask a volunteer to draw the boxes shown in the diagram on the flip chart under your guidance).*

![Diagram showing the relationship between excessive worrying, physical state, emotions, and actions.](image-url)
Take the following steps to manage excessive worries when we are going through tough situations.

Step 1: Identify your worries

Excessive worries can be recognized by at least one of these features (symptoms of excessive worry):

1. You think too much about a problem, to the point that it interferes with other activities such as spending time with family or friends, enjoying entertainment or concentrating on your work.
2. You imagine the worst possible outcome of the problem, you magnifying the negative possibilities and ignoring any possible positive outcomes. This kind of thinking is known as “catastrophizing.”
3. Physically, you will feel sick with pain in muscles, palpitations fast breathing, headache, stomach problems, unable to sleep etc.)
4. Emotionally, you will be filled with fear and always feeling as if something bad is going to happen to you.

Step 2: Challenge your Worry Thoughts

Can I get more evidence by asking someone about this situation? It’s often helpful to get another person’s opinion about the situation.

- For example: you’ve been worrying constantly that your health will keep getting worse – so you speak to the clinic nurse, who informs you that most people with your health condition are able to stabilize their symptoms.
- Would most people agree with this thought? If not, what would most people think?
- Imagination: imagine how most people will react to a worry thought, this can help you to come up with a more fair and realistic way of thinking
- What would I say to a friend, if my friend were in a similar situation?

It’s likely that you would be able to help her think about the situation more fairly, looking at it in a more balanced way. You might remind your friend of tough situations she handled in the past. You might find it easier to think in a realistic way for a friend than for yourself.
Step 3: Replace your worry thoughts with realistic ones)

Think of a situation about which you’ve been worrying. First, make a brief note about the situation. Second, write down the Worry Thoughts that were making you anxious.

Third, think about the situation and try to come up with more calming and realistic thoughts, using the Reality Questions below.

Examples of reality questions. When you step outside yourself and examine your thinking from another perspective, it’s easier to see how your thoughts might be distorted.

Step 4: Practice Calming and Realistic Thinking

It’s not enough to come up with a calming and realistic thought just once. When you find yourself in stressful situations, deliberately practice calming thinking. Don’t assume that it will happen on its own. Talk back to the worry thinking. Don’t allow excessive worry to occur without replying to it. Every time you talk back, you make the worry thinking weaker and the realistic thinking stronger. Eventually, realistic thoughts will have more influence over you than Worry Thoughts.

- For example: You may think: My illness is more serious than my doctors realize
- Realistic thought: There is a high chance that my illness is not serious, in fact, I will get better. Repeat this thought over and over.
- Realistic thinking can be termed as truthful thinking. It is acquired by repetition overtime, and once it is acquired one can accept the realistic thoughts naturally.

Step 5: Schedule Worry Time

It is helpful to schedule a particular time during the week when you can concentrate on worrying about your problems than trying to stop thinking about them through scheduling worry time, one is able to compartmentalize bad events and keep them from affecting all areas of life. In this way one parks his/her worries for a time, and thereby gets distracted from them and thinks about something else, and focus on the job/tasks at hand”
Session 5.5: Practicum on essential coping strategies to overcome depression, GSP
Module 6: Problem solving strategies and coping with stigma

LEARNING OBJECTIVES

By the end of this Module, participants will be able to:

- Describe the steps in effective problem solving
- Understand the importance of self-disclosure during counseling
- Explain Stigma and discrimination
- Describe the harmful effects of stigma
- Describe the steps to cope with the stigma

TIME: 100 minutes (1hr 40 minutes)

Content

Session 6.1: introduction to problem solving
Session 6.2: Steps in problem solving
Session 6.3: Self disclosure
Session 6.4: introduction to Stigma and discrimination
Session 6.5: essential coping strategies for stigma and discrimination
Session 6.6: Practicum on problem solving skills and coping with stigma, GSP 6

PREPARATIONS/ MATERIALS

- Flip chart paper
- Flip chart stand
- Markers
- Masking tape
Session 6.1: Introduction to problem solving

Say the following: You are all welcome to this learning session on problem solving. Through the steps in this session you will broaden your understanding of problem solving. The following topics will be covered:

- Problem solving
- Problem solving skills
- Steps in effective problem solving

Ask the large participants group the following question: What is your understanding of the words: “problem” and “problem solving”?

Listen to a number of responses from the group. Then ask one of the participants to write the responses on a flip chart and summarize their ideas as you review each point. Then thank the participants for the contributions, conclude by summarizing their understanding of a problem and problem solving. Then say:

There are several meanings of the two words, problem and problem solving, but for the purpose of this training and GSP in general we will use the following definitions:

<table>
<thead>
<tr>
<th>Definitions of “problem” and “problem solving”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem</strong> is an undesirable situation that needs to be dealt with or else someone suffers the situation or its consequences, e.g. dilemmas, crises, discrepancies, contradictions, etc.</td>
</tr>
<tr>
<td><strong>Problem Solving</strong> is the process of working through the details of a problem in order to reach a solution.</td>
</tr>
</tbody>
</table>

Explain by saying:
Life is full of problems which require decisions but many people do not have the appropriate skills to manage problems. And often, the lack of appropriate problem solving skills is more problematic than the problem to be solved.

Problem Solving Skills – (45 minutes)

Facilitate a plenary brainstorming about problem solving skills. Call for answers by show of hands and write down the answers on a flip chart. Review the answers with the participants and then say the following:

Problem solving skills are capacities or strategies of solving problems. For example:

I. Distinguish between “small” and “manageable” aspects of the problem. When a problem is viewed as manageable, there is a big likelihood that you can solve it. Looking at the problem as small does not guarantee one’s ability to solve it.

II. Be mindful, conceiving problems in large global terms makes them unmanageable, e.g.
   - There is no hope.
   - I can’t do anything.
   - He will never change.
   - No one can help in any way. “I seem to have the world on my shoulders.”

III. Try to establish and obtain relevant facts to the problem.

IV. Be realistic and adopt a mindset that you can solve or cope with a problem; this increases the likelihood that you will come up with a solution to it.

V. Identify the aspects of the problem which you have control over; involve yourself in the intervention because feelings of helplessness reduce one’s willingness and ability to solve problems.
VI. Take time to learn from others’ styles of problem solving. Interpersonal problem solving skills are learned from experiences of interactions with others in situations that give rise to interpersonal difficulties.

VII. Problem sensitivity; involves:

- Ability to be aware of problems that arise out of social situations.
- Sensitivity to the kinds of social situations out of which interpersonal difficulties may arise.
- Ability to examine relationships with others in the here and now.

VIII. Alternative solution training; which is the ability to generate a wide variety of potential solutions to the problem.

IX. Brainstorming; involves:

- The creative art of generating the greatest number of ideas in the shortest possible time.
- Acceptance of every idea uncritically
- Aiming at quantity not quality of ideas
- At this stage do not initiate any discussion
- Listing the ideas
- Setting time limits

X. Means-ends thinking; it involves the:

- Ability to articulate the step by step means necessary to carry out the solution to a given problem.
• Ability to recognize obstacles and consequences deriving from the identified solutions.

• Recognition that problem solving, especially interpersonal problem solving takes time.

XI. Consequential thinking; involves:

• Being aware of the consequences of social acts as they affect you and others.

• Ability to generate alternative consequences to potential problem solutions before acting.

Session 6.2: Steps in problem solving

Say the following:

Different people have used different methodologies of problem solving but all of them seem to agree that an appropriate problem solving process involves the following steps:

Phase 1. Define what appears to be the problem

The real problem may not surface until facts have been gathered and analyzed. Therefore, start with what you assume to be the problem that can later be confirmed or corrected. This is the most critical step.

Phase 2. Assess the nature of the problem (gather facts, feelings and opinions)

• What happened?

• Where, when and how did it occur?

• What caused the problem?

• What are its size, scope, and severity?

