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# Recommendation Paper on Training and Capacity Development in Mental Health and Psychosocial Support (MHPSS) in Development Cooperation

As Exemplified in the Context of the Crises in Syria and Iraq





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## Background and objective of the recommendation paper

This recommendation paper was commissioned by the German Federal Ministry for Economic Cooperation and Development (BMZ) and produced by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH in cooperation with and from the point of view of civil society actors and freelance psychologists working in the field of Mental Health and Psychosocial Support (MHPSS) with refugees and internally displaced persons (IDPs) in both the Middle East and Germany. Developing the paper was identified as a priority in light of the widespread need for psychosocial support and the simultaneous shortage in those services in the context of the crises in Syria and Iraq, which makes training and capacity development in MHPSS in the region an urgent imperative. To this end, the paper intends to provide context-specific, experience-based, practically approved and implementable recommendations for those who are responsible for designing and implementing trainings, such as local and international organizations and institutions that provide MHPSS trainings as well as the trainers they employ, and to point out what to consider in this process. It can also provide donors guidance regarding the considerations and elements that should be included in programmes offering capacity development in this field. The recommendations are partly based on an extensive review of literature on the subject, but mostly draw on and reflect multiple organisations' extensive practical experience with capacity development and service provision in MHPSS in the Middle East. More than 100 representatives of local organisations from Syria, Lebanon, Iraq and Jordan as well as representatives from German and international organisations working in the region gave feedback (in validation workshops, in writing or during personal interviews) on two draft versions of the paper and shared best practices and lessons learned with us, which were incorporated into the final version. We are very thankful for all feedback received! In addition, the document will constantly be open for review. If you have any questions, suggestions or feedback regarding this recommendation paper, please do not hesitate to contact us at [contact-RP-MHPSS@giz.de](mailto:contact-RP-MHPSS@giz.de).

The paper's main objective is to give those who design or implement trainings well-founded guidance on what to consider in a given context to prepare trainees to meet the needs of future beneficiaries while taking the conditions at hand into account. The recommendations put forward thus strongly relate to the current circumstances in the region, which are marked by ongoing conflict in Syria, a volatile post-conflict situation with only some MHPSS services in Iraq and an unstable situation for refugees in Jordan, Lebanon and Turkey with a strong need for MHPSS services that currently cannot sufficiently be met. Psychological distress in (post-)conflict situations is in most cases a natural reaction to an abnormal situation and most distressed people can cope with what they have experienced if they find themselves in a secure, supportive environment and are offered basic psychosocial support. Only a very small portion of the population needs specialised clinical mental health care. MHPSS is in these contexts mainly about empowerment and stabilisation, which makes non-specialised MHPSS services focused on these concepts particularly relevant (especially for development cooperation). The focus of this recommendation paper is therefore on in-service trainings and vocational trainings for people who will work as psychosocial counsellors or who will provide non-specialised psychosocial support in the context of their work, for example social workers, community workers or teachers. Training professionals for specialised mental health services is an important

part of building up a structurally anchored and sustainable psychosocial care system in the long term, which is particularly relevant in post-conflict contexts that are not affected by immediate violence. Given the above, however, while all recommendations formulated are also valid for psychotherapists and psychiatrists, specific further requirements for this group are not the focus of this paper.

This recommendation paper is not intended to be a manual and therefore does not provide a blueprint for a training. Rather, we consider it important that trainings be tailored to the specific context, to the requirements and backgrounds of the trainees and to the needs of their future beneficiaries. The recommendations provided outline what needs to be considered in these regards. To keep the paper as practicable and easy to handle as possible, all chapters stand on their own and can be read individually, depending on which information the reader is looking for. Each chapter starts with a summary of the key recommendations with further information and explanations following in the text.

### If you only take away three points from this paper, make it these three:

- ➔ The most important competencies in any work in the field of MHPSS relate to building and managing supportive interaction and relationships. Strengthening these skills requires time and the opportunity for reflection on one's own personality and way of interacting with others. Plan long-term, multi-step trainings with ample opportunity to practice and sufficient room for reflection on one's own psychosocial support practice under professional supervision (see chapter 12).
- ➔ Given the emergency context and the fact that many trainees have already worked with people in psychosocial distress and have developed experience-based expertise: Work with existing capacities and build on what trainees already know (see chapter 12).
- ➔ Always assess, take into account and adjust the training content, didactics and setting to contextual factors, such as the (post-)conflict situation, trainees' professional backgrounds, local conceptions of psychosocial distress etc. Taking this context into account often involves considering what can actually be done in a training under the existing circumstances rather than focusing solely on what should ideally be done (all chapters).

## Terms and definitions:

**Mental health and psychosocial support (MHPSS):** The composite term MHPSS describes all measures designed to preserve and improve psychosocial wellbeing. It emphasises that mental health and psychosocial wellbeing are interlinked and that psychological dispositions and social circumstances go hand in hand. Psychosocial support refers to all measures, actions and processes that promote the holistic psychosocial wellbeing of individuals in their social world and help people deal with psychological problems and related social conflicts and stresses. It includes support provided by various support systems, for example social workers, teachers, psychosocial counsellors, family and community. Mental health care is a highly specialised form of psychosocial support for people with clinically relevant mental health conditions (such as depression, schizophrenia, anxiety disorder etc.), which is delivered by psychotherapists or psychiatrists ([1]; [2]).

**Psychosocial distress** broadly refers to a (short or prolonged) unpleasant experience of an emotional, psychological, social, or spiritual nature that gets in the way of daily life, personal growth and constructive relations with others and that interferes with the ability to cope with the events causing the distress. It encompasses a continuum, from common feelings of vulnerability, sadness, and fears to severe distress, traumatisation and mental health conditions like anxiety disorder or major depression [3].

**Empowerment** in MHPSS refers to all activities and approaches that encourage and support individuals to (re-)discover their own strength and to regain their autonomy, feeling of control, and dignity. Empowerment also looks at (re-) building interpersonal relationships that enable mutual support and at creating new goals and life plans by activating existing resources (personal skills, positive world-views, social networks etc.) [4].

**Stabilisation** in MHPSS refers to all measures taken to support individuals in shock or acute severe psychosocial distress in calming down and moving past the prevailing emergency mind-set. This includes making them feel safe, giving them orientation and helping them to regulate their physiological reaction.

## List of abbreviations and acronyms:

<b>BMZ</b>	German Federal Ministry for Economic Cooperation and Development
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
<b>IASC</b>	Inter-Agency Standing Committee
<b>IDP</b>	Internally Displaced Person
<b>LGBTI</b>	Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersex
<b>MHPSS</b>	Mental Health and Psychosocial Support
<b>M&amp;E</b>	Monitoring and Evaluation
<b>NGO</b>	Non-Governmental Organisation
<b>PFA</b>	Psychological First Aid
<b>PTSD</b>	Post-Traumatic Stress Disorder
<b>SGBV</b>	Sexual and Gender-Based Violence
<b>ToT</b>	Training of Trainers
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>WASH</b>	Water, Sanitation and Hygiene
<b>WHO</b>	World Health Organization

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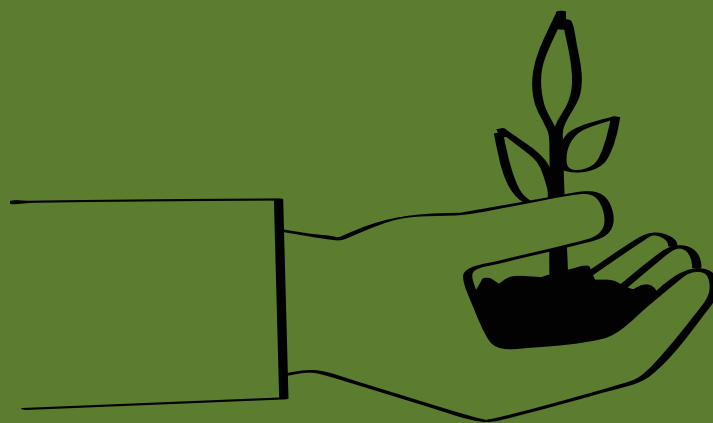
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# The Context: Conditions and considerations for capacity development in MHPSS in the context of the crises in Syria and Iraq

1. What to consider when training in contexts with ongoing violence, post-conflict or crisis settings ..... 12-14
2. How are MHPSS and the socio-political context interlinked? ..... 15-17



The devastating and prolonged civil war in Syria and the conflicts in Iraq, which have been marked by severe war crimes and crimes against humanity, have resulted in forced displacement on a massive scale. More than 12 million Syrians [5] and 2.1 million Iraqis [6] have been displaced from their home regions. Many people have witnessed massacres, executions and bomb attacks. Large numbers have had to endure kidnappings, imprisonment, torture and rape. Countless people have lost family members and friends or are living in a state of uncertainty regarding their future. In refugee camps and emergency accommodations, the disintegration of social structures, destroyed social and familial protective networks, precarious life circumstances and a lack of prospects are omnipresent and often give rise to new acts of violence. Forced marriages, child marriages and forced prostitution are common [1]. Experiences of conflict-related violence, uncertainty about relatives' and friends' wellbeing, and concerns about the situation in the home country are compounded by the stressors that come with displacement, which often include economic hardship, unemployment, difficulty in securing basic needs, continuing risk of violence, discrimination and isolation [7].

These experiences and deprivations put those affected in a position in which support is needed on a multitude of levels. Among those needs are often safety, the provision of food and water and shelter. Political developments also play an important role for affected persons' wellbeing in (post-)conflict situations, and many people also need economic opportunities to secure an income and regain a sense of purpose. Additionally, flight and migration are almost always accompanied by immense insecurities and can be marked by intense experiences of loss, fear or lack of control, often leading to high levels of psychosocial distress among refugees and IDPs. Suffering from psychosocial distress often impairs individuals severely, preventing them from carrying on with their lives as before and functioning in a way that allows them to sustain themselves and thrive as a person. In conflict settings, traumatisation can also have a collective dimension with implications for the society at large ([8]; [9]; [10]).

In addition to other services, psychosocial support is therefore desperately needed. However, there is a lack of qualified personnel in both Syria and Iraq and a deficit of academic programmes or licensure in the field [11], aggravated by widespread stigmatisation of both psychological distress and the utilisation of MHPSS services in the whole region [12]. Psychosocial support services and mental health care in neighbouring countries of asylum are likewise scarce and not equipped to meet the enormous need ([7]; [13]; refer to the following publications for information on the MHPSS service systems in Syria [14], Iraq [15], Jordan [16] [17], Lebanon [18] [19] and Turkey [20] [21]). The strong need for psychosocial support in combination with a lack of services makes trainings and capacity development in MHPSS in the context of the crises in Syria and Iraq an urgent necessity. In order to be effective and adequately prepare trainees for meeting the needs of their future clients, such trainings first and foremost need to be highly sensitive to the given context.

# 1. What to consider when training in contexts of ongoing violence, post-conflict or crisis settings

## Recommendations in short:

- ➔ Consider an ideal situation vs. the emergency context and the existing possibilities therein when designing the training (what should be done often has to be weighed against what can pragmatically be done).
- ➔ Ensure the safe accessibility of the training venue.
  - If no rooms are available, outdoor spaces or tents can be considered (it is imperative to ensure privacy and safety).
  - Providing the training in another area or offering excursions to other settings can be helpful both to ensure a safe environment and also to get to know different approaches and perspectives.
- ➔ The venue should be a safe space for the sometimes very personal topics discussed and should allow for unreserved self-reflection.
- ➔ Risk management: Sensitise trainees for and prepare them to deal with risks of aggression and violence (due to their new role as an MHPSS worker and the visibility it entails).
- ➔ Many trainees might themselves have gone through traumatic experiences: As a trainer during the training, pay attention to individual vulnerabilities and stress reactions, provide individual support when needed (if possible, work with two trainers in order to be able to do so).
- ➔ Deconstruct the image of the “unwavering counsellor”.
- ➔ Train participants in (actively) identifying and reaching out to people in need who otherwise have difficulties accessing services.
- ➔ In (post-)conflict contexts, where people in need are often out of reach of services, training people on the ground or in the diaspora in online counselling can be advisable (training the diaspora should not be prioritised over capacity development in the affected countries).

