

# Training psychosocial counselling in Nepal: content review of a specialised training programme

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*This paper describes the training of psychosocial counsellors as conducted by the Centre for Victims of Torture, Nepal. Both the proceedings of the training and the content are described. For clarity purposes a division is made between that part of the training in which skills are taught that can be used with more frequently encountered problems and that part of the training that deals with problems requiring a more specialised approach, such as HIV AIDS.*

**Keywords:** problem-solving therapy, counselling training, HIV AIDS counselling, holistic care.

## Counselling in Nepal

Attention to psychosocial counselling as part of rehabilitation programmes for vulnerable and trauma-exposed groups is relatively new in Nepal. Although many organisations have, by name, included such service within their programmes, these programmes rarely correspond to the common notion of what psychosocial counselling should be (UNICEF, 2000), because the assistance provided is limited to the provision of advice and information. Nevertheless, the existence of such practices indicates a need or desire for forms of assistance that focus on psychological well-being. In response to a growing need for skilled counsellors, there is a growing need

for adequate training programmes that deliver them. Many mental health problems exist in Nepal, especially among vulnerable populations (e.g. torture survivors, refugees, youth affected by armed conflict, trafficked girls and women) and adequate assistance is not available (Shrestha et al., 1998; Tol, 2002; Van Ommeren et al., 2002; Jordans, 2001; Thapa et al., 2002; Robertson, 2001). Human rights abuses have increased significantly, due to the present conflict situation in Nepal (Amnesty International, 2002a, 2002b).

The approach for training psychosocial counsellors as conducted by the Centre for Victims of Torture, Nepal (CVICT) is new for Nepal, as previous counselling training courses were typically short-term, mainly theoretical, and did not include supervised practice (van Ommeren et al., 2002).

The most important aspect of this medium-term (generally 4 months) skill-based approach is that it combines minimal classroom teaching with extensive supervised practice, which makes it an efficient training method. Our experience of CVICT is that short-term training programmes in psychosocial interventions tend to have very limited impact (Jordans et al., 2002).

A substantial part of the training programme is based upon incorporating the

knowledge gained during case discussions following placements of trainees with different organisations.

### **Proceedings of the training**

The theoretical background of CVICT's approach and future implementation of the programme is described in more detail elsewhere (Jordans et al, 2002). Counselling as taught by CVICT involves two main components, namely (1) providing emotional support, and (2) assisting with problem solving. The former is to be achieved mainly through communication, listening and counselling skills and the counsellor's attitude (e.g. empathy, attention, acceptance, encouragement). The latter refers to a counselling process that clarifies the problem, identifies what the client wants as outcome, assists the client in finding and implementing strategies to achieve the desired outcome, thereby resolving or reducing the impact of the identified problem situation. Counsellors are (also) taught to work with the positive qualities of the client and/or in the client's situation, which include personal strengths, finding positive aspects to his/her problem-story, finding exceptions to the problems, finding positive elements in his/her life and focusing on positive social and cultural support systems.<sup>2</sup>

Furthermore, the psychological assistance is embedded within holistic care. Counselling is clearly only one element of overall care. Though the emphasis in counselling lies on helping the client with alleviating distress directly through the counselling sessions, it acknowledges that other agents of care are vital in recovery or healing, namely the family and other community structures (such as the school, women's groups). Such primary agents of care should be the fundament of the care pyramid. Nevertheless, one needs to simultaneously plan interven-

tions for a certain percentage of the experienced problems that cannot be dealt with at this basic level but do not directly need specialised care either (the top of the care pyramid; doctors, psychiatrists, psychologists). It is exactly between these two levels that the training programme aims to put care interventions in place. Albeit, as discussed earlier, in a holistic and multidisciplinary manner. 'Psychosocial' means that the approach followed is one that focuses, from this programme's perspective, on psychological well-being and/or mental health, which entails the emotional, cognitive and behavioural stability of the individual. Secondly, it emphasises the social environment of the clients in terms of understanding the problem situation as in terms of problem solving too (e.g. in terms of social connections and support). Thirdly, it entails working from the significance and appropriateness given by existing culture and values (the Psychosocial Working Group, 2002).

Any such work needs to be conducted on the basis of the 'institutionalisation' of counselling through guidelines for quality of care, best practice experiences, codes of conduct, accreditation and certification.

Finally, we emphasise the essential process of adapting the training programme according to the existing sociocultural setting. At CVICT we encompass these adaptations in our training courses. Some practical examples can be found in box 1 below.