• Who and what is affected?

• Is it likely to happen again?
• What needs to be corrected?
• May need to assign priorities to critical elements.

Phase 3. Identify (or develop) alternative solutions
• Generate as many ideas as possible.
• Do not eliminate any possible solutions until several have been discussed.

Phase 4. Evaluate alternatives and select the best option
• Which will provide the optimum solution?
• What are the risks?
• What are the costs in keeping with the benefits?
• Will the solution create new problems?

Phase 5. Implement the best option; choosing a solution does not immediately solve a problem. Putting a solution into action may prove as difficult as deciding on one. The implementation stage requires action planning, which is a process that requires you to answer the following questions:
• Who will do it?
• What must be done?
• Who must be involved?
• To what extent?
• How, when and where?
• When will key milestones be completed?
• Who will the decision impact?
• What might go wrong?
• How will the results be reported or verified?

Phase 6. Evaluate the outcomes/results of the solution.
- Test the solution against the desired results.
- Make revisions if necessary.

**Conclusion (10 minutes)**

_Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session 5.2. Review their information intake by asking them to name the main themes discussed during this session._

_Say:_

_You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes that we have covered during this session. What have you learnt about; by show of hands?_  

_Conclude the session by naming the themes as covered in each step of the session. Say:_

_We have covered:_

- Problem solving
- Problem solving skills
- Steps in effective problem solving

_Thank you so much._
Session 6.3: Self disclosure

Step 1: Introduce “Self-disclosure” [30 minutes]

Say the following

We welcome you all to this learning session on self-disclosure in counseling. Through the steps in this session we will work to improve on your understanding of self-disclosure. The following topics will be covered:

- Definition of self-disclosure
- Characteristics of self-disclosure
- Reasons for self-disclosure in counseling
- Guidelines for appropriate self-disclosure in counseling

Ask the large group the following question: What is the meaning of the word self-disclosure?

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of self-disclosure, say

<table>
<thead>
<tr>
<th>Definition of “Self-disclosure”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Self-disclosure</strong> can be defined as making oneself known to another person by revealing personal information.</td>
</tr>
</tbody>
</table>

Explain by saying:

- It is important to note that Self-disclosure involves opening up to others through our communication i.e. by telling others things about ourselves which help them to see our uniqueness or similarities as human beings.

- In self-disclosure, one person reveals information about himself or herself to another for a positive or supportive purpose.
• Self-disclosure is a conscious and intentional technique in which counselors share information about their lives outside the counselling relationship. It requires counselors to communicate a common message in a tailored way, with a different objective and external focus to help the clients understand their conditions better.

Step 2. Characteristics of self-disclosure (15 minutes)

Facilitate a plenary brainstorming about the characteristics of self-disclosure. Call for answers by show of hands.

Then say the following:

Self-disclosure has a number of characteristics; the most common ones are the following:

- It is influenced by Culture.
- Self-disclosure usually occurs in dyads (between two parties).
- Usually requires confidentiality.
- Has the purpose of helping the other person see their condition better.

Step 3. Reasons for self-disclosure in counseling – 40 minutes

Facilitate a plenary brainstorming about the reasons for self-disclosure. Call for answers by show of hands.

Then say the following:

The counselor reveals some information about himself or herself in a counseling session in order to;

- Establish a connection with the client, thus creating rapport, trust and improving interpersonal communication. This facilitates client disclosure through modeling.
• Help the clients to not feel alone.
• Decrease client anxiety.
• Improve clients’ awareness of different viewpoints.
• Increase the counselor’s genuineness.
• Increase the clients’ self-awareness and mindfulness to personal strength or suffering.
• Lead to a catharsis.
• Promote self-clarification with the clients.
• Encourage self-validation.
• Encourage reciprocity.
• Aid impression management.
• Control the therapeutic process.

Step 4. Guidelines for appropriate self-disclosure in counseling [20 minutes]

Say the following:

Self-disclosure can be harmful if it is done wrongly. Therefore, in order to achieve the intended goals, self-disclosure should be according to the following guidelines:

• Do it with persons that are important to you (your clients are important people)
• The risk of self-disclosing should be reasonable; the intended benefit should be high.
• The amount and type of self-disclosure should be appropriate.
• The self-disclosure should be relevant to the situation at hand; should fit within the context.
• The self-disclosure should be reciprocated; it should receive a response (positive response).
• The effect of the self-disclosure should be constructive; aimed at moving the clients forward in a positive direction.

• The self-disclosure should be clear and understandable to both clients and counselor

• The process should only be used after considering other options

• Self-disclosure should not be used frequently

• Self-disclosure should not add to the client’s problems and negative outcomes.

*Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session 6.4. Review their information intake by asking them to name the main themes discussed during session one.*

*Say:*

You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

*Conclude the session by naming the themes as covered in each step of the session. Say:*

We have covered:

• Definition of self-disclosure

• Characteristics of self-disclosure

• Reasons for self-disclosure in counseling

• Guidelines for appropriate self-disclosure in counseling

Thank you so much.
Session 6.4: Introduction to Stigma and discrimination

a) Understanding stigma ……30 minutes

Our next discussion regards the ways of coping positively with stigma but before getting into a discussion of how to cope with stigma, it is helpful to know what the term stigma means to you as GSP members.

Activity: give examples of stigma and discuss the reasons that lead to stigma (5-10 min). You can give the mental image or words that you associate with stigma.

Group facilitator: one definition of stigma is, a condition when someone views a person in a negative way because s/he has a distinguishing characteristic or personal trait that’s thought to be, or actually is, a disadvantage (a negative stereotype). In this sense, stigma can be defined as negative attitudes and beliefs toward people who have an abnormal condition or behavior such as people with mental illness, HIV/AIDS, depression and other social problems. Unfortunately, such attitudes and beliefs are common toward people with those problems.

Group facilitator explains that

•

• This can remain a general discussion about the reasons for stigma usually leads to talking about stigmatization of people who have HIV/AIDS and depression problems.

• It is now time to talk about common myths about mental illness and HIV/AIDS some people:

• Believe that individuals with depression are seeking attention and are unwilling to take responsibility for their behavior.

• Fear individuals who hear voices and talk to themselves because they mistakenly associate such behaviors with violence.

• Believe that individuals who have major depression are really just lazy.

• Believe that individuals who have substance use and depression problems make the problems worse by refusing to take responsibility for their behavior.

Talking about these, and other, examples is a comfortable way for many patients to begin relating the discussion of stigma to their own personal lives.
All people experience some stigma at one point in life. So it is necessary that we briefly discuss personal experiences of stigma and can ask participants to share their own experiences with the group. It is helpful if the facilitators begin the discussion with a non-threatening example of how they have experienced stigma themselves.

For example, I often talk about how I grew to six feet tall before I was 12 years old and was laughed at and discriminated against because everybody else in my class, including (and especially!) all of the boys, were so much shorter than I was.

Another example could be “… after suffering a terrible rash on my skin in primary school, I was known as “The snake girl.”

**Why is it important to talk about stigma?**

Stigma has negative effects on the victims including the following among others:

- Reluctance to seek help or treatment
- Lack of understanding by family, friends, co-workers or others you know
- Fewer opportunities for work, school or social activities or trouble finding housing
- Bullying, physical violence or harassment
- Health insurance that doesn’t adequately cover your mental illness treatment
- The belief that you’ll never be able to succeed at certain challenges or that you can’t improve your situation

**Session 6.5: Essential coping strategies for stigma and discrimination**

Now that we know how harmful stigma is, we are going to talk about the different ways of coping with stigma

- Get treatment.
• You may be reluctant to admit you need treatment. Don't let the fear of being labeled with a mental illness prevent you from seeking help. Treatment can provide relief by identifying what's wrong and reducing symptoms that interfere with your work and personal life.