A determining factor for training design and provision in conflict or post-conflict contexts is the setting of ongoing violence, crisis and/or displacement, which poses specific challenges and determines possibilities for trainings. Designing training concepts that meet the specific requirements of the beneficiaries and that are also feasible in crisis and (post-)conflict contexts can be a major challenge: The way trainings should ideally be

designed often has to be weighed against the way they can pragmatically be designed under circumstances that are marked by a lack of regularity and predictability as well as by a lack of resources for continuing stabilising measures.

First and foremost, all measures and interventions, particularly in contexts of ongoing violence such as in Syria, need to be considered from a risk management perspective – which risks and dangers exist for people attending a capacity development programme in a volatile setting? The choice of a suitable venue for the trainings is an obvious and important example in this regard. Factors that should determine the selection of the venue are the safe accessibility for all trainees and the potential of the place to be a safe space for the sometimes very personal topics, in which the participants feel comfortable and have the opportunity for unreserved self-reflection and exchange with others. A learning environment that the trainees perceive as distressing or discomforting is detrimental to the training process. In crisis settings, finding a venue that fulfils these requirements can be a major challenge. If proper meeting rooms and facilities are not available, outdoor meeting spaces or tents can be considered as an alternative – if they provide a minimum of privacy and can function as a safe space [22]. Where possible, excursions to other areas or even countries might be helpful both to guarantee a safe environment and also to get to know different approaches and perspectives. Furthermore, it is of utmost importance to ensure that trainers and trainees monitor and analyse risks that might arise when participating in trainings or using newly acquired counselling skills. Especially in contexts of violence and insecurity, which often involve shifts in hierarchies or traditional roles within families, but also under oppressive regimes, participants might be more exposed or visible in their communities by practicing their newly gained knowledge and skills, which can put them at risk of aggression or exclusion. Working with people under stress, in and of itself, brings with it a risk of becoming the target of physical aggression and violence.

A particular challenge in (post)-conflict contexts is that local trainees have often themselves experienced traumatic events, and it can reasonably be assumed that many of them are still struggling with the impact that these events have had on them. This can entail several risks, which can ultimately lead to dysfunctional practices during their future work in the field of MHPSS (and might in some cases even mean that this kind of work is not suitable for a particular person). Traumatic experiences provoke survival strategies and defences, not all of which are helpful in the long term. An MHPSS practitioner who has experienced traumatic events might excessively focus on and strengthen these defences and deny and repress perceived weaknesses. This can adversely affect the relationship between the MHPSS practitioner and the beneficiaries as well as the psychosocial support process as a whole. In addition, working with people who have gone through comparable situations and hearing about their experiences can lead to re-experiencing traumatic stress for MHPSS workers. To address these specific challenges in qualification programmes in conflict- or post-conflict scenarios with potentially traumatised trainees, the trainers should ensure that special attention is given to the vulnerabilities and stress reactions of their trainees, the creation of a secure environment in which trainees support themselves, a focus on the importance of self-care and staff care, an approach to trauma that acknowledges the need to share weaknesses as well as an ongoing supervision after the training. During the training, the image of the unwavering, perfect counsellor should be deconstructed to allow for more realistic and adapted conceptualisations. At the same time, it should be noted that MHPSS

workers who have experienced traumatisation themselves also have the chance to use this as a resource. Through their own experience of learning to cope with their trauma and through their empathy, they might be better able to support others in this process. Having themselves experienced traumatisation can help such trainees create a more trusting and open relationship with their clients, who might feel better understood [23].

Another important factor in (post-)conflict contexts and contexts of displacement is that it might be difficult for many people in need to access psychosocial services. This can for example be the case for people with physical handicaps, for the elderly, for people living in remote areas or camps, for women whose mobility is often limited, and for people who are otherwise unaware of the existence of such services, which is often the case for refugees and IDPs. A core competency that should be a part of an MHPSS training is therefore (actively) identifying and reaching out to these people (e.g. through home visits). If technically feasible and appropriate for the people seeking help (i.e. if they are stable enough, not suffering from psychosis, dissociative states or suicidal ideation), e-counselling can be useful to reach clients who do not have the possibility to attend sessions in person. The anonymity of online counselling sometimes helps people to open up, particularly in an environment marked by a strong stigmatisation of psychological distress (however, relationship-building – a crucial component in the psychosocial support process – can be impeded in this format). Training suitable people in the region as well as in the diaspora in online-counselling can therefore be a valuable addition to capacity development for counselling and therapy in a personal setting. Training online counsellors in the diaspora should not be prioritised over capacity development in the affected countries themselves, though, in order to work towards the sustainability of services and improvement of the psychosocial care system in the region.

## 2. How are MHPSS and the socio-political context interlinked?

### Recommendations in short:

- Consider the socio-political context when designing a training in (post-)conflict settings (psychosocial distress in these contexts is in most cases related to the socio-political situation and related developments and therefore has a socio-political dimension).
- Create a safe space that makes an acknowledgment of political injustices possible, if appropriate and indicated, as this can be important for the healing process and for reconciliation.
- Leave room for political topics to come up, but don't push for them to be discussed.
- It can make sense to introduce MHPSS approaches specifically aimed at reconciliation to promote individual and collective healing as well as peacebuilding processes.

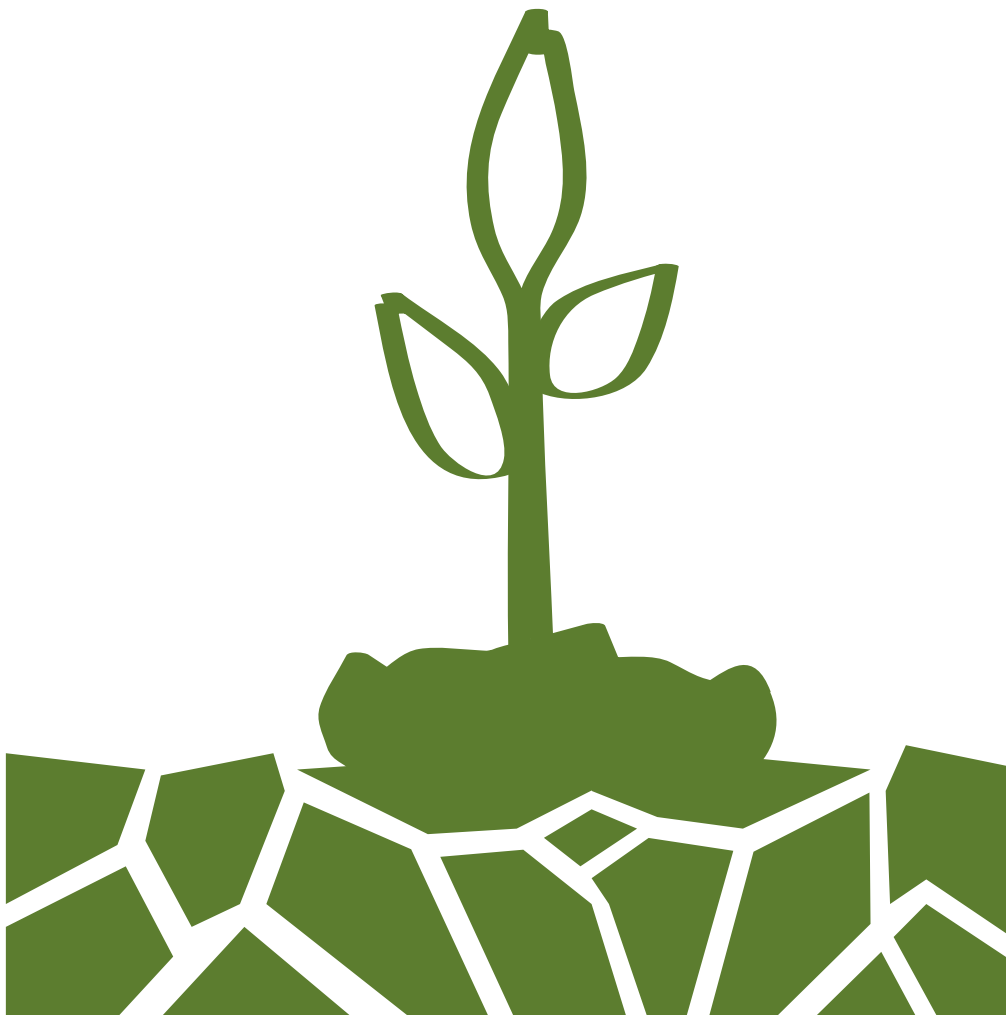
An important contextual factor when working with refugees and IDPs – but also with beneficiaries from hosting communities – in the field of MHPSS is the interrelation between psychosocial distress and the larger socio-political situation. People who have been forced to leave their homes and flee from war and conflict have in most cases witnessed, been threatened with or been subjected to human-made violence, including atrocities and severe human rights violations. These experiences in their home countries and during flight are often a source of psychosocial distress or even traumatisation. However, in the situation of displacement itself, psychosocial wellbeing is still highly influenced by (political) conditions, which shape refugees' and IDPs' safety, autonomy and ability to address basic needs. Psychosocial distress in these settings therefore has a socio-political dimension and should be understood on a collective level.

An acknowledgement of the politically induced suffering and the associated injustices and human rights violations that allows for mental healing and a coping process is an important element of an MHPSS approach that takes the socio-political dimension of human suffering, stress and trauma into account [24]. In this sense, the context of violence must not be neglected by “medicalizing” the consequences of war [8]. This is not only true for the individual level: Acknowledging injustices is also a prerequisite for reconciliation and peacebuilding – the political, institutional, economic and social reconstruction of a post-conflict society [25]. MHPSS and the work on (collective) trauma in (post-)conflict contexts are therefore also closely interlinked with peace work ([26]; [27]). This can make MHPSS approaches specifically aiming at reconciliation as well as training elements with this aim important (please refer to chapter 10 in this regard).

Yet, touching on politics or acknowledging socio-political injustices within trainings or in (group) counselling sessions in (post-)conflict settings is often a highly sensitive and delicate or even dangerous matter. Many local MHPSS professionals, counsellors and

therapists refrain from talking about political issues or human rights violations with beneficiaries, who are often equally unwilling to talk about these issues. Reasons range from risks of persecution (going back to the fear that what is said in a counselling session will not remain confidential) to personal resistances and emotions being triggered (for example when the MHPSS worker and the distressed person belong to different ethnic, religious or political groups). However, dealing with this dilemma in some manner is unavoidable in a context of conflict, violence and displacement and there is no one-size-fits-all solution to it that can be conveyed in a training. Every future counsellor in such contexts should be sensitised in trainings to the fact that in many cases, psychosocial distress will have a socio-political dimension and should be prepared and supported in finding his or her own way of dealing with this issue. Leaving room for political topics related to the suffering to come up while not actively pursuing (or worse, pushing for) them seems to be a suitable approach in many cases.





# Preparing and designing trainings in MHPSS

3. Which kinds of trainings are there and who are they for?..... 19-21
4. The Trainees: What are preconditions for participation and how should suitable candidates be selected?..... 22-24
5. The Trainer: Which qualifications and personality traits are conducive for conducting trainings in MHPSS?..... 25-26
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### 3. Which kinds of trainings are there and who are they for?

#### Recommendations in short:

- Considering the goal of the training and its target group (e.g. social workers, psycho-social counsellors, psychotherapists, health staff, teachers, humanitarian workers etc.), decide which kind of training is suitable: sensitisation workshops, in-service training, vocational training or academic education.
- The choice of an appropriate kind of training determines other parameters (e.g. training length).