### **Structure of the training**

CVICT's four-month training programme starts with a two-week core training, followed by approximately 4 cycles of alternated practical placements and further training sessions. Placements entail that the trainees go to a local organisation, which helps people prone to psychosocial prob-

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lems. During the placement, trainees practice their counselling skills under clinical supervision. Additionally, the training programme provides the participants with the opportunity to go through learning therapy in order to understand the intervention and themselves in relation to such intervention. At the time of writing, CVICT is in the

### **Box 1: Examples of Cultural Adaptations for Counselling in Nepal**

*This box describes how the training programme, the trainees and CVICT make counselling culturally appropriate, and is the result of two specific training sessions on culture and counselling as well as practical experiences of CVICT counsellors and participants' placements.*

- *In comparison with therapy in the West, questions are generally asked more indirectly, some topics even being avoided altogether because of cultural inappropriateness (e.g. sexual issues in certain instances).*
- *Counsellors use a way of questioning that is culturally adapted, namely the EMIC Clinical History and Explanatory Model (Weiss, 1997) questionnaire. These are open questions that encourage the client to express the problem situation from his/her own explanatory model and perception.*
- *Counsellors in Nepal are possibly more attuned to issues related to the client's prestige within the family structure and/or the community. It is considered very important that the client never loses face.*
- *Traditional forms of healing tend to be encouraged and psychosocial counselling is seen as a parallel form of treatment that is given in response to the client's need and wish.*
- *Overall, challenging as a counselling skill is less common in a Nepalese counselling setting than in a Western counselling setting. Specifically, counsellors in Nepal consider it important not to directly challenge statements on intimate relationships (e.g. 'my marriage is great'), even if they have the impression that the statement is not correct and constitutes part of the problem situation.*
- *Open expression of emotions generally happens later in the counselling process (as opposed to a Western therapeutic setting where the open expression of feelings is quite commonly the starting point). This is related to a tendency, in Nepal, to emphasise positive events and feelings and, initially, to hide the negative ones. The counsellors react to these tendencies accordingly.*
- *Attribution of problems, in Nepal, is often external (luck, god, Karma, position of the stars, etc). This is followed by the counsellors, who generally put less emphasis on self-reflection and internal locus of control that is so common in a Western therapeutic relationship.*
- *In Nepal, counselling an older person makes a difference, in that the counsellor will show more respect, since an older client might be reluctant to share his/her thoughts with a younger counsellor.*
- *Obviously, the problems experienced by people in Nepal and by people in the West are different, due to social, cultural and economic differences. Specifically, it is noticeable that in Nepal, many clients seek help with physical/psychosomatic complaints, which in turn are often relieved by dealing with psychological distress.*
- *Generally speaking, Nepal has many 'taboo topics' (e.g. homosexuality) to which the counsellors are sensitive. This is arguably more so than in a Western setting.*
- *Abstract methods, activities and thinking as part of the counselling process is less adequate in Nepal, as these are not as much part of the educational system in Nepal as in the West.*
- *An informal introduction to any counselling session is essential before turning directly to counselling issues, in contrast to almost instant issue-related conversation in a Western counselling session.*
- *Having said all the above it is generally felt that psychosocial counselling as trained and conducted within CVICT and this programme is very much possible within a Nepalese setting.*

process of conducting its 9<sup>th</sup> such programme, thereby training 97 counsellors. This includes postgraduate-level psychologists as well as paraprofessional NGO staff. Priority is also given to the practical issues of implementation within the community setting after the training. This means that counsellors are trained how to set up a counselling centre (e.g. filing system, creating a client-friendly setting). They are stimulated to work directly with relevant people in the community, for example, primary agents of care, community leaders, community health workers and traditional healers, to create awareness about psychosocial well-being. In this way potential clients can be detected and referred, thus avoiding re-victimisation or re-traumatisation.

The training is followed up by continued clinical supervision and refresher training courses.

### Training methods

As the training programme is skill-based it demands practical methods of teaching. Throughout the course the following methods are used:

*Role-plays* are considered the most important training tool to understand and learn the skills and concepts that form the fundamentals of psychosocial counselling. The structure of using role-plays is changed. At times 'group role-plays' are conducted, which entails that one person is the client and all the participants the counsellors, turn by turn. This method is useful for obtaining an overview of all of the participants' functioning, as well as an opportunity for them to learn from each other, especially as the role-plays are being discussed, during or afterwards. For the same reasons, though with more focus on individual performance, we conduct 'individual role-plays in front of the larger group' (who are asked to

be active observers). Thirdly, at times the participants are asked to sit in pairs to role-play with each other, with a third participant taking the role of an observer.

*Group-work* is done frequently as it activates individuals and stimulates general discussion, which is especially useful in building on existing experience, knowledge or ideas. As a rule, group work promotes *brainstorming* among participants to clarify concepts important to counselling.

*Supervision* takes place daily during placements. *Case discussions* are the core activity of the supervision meetings, where participants have the opportunity to share and analyse the cases they are currently dealing with. The trainer facilitates the discussion through a case discussion format that focuses on the client's situation and problems as well as on the counselling goals and the counsellor's concerns and feelings.