• **Don't let stigma create self-doubt and shame.**

  • Stigma doesn't just come from others. You may mistakenly believe that your condition is a sign of personal weakness or that you should be able to control it without help. Seeking psychological counseling, educating yourself about your condition and connecting with others with mental illness can help you gain self-esteem and overcome destructive self-judgment.

• **Building your Social Shield:** Surround yourself with people who accept you the way you are. Your family, friends, clergy or members of your community can offer you support if they know about your mental illness. Reach out to people you trust for the compassion, support and understanding you need.

• Learning social skills (**Skill learned and practiced**): learn and practice Social communication (mirroring, validating, and empathizing) and conflict-resolution techniques (disclosure and dealing with discrimination).

  • **Boosting Self-Esteem:** Exploring the group’s sources of self-image and self-esteem and ways these concepts impact their coping styles.

  • Learning to accept one's deficits as well as to acknowledge one's strengths.

  • **Empowerment: Turning Crisis into an Opportunity:** Becoming aware of negative thought patterns and learning how to reframe them positively.

  • **Skill learned and practiced:**

    1) **positive self-talk:** Talk back at negative views about oneself

    2) **Don't isolate yourself:** Reach out to people you trust for the compassion, support and understanding you need. Your family, friends, clergy or members of your community can offer you support if they know about your mental illness.
3) Join a support group.

- **Speak out against stigma.** Consider expressing your opinions at events, in letters to the editor or on the Internet. It can help instill courage in others facing similar challenges and educate the public about mental illness.

Others' judgments almost always stem from a lack of understanding rather than information based on the facts. Learning to accept your condition and recognize what you need to do to treat it, seeking support, and helping educate others can make a big difference.
Module 7: Poverty, depression and livelihood skills

Learning Objectives

By the end of this Module, participants will be able to:

- By the end of this Module, trainees will be able to:
  - Describe the relationship between poverty and depression
  - Describe the livelihood skills required to reduce poverty

TIME: 100 minutes (1hr 40minutes)

Content

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<td>Session 7.3: Enterprise selection</td>
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<td>Session 7.4: Record keeping and marketing skills</td>
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<td>Session 7.5: The marketing process</td>
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<td>Session 7.6: Strategies for mobilizing resources</td>
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<tr>
<td>Session 7.7: Practicum on creating a simple business plan GSP, session 7 and 8</td>
</tr>
</tbody>
</table>

PREPARATIONS/ MATERIALS

- Flip chart paper
- Flip chart stand
- Markers
- Masking tape
Session 7.2: Introduction to basic livelihood skills

Step 1. Step 1: Introduce “Livelihood” and enterprise [30 minutes]

Say the following

You are all welcome to this learning session on livelihoods. Through the steps in this session we will work to improve on your understanding of livelihoods. The following topics will be covered:

- Definition of “livelihoods” and “enterprise”
- Define “demand” and “supply”
- The law of demand and supply
- The factors that affect demand and supply
- Factors for enterprise selection

Ask the large group the following question: What is the meaning of the word livelihood?

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of livelihood, say

Definition of “livelihood”

Livelihood refers to one’s means of securing the basic necessities like food, water, shelter and clothing in life.

Explain by saying:

Livelihood is defined as a set of activities, involving securing water, food, medicine, shelter, clothing and the capacity to acquire above necessities working either individually or as a group.
by using endowments (both human and material) for meeting the requirements of the self and one’s household on a sustainable basis with dignity.

The livelihood activities are carried out repeatedly, e.g. farming, fishing, driving, teaching, building, etc.

In simpler terms, livelihood is the job one works at to earn the income that supports them. It is the way one makes their living and pay for the basic things you need in life like medical bills, food, water, shelter, etc.

Session 7.3: Enterprise selection

What is the meaning of the word enterprise?

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of enterprise, say

Definition of “enterprise”

Enterprise is a unit of production, e.g. a potato garden, poultry, goats keeping, bee keeping, basket making, cloth making, grain milling, etc.

Explain by saying: In simple terms, an enterprise is a business or a project from which someone earns an income.

Step 2. Demand and Supply (15 minutes)

Facilitate a plenary brainstorming by asking the large group the following question: What do the following words mean: 1. Demand and 2. Supply?

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of enterprise, say

Definition of “demand” and “supply”

Demand is the willingness of buyers to buy a commodity at a given price, place and time. Whereby, Supply is the willingness of the seller to sell a commodity at a given
Step 3. The Law of Demand and Supply **(15 minutes)**

Say the following: The law of demand and supply states that “the lower the supply, the higher the demand and the higher the supply, the lower the demand.”

Add by saying that: It is important to note that the price of a commodity also influences that commodity's demand and supply in the following ways.

i. **Price and demand**: the higher the price, the lower the demand and lower the price, the higher the demand. Whereas,

ii. **Price and supply**: the higher the price, the higher the supply and the lower the price, the lower the supply.

Step 4. Factors the Affect Demand and Supply **(30 minutes)**

Facilitate two small groups discussion about the factors that affect demand and supply. Give two flip chart sheets to each group and ask them to outline, on the flip chart sheets provided, the factors that: for group 1. **Affect demand** and 2. **Affect supply**. Instruct each group to pin up their work sheets on the wall. Then put all the group members together and go round reviewing the work each group. Ask everyone to feel free to add to the list of the factors written down by the group under review. Then add any of the following factors that might not be outlined through the group discussion. Say the following:

Thank you so much for the work well done. We have however realized that we have the following factors to add to the list of the factors that: 1. Affect demand and 2. Affect supply, which you have regenerated. We have the following to add:

1. **Factors that Affect Demand Include:**

   - **Size of population**: the higher population the more products will be needed. All other things constant, demand is increased as population increases.
• **Taste and preferences of consumers**; tastes and preferences change with time and other factors.

• **Income and distribution of wealth of the buyers**; higher income results in more products being purchased.

• **Prices of all goods that are substitutes e.g. milk and eggs**; with a limited budget, when the price of a substitute item decreases, consumers will purchase more of the substitute.

• **Price of goods that are complements, e.g. seeds and fertilizers**; when the price of a complement (items used together) decreases, more of the item will be purchased.

2. **Factors that Affect Demand Include:**

   • **Technology**; generally, technology decreases the cost of production, making it cheaper to produce more of the product, e.g. using tractors to produce maize.

   • Cost of production; when prices of inputs, e.g. been seeds go high, the level of production of beans goes down and vice versa.

   • Price of other products; if a firm can produce a different product that has a higher price, it may produce more of that product than a product with a lower price on the market.

   • Seasonality of production; different products are more during certain seasons and less at other times, mangoes are more at harvest time in December – January and less at off-harvest time in March -April.

**Step 5. Factors for Enterprise Selection [40 minutes]**

*Facilitate three small groups discussion about the factors for enterprise selection. Give two flip chart sheets to each group and ask them to outline, on the flip chart sheets provided, the factors they would consider to select an enterprise. Instruct each group to pin up their work sheets on the wall. Then put*
all the group members together and go round reviewing the work each group. Ask everyone to feel free to add to the list of the factors written down by the group under review. Then add any of the following factors that might not be outlined through the group discussion. Say the following:

Thank you so much for the work well done. We have however realized that we have the following factors to add to the list of the factors for enterprise selection which you have regenerated. We have the following to add:

I. **Availability of Inputs (factors of production);** the things you use produce a product, e.g.
   - **Land:** includes everything in nature used in production like soil, minerals, etc.
   - **Capital:** includes things used in production that are man-made like cash, equipment, buildings, fertilizers, seeds, pesticides, etc.
   - **Labour:** is the physical energy supplied by humans in the form of workers.
   - **Management:** is the decision making function of the business like, directors, managers, etc.

II. **Cost of production;** it is the money spent on inputs. Very high cost of production hinders investment in some enterprises.