MHPSS is not only provided by those working specifically as psychosocial counsellors or psychotherapists but also by other professionals who work with distressed and potentially traumatised populations on a regular basis. What kind of training is most suitable in a specific context primarily depends on the trainees' backgrounds and (future) areas of work.

The following institutions or professions are generally in frequent contact with potentially distressed or traumatised people. They provide services that are relevant for their beneficiaries' psychosocial wellbeing and therefore have a need for training in MHPSS. All of these groups can include paid and unpaid workers (volunteers), national and international staff from humanitarian organisations and from government offices (e.g. [24]; [28]; [29]):

- MHPSS practitioners (e.g. psychosocial counsellors, psychiatrists)
- Health staff (e.g. nurses, doctors, community health workers)
- Social workers
- Staff in the education system (e.g. teachers, sport trainers)
- Staff in the justice system (e.g. clerks in public offices, the police)
- Humanitarian aid and development cooperation personnel (NGO staff – e.g. WASH, food provision, shelter specialists, assessment teams in those areas)

There are different kinds of trainings that make sense for different groups of trainees and their respective (future) areas of work. The choice of a training type also depends on the objective of the training itself, e.g., is it urgent to provide rudimentary training to some people who can then engage in basic initial stabilisation interventions or are the trainees meant to become professional MHPSS staff in the long term?

**Sensitisation workshops for MHPSS:** Sensitisation workshops usually last for only a few days and are specifically designed for service providers who are in a position in which they directly work with or make decisions about the fate of potentially distressed or traumatised people, but are not MHPSS practitioners themselves (e.g. teachers, social workers, health workers, clerks, development workers etc.). Sensitisation workshops aim at informing trainees about the psychosocial needs and stresses of distressed people, enhancing their self-awareness, developing competencies in stabilisation and supportive interaction with people in distress and showing them psychosocially sensitive ways of providing their services.

**In-service trainings in MHPSS:** In-service trainings are usually designed for people working with distressed populations in a field related to MHPSS and they are usually requested or organised by an organisation for (parts of) their staff. During in-service trainings, which usually last multiple weeks or are split up into several modules that are delivered separately over the course of several months (multi-step trainings), those professionals for example receive training in one (or several) specific MHPSS intervention(s) as an additional qualification to enhance the work they are already doing.

**Vocational trainings in MHPSS:** Vocational training qualifies a person as an MHPSS practitioner, so that they are then able to offer psychosocial support and counselling at the community or individual level. Vocational trainings can be designed for both non-specialised and specialised MHPSS services. Usually, vocational training programmes offer a comprehensive, lengthy (i.e. months or even years) education in MHPSS, including theoretical and practical modules.

**Academic education:** Academic programmes are usually provided by or in cooperation with universities. An academic education in Psychology, which takes several years, often aims at a scientific education regarding different aspects of psychology for people who will later on offer specialised MHPSS services. A scientific background in psychology is a good foundation for working in this field, but does not replace a practical education in counselling, psychotherapy or psychiatry.

Sensitisation workshops can open doors for further capacity development in MHPSS. More university programmes that embrace enough practical training with clients under supervision and that train people as specialised MHPSS professionals (e.g. psychotherapists) would be important to build up a comprehensive psychosocial care system in the long term. As was explained in the previous chapter, though, training people who can offer non-specialised psychosocial support and counselling for individuals and communities is particularly important in (post-)conflict contexts and contexts with ongoing violence, where many people are in need of psychosocial support and suffering, often has a collective dimension. While all forms of training are important in their own

right, this paper will – in light of the given context – focus on vocational trainings and in-service trainings for people who will provide non-specialised psychosocial support or psychosocial counselling at the individual or community level (for further information on trainings on a specialised level, please consider [29] and [30]; to address the lack of focused and specialised MHPSS professionals in adversity-affected and low-resource settings in a scalable manner, the World Health Organization (WHO) has also developed the internationally widely-used PM+ [31] and mhGAP [32] trainings). It is of utmost importance to state that the core competencies needed as a psychosocial counsellor need time to develop and require more accompaniment than can usually be offered during a training workshop that only lasts a few days.



## 4. The Trainees: What are preconditions for participation and how should suitable candidates be selected?

The trainees are at the core of any training. They will be the ones offering MHPSS services to those affected by conflict and whose abilities and skills might make a difference for beneficiaries who are suffering. The selection of trainees is therefore highly important when preparing an MHPSS training. However, in many cases the selection of candidates for a training is influenced or even completely carried out by participants' organisations or other authorities. These authorities and superiors are often not familiar with the topic of MHPSS, do not know the content of the training and nominate participants according to their own criteria, without checking their availability and motivation and without thoroughly contemplating for whose working context such a training would be most useful. The success of a training and the possibility for trainees to apply their newly gained skills, however, largely depends on the fit between the training content and the trainees' backgrounds. Therefore, organisations providing trainings in MHPSS should try to cooperate with authorities in the selection process and should work towards the selection of suitable candidates, for example by informing authorities in depth about the training content, purpose and scope or by suggesting which potential participants would be particularly suitable as trainees.

### Conditions for participation

#### Recommendations in short:

- ➔ Trainees should be locals.
- ➔ The only hard conditions for participation are that trainees are willing to learn, willing to be empowering, open for self-reflection processes and treat clients respectfully.
- ➔ Suitable trainees should also
  - have basic relationship-building abilities to build on in the training.
  - have the capacity to recognise their own stress level or be open to learn how to recognise and regulate their emotional state.
  - be able and committed to tolerating differing value systems.
  - speak the relevant course language.
- ➔ For vocational trainings as psychosocial counsellors: Previous education or experience in MHPSS or working in a social area is an asset (depending on the length and purpose of the training, this can also be an obligatory requirement).
- ➔ It is advisable to ensure (as far as this is possible) that participants will be working in the field of MHPSS after the training is completed and will thereby be able to put what was learnt into practice.

In case the selection of candidates can be influenced or carried out by the training organisation itself, the question of suitable admission requirements arises. Especially in the field of MHPSS, the cultural background of a professional is a relevant factor: Local staff (even if personally unknown) is often seen as part of the community and trust can be established more easily, which facilitates psychosocial support processes. Psychosocial support should therefore be performed by local staff, who speak their future beneficiaries' language and are sensitive to local socio-cultural specificities. Considering the specific conditions of (post-)conflict settings – tight resources and great need –, there are only few further pre-conditions that have to be met in any case when taking part in a training in the field of MHPSS: the willingness to treat beneficiaries at eye level and be empowering, encouraging and respectful as well as the willingness to learn and to engage in self-reflection.

Additionally, basic social skills, especially empathy, a basic level of self-awareness and the ability to tolerate situations with no quick solutions are important characteristics of suitable trainees that should ideally already be present to a certain degree before the training starts. In addition, the ability to tolerate differing world views and value systems (or at least a readiness to do so in the future) as well as the ability to consciously reflect on one's own values, beliefs and prejudices is important for anyone who is going to work in this field. If possible, ensuring that trainees will actually work in the field of MHPSS in the given context after the training is completed ensures the training's utility for the trainees and for the local community they (will) work in.

## Finding and selecting suitable candidates

### Recommendations in short:

- ➔ Advertise for the training in relevant media (social media, internet, TV, newspaper, on black boards in highly frequented places etc.) – but be aware that this can have unintended negative effects like putting trainees at risk by making the existence of the training widely known.
- ➔ If they can be expected to be helpful, consult local leaders for the identification of suitable trainees.
- ➔ Enter into agreements with relevant local NGOs and authorities to provide time and resources for their staff to attend.
- ➔ Avoid brain drain as an effect of the training.
- ➔ Choose participants from all genders and ages – check if and how they can best attend (sometimes it might be advisable to separate training groups according to gender and age).
- ➔ Choose participants from different ethnic and religious groups (while being aware of possible conflicts between trainees with different backgrounds).
- ➔ If possible, cover travel and accommodation costs for participants who live far away from the training venue.

Finding local candidates who can find the time and possibility to take part in the training can be a difficult task in some contexts. Competition, especially among local staff, is common in (post-)conflict or crisis settings [29]. This raises the question of how to reach out to and identify suitable trainees. Advertising the training in relevant media can be a good way of reaching out to potential trainees (e.g. via internet, radio, newspapers, on boards of organisations such as NGOs, through flyers or posters in public gathering places or at places frequented by many people like hospitals, community centres etc.). However, it is important to take into account possible unintended negative effects of publicly reaching out to potential trainees – openly advertising the training and thereby making its existence widely known can potentially put trainees and trainers at risk of aggression or exclusion by those who do not approve of such trainings or of MHPSS services in general for various reasons. This possibility should be considered and assessed in advance. Consultations with local leaders can be another way of identifying appropriate candidates [24]. Entering into agreements with relevant local NGOs and authorities whose staff might benefit from trainings in MHPSS to ensure that time and resources are made available for their staff to attend can also be a fruitful approach.

The IASC Guidelines on MHPSS provide guidance on how the recruitment process can be organised and designed in a fair, transparent and consistent way [29]. While the widest possible pool of qualified candidates should be attracted, (particularly international) training organisations should also pay specific attention to avoiding the brain drain effect that might occur when offering trainees jobs with far more attractive conditions than local organisations as a consequence of the training.

It is furthermore vital to make sure that participants of all genders and ages as well as representatives of the main cultural, religious or ethnic groups are trained (while at the same time being aware of potential conflicts between the trainees based on ethnic or religious identity) to ensure that distressed beneficiaries can choose an MHPSS worker they feel comfortable with [29]. It can be beneficial for the training to separate training groups according to factors like gender or age. Allowing for different groups' inclusion into the training implies checking whether and how they can best attend the training. Making the training accessible to potential candidates from distant, rural areas – for example by covering travel and accommodation costs – is advised.



## 5. The Trainer: Which qualifications and personality traits are conducive for conducting trainings in MHPSS?

### Recommendations in short:

- ➔ Trainers should have substantial cultural and political background knowledge (especially regarding local expressions of distress, explanatory models for distress, coping mechanisms, ways of approaching MHPSS services etc., but also concerning for example context-specific gender dynamics)
  - If possible, hire qualified local trainers
  - If no local trainer is available, international trainers who are familiar with the cultural context and aware of their own assumptions and prejudices can be hired; trainer-tandems with local and foreign trainers are advised.
- ➔ Trainers should familiarise themselves with the trainees' concrete working environment to adapt the training accordingly.
- ➔ Trainers should display an empowering, respectful and non-judgemental attitude and meet trainees at eye level.
- ➔ Trainers should use an open, questioning teaching style and see themselves as facilitators of a group of knowledgeable people.
- ➔ Trainers should be transparent about their theoretical positions and assumptions within the variety of psychological schools of thought.
- ➔ Profound expert knowledge in MHPSS as well as long-standing practical experience of working in MHPSS is highly desirable.

The choice and preparation of the trainer is one of the most important aspects that determine the success of the training and the ability of (future) professionals in the field of MHPSS to support beneficiaries. Not only the trainers' skills and qualifications are important, but their own background and context-sensitivity is also relevant. An inside knowledge of the local context (including power dynamics and gender dynamics), of local ways of dealing with distress and approaching MHPSS services, of the local political and social conditions and of their recent developments is an invaluable resource for trainers that can potentially outweigh more profound theoretical expertise in MHPSS. It is therefore highly advisable to hire local trainers.

Due to the shortage in academic and non-academic programmes in MHPSS and the novelty of the topic in the region, however, it can be difficult to find trainers with a local background and experience in MHPSS and it can therefore be necessary to work with international trainers. International trainers need to understand and respect contextual

factors and be strongly aware of their own prejudices and biases. Trainer tandems, which include a local trainer and a foreign expert in MHPSS, are advisable in this case. The cooperation between an international trainer and local trainees can, however, reproduce post-colonial power dynamics. International trainers should be able to recognise and deal with those dynamics, by being especially sensitive to them, valuing trainees' experiences and insights (which are often more context-sensitive and adapted than their own experiences) and taking care to display an egalitarian attitude. Particularly for international trainers, there is a risk that concepts and assumptions from the Global North are transferred without reflection. Local trainees often even seem to be asking for quick recipes and culturally non-sensitive guidelines. The trainer must know how to deal with these expectations and must be able to dispel expectations of quick and easy interventions that can supposedly be exported from the Global North.