*Lectures* are used as little as possible as we believe it is not the ideal method in a training programme that focuses on learning skills. At the same time, focused lectures are considered useful in introducing new skills, concepts or theoretical frameworks (e.g. what is empathy, self-esteem, sexuality). Generally, such topics are explained through combining lectures and group work.

*Exercises* are used for different reasons, for example, creating awareness by exploring oneself as a service provider, providing an example function by doing exercises that focus on participants' personal experiences or problems, revitalising attention by doing relaxation exercises or energisers and practising communication skills, or asking the participants to respond to a certain client statement with a relevant communication skill.

*Videotaping participants' counselling sessions* as a training tool is used occasionally, both of role-plays and with real clients, always with

client's and organisation's permission, through a counselling room equipped with an installed camera. These videos are then analysed in the entire group, to discuss the skills and process and thereby serve as an observational learning tool.

*Learning therapy* entails that trainees are encouraged to go through counselling sessions themselves (with more experienced counsellors), aiming to provide a model intervention as well as to create personal awareness and self reflection. This increases the trainee's understanding of themselves within a counselling process and what it is like to be a client

### **Content of the training: the common module**

The strategy for the vast majority of psychosocial problems is problem-solving therapy (also known as problem-management counselling, Egan, 1998). This form of counselling is used for a wide range of problems, some of which can be classified as mental disorders, such as ICD-10 depression and anxiety. However, most frequently presented problems by clients are social problems (e.g. loneliness, stigma, conflicts, marital problems), emotional problems (fear, feeling unsafe, worries, sadness, feeling humiliated, anger), and behavioural problems (sleep difficulties, passivity, aggressive behaviour). The topics presented in the common module are depicted in Box 2.

The process that counsellors are taught to generally follow in order to manage these psychosocial problems is described below.

Firstly, the counsellors are taught to *identify* people and behaviours that could be helped by psychosocial counselling. This is done by providing profound knowledge of: (a) what type of problems might emerge which could be helped by these interventions, (b)

what the role of the counsellor is in the process of helping to match the presented or identified problems with an intervention, (c) intake criteria such as: presentation of problem or dissatisfaction, an expressed need for such assistance, emotional imbalance, disabled daily functioning due to psychosocial stress, and (d) the difference between psychosocial problems relevant for counselling and problems that need to be managed by specialists (e.g. psychiatrists, psychologists).

Secondly, when it is decided, on the basis of the initial identification, that counselling should be initiated, and if the client wishes to continue, the counsellor is taught to start with a thorough *introduction* of the intervention. Most people in Nepal have no clear idea of how talking with a counsellor could help. Instead they expect to be helped more directly through medicine or advice, for example. Thus the purpose of counselling needs to be explained. This is essential to reduce false expectations. Quite an extensive informal introduction is needed in the Nepalese counselling setting, which also serves to *build rapport*.

Thirdly, when the problem situation is presented by the client, the counsellor is taught to explore the problem situation (*assessment*), and to understand the problem from the client's perspective and context. Western textbooks often focus on the importance of assessing psychopathology, the client's current life setting, personal history, and family history. Even though all of these areas are important, at CVICT counsellors are encouraged to pay special attention to understand what medical anthropologists call *illness experience* (Kleinman, Eisenberg, & Good, 1978). Illness experience includes the perception of the causes, nature, severity, and con-

**Box 2. List of topics in the common module****Understanding psychosocial counselling**

- What is counselling and why counselling
- Principles of counselling
- Counselling approach/ psychosocial approach/ holistic approach
- Process of counselling

**Being a counsellor**

- Self-awareness (me-map, self drawing, personal strength and weaknesses, values)
- Functions and roles of a counsellor
- Ethics of counselling

**Understanding psychosocial problems (identification, symptoms)**

- Target groups related problems (e.g. bereavement for armed conflict, stigmatisation for torture)
- Nepalese words for feelings/ idioms of distress

**Performing psychosocial counselling***Basic skills*

*Basic communication skills (reflection of feelings, questioning, paraphrasing, restatements, summarising – empathy)*

*Goal setting*

*Brainstorming*

*Working with coping strategies*

*Assessment skills*

*EMIC*

*Positive assets search (personal strength inventory, social support mapping, cultural strength mapping)*

*Documentation*

*Advanced skills*

*Alternative tools for counselling (role-play, drawing, play, journal writing etc)*

*Advanced Communication Skills (psycho-education, self disclosure, feedback, challenging)*

*Handling reluctance*

**Knowledge about mental health problems (identification, symptoms)**

- Suicide and depression
- Introduction to general mental health (depression, anxiety, psychosis, substance abuse)
- Cultural psychopathology

**Specialized or additional topics**

- Child development, child rights, child needs
- Culture and counselling
- Focusing on the core problem
- Group counselling
- Medically unexplained somatic complaints
- Trauma and trauma treatment
- HIV AIDS and counselling
- Task oriented counselling
- Sexuality
- Self Esteem
- Case management/ referral

**Additional training components**

- Establishing counselling centres
- Community training preparation

sequences of the illness by the client and the community, as well as the client's reasons for seeking help, and expected outcomes.