III. **Cultural and religious beliefs;** for instance Muslims and Seventh Day Adventists do not rear pigs.

IV. **Availability of market;** it is any place where sellers and buyers meet to sell and buy goods.

V. **Market price;** it is the amount of money at which sellers are willing to sell and buyers are willing to buy a product. Choose enterprises with a favourable market price.
VI. **Market Demand:** it is the number of buyers of a particular product at a given time. Choose enterprises with a big demand for a long time.

VII. **Market Supply:** it is the amount of a product on the market at a given time. Choose enterprises with a low supply so as to benefit from the monopoly.

VIII. **The relationship between demand and supply:** choose enterprises with high market demand but with low market supply for a long time.

IX. **Profitability:** it is the probability of the enterprise to yield high profits rather than losses.

X. **Relationship between Enterprises, e.g.**

- The enterprises that can be combined to maximize profits like maize growing and grain milling.

- Supplementary enterprises; where one enterprise supplements the income of another like a sports stadium used for concerts, a garden tractor used for transporting harvest to the market.

- Complementary enterprises; where one enterprise produces the inputs for another, for instance cattle keeping producing manure for growing crops, maize growing producing mulch for coffee.

- Competitive enterprises are those where one enterprise interferes with another, for instance enterprises competing for labor resources.

XI. Demand; select enterprises with high market demand in order to maximize profits.

XII. Supply; choose enterprises with less or no supply on the market maximize profits.
Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session 7.1. Review their information intake by asking them to name the main themes discussed during session one.

Say:

You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

Conclude the session by naming the themes as covered in each step of the session. Say:

We have covered:

- Definition of “livelihoods” and “enterprise”
- Definition of “demand” and “supply”
- The law of demand and supply
- The factors that affect demand and supply
- Factors for enterprise selection

Thank you so much.
Session 7.5: The marketing process

Step 1: Introduce “market”, “marketing” and “records” – [20 minutes]

Say the following:

You are all welcome to this learning session on marketing and record keeping. Through the steps in this session we will work to improve on your understanding of the marketing process and record keeping. The following topics will be covered:

- Definition of the words: “market”, “marketing” and “records”
- The marketing process
- Record keeping

Facilitate a plenary brainstorming by asking the large group the following question: What do the following words mean: 1. Market, 2. marketing and 3. Records?

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of “market”, “marketing” and “records”, say

<table>
<thead>
<tr>
<th>Definition of “market”, “marketing” and “records”</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Market</strong> is any place where sellers and buyers meet to sell and buy commodities.</td>
</tr>
<tr>
<td>Whereby; <strong>Marketing</strong> is the process of handling commodities from the moment of production to the moment of selling. And; <strong>Records</strong> are all documents written about the whole process from production to marketing.</td>
</tr>
</tbody>
</table>
Step 2. The Marketing Process (15 minutes)

Say the following:

The marketing process involves the following main activities:

1. **Value addition**: involves processing commodities into more usable forms, e.g. maize grain into maize flour. Value added commodities command higher prices for more profits than raw materials.

2. **Storage of the produce**: this involves sorting commodities into uniform lots and keeping them in safe spaces known as stores until marketing time.

3. **Market identification**: involves finding markets where the commodities can be sold at higher prices for profit maximization.

4. **Transport**: involves transferring the commodities to the market or the buyers.

Step 3. Record Keeping (40 minutes)

Say the following:

Record keeping involves safe custody of all useful documents written about the production and marketing process for future reference. Record keeping has many benefits, for instance:

- Used in determining the profitability of enterprises, i.e. calculating profit or loss
- Can be used to get credit (loan)
- Can help in deciding which enterprises to keep and the ones to drop

**Add by saying that:**

There are many types of records but the following are the basic ones include the following:

1. **Expenditure Account**: this is where you write the monetary value of all the resources spent on production, e.g. hire of land, labour, management, etc.

   It can look like:
Expenditure Account (1st January 2016 – 30th June 2016) for Maize Growing

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Number of units</th>
<th>Unit Cost (Shs)</th>
<th>Total Cost (Shs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/1/2016</td>
<td>Maize seeds</td>
<td>200 kg</td>
<td>2,000</td>
<td>400,000</td>
</tr>
<tr>
<td>2/1/2016</td>
<td>Fertilizers</td>
<td>100kg</td>
<td>3,000</td>
<td>300,000</td>
</tr>
<tr>
<td>3/5/2016</td>
<td>Transport</td>
<td>-</td>
<td>45,000</td>
<td>45,000</td>
</tr>
<tr>
<td>13/1/2016</td>
<td>Labour</td>
<td>2 workers</td>
<td>80,000</td>
<td>160,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>expenditure</strong></td>
<td>-</td>
<td>-</td>
<td><strong>905,000</strong></td>
</tr>
</tbody>
</table>

2. **Income Account**: this is where you write the monetary value of all the products sold, e.g. maize, beans, baskets, etc.

It can look like:

Income Account (1st January 2016 – 30th June 2016) for Maize sold

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Number of units</th>
<th>Unit Cost (Shs)</th>
<th>Total Cost (Shs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2016</td>
<td>Maize</td>
<td>23 bags</td>
<td>80,000</td>
<td>1,840,000</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td><strong>1,840,000</strong></td>
</tr>
</tbody>
</table>

3. **Profit and Loss Account**: this is where you record both expenditures and incomes for the purpose of determining the profitability of the enterprise. It can look like:

Profit and Loss Account of the Maize Enterprise as at 1st July 2016
Congratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session 7.2. Review their information intake by asking them to name the main themes discussed during session one.

Say:

You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

Conclude the session by naming the themes as covered in each step of the session. Say:

We have covered: - The definition of “market”, “marketing” and “records”
- The marketing process
- Record keeping

Thank you so much.
Session 7.6: Strategies for mobilizing resources

Step 1: Introduce “resource mobilisation” – (10 minutes)

Say the following:

You are all welcome to this learning session on resource mobilisation. Through the steps in this session we will work to improve on your understanding of resource mobilisation. The following topics will be covered:

- Definition of the words: “resource mobilisation”
- The strategies for resource mobilisation

Facilitate a plenary brainstorming by asking the large group the following question: **What do you understand by the term “resource mobilisation”?**

Listen to a number of responses from the group. Then write the responses on a flip chart and summarize their ideas as you review each point. By way of concluding the definition of “resource mobilisation”, say

```
<table>
<thead>
<tr>
<th>Definition of “resource mobilisation”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource mobilisation refers to all activities involved in securing new and additional resources for your business.</td>
</tr>
</tbody>
</table>
```

*Explain by saying:*

Resource mobilisation also involves making better use of, and maximizing, existing resources.

Step 2. Strategies for Mobilising Resources (40 minutes)

*Say the following:*

Resource mobilisation is a process that includes doing many things. Among them are the following basic strategies:
I. Resource analysis:
   a. Identify what and how much resources you need to cover the task at hand through activity planning and budgeting. This can be done using a simple template. For example, making baskets can be planned as follows:

   **Plan and budget for basket making (1\(^{st}\) January – 31\(^{st}\) March 2016)**

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Quantity</th>
<th>Unit cost (Shs)</th>
<th>Total cost (Shs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thread bundles</td>
<td>25</td>
<td>5,000</td>
<td>125,000</td>
</tr>
<tr>
<td>Knitting needles</td>
<td>5</td>
<td>500</td>
<td>2,500</td>
</tr>
<tr>
<td>Transport</td>
<td>-</td>
<td>-</td>
<td>15,000</td>
</tr>
<tr>
<td><strong>Total budget</strong></td>
<td>-</td>
<td>-</td>
<td><strong>142,500</strong></td>
</tr>
</tbody>
</table>

   b. Assess what and how much you have at hand by looking at the savings at hand, e.g. Shs 78,000.
   c. Determine what and how much you need to find elsewhere by subtracting the savings at hand from the total budget, e.g. for basket making: 142,500 – 78,000 = 64,500. We need to get Shs 64,500.
   d. Identify where you can get what and how much you need, e.g. a friend, a bank, SACCO.