In addition to professional expertise and training skills, it is vital that trainers have and display a certain attitude. Counselling and therapy are inherently respectful, non-judgemental processes and it is therefore important for the trainer to pursue an equally egalitarian, non-judgemental approach to training. He or she should be respectful, encouraging and supportive towards the trainees. This will on the one hand positively affect trainees' motivation and engagement in the training and on the other hand serve as a role model for the trainees themselves, who should assume the same attitude vis-à-vis their beneficiaries in order to provide services in empowering, constructive ways. Trainers should assume an open, questioning teaching style, in which relevant theories, models and approaches are openly discussed with participants as colleagues, instead of adopting an "all-knowing" attitude. The trainer's own values, attitudes and presumptions (especially the commitment to one psychological approach or the other), which are necessarily present in any trainer, should be made explicit for trainees' understanding of the training content and facilitation of the search for their own approach to MHPSS. Trainers should be aware of the fact that they are not omniscient but rather represent a facilitator for a group of participants with different backgrounds, expertise and skills in a process of jointly discovering ways to support distressed people [23]. At the same time, trainees' expectations regarding teaching style can be challenging in this regard. For trainees educated in a context in which a more hierarchical teaching style is prevalent, employing an open, questioning style of teaching can mean that trainees have to be particularly encouraged to participate and weigh in with their own knowledge, experiences and suggestions, which they might consider too unimportant to share (for more on ways of encouraging trainees to participate, please refer to chapter 12). Trainers need to be sensitive and patient in this regard.

## 6. Interpreting during the training: What is important?

### Recommendations in short:

- ➔ In case of different linguistic backgrounds and even if trainers/trainees speak English at a working level: Provide competent interpreting.
- ➔ Interpreters should speak both languages at a high level.
- ➔ Interpreters should have some background knowledge in MHPSS or preparation time with the trainers prior to the training.
- ➔ Interpreters should translate as precisely, literally and neutrally as possible, but also be able to give useful hints regarding common non-verbal ways of communication that the trainer might be unaware of.
- ➔ Trainers and interpreters should ideally meet each other beforehand and go through the training's anticipated proceeding and details.
- ➔ Written material should be given to interpreters in advance for translation.
- ➔ Interpreters have to be impartial, confidential and respectful towards trainees and ideally sign a confidentiality agreement.
- ➔ Interpreters should have access to staff care measures.

While the aim of a qualification programme in MHPSS is to train local trainees, finding local trainers and supervisors can prove to be difficult. Moreover, some trainings will take place in multilingual settings (e.g. in the Kurdistan Region of Iraq). Many trainings will therefore have to be conducted with interpreting, even if trainers and trainees have a working knowledge of English and even if a local co-trainer is present (as is strongly recommended). However, poor interpreting can lead to a lack of real communication between trainers and trainees. The quality of the translation and skills of the interpreter affect the trainees' learning progress and comprehension and is therefore important for the success of a training.

It is thus essential that interpreters' abilities go beyond simply speaking both languages at a high level. In order to provide informed interpreting, interpreters should optimally either already have some background knowledge in MHPSS and be (to a degree) familiar with basic psychological concepts and models or have some preparation time (ideally together with the trainers) to clarify terms and concepts. Good translation does not necessarily have to come from professional interpreters; it is often provided by non-professionals who are sensitive to the topic of MHPSS and have a good understanding of their role as interpreters. Interpreters in training settings should translate as precisely

and literally as possible. Particularly in discussions, they should “translate the chaos”, rather than paraphrasing or summarising and thereby also producing their own version of what has been said. This allows trainers to understand and handle the dynamics that arise. However, particularly when interpreting in intercultural contexts, word-by-word translations can cause confusion, especially with regard to culturally and socially influenced expressions (verbal and non-verbal) that require background knowledge [33]. Interpreters should be able to give useful hints regarding common methods of non-verbal communication (e.g. common gestures etc.), which can help the trainer understand what is being said and the meaning behind it and facilitates dimensions of understanding on a relationship level [34]. It is important to keep in mind that in any process involving interpreting, the communicative transfer can be shaped by the interpreter’s personal views. For example, interpreters’ sympathies with specific individuals or groups can unconsciously play into the translation and affect the training process. For these reasons, interpreters have a great deal of power in terms of information and influence on the training content. They should be very aware of this and ideally consciously be able to balance this power [33].

A meeting between the trainer(s) and interpreter(s) prior to the start of the training is helpful in order to inform the latter about the overarching goal of the training, the planned proceedings and other details of the training. Written material should be forwarded in advance to interpreters for translation, with sufficient time before the training starts. It goes without saying that interpreters have to be confidential, impartial and respectful towards the trainees, given that sensitive topics will likely arise. Ideally, they should sign a confidentiality agreement prior to the training.

Just like for trainees, there is a chance that interpreters have themselves gone through traumatic experiences and are at risk of being overwhelmed by the contents shared in the training or are for other reasons themselves distressed while dealing with the emotional distress coming with some of the training contents. Interpreters should therefore also receive support from the training institution in dealing with this distress as part of an inclusive staff care concept.

## 7. Which questions need to be assessed to tailor the training to the given context?

### Recommendations in short:

- ➔ A training needs to be tailored to the context and to trainees' backgrounds and (future) tasks. This requires assessing the framework parameters that the training will be set in:
  - Relevant assessment questions look at the contextual conditions (e.g. with respect to risk management considerations), trainees' background (e.g. current positions and tasks in their organisation, previous trainings received, the training's potential for sustainability (e.g. local anchoring of the training) and financial framework conditions. These questions should be the basis for training design.
- ➔ The assessment team should preferably consist of or include locals.
- ➔ The assessment questions should be kept in mind throughout the training and the training concept has to remain flexible and adaptive in case conditions change.

A training should always be tailored to the specific requirements and challenges in the given context and to the trainees' backgrounds and (future) tasks in order to ensure its adaptability and usefulness for both the trainees and their future beneficiaries. When a suitable training format has been chosen (e.g. in-service training or vocational training), a thorough assessment of the framework parameters for the training is essential for its design and preparation (albeit often difficult due to ongoing conflict and lack of safety). It is recommended to look into the following questions prior to the training (keeping in mind that it will often not be possible in (post-)conflict contexts such as in Syria and in some parts of Iraq to look into all of these questions).

**Context – which contextual factors have to be taken into account when designing the training?** Trainings have to be tailored to the context to prepare trainees for their tasks – contextual factors therefore have to be known when designing a training. Relevant questions include:

- How freely can the trainers and the training organisation work, and which compromises would they have to make in order to provide the training?
- What are the legal framework conditions affecting the training? (E.g. is the trainer at risk of being legally prosecuted for conducting the training in a certain way or with certain participants?)
- Which implications does participating in the training have for the trainees? How can the safety of the trainees be guaranteed? Are there any possible unintended negative consequences of participating in the training (e.g. risks of aggression or exclusion)?
- Which other MHPSS service providers and training institutions are already on-site?

Which kinds of services do they offer and which approaches do they teach? (Both unnecessary duplication and a shortage of relevant services resulting from a lack in coordination should be avoided)

- What would be a suitable (i.e. safe and accessible) venue for the training? In case the trainees all come from the same town or organisation: Should the training be conducted in the trainees' home town (familiar place, less effort) or away from their home town (release from obligations at home, e.g. house work)?
- What is the (political/historical) background of the suffering? What was or is the conflict dynamic? Are there specific intervention approaches that seem especially appropriate?

**Trainees – who is taking part in the trainings?** For the training to be helpful for trainees, it needs to be tailored to their level of knowledge and to their (future) work. Relevant questions include:

- With which organisations do trainees work? In which positions do trainees currently work? How can the training improve their work in alleviating beneficiaries' psychosocial distress? (e.g., if trainees have already been selected and largely work on a managerial level, the training concept will have to be different from one for trainees who (will) directly work with beneficiaries as MHPSS practitioners.)
- What is the working context of the trainees and how have they worked with psychosocially distressed beneficiaries so far (i.e. which approaches to psychosocial support do they employ implicitly or explicitly)? It is highly desirable that trainers familiarise themselves with the working environment and working contents of their trainees. If possible, trainers should gain a personal impression of the tasks, challenges and defining factors of trainees' working context before the training (e.g. through a visit at work).
- Which trainings have they received already?
- What are trainees' interests and motivations to take part in the training?
- How have they been selected?
- Is translation needed?
- When can the training take place? Can it be a full-time training or do some trainees need to work during the day in order to sustain themselves (and potentially also other members of their family) or because they are indispensable for their organisation? (It is important to ensure that trainings do not interfere with the provision of emergency aid by withdrawing those people who would otherwise provide it or benefit from it.)

**Sustainability – how can sustainability of the training be ensured?**

In order for the training to be sustainable at all, it is relevant that it is not only offered by international organisations in the context of the acute crisis, but is also anchored in local institutions and structures. Relevant questions include:

- Is the training externally induced or locally anchored?
- Are there local institutional structures (e.g. universities) the training could be attached to and that could also create synergies with regard to resources?
- How can follow-up trainings and supervision structures be provided?
- How can upscaling be achieved? Is the implementation of a Training of Trainers approach feasible and reasonable?

- How is MHPSS anchored in the given country in state structures? Does this relationship provide opportunities for cooperation or challenges for conducting the trainings (e.g. in case of competition among actors)?
- Are there opportunities for trainees to work in this field after completing the training?
- Which kind of certification makes sense for the specific training? Are there already legal frameworks on a national level that determine the kind of certification used?

**Financial framework conditions – who pays for the training?:** The question of which costs will arise (including transport, board and accommodation) and who pays for the training is highly relevant in practice. There are many different options that are commonly used. In some cases and especially in in-service trainings, trainees' employers pay for the training. Some providers of trainings charge a course fee that is usually paid by the trainees, others offer the training for free (out of their own budget or with funding from e.g. international organisations or state institutions) and some even offer incentives for taking part in the training. Other individual options are also possible. Financial conditions can ultimately influence the training's quality, as they also affect who takes part in it. If financial incentives are offered for the training, for example, they might attract some trainees who are not interested in MHPSS as such and are not intrinsically motivated to work in this field. Conversely, the intrinsic motivation and commitment among trainees can be high if they pay for the training, but some highly motivated and suitable candidates might be excluded because they cannot afford it. If the training is paid for by another institution (such as state structures or trainees' employing organisation, e.g. in in-service trainings), this institution will likely want to influence the training by formulating some conditions, e.g. choosing the trainees. In these cases, it is often not the most suitable (regarding working context) or most intrinsically motivated participants who are chosen for a training. In many such situations, trainings will be "filled up" with less suitable and less interested employees, which again influences the quality of the training. Who pays for the trainings and what implications this might have should therefore be thoroughly considered before deciding on an option. The financial conditions are also essential with regard to sustainability and the question of how the continuation of the training can be ensured in the longer term.

Assessment and analysis of these questions should ultimately inform training design, which should – if possible – also be carried out by or together with locals who are familiar with contextual factors that outsiders are sometimes not aware of or do not perceive. All of the above assessment questions should be kept in mind throughout the training process and trainings need to be flexible and adaptive in case conditions change.

# Training content: Which knowledge and competencies should be acquired and strengthened in MHPSS qualification programmes?