Counsellors are taught to *follow the client's perspective* when helping. For example, the client that has gone through a traumatic event, but actually only complains about the daily problems that she/he is experienc-

ing (whether or not as a result of the traumatic event), will be helped for the present-ed complaints rather than mainly focusing on resolving emotions related to the traumatic event. Having said that, at times the counsellor will use her/his clinical knowl-edge to probe for certain information, or will help in a certain way (e.g. after the

daily problems are dealt with or cannot be dealt with, focusing on the actual traumatic event might be found necessary). But this is never the starting point. Besides the usual assessment techniques such as forms, observation and interview, the training gives emphasis to the use of: *problem statements* (mutually agreed formulations of the problem situation) and *focusing on the core problem* (identifying and dealing with the underlying causes of the problem situation as opposed to merely dealing with the presented problems).

Fourthly, counsellors are taught how to identify what the client wants from the intervention. This should result in:

1. one or more realistic, specific and relevant goals (through goal-setting skill);
2. identification of future opportunities (through future-oriented probes);
3. prioritising the goals according to importance according to the client's needs.

This serves two purposes: to reduce false expectations that the client might have regarding the intervention, and to give the counselling process a clear direction and target, which might enhance motivation, clarity and sense of achievement. In Nepal this has proven to be a challenging skill to teach and a challenging step to implement. This approach seems to be foreign to many Nepalese students, who have described it as too straightforward.

Fifthly, counsellors are taught to actually help the client deal with problem situations, by working towards achieving these set goals. This could be assisting in problem solving, reducing the problem situation, reducing the impact of the problem situation or providing emotional support. This entails that the counsellors are taught to assist the client by

1. stimulating the client to think about solutions or strategies to change the problem situation,
2. exploring the consequent advantages and disadvantages of these solutions and strategies,
3. strengthening the client's constructive coping behaviours and modifying the destructive ones,
4. working from an understanding of the client's social support system as well as other resources (e.g. cultural/spiritual),
5. setting up a plan of action (e.g. linking a possible strategy to a timeframe).

Furthermore the counsellors are taught to use some additional techniques, for example brainstorming as an idea stimulation technique, reattribution through psychoeducation, relaxation exercises as symptom management, journal writing as monitoring exercise, and role-playing as practice for social issues.

Sixthly and finally, counsellors are taught how and when to terminate the counselling process. The guidelines given to the counsellors are:

1. discuss the reasons for stopping (e.g. due to circumstances, because the problem is solved or goals achieved, due to lack of progress or change or dissatisfaction, due to problems related to the counsellor-client relationship),
2. give an overall summary of the counselling process, including main themes and changes,
3. discuss the transition period, and how to implement and/or generalise the changes outside the counselling setting,
4. give feedback on the client's inputs and progress (Jordans et al, 2001).

*Children.* The process described above is taught as such for young people as well,

although counsellors are made aware that counselling young people needs many adaptations and additional techniques. This starts with having an understanding of child and adolescent development, rights and protection issues as well as the difference in interactions. In addition to the problem solving approach described above, counsellors are taught to use task-oriented counselling for young people (which entails formulating simple tasks that could change the present situation and implementing these). Especially with younger children,

the counsellors learn to use less verbally oriented techniques such as play, sentence completion and drawing. These techniques can be used for assessment purposes and as a means to express, communicate, understand or handle emotions, events or problems. They have been adapted to what was found culturally valid and feasible for this level of training and range of problems.

When using drawings, the children are asked to draw a specific situation (relevant to the reason for intake) and the drawing is then used as a tool for dialogue and further exploration through more specific drawings.

When using play, the child is encouraged to create a story. The counsellor recognises relevant themes in the child's play and directly or indirectly encourages the child. In addition, the counsellor verbalises the child's play and expresses his impressions of the emotions and thoughts of the child (as opposed to questions that might distract the child from the actual play) (Jordans et al., 2001).

The sentence completion tool<sup>3</sup>, in which the child is asked to complete sentences that might be emotionally charged, has been found very useful in Nepal. It serves as an assessment tool to identify possible emotional or critical issues and at the same time as a way to initiate conversation about certain topics.