II. Resource acquisition; you can acquire resources through many ways like fundraising. Fundraising means the activities you do in order to get the resources you need for your business. Fundraising can be done in many ways, e.g.

   - Your own contribution like land, money, labour, management, etc
   - Donations from friends and well wishers
   - Borrowing from a friend
   - Borrowing from a credit facility like a bank, SACCO.
- Writing fundraising letters or proposals

III. **Expenditure management and accounting;** this is possible through proper record keeping as described in session 7.2.

*Conclude by asking the participants for any questions or comments about the discussion of this session.*

*Finally say:*

It is always important for the business person to know and have appropriate strategies for resource mobilisation, otherwise the business fails.

*Conratulate the participants for actively contributing to the discussions of the session. Let them know that this is the end of session 7.2. Review their information intake by asking them to name the main themes discussed during session one.*

*Say:*

You have been very active participants throughout this session, and that has been very encouraging to see that you have a high level of motivation. I would however like to ask you to name the main themes of discussion that we have covered during this session. What have we learnt about; by show of hands?

*Conclude the session by naming the themes as covered in each step of the session. Say:*

We have covered:

- The definition of “resource mobilisation
- The strategies of resource mobilisation
Module 8: Self Care Strategies, Evaluations and Graduation

Introduction

Decades ago, researchers began exploring the rates of emotional and physical fatigue among those whose jobs required attending to the emotional needs of others.

Research by and among those in the human-service professions led to a general understanding of burnout as a feeling of no longer being able to give of oneself.

While all employees are subject to experiencing burnout, it is especially common among teachers, clergy members, health practitioners and caregivers.

People with tendencies to place too-high expectations on themselves also may be more prone to burnout. When carried too far, compulsiveness, perfectionism, and inflated self-confidence can have detrimental impacts on your professional and personal life.

Setting unrealistic goals, thinking anything is possible with the right amount of work, and taking on more than you know you can handle will leave you striving to maintain an intensity that simply cannot be sustained over time.

What is burnout?

Burnout is a physical, mental, and emotional response to constant levels of high stress. In this sense, burnout is a reaction to continuous experience of stress that results in physical, mental, and emotional reactions. The most commonly discussed types of burnout are job burnout and caregiver burnout. Burnout is sometimes confused with stress but the two are different.

What is the difference between stress and burnout (?)

Burnout is not simply excessive stress. Rather, it is a complex human reaction to ongoing stress, and it relates to feeling that your inner resources are inadequate for managing the tasks and situations presented to you. The signs and symptoms of burnout are similar to those of stress, but burnout includes an emotional exhaustion and an increasingly negative attitude toward your work and, perhaps, your life.

What are the stages of burnout?
Burnout has been found to proceed in stages that blend into one another so smoothly that you might not realize what is happening until you are in a state of despair and physical and emotional breakdown.

**Early warning signs of Burn Out**

- Psychosomatic illnesses (psychological/emotional problems which manifest themselves physically)
  - Digestive problems
  - Headaches
  - High blood pressure
  - Heart attacks
  - Strokes
  - Fatigue

**When you are on the verge of burnout, you may feel:**

- Powerless
- Hopeless
- like a candle burning at both ends
- Frustrated
- detached from people and things around you
- Little satisfaction from your work
- bored
- Resentment for having too much to do
- Like a failure
- stuck in a situation from which you cannot extricate yourself
• unsure about your choice of job or career
• Withdrawn, isolated from coworkers and friends
• Insecure about your competence and abilities
• irritable
• anxious

Under prolonged conditions of chronic stress, the body begins the downward progression to burnout.

- You may be unable to sleep or unable to stay awake.
- You might even turn to escapist behaviors such as sex, drinking, drugs, partying, or shopping binges to try to escape from your negative feelings.
- Your relationships both at and outside of work may begin to fall apart.
- Burnout can impair your job performance as well as your health.
- Some people experiencing burnout will feel as if their jobs are no longer interesting or enjoyable.
- They become indecisive, their productivity drops, and their work deteriorates.
- They may not even care about doing a good job and often perform tasks by rote.
- These people feel bored and put-upon, they may dread going to work in the morning, and they may feel envious of others who are happy with their work.
- If you suspect you are suffering from burnout, consider making changes in your life to improve your overall well-being and help you cope better with daily demands.

What causes burnout?

Burnout arises in response to expectations placed upon us, either by ourselves or others. It is common in home or work situations where there are highly stressful demands on our time and energy, or when we feel others are dependent upon us. Most people are stretched thin, concerned about keeping their jobs, and may feel uncertain about the future. The American
Counseling Association notes that job insecurity and changes among and within corporations leave many employees feeling anxious over their inability to control their careers.

**Answer the following questions to explore the possible causes of job-related burnout:**

- **What?** Have you faced changes in the organization, the demands of the job, your supervisor, or the industry?
- **When?** Was there a pivotal occurrence that changed the way you viewed your job - a new boss, coworkers, or responsibilities?
- **Why?** Have you changed? Are your interests or values pertaining to work now different than they were? Has the company's mission changed? Are your abilities and skills not being utilized?

---

**Identifying Burn Out**

- Do work activities you once found enjoyable now feel like drudgery?
- Have you become more cynical or bitter about your job, your boss or the company?
- Are non-work relationships (marital, family, friendships) affected by your feelings about work?

*Do you find yourself:*

- dreading going to work in the morning?
- easily annoyed or irritated by your co-workers?
- envious of individuals who are happy in their work?
- caring less now than you used to about doing a "good job" at work?

*Are you:*

- regularly experiencing fatigue and low energy levels at your job?
If you answered yes to five or more of the above, you may be suffering from job burnout.

Prevention of burnout

To prevent and reduce burnout, you can make the following changes to improve your physical, mental and social well-being.

Physical: Your body's ongoing response to stress wreaks havoc on your physical health. If you think you are experiencing burnout you should:

• See a doctor. Schedule a complete physical check-up with your doctor to discuss your concerns and any symptoms you’ve noticed.
• Sleep. Make sure you are getting the sleep your body desperately needs.
• Eat right. Develop healthy eating habits, including having breakfast and high-protein snacks to help sustain your energy throughout the work day.
• Exercise. Increase exercise by learning stretches that can be done in your office, taking walks during breaks, or beginning a new type of activity, such as any sport.

To address the psychological effects of burnout you can:

• Hone your coping skills. Develop coping skills for dealing with stress including using muscle relaxation techniques, mental imagery and positive self-talk. You might consider finding a professional such as a therapist or life coach to help you hone these skills.
• Arm yourself with self-knowledge. If you are people-oriented, a perfectionist, or have a low level of assertiveness or a strong need for approval, you may be more prone to develop burnout than someone who is authoritarian and task-focused. Understanding your strengths and weaknesses can help you learn better ways to deal with day-to-day stress. For example, if you know you are the kind of person who has difficulty saying “no” without guilt, recognize how this pattern affects
you and consider talking to a professional or respected peer or mentor about how
to avoid taking on more than you can handle.

• Monitor depression. If you have a history of depression, burnout can reactivate it.

• Learn effective time management. To help you develop control over your work and home life,
you might consider taking more time off, scheduling more frequent breaks while at work, or
delegating tasks.

• Set realistic goals. This will add direction, clarity and focus to your life. Establish
personally meaningful goals, divide them into short- and long-term, and establish
a plan for attaining them and setting new ones. Striving, learning and reaching for
new accomplishments will give you a real sense of purpose.

• Put yourself first. Regularly set aside time to be alone and to do something you
enjoy. Ask yourself, “What recharges my batteries?” Maybe you long for time to
read a good novel or to return to a favorite but long-forgotten hobby. Schedule
“me time” into your day or week, and keep the commitment as faithfully as you
would keep a doctor’s appointment.