8. Competencies in building and managing supportive interaction and relationships ..... 36-42
9. Competencies in accompanying a psychosocial support process ..... 43-51
10. Dealing with topics that become particularly relevant in (post-)conflict and displacement contexts ..... 52-57
11. Theoretical background knowledge ..... 58-59





MHPSS refers to all measures designed to preserve and improve psychosocial wellbeing. While the definition of “wellbeing” largely depends on the individual’s language, culture, social context, and value system, psychosocial wellbeing in the context of this recommendation paper refers to a positive mental state that fosters personal growth, enabling the individual to relate constructively to other people. It is a lifelong, dynamic process [1]. Various interlinked kinds of support are provided to respond appropriately to the wide range of psychosocial needs and distress in a given context. Usually, four layers of support are differentiated in MHPSS:

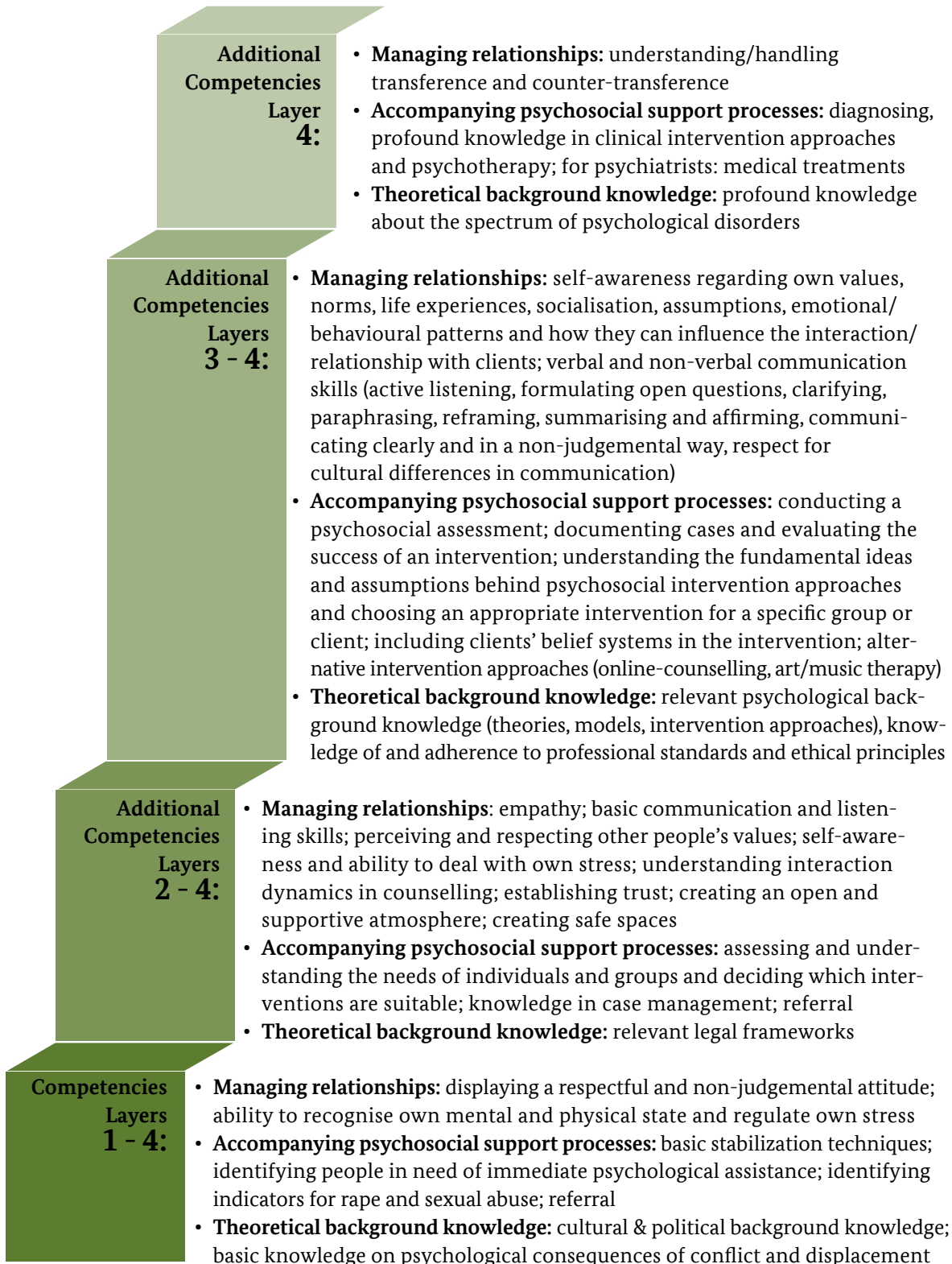
- (1) A large majority of an adversity-affected population (according to the most recent WHO estimates nearly 80%; [35]) can stabilise themselves psychosocially if they find themselves in a secure and supportive environment. At the same time, most displaced people will depend on the provision of basic services, such as food, shelter or WASH-services. An MHPSS-sensitive provision of those services means that they are provided in a dignified and reliable way and avoid negative consequences, such as leaving beneficiaries feeling disempowered.
- (2) For many people, initiatives and activities aiming at the establishment of stable relationships and social networks (e.g. through sports or artistic activities) and the creation of safe spaces can be enough to empower them, to enhance their wellbeing and to support them in regaining a feeling of agency and control.
- (3) Only a smaller group of people needs explicit MHPSS interventions, such as individual, family or group counselling or dialogue processes, which aim at stabilising and empowering beneficiaries and professionally accompanying them in processing their distress. Such interventions can be provided by psychosocial counsellors, social workers etc. Services on layers one, two and three are called non-specialised support.
- (4) A comparatively small fraction of the population (according to WHO estimates around 5% of adversity-affected populations; [35]) needs MHPSS interventions on a clinical level (such as psychotherapy or psychiatric interventions), for example because they have experienced massive violence or because of pre-existing mental health conditions. Such services should only be provided by relevant professionals, such as psychotherapists. Interventions on layer four are called specialised support.

All of the layers mesh and MHPSS is ideally expected to take place on all four layers simultaneously in a holistic approach, since it includes the expertise of various actors and since psychosocial wellbeing depends as much on the accessibility of food and shelter as on the emotional stability needed to manage everyday challenges.

When providing psychosocial support to survivors of armed conflict in (post-)conflict settings, the most important competencies are empowerment and stabilisation of beneficiaries and helping them cope with their experiences and distress and develop perspectives in spite of them. On all layers, **competencies in building and managing supportive interaction and relationships** are any MHPSS worker’s most relevant competencies and are vital to achieving these goals. They should therefore be at the core of MHPSS training concepts. For MHPSS professionals who accompany longer group or individual psychosocial processes (especially on the third and fourth layer and to an extent on layer two), **competencies in accompanying a psychosocial support process**

are needed and should therefore be part of vocational or in-service trainings. Instruction on *relevant theoretical concepts* is likewise important, but they should mainly be a means to enable trainees to use their (often already existing) knowledge and abilities more consciously and to provide a foundation for their practical skills and competencies in managing relationships and the psychosocial support process. Naturally, the skills and competencies needed in MHPSS cannot be clearly categorised according to the layers (which constitute a theoretically constructed distinction that does not always necessarily adequately depict reality), but in many respects overlap. Nevertheless, the graph on page 35 attempts to give a simplified, systematic presentation of which competencies are needed on which layer (Competencies stack up additively from bottom to top, with each layer requiring further skills in addition to the ones of the layers below).

Summary of competencies required at the different layers of support








## 8. Competencies in building and managing supportive interaction and relationships

A psychosocial support process can only become effective when the MHPSS practitioner and the beneficiary experience the contact between them as personal and meaningful. The focus of a vocational or in-service MHPSS training for all actors working in this field (including social workers, community workers, psychosocial counsellors, teachers, psychotherapists etc.) should thus be on skills for creating a safe atmosphere, making contact with a person, trying to understand their experiential world and empowering them. Competencies in building and managing supportive interaction and relationships are thus central on all layers of support and are the basis for any psychosocial work. Key competencies include self-awareness and self-reflection, the ability to build meaningful relationships and profound communication skills. Moreover, a sound staff care concept is required to ensure a professional's long-term ability to work in this field and be able to build stable relationships.

### Self-awareness and self-reflection

#### Recommendations in short:

-  Promote trainees' self-awareness regarding their own values, norms, life experiences, socialisations, assumptions, prejudices and emotional/behavioural patterns and how they can influence the interaction/relationship with clients.
-  Provide a space to reflect on one's own vulnerabilities and strengthen the ability to confront and deal with them.
-  Give time and space in the training to reflect on one's own potential experiences of violence, loss or traumatisation (How do I react to stress? How can I deal with triggers and stabilise myself?) and how they might either be a hindrance or a resource as an MHPSS worker.
-  In order to allow for self-reflection, trainings must be held in safe and trustful spaces; it must be voluntary to share personal stories and self-reflections.
-  Work with a minimum of two trainers to be able to provide support if a trainee is in need of stabilisation and plan extra time for this (possibly outside of the training hours).

In order to support people in psychosocial distress, it is necessary to engage in supportive contact and interaction and to offer and manage safe and supporting relationships. A key competence for this is the ability to change perspectives and to perceive, tolerate and accept differences in other people's norms, values and perspectives. This, in turn,

presupposes self-awareness and self-reflection about one's own values, life experiences, socialisation and the assumptions or prejudices with which one meets beneficiaries and an awareness of the fact that these may influence interactions with them. For example, a topic that often leads to defensive reactions and conflicts of values among MHPSS staff in the Middle East is that of homosexuality. Tolerance for other peoples' self-concepts and the ability to engage all beneficiaries first and foremost as fellow human beings in an unprejudiced way despite personal value systems is an important trait of an MHPSS worker, and self-reflection is essential to achieving this goal. Self-reflection is therefore an integral part of any in-service or vocational training for professionals who (will) work in the field of MHPSS [7]. Trainees who (will) work on a more focused layer of psychosocial counselling need to understand their own personality even better with regard to biographic-subjective aspects and their socio-historical context. They have to understand their own thinking patterns, feelings and behaviour in order to avoid letting their own fears, defences and desires influence an interaction, which can cause harm to the beneficiaries.

The ability to self-reflect and understand which elements of one's own experiences influence one's behaviour and relationship with a beneficiary becomes especially relevant in a training context in which many trainees have themselves experienced traumatic events and live under ongoing threat and tension. Trainees need to learn first and foremost how they themselves react to stress, how they can recognise triggers that might lead to reliving their own fears and threatening memories and how they can deal with these triggers and feelings to stabilise themselves. Emotional instability, high tension or even a breakdown or dissociation of an MHPSS worker due to a lack of self-reflection can be very harmful and destabilising for beneficiaries. A related risk that is likewise associated with a lack of self-awareness is over-identification with the distressed person with the tendency to help relentlessly without strengthening beneficiaries' resources and autonomy, which can lead to passiveness, regression, lethargy and ongoing dependency on their side. Being able to distance one's own feelings and experiences from those of the beneficiary and becoming aware of own needs are important lessons to learn during self-reflection exercises.

Given the above, self-reflection is also a big challenge for every trainer, as it transforms the training space itself into a counselling and sometimes even therapeutic space. In order to allow for this in a sensitive and responsible manner, it is of utmost importance to create a safe and trustful space among the group of trainees and ideally to work with at least two trainers to have the option to offer individual counselling during or after the training in case a participant needs more attention and stabilisation. Of course, it must be voluntary for trainees to open up and reveal self-reflections.

## Offering supportive contact and building relationships

### Recommendations in short:

- ➔ A supportive relationship between counsellor and client is essential for the outcome of the counselling process: Strengthen trainees' personal competencies in this regard (empathy, perceiving and respecting clients' values, dealing with differences, communication skills, resource-orientation, giving a secure frame etc.).
- ➔ Strengthen trainees' competencies in establishing trust, creating an open, supportive atmosphere and safe spaces and an attitude that is conducive to relationship building in a psychosocial support process.
  - The relationship between counsellor and client should be open, transparent and non-hierarchical.
- ➔ After the training, trainees should know about and work on the basis of culture specificities regarding relationship building and should at the same time be sensitised to the fine line between cultural sensitivity and culturalisation.