In general, it is found that concrete tools are highly useful, both for the children, as is generally recognised in child psychology, but also for the counsellors, as it gives them concrete tools to engage in the process of assistance. Among Nepalese counsellors-in-training this is especially true, as it concerns more tangible materials or interventions, which in turn increases the counsellors' feeling of capability. Moreover, with respect to

### **Box 3: case example**

*Client: A 16-year old Nepalese adolescent, trafficked to India and repeatedly sexually abused, feels extremely lonely, often has nightmares, feels hopeless and has recurrent thoughts of suicide.*

*Training: During the daily supervision meeting one trainee indicates that she does not know how to continue as the client is presenting many problems. The feedback from the group/trainers mainly concentrates on trying to identify and trying to deal with the core-problem(s) and providing emotional support by giving the client an opportunity to express, with many problems and emotions.*

*Counselling: After continuing with the client's story it becomes clear that the client has not talked to anyone about her problems and feelings before. The sharing of her story, though very emotional, has given her the feeling that someone cares. She looks forward to discuss other problems she has kept to herself for so long. The following sessions showed that a deep feeling of humiliation and stigmatisation were related to her present problems. When this had become clear, the counsellor and client were able to work on increasing her self-esteem and prepare for reintegration into society.*

concrete interventions, it more closely fulfils the expectations of Nepalese clients who are unaware of talking as a form of formal treatment. Relaxation and psycho-education have been found to be particularly important skills in the Nepalese setting, because the presented problems of clients are often somatically framed (e.g. physical tensions).

### **Content of the training: specialised modules**

Some of the problems that counsellors need to deal with are particularly specific. In addition to intervention strategies as described above, counsellors are taught about these specific problems, as these are relatively frequent among the indirect beneficiaries of the training programmes in Nepal, especially among people affected by armed conflict and other forms of institutionalised violence, and because they require specific skills and measures.

*HIV AIDS counselling.* Before training counsellors in intervention strategies for people with HIV AIDS, the training emphasises the counsellors' and society's attitude towards the disease. In Nepal a very negative attitude (e.g. the disease is a punishment by a God or is the patient's own fault) towards this disease exists, causing severe social problems. Secondly, especially for sexually exploited/abused groups of people, it is emphasised that HIV AIDS is a multiple tragedy as having this terminal disease overlaps with aforementioned stigmatisation and earlier experienced traumatic event(s).

The counsellors are educated in counselling people with HIV AIDS, which entails assisting patients through the following relatively long-term process:

1. pre-test counselling, which entails that the client is prepared for the HIV testing;

2. dealing with initial reactions (crisis phase), which entails providing supportive counselling throughout a period of intense emotional reactions as well as providing psycho-education regarding the test results and its implications;
3. dealing with psychosocial problems as a result of the disease (acceptance phase), which entails assisting the client in reorienting her life by dealing with the social (e.g. stigmatisation), psychological (e.g. depression) and emotional issues (e.g. fears) as a (in)direct result of the disease;
4. coping with impending death, which entails that the counsellors helps the client with synthesising her life and/or deal with issues of fear, pain or after-death ideas.

*Suicidal tendencies.* In addition to 'regular' counselling strategies, and besides being able to understand the causes of suicidal tendencies, counsellors are primarily taught

1. to identify suicidal tendencies through questions and familiarity with warning signs.
2. to assess lethality by assessing how close the client is to actually committing suicide.
3. to reduce direct risks of suicide (crisis intervention). This means that feelings of crisis should be reduced as well as help with putting in place protective measures for the client (e.g. avoid being alone, reduce access to objects of risk).
4. to explore and deal with reasons for wanting to die. Once reasons have been determined, counselling is the same as for frequently observed psychosocial problems, with the note that counsellors are made aware that in the meantime they should follow the initial steps again to prevent relapse to crisis-level.

The last step is especially difficult as it often

*Case Example*

*Client:* A 20-year-old woman, HIV AIDS patient who is aware that her life is ending, resulting in anxiety and extreme passivity.

*Training:* During the daily supervision meeting the counsellor expresses that she has difficulties dealing with this client and asks the group/trainers for suggestions. The counsellors are given the feedback to set goals with the client to engage the client within and out of the counselling setting, and at the same time focus on providing emotional support.

*Counselling:* In assisting the client to deal with her ending life, the counsellor asks the client what she still wants to accomplish before dying, to which the client reacts with various issues; she wants to be accepted by her family, she wants to be more active, she wants to resolve a conflict with a friend, she wants to discuss her fears of dying, among others. In the following sessions the client and the counsellor discuss each of these issues, resulting in the client becoming more active and open in discussions about her personal experiences and feelings.

entails a complex set of interrelated problems that drove the client to despair. Counsellors who do not feel sufficiently capable of handling such problems are advised to refer, where specialised mental health services are available.