Social

Although time alone is important, maintaining a balanced life also means spending time
cultivating your relationships with others. Poor relationships can contribute to burnout,
but positive relationships can help prevent or reduce it. Steps you can take to improve
your work and home relationships include:

• Nurturing your closest relationships such as those with your partner, children or friends.
These relationships can help restore energy and alleviate some of the psychological effects of
burnout, such as feelings of being underappreciated.

• Connect with a cause or a community group that is personally meaningful to you. Joining a
religious, social, or support group can give you a place to talk to like-minded others about how
to deal with daily stress. If your vocation has a professional association, you can attend meetings
and befriend others coping with the same workplace demands.

• Address your dissatisfaction at work. Talk to a supervisor to explore options
that may alleviate your stress. Perhaps your job responsibilities can be reviewed or your hours changed to better suit your needs.

- Practice healthy communication. Express your feelings to others who will listen, understand and not judge. Burnout involves feelings that fester and grow, so be sure to let your emotions out in healthy, productive ways.

In summary, to prevent or recover from burnout, learn to cultivate methods of personal renewal, self-awareness, and connection with others, and don’t be afraid to acknowledge your own needs and to find ways to get your needs met. Think of your personal energy in terms of not only energy expenditure, but also energy renewal, and focus on creating a balance in your life. To enjoy a healthy, sustainable life, let your mind, body, and spirit be continuously renewed.
**GSP Appendix**

**Agenda of the Group Support Psychotherapy (GSP) Training Workshop for Primary Health Care Workers in Gulu, Pader, and Kitgum districts in northern Uganda.**

**Day 1**

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00 am</td>
<td>Registration</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>9:00-9:15 am</td>
<td>Welcome, Introductions and Ground rules</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
</tbody>
</table>

**Module 1: Course overview and Introduction to the Training workshop**

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>9:15-9:30 am</td>
<td>Review of training agenda and objectives</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>9:30-10:00 am</td>
<td>Baseline health work survey</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>10:00-10:30 am</td>
<td>Pre-training assessment</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>10:30-10:45 am</td>
<td>Tea-break</td>
<td>Ms. Monica Akello</td>
</tr>
</tbody>
</table>

**Module 2: Introduction to Group Support Psychotherapy (GSP)**

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>10:45-11:15 am</td>
<td>The Background of GSP</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>11:15-11:45 am</td>
<td>The group therapy process</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>11:45-12:00 pm</td>
<td>Roles and responsibilities of the group facilitator</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>12:00-1:00 pm</td>
<td>Practicum on introduction to GSP, session 1</td>
<td>Ms. Paska Ayoo</td>
</tr>
<tr>
<td>1:00-2:00 pm</td>
<td>Lunch break</td>
<td></td>
</tr>
</tbody>
</table>

**Module 3: Depression and HIV/AIDS**

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>2:00-2:10 pm</td>
<td>Definition, categories and causes of depression</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>2:00-2:20 pm</td>
<td>The difference between sadness and depression</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>2:10-2:20 pm</td>
<td>How does depression present</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>2:20-2:30 pm</td>
<td>How is depression diagnosed and treated</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>2:30-2:40 pm</td>
<td>What are the complications of untreated depression</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>2:40-2:50 pm</td>
<td>Relationship between depression and HIV/AIDS</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>2:50-4:10 pm</td>
<td>Practicum on psycho-education</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>4:10-4:30 pm</td>
<td>Tea-break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>4:30-5:30 pm</td>
<td>Practicum on psycho education</td>
<td>Dr. James Okello</td>
</tr>
<tr>
<td>5:30-6:00 pm</td>
<td>Evaluation of day 1 training</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
</tbody>
</table>
Day 2

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00 am</td>
<td>Registration</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td><strong>Module 4: Counseling skills required to deliver GSP</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:30 am</td>
<td>Key counseling skills for group facilitators</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>9:30-10:00 am</td>
<td>Common errors made by group facilitators</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>10:00-10:20 am</td>
<td>Communication in counseling</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>10:20-10:30 am</td>
<td>Self disclosure</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>10:30-10:45 am</td>
<td>Tea –break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>10:45-11:15 am</td>
<td>Sharing personal problems</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>11:15-11:45 am</td>
<td>Group facilitator’s attitudes and values</td>
<td>Mr. Isaac Ogwal</td>
</tr>
<tr>
<td>11:45-12:45 am</td>
<td>Practicum on counseling skills GSP session 3 and 4</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>12:45-1:00 am</td>
<td>Field experiences with GSP sessions 3 &amp; 4</td>
<td>Ms. Alice Kipwola</td>
</tr>
<tr>
<td>1:00-2:00</td>
<td>Lunch break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td><strong>Module 5: Problem solving strategies and coping with stigma</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2:00-2:10 pm</td>
<td>Introduction to problem solving</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>2:10-2:20 pm</td>
<td>Problem solving strategies</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>2:20-2:30 pm</td>
<td>Steps in problem solving</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>2:30-2:40 pm</td>
<td>Negative coping strategies</td>
<td>Mr. Isaac Ogwal</td>
</tr>
<tr>
<td>2:40-2:50 pm</td>
<td>What is Stigma</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>2:50-3:00 pm</td>
<td>Coping strategies for stigma</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>3:00-4:00 pm</td>
<td>Practicum on problem solving and coping with stigma</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>4:00-4:30 pm</td>
<td>Tea –break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>4:30-5:30 pm</td>
<td>Practicum on problem solving &amp; coping with stigma</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>5:30-6:00 pm</td>
<td>Evaluation of day 2 training</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
</tbody>
</table>
Day 3

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00 am</td>
<td>Registration</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td></td>
<td><strong>Module 6: Poverty, depression and livelihood skills</strong></td>
<td></td>
</tr>
<tr>
<td>9:00-9:10 am</td>
<td>Poverty and depression</td>
<td>Dr. Nakimuli Ethel</td>
</tr>
<tr>
<td>9:10-9:20 am</td>
<td>Introduction to basic livelihood skills</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>9:20-10:00 am</td>
<td>Enterprise selection</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>10:00-10:30 am</td>
<td>Record keeping and marketing skills</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>10:30-11:00 am</td>
<td>Tea break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>11:00-11:30 am</td>
<td>The marketing process</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>11:30-12:00 pm</td>
<td>Strategies for mobilizing resources</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>12:00-12:10 pm</td>
<td>Field experiences on livelihood sessions</td>
<td>Ms Paska Ayoo</td>
</tr>
<tr>
<td>12:00-1:00 pm</td>
<td>Practicum on Enterprise selection &amp; resource mobilization</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>1:00-2:00 pm</td>
<td>Lunch break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>2:00-3:00 pm</td>
<td>Practicum on creating a simple business plan</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>3:00-4:00 pm</td>
<td>Presentation of business plans</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>4:00-4:30 pm</td>
<td>Tea break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>4:30-5:30 pm</td>
<td>Presentation of business plans</td>
<td>Mr. Kizito Wamala</td>
</tr>
<tr>
<td>5:30-6:00 pm</td>
<td>Evaluation of day 3 training</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
</tbody>
</table>
## Day 4

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00 am</td>
<td>Registration</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td><strong>Module 7: Essential coping strategies to overcome depression</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:10 am</td>
<td>What is coping?</td>
<td>Mrs Gloria Abura</td>
</tr>
<tr>
<td>9:10-9:30 am</td>
<td>Positive coping strategies</td>
<td>Mrs Gloria Abura</td>
</tr>
<tr>
<td>9:30-10.00 am</td>
<td>Positive thinking to overcome negative thinking</td>
<td>Mrs Gloria Abura</td>
</tr>
<tr>
<td>10:00-10:30 am</td>
<td>Coping with excessive worries</td>
<td>Mrs Gloria Abura</td>
</tr>
<tr>
<td>10:30-11:00am</td>
<td>Tea break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>11:00-11:20 am</td>
<td>Negative coping strategies</td>
<td>Mrs Gloria Abura</td>
</tr>
<tr>
<td>11:20 – 11:30 am</td>
<td>Field experience with GSP</td>
<td>Ms Alice Kipwola</td>
</tr>
<tr>
<td>11:30-01:00 pm</td>
<td>Practicum on effective coping strategies, GSP 5</td>
<td>Ms Alice Kipwola</td>
</tr>
<tr>
<td>1:00-2:00 pm</td>
<td>Lunch break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>2:00-4:00 pm</td>
<td>Practicum on effective coping strategies, GSP 5</td>
<td>Mrs Gloria Abura</td>
</tr>
<tr>
<td>4:00-4:30 pm</td>
<td>Tea break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>4:30-5:30 pm</td>
<td>Evaluation of day 4 training</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
</tbody>
</table>
Day 5