The success of psychosocial support processes in any setting (school, social work, counselling, psychotherapy etc.) strongly depends on the professionals' social interaction with their beneficiaries. Especially in MHPSS, the quality of the interpersonal contact in the relationship between professional and service user is of utmost importance for a positive support process and its outcome [36]. Building relationships is thus an essential competence for professionals working in MHPSS on any layer of support ([23]; [37]).

Some key competencies and attitudes when building trusting and meaningful relationships that should be strengthened in trainings include the following ([1]; [37]):

- Empathy (without giving up boundaries)
- Ability to provide a securing frame even in tragic situations and create safe spaces
- Communication and conflict management skills, impartiality in conflicts (especially when working on the community level); differentiation between offender and offence
- Ability to strengthen existing resources, building on the distressed person's self-healing powers and empathically supporting their efforts in the healing process
- Sensitivity for those who have become victims of violence and an attitude of human solidarity towards the target population
- Being open to learn and question one's own beliefs and adapt new knowledge
- Fostering people's self-efficacy
- Respect for all people, belief in human dignity
- Gender- and cultural sensitivity
- Avoidance of being overly directive or judgemental
- Commitment to non-violence and no abuse of positional power
- Awareness of one's own role related to the psychosocial support process

Refugees and IDPs have often gone through a sequence of potentially traumatising events, have lost social networks and support systems, continue to live in ongoing conflict situations and/or precarious and stressful economic and social situations and are often confronted with rejection and discrimination. Building trust and providing a supportive relationship under these circumstances can be particularly challenging and might require a great deal of patience and sensitivity. Especially when the MHPSS practitioner comes from a different background than the beneficiary, cultural or social differences in relationship building might also come into play. Training elements directed at skills in relationship building should thus also relate to patterns and specificities in building relationships in the target group.

Working with refugees and IDPs in the Middle East requires attention to specific aspects in relationship building that trainers should be aware of and that should be reflected on in trainings. Many IDPs and refugees from the Middle East were raised in societies where a high importance is placed on relationships in all facets of life – professional and private. Interpersonal relationships are characterised by a specific understanding of closeness and distance and an internalised concept of honour, which also depends on the interacting parties' gender [38]. Some societies are highly patriarchal and on top of that, endorse a high respect/esteem for the elderly – knowledge is transferred from older people to younger people [38].

Psychosocial support is not a prominent concept in the region in general and particularly counselling is not yet a familiar form of intervention. As a result, many clients in psychosocial counselling expect a hierarchical doctor-patient-relationship, give answers as socially expected and hope for quick relief through medication [23]. Instances have been reported in which clients did not show up for their second appointment because they were ashamed and discouraged that their problem had not disappeared after the first session. Clients also often expect counsellors to explain symptoms, give advice and solutions, which does not conform with psychosocial counselling as a process that requires clients' active cooperation.

In any psychosocial support process, the relationship between professional and service user should be open, transparent and non-hierarchical. Beneficiaries should be empowered to find their own ways and solutions for dealing with distress in order to avoid reinforcing feelings of powerlessness and loss of control and to avoid creating situations in which beneficiaries feel subordinate and dependent on the resources and expertise of the MHPSS professional [7]. Being transparent about the aims of the counselling or support process and the roles of the service user and the service provider (community worker, social worker, psychosocial counsellor, teacher etc.) in the process are therefore all the more important.

While it is indispensable for MHPSS workers to be sensitive to norms and values and to know about common behavioural patterns influenced by socialisation and culture in the context they work in, culture-sensitivity

also bears a risk of turning into culturalisation. Working with people from other socialisation spaces such as refugees and IDPs can cause differences to be perceived more strongly, forming (negative or positive) stereotypes and putting people into boxes. Such a generalised categorisation according to culture (i.e. culturalisation) conceals individual traits, behaviours, emotions, problems and needs and is often harmful. Moreover, when working with refugees and IDPs, there is a tendency to generally assume that all “of them” are traumatised, which is not the case. Trainings should explicitly address and sensitise trainees to the risk of culturalisation and of thinking in categories of “us” and “them” vis-à-vis service users. They should work towards a good understanding of the context while preventing trainees from falling into the trap of focusing too much on what they perceive to be culturally influenced behaviours, emotions and cognitions or of generally assuming that all refugees and IDPs are traumatised.

## Communication

### Recommendations in short:

- ➔ Strengthen verbal and non-verbal communication skills (active listening, formulating open questions, clarifying, paraphrasing, reframing, summarising and affirming, communicating clearly and in a non-judgemental way, non-violent communication).
- ➔ Trainees should learn to respect cultural differences (e.g. indirect vs. direct expressions when talking about distress etc.) and engage clients within their common communicative manner.
- ➔ Strengthening conflict-management skills can be helpful, especially for people who will work in community-based or group-settings.

A supporting relationship between MHPSS worker and service user strongly depends on the professional’s communication skills. Verbal and non-verbal communication and interviewing skills as well as non-violent communication skills are thus among the most important competencies to be strengthened during an MHPSS training ([22]; [28]; [39]). This includes active listening skills, formulating open questions, clarifying and paraphrasing and reframing as well as summarising what the other person has said [39]. At the same time, training in the realm of communication also has to happen in a way that is sensitive to specificities in the given context. Trainers, especially international trainers, should become aware of relevant patterns in communication in the given context and shape the training accordingly.



While it is already common to resort to indirect expressions when asked about personal wellbeing in the Middle Eastern region, actual or anticipated stigmatisation can lead to even more indirectness on the distressed person's part. Problems, worries, and distress are usually only discussed within the family nucleus in this region and even then, shameful and particularly harmful elements are omitted [38]. In a psychosocial support process involving a personally unknown professional, people from this region often initially use a formal, impersonal and reserved style of communication [38].

Engaging with service users, clients or patients using their familiar communicative manner is crucial in establishing a trusting relationship. It might take a long time for them to speak about personal topics, which should gently and patiently be supported by the social or community worker, counsellor or therapist. Given the particular socio-political context in (post-)conflict settings and the often existing demand to work in community-based or group settings (also to work towards reconciliation and social healing), conflict management skills (identifying dispute mechanisms as well as different stages of disputes and being able to manage them) can become especially important (see chapter 10).

## Staff care and self-care

### Recommendations in short:

- Highlight the importance of staff care and self-care as an integral part of trainees' future work.
- Staff care is vital for the provision of safe and effective services: Sensitise and empower trainees to claim their right to staff care.
- Foster trainees' realistic assessment of what they can achieve and point out the importance of dividing responsibilities among different service providers. Foster an understanding of how to divide tasks.
- Strengthen trainees' emotional and body-awareness as well as their capacity for self-care; teach basic self-care techniques.

Working in the field of MHPSS is highly demanding. Many service providers working with people affected by conflict, displacement and violence in humanitarian aid or development cooperation – and particularly those dealing with their psychological suffering – feel overcharged and mentally strained themselves. Motivated staff is prone to overtaxing themselves, which can lead to compassion fatigue or even vicarious trauma, depression or burnout. This can have deteriorating effects on the personal wellbeing of the caregiver and also impair staff's ability to deliver services and support and em-

power the people they work with and for [40]. Staff care – i.e. measures to support staff working in MHPSS in dealing with the many stresses and pressures they are confronted with during their work as well as measures to enhance staff’s wellbeing – is vital in such contexts. Staff need an enabling working environment and access to sufficient support within their organisation in order to provide safe and effective services ([40]; [41]). Regular exchanges on the demanding conditions, stresses and challenges under external supervision are one example of a very helpful staff care measure, and room for such reflections should be provided within any organisation whose employees work with distressed people.

Empowering trainees to feel confident within their organisation to communicate strengths, problems and needs openly as well as to claim their rights to staff care and recreational measures is an important aspect to consider in trainings. During in-service trainings, trainees working in managerial positions are often present, which is a good opportunity to raise awareness for the need of a sound staff care concept at the organisational level directly in the training. Furthermore, trainees should already within the framework of the trainings gain an understanding of what they can realistically achieve in their individual work, that there is a division of responsibilities among different service providers and that coordination with other actors is highly relevant in MHPSS. Awareness on how to communicate, divide tasks and cooperate in a team and with other actors providing (psychosocial) support should be raised in order to prevent work overload.

Emphasising the importance of self-care and strengthening trainees’ capacity in this regard as well as their emotional and body awareness are vital components of MHPSS trainings [42]. After a training, participants should be able to recognise indicators of stress in themselves as well as in others and they should have learned some basic self-care techniques and principles that they can draw on in their work (such as breathing techniques, imagination exercises, relaxation techniques etc.). Trainees should also have gained insights into how their own and their colleagues’ resilience can be strengthened as a preventative measure (this, in turn, largely relies on a staff care concept at the organisational level). It is advisable to encourage the development of peer support programmes on the job. Only an MHPSS worker who recognises stress, is supported by the organisation through staff care measures and engages in self-care is able to support psychosocially distressed beneficiaries in the long term.

## 9. Competencies in accompanying a psychosocial support process

The focus of this recommendation paper is on vocational or in-service trainings particularly for people who will work as psychosocial workers and counsellors in community-based as well as individual settings (layers two and three). This chapter will therefore discuss relevant skills in accompanying and guiding the psychosocial support process particularly for those two layers – all while being aware that competencies cannot be partitioned neatly according to the layers and vary from working context to working context.

### Psychosocial assessment and diagnosis

#### Recommendations in short:

- ➔ Enable trainees on all layers of support to conduct a psychosocial assessment – this includes summarising and sorting the distressed person's main problems, identifying resources, explaining problems and their interrelation in the context of psychological background knowledge and developing a plan of intervention in a collaborative way with the distressed person.
- ➔ Those in specialised services should be familiarised with the spectrum of psychological disorders and be trained in diagnosing them (including using applicable diagnostic instruments).
- ➔ Sensitise trainees for potential consequences of diagnosing (relief vs. harm/labelling/stigmatisation); having passed through a potentially traumatising situation does not automatically mean developing a symptomatology of clinical relevance.
- ➔ Sensitise trainees that since assessment or diagnosis primarily takes place in the first sessions (while being an ongoing process), it has to be conducted in a very sensitive and transparent way and that it is most important to stabilise the distressed person and create a comforting atmosphere and safe space in this phase (do not increase disempowerment by making the client feel like a "case").
- ➔ The results of the assessment/diagnosis should be shared with the client/patient in an appropriate, transparent and comprehensive manner (include modules on psycho-education in the training).
- ➔ Familiarise trainees with culturally influenced understandings and idioms of distress / explanatory models of suffering and sensitise them to the high degree of somatisation in the region.

In the beginning of each counselling or therapeutic process, the professional conducts an assessment of the psychosocial problem(s) at hand, which is continuously revised and revisited - a skill that has to be developed during a training. MHPSS staff working on all layers of support and in both individual and group settings should be able to conduct a psychosocial assessment.

### **What is a psychosocial assessment?**

A psychosocial assessment aims at summarising and sorting the distressed person's core problems as experienced by him- / herself, his / her needs, difficulties as well as strengths and resources. It takes the context and systemic level (relationships, family, community) into account. Utilising his or her theoretical psychological background knowledge and in a collaborative process with the client, the MHPSS worker relates the service user's problems to one another and explains how and why he / she may have developed these difficulties at this particular time and in this particular situation. Based on this, the psychosocial assessment gives rise to a plan for intervention, i.e. an explanation of what can be done to reduce or deal with the problems at hand (drawing on the distressed person's resources) and a target definition for the psychosocial support process that is transparent for both the MHPSS professional and the service user [43]. Psychosocial assessment is in this sense a process of ongoing collaborative sense-making that is constantly open for revision and re-formulation ([37]; [44]). A psychosocial assessment is accordingly best evaluated in terms of its usefulness or appropriateness for the beneficiary (not an "objective truth") - it summarises meanings and negotiates shared ways of understanding and communicating about them [45].