*Trauma reactions.* The training programmes conducted so far have almost all been organised to benefit target groups that have frequently gone through traumatic experiences (e.g. young people and women trafficked for sexual exploitation, victims of armed conflict). Because of the severity of

problems and frequency of traumatic reactions among these groups, the training programme gives extensive emphasis to traumatic stressors, traumatic reactions and trauma treatment. It briefly discusses Post Traumatic Stress Disorder (PTSD; according to its three main categories, re-experiencing, avoidance and hyper-arousal) as well as other traumatic reactions, such as emotional reactivity, stress and depression. In our view PTSD is a relevant concept in our setting, but not a sufficient one. Its cultural validity and usage with individuals who have been repeatedly subjected to prolonged trauma has still to be resolved (e.g. Herman, 1992; Turner, 2000).

Firstly, counsellors are taught to *identify the present problems* that the client is experiencing, as a direct or indirect consequence of the traumatic event(s). This means going through intervention strategies as indicated for frequently observed psychosocial problems, thus emphasising the provision of emotional support and assistance with problem solving, which should create the basis for restoring safety (focusing on self protection), as explained by Herman (1992). As trauma experiences in Nepal often lead to social problems, such as stigmatisation and isolation, it is emphasised that part of the problem solving consists of giving attention to the *reconnection* process in society at large (e.g. through creating new connections and relationships and restoring old ones) (Herman, 1992).

Secondly, counsellors are taught to *give information* during the counselling session. This refers to the counsellor informing the client about what trauma is and how people generally react to such high levels of stress (e.g. providing clients with the information that their problems or reactions are 'normal')

and similar to other peoples' reactions). The main function is to normalise the client's reactions, especially if these are perceived as strange or exaggerated by the client. Counsellors are taught to use a text to achieve this or to talk about the relationship between traumatic events, stress and reactions (see for example De Jong & Clarke, 1996).

Thirdly, if, when clients start talking of the traumatic event(s), the counsellor has the impression that the client expresses a need to share this or if the counsellor believes that it may be helpful for treatment, counsellors are taught to deal with such a development through a process called *retelling*. The counsellors are taught

1. to carefully support the client throughout the retelling, by emphasising present safety and giving empathy
2. to follow the client's pace and depth of sharing, which entails not unnecessarily interfering (e.g. no questions, but rather reflections).
3. to explore the client's account in more detail if the client initiates or wants that (questions can be useful, such as; 'how did you feel?' 'how did you react?').
4. relaxation exercises (such as guided imagery or muscle relaxation) to reduce the level of stress as a result of the retelling process<sup>4</sup>.
5. to check the client's feelings during and at the end of the process of retelling; it is on the basis of the client's feelings whether to explore in more depth (in case of relief) or to merely focus on the client's feelings (of distress) throughout the retelling.

The rationale behind retelling, as with exposure-based interventions as shown below, is that it reduces avoidance and so promotes re-experience, at the same time

teaching the client that she is capable of coping with negative memories of traumatic event(s).

Furthermore, counsellors are made familiar with the existence of formal trauma interventions (such as exposure, EMDR, testimony therapy), as it is found to be important to convey know-how on these recognised interventions. However, these formal interventions are not taught during the 4-month course. The reasons for not teaching for trauma interventions are as follows:

1. The social and emotional problems can be so intense and disturbing that they often need first attention, which has been confirmed by CVICT's clients' complaints and needs that are mainly focused on the present.
2. The strategy as outlined above is closely related to one of the training's important components, which is that the counsellors, as far as possible, are taught to identify, respect and deal with the client's perceived problems.
3. It is found that training in formal trauma interventions, which needs extensive guidance and expertise, might be beyond the level of this training programme, and therefore possibly harmful and arguably unethical.
4. Finally, at the present time, it is unknown whether such interventions are appropriate or effective in Nepal.

*Stigmatisation.* One type of problem that is regularly encountered is stigmatisation, involving negative thoughts, beliefs or self-image that have been shaped by general beliefs and attitudes within society at large. After rape or sexual abuse, for example, which frequently leads to feelings of inferiority and negative self-concepts. Other specific examples that involve stigmatisation are; perceived low self-worth due to the stig-

ma of being pregnant as an unmarried woman; feelings of being *bigriyo* ('spoiled' or 'gone bad') after having been sexually exploited; present sexual dysfunction due to past acts of masturbation; perceived accumulation of fat around the lymph nodes due to swallowing semen after homosexual contact.

Generally, counsellors are taught to respect the client's cultural belief systems, as will be explained below, although it is also emphasised that certain belief systems have a negative effect on the client's daily functioning and are not caused by the client's conviction or faith, but rather by that of society. In that case it may be beneficial to the client to challenge those beliefs that stand in the way of improvement.

Freeing the client of such negative beliefs, then, is mainly taught through gently *challenging*<sup>5</sup>. Within the training programme this skill refers to the ability to make the client aware of issues that are not directly obvious to him or her, namely discrepancies or incongruities in the client's story that are related to the negative belief. More specifically, this entails that the counsellor challenges the client to question society's influence on his or her problem, or to consider the client's strength opposing the particular negative belief or to challenge the client with contradicting examples, or to reflect on the factual situation, for example through psycho-education.