<table>
<thead>
<tr>
<th>Time</th>
<th>Training Activity</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30-9:00am</td>
<td>Registration</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td></td>
<td><strong>Module 8: Emotional self care</strong></td>
<td></td>
</tr>
<tr>
<td>9:00-9.30am</td>
<td>Introduction to Emotional Self-Care</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>9:30 -10.30am</td>
<td>Emotional Self-Care strategies</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>10:30-11:00am</td>
<td>Tea break</td>
<td>Ms. Monica Akello</td>
</tr>
<tr>
<td>11:00-11:30am</td>
<td>Post-training assessment</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>11.30-12.30pm</td>
<td>Training workshop evaluation</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>12.30-1:00pm</td>
<td>Field Practical GSP sessions</td>
<td>Dr. Ethel Nakimuli</td>
</tr>
<tr>
<td>1:00-2:00 pm</td>
<td>Lunch break &amp; Closing</td>
<td>Ms. Monica Akello</td>
</tr>
</tbody>
</table>
Module 2 Practicum

Practicum on introduction to Group Support Psychotherapy

Role Play of GSP session 1

- Divide participants into small groups and give each a flip chart or flip chart sheet.

- Their task is to plan how they would conduct the Introductory session of group support psychotherapy with a group of 8-10 individuals with HIV and depression.

- After 15 minutes of discussion a group should elect 2 persons to demonstrate how to facilitate the introductory session of group support psychotherapy.
Module 3 Practicum

Practicum on psycho education, GSP, session 2

- Divide participants into small groups and give each a flip chart or flip chart sheet.

- Their task is to plan how they would conduct psych-education on depression to a group of 8-10 individuals with HIV and depression.

- After 15 minutes of discussion a group should elect 2 persons to demonstrate how to conduct psych education on depression and HIV.

HIV medications can also have side-effects that can cause depression

<table>
<thead>
<tr>
<th>HIV Medication</th>
<th>May trigger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interleukin</td>
<td>Depression, disorientation, confusion and coma</td>
</tr>
<tr>
<td>Steroids</td>
<td>Mania or depression</td>
</tr>
<tr>
<td>Efavirenz (Sustiva)</td>
<td>Decreased concentration, depression, nervousness, nightmares</td>
</tr>
<tr>
<td>Stavudine (Zerit, d4T)</td>
<td>Depression or mania, asthenia</td>
</tr>
<tr>
<td>Zidovudine (Retrovir, AZT)</td>
<td>Mania, depression</td>
</tr>
<tr>
<td>Interferon</td>
<td>Neurasthenia fatigue syndrome, depression</td>
</tr>
<tr>
<td>Zalcitabine (Hivid)</td>
<td>Depression, cognitive impairment</td>
</tr>
<tr>
<td>Vinblastine</td>
<td>Depression, cognitive impairment</td>
</tr>
</tbody>
</table>
HEALTH TALK ON DEPRESSION

Good morning ladies and gentlemen,

This morning, I am here to talk to you about a disease that affects our feelings, our thinking and our behavior. Have you ever found yourself in a situation where you no longer enjoyed the things that you used to enjoy? For example, you enjoyed going to work in your garden or office but now, you don’t, you enjoyed spending time with friends and family, but now you don’t. On top of that, you no longer enjoy the food you eat, you start to lose sleep at night, you lay in your bed thinking and worrying. In addition, you lose your energy. You have to drag yourself to work, you have difficulty in concentrating on your work and you feel tired before getting any work done.

If you are in this situation you have signs and symptoms of a disease condition known as depression. Without the appropriate timely evaluation and intervention, these symptoms will intensify and gradually become unproductive at work, at home and in your community, feel useless, worthless and hopeless. When you lose hope, you see no need to provide for your family, or to send your children to school. If you happen to have any chronic condition that requires medications for life, you see no need to take these medications. In the worst case scenario, you will resort to excessive use of alcohol and /or illicit drugs or you may take your own life.

There are so many people around the world (350 million people) in this situation we refer to as depression. Seventy-five percent of sufferers are likely to be living in resource-poor areas, and 85 percent of these people are unlikely to be receiving any treatment.

Among persons in with HIV /AIDS, research has shown that 1 in three have this disease and it interferes with their ability to take their anti-retroviral therapy.

Have you at any time found yourself in a similar situation? Do you have excessive worries, poor sleep, reduced energy, loss of interest in your work? Do you find yourself getting tired before getting any work done? Have you lost your job or failed to work in your garden because you have no energy? Do you find yourself feeling worthless and thinking that death is the only way out? OR do you wish you could go to sleep and never wake up? Do you find yourself drinking alcohol every day, from morning to evening so that you can cope with problems in your life?

If the answer to these questions is yes, you might be suffering from depression. Please come to us for further evaluation.
### SELF REPORTING QUESTIONNAIRE (SRQ-20) FOR MALES
Tick YES or NO in the boxes against the picture.

<table>
<thead>
<tr>
<th>No.</th>
<th>ITEM</th>
<th>MALES IMAGE</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Do You Often Have Headaches</td>
<td><img src="1.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Is your appetite poor?</td>
<td><img src="2.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do you sleep badly?</td>
<td><img src="3.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Are you easily frightened?</td>
<td><img src="4.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Do your hands shake?</td>
<td><img src="5.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Do you feel nervous, tense or worried?</td>
<td><img src="6.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Is your digestion poor?</td>
<td><img src="7.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you have trouble thinking clearly?</td>
<td><img src="8.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you feel unhappy?</td>
<td><img src="9.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you cry more than usual?</td>
<td><img src="10.png" alt="Image" /></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Question</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you find it difficult to enjoy your daily activities?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you find it difficult to make decisions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Is your daily work suffering</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Are you unable to play a useful part in your life?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Have you lost interest in things</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Do you feel like you are a worthless person?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Has the thought of ending your life been on your mind</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Do you feel tired all the time?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Do you have uncomfortable feelings in your stomach?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Are you easily tired?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Module 4 Practicum

Practicum on counseling skills

Active Listening Activity
Instructions:
• In small groups, let participants read over the scenario below:
• Discuss any observations you have about this communication.
• Given the skills you have learnt today, how would you respond if you were Agnes?

Scenario # 1
Marie –“I am so tired and worn out today, I don’t think I’ll be able to spend time with you after work today as we planned. Sorry.”