Psychosocial assessment is thereby an alternative to diagnosis, which would aim at assigning a clinical category to an individual according to the reported symptoms in a non-collaborative way according to a comparatively rigid classification system. In contrast to a more comprehensive and adapted psychosocial assessment, diagnoses can be disempowering and stigmatising, as they individualise and medicalise problems and usually do not look at relationships or the general context service users find themselves in.

A psychosocial assessment should therefore be the first step on any layer of support. Should an individual show levels of distress that are of clinical relevance or symptoms indicating mental health conditions, a psychotherapeutic diagnosis should be carried out by a specialist in a second, additional step.

In addition to a psychosocial assessment, MHPSS professionals who offer specialised therapeutic services should be trained to conduct clinical diagnoses. This means that they should receive extensive theoretical instruction on the spectrum of mental health conditions and should be trained in diagnosing for example depression, anxiety disorders, psychoses and dissociative disorders as well as post-traumatic stress disorder (PTSD). Risk and protective factors on the individual, family and community levels as well as common co-morbidities must be understood [29]. Practicable (and if possible lo-

cally adapted) diagnostic instruments should be included in the curriculum. With regard to the process of diagnosing, trainings in MHPSS on a more specialised layer should also address that a clinical diagnosis might be helpful and necessary, for example because it provides the patient with a clinical explanation, which might lessen the burden for some beneficiaries. In some circumstances, it is even necessary to diagnose in order to initiate a process of treatment, medication and coverage of the costs through health insurance ([39]; [46]). On the other hand, diagnoses can also be harmful, as they bear the risk of leading to stigmatisation and of pathologising and medicalising a normal reaction to abnormal events.

For future MHPSS professionals it is relevant to understand that trauma and traumatisation are fluid concepts that often (and especially in contexts of conflict and forced migration) cannot be captured by the diagnostic category of post-traumatic stress disorder alone. Particularly in conflict contexts, it is much more fitting to understand trauma and stress as a process – a sequence of adverse events that lead to repeated experiences of helplessness and powerlessness (e.g. experiences of violence, loss and war in the home country, being forced to flee, loss of control over one’s life in refugee camps etc.) [47]. Moreover, trainees need to understand that there is a difference between people feeling traumatised and people having developed specific trauma-related symptoms in a clinically relevant manner. Trainees for MHPSS have to be sensitised to the fact that having passed through a potentially traumatising situation does not automatically imply developing a trauma-related symptomatology of clinical relevance – some people manage to cope due to personal resources or support from the family or society; others may actually be suffering from symptoms of depression and anxiety related to current stressful situations that make different interventions necessary and effective. Diagnoses should for this and other reasons never be given casually.

Especially given the fact that the psychosocial assessment or diagnosis shapes particularly the beginning of a psychosocial support process, it is important that MHPSS professionals do not leave those using their services with the feeling that they are “making a case” out of their suffering. Several measures are recommended in this regard:

- The first session should not only consist of an assessment/diagnosis and taking notes, but should mainly be directed at stabilising the client/patient and creating a warm and comforting atmosphere / safe space in a context where private, secure spaces are rare.
- It is vital to avoid further disempowerment by being transparent and participative in the assessment or diagnostic process and showing a genuine interest in the client or patient as a person and not as a case.
- Beneficiaries should always be informed about what psychosocial support, counselling or therapy are, what they can and cannot do and how the intervention will proceed.
- Beneficiaries should understand that MHPSS interventions are long-term processes shaped by both sides and that an initial lack of success of the intervention does not

mean it is their fault or that psychosocial counselling or therapy does not work for them.

- The explanations developed in the psychosocial assessment or diagnosis should be shared with the beneficiaries in an appropriate, transparent and comprehensive manner that makes the identified sources of distress, dysfunctional patterns of thinking and/or behaviour and their interrelations clear to them in a way that is understandable for non-professionals (psychoeducation). This can also help clients better understand their psychosocial suffering, adopt (more) functional coping strategies and understand and comply with the intervention. Psychoeducation moreover has a stabilising effect, as it gives the distressed person orientation and thereby a form of security. Including modules on psychoeducation into trainings for future psychosocial counsellors or psychotherapists is therefore highly important.

When assessing MHPSS needs, problems and resources, it is crucial to be aware that events that lead to distress or traumatisation and the ways of reacting to these events not only differ between individuals, but are also influenced by culture and socialisation. For example, in parts of Iraq, Syria and other societies in the Middle Eastern region, aggressions like sexual harassment of women are understood as fundamental aggression towards the communities' basic values and have a collective impact beyond the individual experience of the survivors due to a prevalent concept of honour and shame that extends to the family and community. Moreover, suffering is expressed through different culturally influenced idioms of distress ([7]; [48]; [49]), which relate to the distressed person's specific experiential world and explanatory models for their suffering. Idioms of distress are a context-based set of vocabulary for expressing distress. The vocabulary is usually understood by members of the same context and culture and accepted as such to a certain degree. People in different parts of the world express their reactions or emotions in the frame of certain social or cultural contexts and in ways that do not necessarily coincide with international frameworks (such as diagnostic standards). In turn, similar "symptoms" (as identified with the same diagnostic instrument) in different contexts do not necessarily mean that the people have had comparable experiences, interpret their experiences in the same way or that these "symptoms" have to lead to the same conclusion in a psychosocial assessment or diagnosis [49]. Explanatory models of distress are cultural systems of knowledge, beliefs, and practices that refer to the ways people explain and make sense of their symptoms or problems. In particular, they suggest how people view causes, course and potential outcomes of their psychological problem, including how their condition affects them and their social environment and what they believe is an appropriate treatment [7].

In many contexts in the Middle East – depending on the level of education and the societal living context (e.g. rural or big cities with a more transitional influence, form of religion and religious identity and practice) – idioms of distress are based on a complex system of metaphors and proverbs, which MHPSS professionals need to understand in order to better identify stress reactions or signs of psychological disorders, intervene adequately, communicate more effectively with the client and increase the client's acceptance of the service [7]. In Islamic belief, the soul and body form a unit and physical and psychological aspects of experiences are closely intertwined. Often, symptoms are expressed through (and genuinely felt as) bodily sensations

such as physiological pain or malaise. Common examples include (see [7], p. 23ff. for an extensive list of idioms of distress in the Syrian context):

- My psyche is suffocating (hopelessness, boredom, rumination)
- I feel like my soul is leaving me (sadness, inability to cope, worry)
- Blindness got to my heart (sadness, worry, being pessimistic)
- My breath is short (low mood)
- My heart is aching / I have pain or a feeling of pressure in my chest (stress, anxiety, sadness)
- My heart is squeezing (anxiety, worry)

Apart from differences in experiencing and expressing distress – the concepts of certain forms of distress do not necessarily overlap between cultures. There are, for example, different concepts of (and words for) anxiety and trauma in Arabic, referring to different feelings of anxiety depending on the situation or type of “trauma”. Experiencing psychological symptoms is in this context also often linked with the fear of “going mad” including the fear of being stigmatised in the society, which is why such symptoms might not be reported in a first interview and before a sufficiently trustful relation is established.

Being familiar with local idioms of distress and explanatory models for mental health problems (particularly relating to traumatisation) helps to understand psychological issues when working in the region and therefore needs to form part of a training, especially for MHPSS professionals working in a more focused person-to-person setting. Given the above explanations, diagnostic instruments from the Global North are not necessarily applicable for diagnosing psychological disorders in other cultural contexts. Culturally adapted diagnostic instruments might be better suited to assess the symptoms in a more adequate way and avoid potentially harmful misdiagnoses that might lead to the application of inadequate interventions in counselling and therapy [46]. In light of the above explanatory models and idioms of distress, trainees on all layers of support in this context should furthermore be made aware of the high degree of somatisation – i.e. experiencing physiological reactions like pain that have no biological cause, but are attributable to psychological processes. They should receive thorough training on how to determine whether the physiological suffering described by the service user could actually relate to psychological distress and how to explain this fact to the distressed person in a way that does not leave them feeling not taken seriously or deterred from using MHPSS services.

## Understanding and deciding which interventions are suitable and adapting them to case and context

### Recommendations in short:

- ➔ Include an introduction to the ethical, philosophical and theoretical backgrounds (“schools of thought”) of the intervention approaches introduced during the training.
- ➔ Ensure that trainees understand the fundamental ideas and assumptions behind an intervention approach and encourage and enable trainees to choose an approach that is useful for themselves, for their working context and for the specific needs of their clients.
- ➔ Enable trainees to decide which support systems should best be activated to support the distressed person (case management) and which service providers to include in / refer to regarding this process.
- ➔ Alternative intervention approaches like storytelling, art or music therapy, spiritual approaches etc. can be helpful for helping beneficiaries to open up and foster resources.
- ➔ Combining aspects of indigenous practices related to mental healing with psychosocial interventions can be helpful.

Staff working in psychosocial support need to understand the basic assumptions and theories of change behind an intervention in order to use it in a meaningful way. This applies to interventions on all layers. Trainees working on layer one or two need to understand how they could, for example, set up a sports game in order to produce psychosocial benefits. Trainees working as psychosocial counsellors or therapists need to understand the ideas behind certain approaches to counselling or therapy in order to apply them meaningfully for beneficiaries. Following a technical step by step logic without tailoring the intervention to the clients’ or patients’ needs and without analysing whether the surrounding support system is sufficiently developed for the selected method can, in the worst case, cause significant harm for the distressed person. Ultimately, trainees should therefore be encouraged and enabled to choose and adapt an approach or aspects of various approaches they consider useful for their own practice. Trainings that introduce specific psychosocial intervention approaches should therefore include an introduction to the ethical, philosophical and theoretical background and origin of the respective approaches, underlying values, assumptions and definitions of trauma and the academic “schools of thought” behind them. Especially in conflict situations with a high influx of international organisations that offer trainings with often contradictory approaches, trainees should be taught to understand the fundamental ideas behind an approach and the fact that each approach is only one among many in the vast field of psychological and trauma theory and practice.

The following questions might help trainees analyse and decide which approach or method is suitable for a specific context and an individual beneficiary:



- What is the context in which a certain counselling or therapeutic process is envisioned? (e.g. integration or rejection in host communities, difficulty/impossibility to obtain work permits and related feelings of helplessness, dependency, ongoing threats to survival?)
- Is an individual counselling or therapy the most promising approach?
- Is the beneficiary aware of the objectives of the method and able to regulate emotions sufficiently for the implementation of the approach (e.g. to face traumatic memories)?
- How high is the probability that the person will complete the counselling process?
- Has a meaningful relationship between MHPSS professional and service user been established?
- What does the social support system (family, community) look like?
- How does the social support system understand and value the method/approach?
- Which support systems can best be activated to support the distressed person (case management)? The best support mechanisms can for example also be social workers, community workers or teachers instead of counsellors or therapists. A cooperation and coordination among several support systems is often necessary to enhance an individual's psychosocial wellbeing.

With regard to trauma therapy as a relevant example for an intervention in conflict- and post-conflict contexts, evaluating different approaches and adapting them to the specific context can for instance lead to the following considerations: Some trauma therapy approaches assume that it will be important for survivors of traumatic experiences to go more deeply into the memory of the traumatic event at a certain point of the recovery process, to bring it into a narration, to share it with an empathic listener (e.g. a psychotherapist) or share it in a group [50]. It has to be stressed, however, that even this mild form of a trauma-focusing approach requires for the counsellor or therapist to be knowledgeable about differential diagnostics of psychological disorders, about how to handle dissociative reactions and how to minimise the risk of re-traumatisation when disclosing traumatic contents. On the side of the clients/ patients, also a mild form of a narrative approach requires safety and a low level of current psychosocial stress and presupposes that the client or patient is informed about the procedure and deliberately wishes to talk about her / his individual traumatic experiences. These minimum standards of safety and stability are in most cases not met for refugees and IDPs in the context of the crises in Syria and Iraq. Therefore, trainings need to transmit that in-depth-exposure to or processing of trauma may be contra-indicated in the early phase after a traumatic situation and is also contra-indicated when a survivor shows dissociative symptoms, a high tendency for flashbacks, severe depressive mood or suicidal ideation [51]. Instead, intervention approaches focusing on stabilisation and on grief counselling as well as skills- and resource-oriented modules are of central importance in these settings.