*Problems specific to the cultural context.* In addition to stigmatisation, another group of encountered problems is related to the specific cultural context of Nepal. This type includes problems that are related to manifestations of specific cultural or religious belief systems generally held by Nepalese society and, as opposed to the problems above, by the individual in question. It is

for that reason that the counsellor is taught to respect the client's explanation, for it is correct from the client's perspective, and therefore not try to change or challenge such belief.

This category includes possession problems, which in psychopathological terms (ICD-10) refers to a disorder in which an individual is convinced that she has been taken over or controlled by a spirit, ghost, deity etc, often resulting in change in identity, convulsions or loss of normal integration between awareness, memory and bodily movements. Secondly, it includes problems related to the client's cultural and/or religious beliefs system, though not actually the conviction of being possessed. For example the individual might believe that present problems are the result of not performing religious rituals (e.g. 'puja') or the individual might believe that an extreme and unwanted experience of falling in love is due to a spell. Another well-documented culture-specific psychosocial problem is the Dhat-syndrome (e.g. Akthar, 1988). This problem, though, is not regularly encountered in our counselling setting.

The intervention strategies that counsellors are taught to deal with such culture-specific problems are as follows. Initially, the counsellor accepts the client's explanation and experience, even though it might seem unrealistic from the counsellor's point of view. Secondly, the client should be encouraged to visit (instead of or in addition to counselling) a traditional healer. If the counselling process still continues, counsellors should explore the client's explanation and experience through a set of questions geared to the cultural setting and the clients' experience of the problem, for example the Explanatory Model Interview Catalogue (EMIC; Weiss 1997; in Van Ommeren et al, 2002). In addition to training counsellors

to use the EMIC questions, another way of eliciting the client's explanatory models is taught. This concerns examples of questions such as; 'what do you think has caused the problem?', 'what do you think your problem does to you?', 'how severe is your problem?' etc. (Poudyal & Van Ommeren, 2000; adapted from Kleinman, Eisenberg & Good, 1978). Subsequently, counsellors are expected to explore and provide help for present problems that are considered a result of the initial problem (e.g. possession). This is essential for religious and culture-related problems, as the counsellor is not in a position to question such belief systems. However, if the counsellor detects that the problem is the client's mechanism to express or to remove himself from, and thereby protect himself from, a highly stressful, traumatic or emotional condition, thought or situation (dissociation; Kaplan & Sadock, 1997), then the counsellor is taught to continue by dealing with the identified psychosocial cause of the culture-bound problem. If problems are found to be too severe, the counsellor is taught to refer to either a mental health specialist or (and again) to the traditional healer.

*Functional complaints.* It is CVICT's experience that many of the complaints of Nepalese help-seeking individuals concern medically unexplained somatic complaints, such as back pain, head-aches, abdominal pain, dizziness, weakness etc (Centre for Victims of Torture, 2000; Van Ommeren et al, 2002; Tol, 2002; Thapa, 2002). It can be reasoned that this is because CVICT mainly works with people who have been tortured; however, we believe this is a commonly presented complaint in Nepal because of beliefs about the body, or because clients expect to receive physical treatment.

Firstly, as functional complaints also often represent the client's belief system, counsellors are taught to emphasise understanding the client's complaints and explanation for these. Secondly, it is stressed that medical examination should take place and that discussing the results and the client's reaction to these results is the next step (if the complaint is indeed found to be without organic cause). Thirdly, counsellors are taught to identify whether such medically unexplained physical complaints are accompanied by psychosocial problem in the client's life. Fourthly, counsellors must give psycho-education regarding the possible relationship between emotional distress and physical complaints, without forcing this perspective onto the client. Finally, counsellors then link the earlier identified psychosocial problems to the presented physical complaints and try to reduce the latter by dealing with the former (Van Ommeren et al, 2002; Poudyal & Van Ommeren, 2000; Jordans, 2001).

In addition to the above intervention strategies, which are reasoned from a psychosomatic point of view, counsellors are taught that this is not the only way of dealing with functional complaints. A somato-psychic perspective (Sue, Sue & Sue, 2000) is introduced as a parallel for two reasons; firstly, because in Asia it is often believed that psychosocial complaints are the result of somatic complaints (e.g. a headache causes the client to feel stressed and to experience difficulties concentrating) and, secondly, because the psychosomatic approach might not be effective if the client does not believe in such<sup>6</sup>. Therefore, it is emphasised in the training that, depending on the client, counsellor and process of counselling, the counsellor can choose to deal with functional complaints from a somato-psychic approach. This entails that the counsellor

explores the problems and/or consequences the client is experiencing as a result of the physical complaint. (Nota bene: there is a good possibility that both approaches in the end deal with the same stressor with the same results.)