Agnes—“OK, that’s fine. Maybe we can get together next week. I had a busy day too.”
## TYPES OF RECORDS

### Expenditure Account (1st January 2016 – 30th June 2016) for Maize Growing

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Number of units</th>
<th>Unit Cost (Shs)</th>
<th>Total Cost (Shs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/1/2016</td>
<td>Maize seeds</td>
<td>200 kg</td>
<td>2,000</td>
<td>400,000</td>
</tr>
<tr>
<td>2/1/2016</td>
<td>Fertilizers</td>
<td>100kg</td>
<td>3,000</td>
<td>300,000</td>
</tr>
<tr>
<td>3/5/2016</td>
<td>Transport</td>
<td>-</td>
<td>45,000</td>
<td>45,000</td>
</tr>
<tr>
<td>13/1/2016</td>
<td>Labour</td>
<td>2 workers</td>
<td>80,000</td>
<td>160,000</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>905,000</strong></td>
</tr>
</tbody>
</table>

### Income Account (1st January 2016 – 30th June 2016) for Maize sold

<table>
<thead>
<tr>
<th>Date</th>
<th>Item</th>
<th>Number of units</th>
<th>Unit Cost (Shs)</th>
<th>Total Cost (Shs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/1/2016</td>
<td>Maize</td>
<td>23 bags</td>
<td>80,000</td>
<td>1,840,000</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td></td>
<td></td>
<td></td>
<td><strong>1,840,000</strong></td>
</tr>
</tbody>
</table>

**Profit and Loss Account of the Maize Enterprise as at 1st July 2016**
Plan and budget for basket making (1st January – 31st March 2016)

<table>
<thead>
<tr>
<th>Requirements</th>
<th>Quantity</th>
<th>Unit cost (Shs)</th>
<th>Total cost (Shs)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thread bundles</td>
<td>25</td>
<td>5,000</td>
<td>125,000</td>
</tr>
<tr>
<td>Knitting needles</td>
<td>5</td>
<td>500</td>
<td>2,500</td>
</tr>
<tr>
<td>Transport</td>
<td>-</td>
<td>-</td>
<td>15,000</td>
</tr>
<tr>
<td>Total budget</td>
<td>-</td>
<td>-</td>
<td>142,500</td>
</tr>
</tbody>
</table>

Module 5 Practicum

Practicum on problem solving skills and coping with stigma

Mr. X is 41 year old man living with HIV 6 months ago he lost his wife. He now has three children to take care of. He feels very sad and lonely and feels he has no future. His energy has reduced. He can no longer work in his garden. He does not have school fees for his children. No money to buy food. He has heard neighbors refer to him as a moving corpse. Now he is afraid to go out of his house.

In small groups, of 3 or 4 discuss Mr. X's problems. Using the skills, you have learnt, how can you assist Mr. X
Types of depressive thinking.

- Let us consider this example: An HIV positive man/woman says “I cannot do anything now. I am just a cripple, there is really no point. Nothing I do seems worthwhile. I am going to die anyway.”

How to identify depressive thoughts: Let us identify the different negative thoughts in this statement:

- **I cannot do anything now**

  **All or nothing thinking**

  You see the world in extremes eg. entirely healthy or totally ill. Gradual improvement is not enough

- **I am just a cripple**

  **Labeling**

  Labeling involves talking to yourself harshly and calling yourself insulting names

- **There is really no point. Nothing I do seems worthwhile**

  **Over generalizing**

  You may think that if you fail the first time, you’ll fail every time.

- **I am going to die anyway.”**

  **Fortune-telling**

  You feel as though you know what the future will bring, and it’s negative
Depressive Thinking can affect the way you feel, your physical state and actions as illustrated below:

- Our minds generate depressive thinking in stressful situations.
- Take the following steps to manage depressive thoughts during stressful situations:
  - **Step 1**: Remind oneself that they are caused by the difficult situation you are going through.
  - **Step 2**: Replacing depressive thoughts with realistic thoughts by asking oneself some reality questions.
    - Can I get more evidence by asking someone else about this situation?
    - What is a more encouraging and useful way of thinking?
  - **Step 3**: Repeat this realistic thinking over and over until it becomes automatic.
  - **Step 4**: Talk back to depressive thinking. For example if a thought comes: I am a cripple. Talk back I am not a cripple.
  - Every time you talk back you make depressive thinking weaker and the realistic thinking stronger.
Coping with excessive worries

Having a chronic health condition such as HIV/AIDS leads to various problems that may cause you to worry. You may worry whether the condition will become worse, whether you will be able to keep working and look after your family and whether the pain or discomfort will intensify. When worry becomes too much, it will cause more harm than good.

Let me explain more using this diagram

(Ask a volunteer to draw the boxes shown in the diagram on the flip chart under your guidance).

Excessive worrying:

Emotions: anxiety/fear

Physical state: ↑muscle tension, ↑headaches, ↑rapid shallow breathing

Situation: Health condition worsens, financial problems, relationship loss/conflict

Actions: Not relaxing, social withdrawal, excessive focus on poor health
Take the following steps to manage excessive worries when we are going through tough situations.

**Step 1: Identify your worries**

Excessive worries can be recognized by at least one of these features (symptoms of excessive worry):

5. You think *too much* about a problem, to the point that it interferes with other activities such as spending time with family or friends, enjoying entertainment or concentrating on your work.
6. You imagine the *worst possible outcome* of the problem, you magnifying the negative possibilities and ignoring any possible positive outcomes. This kind of thinking is known as “catastrophizing.”
7. Physically, you will feel sick with pain in muscles, palpitations fast breathing, headache, stomach problems, unable to sleep etc.)
8. Emotionally, you will be filled with fear and always feeling as if something bad is going to happen to you.

**Step 2: Challenge your Worry Thoughts**

Can I get more evidence by asking someone about this situation? It’s often helpful to get another person’s opinion about the situation.

- For example: you’ve been worrying constantly that your health will keep getting worse – so you speak to the clinic nurse, who informs you that most people with your health condition are able to stabilize their symptoms.
- Would most people agree with this thought? If not, what would most people think?
- Imagination: imagine how most people will react to a worry thought, this can help you to come up with a more fair and realistic way of thinking
- What would I say to a friend, if my friend were in a similar situation?

It’s likely that you would be able to help her think about the situation more fairly, looking at it in a more balanced way. You might remind your friend of tough situations she handled in the past. You might find it easier to think in a realistic way for a friend than for yourself.
Step 3: Replace your worry thoughts with realistic ones)

Think of a situation about which you’ve been worrying. First, make a brief note about the situation. Second, write down the Worry Thoughts that were making you anxious.

Third, think about the situation and try to come up with more calming and realistic thoughts, using the Reality Questions below.

Examples of reality questions. When you step outside yourself and examine your thinking from another perspective, it’s easier to see how your thoughts might be distorted.

Step 4: Practice Calming and Realistic Thinking

It’s not enough to come up with a calming and realistic thought just once. When you find yourself in stressful situations, deliberately practice calming thinking. Don’t assume that it will happen on its own. Talk back to the worry thinking. Don’t allow excessive worry to occur without replying to it. Every time you talk back, you make the worry thinking weaker and the realistic thinking stronger. Eventually, realistic thoughts will have more influence over you than Worry Thoughts.

- For example: You may think: My illness is more serious than my doctors realize
- Realistic thought: There is a high chance that my illness is not serious, in fact, I will get better. Repeat this thought over and over.
- Realistic thinking can be termed as truthful thinking. It is acquired by repetition over time, and once it is acquired one can accept the realistic thoughts naturally.

Step 5: Schedule Worry Time

It is helpful to schedule a particular time during the week when you can concentrate on worrying about your problems than trying to stop thinking about them through scheduling worry time, one is able to compartmentalize bad events and keep them from affecting all areas of life. In this way one parks his/her worries for a time, and thereby gets distracted from them and thinks about something else, and focus on the job/tasks at hand
Practicum on essential coping strategies for depression

- A health worker has cared for a woman in her Health Center for several years, providing her with care, which has included all her pregnancies and her 3 young children. The health worker has developed a positive relationship with this patient and looks forward to interacting with her when she comes to the facility for care. The health worker sees her often for her prenatal checks, since the woman is now pregnant again.

- One morning, the health worker comes into work and is informed by her co-worker that this patient suffered birth complications last night (post-partum hemorrhage) and died. Although the health worker knows that she will be exposed to death at times in her job, this loss hits her very hard. The health worker knows that this death is going to be extremely difficult for her to cope with.

1. What do you think this health worker might be going through right now physically and emotionally?
2. What do you think this health worker might do to cope with the loss and feel better?
3. Allow participants to discuss how she might be feeling physically as well as emotionally and ways in which this health worker may cope