*Referral if severe psychopathology is presented.* The majority of the problems the counsellors come across are psychosocial problems as described above. At the same time they also encounter mental health problems that they are not trained to deal with, including a group of psychiatric/psychological disorders, such as psychotic disorders, severe depression, personality disorder, and mental retardation. The counsellors are quite probably the first persons to detect psychopathology. Counsellors are trained to recognise and refer such cases and, if relevant, to offer support for secondary psychosocial problems to clients and their family members.

*Other intervention strategies.* Besides the intervention strategies as outlined above, the training also includes other clearly distinguishable intervention strategies, such as group counselling (working with groups through themes) and dealing with clients who are reluctant to interact.

It is however the objective of this paper to give an understanding of the training of counsellors as practised within CVICT, not to describe it fully. *Interested readers are invited to contact us regarding manuals.*

## Discussion

This paper has described the training of psychosocial counsellors as conducted at CVICT, in collaboration with TPO. Though we feel that the described training course delivers qualified psychosocial counsellors, we do acknowledge that the training

course does not encompass certain skills, techniques and topics, for example managing substance abuse.

The training programme follows the guidelines set by the Task Force on International Trauma Training of the International Society for Traumatic Stress Studies (ISTSS) (Weine et al, 2002), as it incorporates recommended core values, such as training mainly recognised interventions and training from different theoretical approaches. In addition, the curriculum of the training programme corresponds with the guidelines, as emphasis is given to listening and communication skills, assessment, problem-solving strategies and medically unexplained somatic complaints, among others.

These guidelines also mention three degrees of evaluation activities: evaluation of trained skills (to which extent do the trainees master the skills that were transferred during the training), evaluation of services supplied by graduated trainees (do they actually use these skills in practice) and the evaluation of beneficial effects from these services. Although the first degree of evaluation is being conducted within the training programme, we have not included empirical research into the question of the conducted practices by graduate trainees. What we do know is that some trained counsellors do not get to put their skills into practice, as counselling is a relatively new concept in Nepal, and some NGO managers do train their employees in counselling but do not seek to utilise their skills. A seminar is currently being organised to advocate and inform (I)NGO managers and executive staff. As for the beneficial effect of supplied services by trained counsellors, no research has been done as yet. For an ILO seminar, our programme has been evaluated and has been top-ranked

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among other counselling training courses and materials in South Asia in terms of coverage of basic issues, theory and practice and cultural adaptations (Frederick, 2002). We would like to add that to maintain standards, periodical refresher training-courses are essential, especially since in Nepal counsellors work relatively independently due to geographical conditions (hills and mountains, lack of roads). Frequent supervision is difficult to organise, but one should never give up attempts to organise supervision. Moreover, as suggested by the Task Force on International Trauma Training, the current training programme overall, as well as the content of specific intervention strategies, has adapted itself to its context, locally and internationally. Specifically, this entails that adaptations have been made to make the intervention culturally sensitive and appropriate and also that the training programme includes clinical supervision.

Although we fully acknowledge the importance of cultural dimensions and have taken that as a core element of our approach, we would like to note the following. The cultural gap between the Western and the Nepalese context, in terms of counselling skills and concepts, should not be exaggerated. Basic communication skills and emotional support, though in different terminology, are not incompatible with existing forms of interpersonal relationships and problem management. Secondly, counselling has largely been positively received by its recipients, based on CVICT's experience and on a pilot TPO-supported cost effectiveness study done at CVICT (Thapa, 2002).

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- <sup>2</sup> There is much evidence for the efficacy and effectiveness of problem-solving therapy (PST) for depression (Dowrick et al 2000, Mynors-Wallis, Gath & Baker, 2000, Mynor-Wallis, Gath, Lloyd-Thomas, Tomlison, 1995). PST is the only psychosocial intervention for depression with strong evidence for effectiveness in primary health care. PST is *par excellence* an intervention that can be carried out by paraprofessionals. Indeed, many counselling psychology and social work programmes across the world commence with teaching PST (Egan 1994).
- <sup>3</sup> The original version is called *Sentence Completion Test*, parts are translated from the Dutch version and some sentences are added, changed or omitted.
- <sup>4</sup> Relaxation is also taught as a useful intervention strategy even if 'retelling' is not engaged in. Counsellors are also taught to teach clients relaxation exercises as a method of stress reduction outside the counselling context (as a coping strategy).
- <sup>5</sup> Challenging is also taught to be used in other instances within the counselling process, for example when client's are contradicting themselves (verbally or non-verbally), which in turn is part of the presented problem situation.
- <sup>6</sup> Sue, Sue & Sue (2000) write: "The dominant view in western culture is the psychomatic perspective, in which psychological conflicts are expressed in physical complaints. But, many other cultures have a somato-psychic perspective, in which physical problems produce psychological and emotional symptoms" (Sue, Sue and Sue, 2000, pp 175).

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