The prevalent stigmatisation of psychological issues in the Middle East as well as different forms of experiencing and expressing suffering can suggest alternative approaches to counselling. Alternative forms of expression (e.g. in creative intervention approaches such as art and music therapy or play therapy for children) can help beneficiaries open up and deal with their suffering. Storytelling and expressing thoughts, feelings and experiences with metaphors in an indirect way is another suitable intervention approach when working with people who perceive themselves to be in a stigmatising and isolating environment. In many contexts, religious and cultural practices are deeply related to mental healing processes and in many peoples' explanatory models for distress and for healing, religion and traditions play an important role in dealing with and integrating traumatic experiences. For these people, religion or traditional practices can be a relevant entry point and key for coping. Sometimes psychosocial interventions can be fruitfully combined with local religious, spiritual and traditional practices for dealing with trauma and loss [28]. For example, burial rituals can be important for bidding farewell to people lost during conflict (for an example on how indigenous approaches can be combined with psychosocial interventions see [52] and [53]).

## Competencies in cooperation with other MHPSS workers and referral

### Recommendations in short:

- ➔ Sensitise trainees to the importance of cooperating with other MHPSS workers within and outside their organisation and of referral, include relevant referral paths, in the training and equip trainees with basic competencies to identify which referral paths are available and indicated.
  - Sensitise trainees to the fact that providing MHPSS services without being qualified to do so can cause harm.
- ➔ Prepare trainees for handling situations in which they cannot provide sufficient support, but also cannot refer to cooperating MHPSS professionals (this includes being aware of and respecting one's own limits while stabilising as much as possible).

A crucial technical skill for professionals working on all layers of MHPSS support is to assess whether they actually have the means and competencies to meet a specific service user's needs or whether the latter needs to be referred to another MHPSS professional and if so, to which one. For anyone working with populations in emergency or crisis settings, this requires the ability to identify indicators of (severe) psychosocial distress or even mental health conditions and the close cooperation with MHPSS providers within and outside their organisation who are qualified to offer appropriate support. It should be noted in this context that MHPSS practitioners working on specialised layers might not always be the right service providers to support a person that is being referred to them and that a professional's ability to support a certain person does not always coincide with the layer they work on [36]. It is important for trainees to understand that trying to

support a person in severe psychosocial distress without being qualified to do so and not referring them to a more qualified service can cause tremendous harm and that having been trained in MHPSS does not mean that one can (or worse, should) deal with all kinds of psychosocial needs. At the same time, and particularly in crisis settings, cooperating with other MHPSS workers is often not possible, since there is simply no other provider (and in many cases no specialised MHPSS practitioner). Preparing trainees for the fact that they might be the sole service provider and might be confronted with cases they consider too severe to handle themselves while having no referral option is therefore important. Trainees should become aware of their personal limits and understand the necessity and value of respecting them, while stabilising and empowering distressed beneficiaries the best they can. Learning how to endure situations in which they cannot solve a person's stressful situation, but can only be present and accompany the person through severe feelings of distress, is a lesson that cannot be conveyed in classroom settings alone, but is learned in supervised practice and should be supported by a sound staff care concept.

## Documentation and evaluation

### Recommendations in short:

- ➔ Trainees should learn how to document cases in order to verify and, if appropriate, adjust diagnosis and intervention. This includes informing trainees about the risks of documentation, especially with respect to data sensitivity/confidentiality.
- ➔ Include modules on how to evaluate whether the achieved impact matches the goals set at the beginning.

In addition to competencies in psychosocial assessment and intervention, case documentation and the evaluation of the intervention approach play an important part in the daily work of MHPSS practitioners. Documentation helps the MHPSS professional verify and, if appropriate, adjust the conclusions of the psychosocial assessment and the intervention approach throughout the psychosocial support process and monitor the service user's progress ([37]; [39]). Teaching trainees to evaluate whether their interventions have actually achieved the goals set at the beginning of the psychosocial support process helps ensure the quality and success of their services. Documentation can also be crucial for insurance, donors or others who are financially involved in the services. In addition and particularly in (post-)conflict contexts, documentation may for example involve human rights violations or war crimes and can thereby be relevant for (criminal and transitional) justice processes. Trainings should therefore incorporate methods of structured documentation. This includes informing trainees about the risks, especially with respect to data sensitivity and confidentiality.

## 10. Dealing with topics that are particularly relevant in (post-) conflict and displacement contexts

### Working with groups and conflict management

#### Recommendations in short:





- ➔ In (post-)conflict contexts, MHPSS approaches that target the community are highly recommended.
  - Enable trainees to create safe spaces and initiate low-threshold group activities, which allow for the experience of becoming an active agent again.
- ➔ Include modules on how to work with groups and how to deal with different stages of group processes.
- ➔ Group counselling/ dialogue sessions with former adversaries can be a good, but also highly sensitive way of working towards reconciliation and an acknowledgement of injustices.
  - Such processes need the explicit consent of everyone involved and preparatory work especially with former victims/survivors.
  - Only initiate such processes if the situation and the participants are stable enough – many people will only be ready to talk about traumatic experiences after a significant amount of time has passed since the event.
  - Provide training on conflict management.

In conflict- or post-conflict settings where many people are suffering from psychological distress and especially in contexts that put a high esteem on the community and social fabric, intervention approaches for the community are generally advisable. In any psychosocial support setting in (post-)conflict scenarios, safe spaces where narratives can be shared, emotions released and information about traumatic stress as well as everyday problems examined, are vital in order to allow for individual and collective change and healing processes [54]. A relevant skill to convey in a training, particularly for trainees who (will) work in non-specialised support, can therefore be initiating low-threshold group activities (such as creative or body work, relaxation and movement activities/sports) or establishing community spaces for people to come together to cook and eat, discuss daily problems and how they could be solved, play with children and exchange ideas. Initiating such activities can be very helpful to activate resources in individuals and communities and allow for the experience of becoming an active agent again. As a first step, this requires an analysis of the situation in the community and community sensitisation activities whose design and conduct can be part of methodological training modules for these layers of support [46].

In light of the collective, socio-political dimension of traumatisation and the strong component of injustice intertwined with individual psychological suffering in post-conflict settings, group counselling can sometimes also contribute to reconciliation and peace-building. When carefully, slowly and gently initiating dialogue and collaboration with others in a setting that promotes feelings of dignity, safety and trust, reconciliation processes can be supported by reducing stereotyping, outgroup discrimination and negative attribution [54]. It is essential to point out that finding the right timing to initiate group discussions aimed at dealing with the past is a delicate matter. Many survivors of severely traumatising experiences are only able to talk about them after significant time has passed and only if they themselves are ready to do so and are not pushed into conversations or confrontations regarding the experience [55]. Particularly psychosocial interventions aiming at reconciliation and involving former adversaries should therefore only be planned when sufficient time after the end of the conflict or war has passed. Group processes aiming at reconciliation require the explicit consent of everyone involved, preparatory work especially with those who were victims/survivors during the conflict and a safe and neutral environment. Furthermore, during group counselling or therapy and especially when involving former adversaries, the risk of re-traumatisation is high, which makes it necessary to reflect on who is stable enough to participate, what support can be offered in the counselling situation and how a safe space can be established. Moreover, specific competencies on the counsellor's side become relevant for these forms of counselling processes. How to work with groups (especially containing former adversaries), e.g. how to establish shared rules for a group setting, how to foster group cohesion and how to identify and deal with different stages of group processes should form part of vocational trainings or in-service-trainings for MHPSS staff in post-conflict settings [46]. Additionally, skills in conflict management and mediation are vital for people working in MHPSS on a community-level.

## Involving the family in individual counselling

### Recommendations in short:

-  Even in person-focused interventions, involving the family can become relevant and might even be expected (it is common in the Middle Eastern context).
  - Sensitise trainees to how violence affects families and how to engage them in psychosocial support processes.
-  Sensitise trainees to the fact that in some cases, the family can also be a source of distress – whether and how to involve the family should always be considered with this in mind.
-  Before involving the family, clarify with the client what should be kept confidential and what will be talked about in the larger setting.
-  When involving the family, be transparent about what psychosocial counselling or therapy is and how it can support the individual in their current situation. Meet scepticism patiently.

Given the importance of the family as the main social reference system in Middle Eastern societies, taking the family's role in a psychosocial counselling process with an individual into consideration can be important in order to effectively work with a client. Interventions have to take into account the often prevailing and culturally influenced conception that the individual can only be perceived through the group to which they belong [38]. Systemic thinking and approaches to counselling and therapy might therefore be helpful, and trainees in vocational trainings as psychosocial counsellors should learn about how violence affects families and communities and how to engage them in MHPSS processes (particularly when working with children, infants or caregivers with MHPSS needs) [39].

However, psychological problems are also often stigmatised and family relations as well as social pressure are deemed more important than intrapsychic conflicts and processing experiences of emotional distress. In addition, the experience of certain forms of (conflict-related) violence – such as sexual and gender-based violence – are often perceived as a shame (also for the family). This can prevent distressed people from seeking professional help in the first place or even put them in danger (e.g. considering the possibility of honour killings). In various cases, the family can also be (one of) the source(s) of distress. For example, perpetrators of sexual and gender-based violence are often family members, in which case the presence of the family might be detrimental for the client's wellbeing and for the counselling process. For these and other reasons, the family can therefore also be a hindering factor in psychosocial interventions. If the family is involved for various reasons, it is important to agree with the client on what should be kept confidential, which issues can be addressed when the family is present and to what extent. Creating privacy despite accompanying family members is a valuable skill for a counsellor in this context. When involving the family in interventions, being transparent about what psychosocial counselling is, what it can and cannot do and how it can support the individual family member and make tangible changes in his or her life situation (and thereby the family's) is advised. It is important to allow for the family's scepticism and react to it patiently in order to gain the family's trust and acceptance regarding the intervention.

## Competencies in dealing with suicidality and handling acute crises

### Recommendations in short:



Prepare trainees for being confronted with suicidality, train them in recognising risk factors and warning signals as well as in taking preventive steps and provide knowledge about referral paths.

- Note that disclosing suicidal thoughts can be highly risky for the person in distress as well as for the MHPSS worker (it is for example a crime in Syria) – sensitise trainees to thoroughly consider all steps and especially referral in the interest of the distressed person.



Train humanitarian and MHPSS professionals in acute stress management, Psychological First Aid and identifying people in need of immediate psychological assistance and familiarise them with referral paths.

Future counsellors and therapists as well as anyone working with people in (post-) conflict contexts or contexts of displacement in development cooperation or humanitarian aid have to be prepared to be confronted with suicidality and for the fact that suicidality is widely prevalent in those contexts ([39]; [56]). Service providers on all layers of support should recognise warning signs as well as risk and protective factors and be able to take first preventive steps. For those working on a less specialised layer of support, referring people who reveal suicidal ideation to specialised services is crucial and referral paths should be known. It is important to note in this context that attempting suicide is a crime in some countries, including for example Syria. Disclosing suicidal thoughts can therefore not only be shameful, but also risky and people are likely not to indicate suicidality at all or else use indirect expressions (e.g. “I wish I could sleep and not wake up”; [7]). Referrals therefore have to be thoroughly considered and should only be made if the referring professional is familiar with the specialist he/she is referring the client to and can be entirely sure that the specialist is willing to support the client in a confidential way. Since disclosing suicidal thoughts is a highly personal act, the client might not be willing to be referred to another counsellor or therapist. In this case, trying to stabilise the client as much as possible while being transparent about one’s own qualifications and respecting one’s personal limits is advised.

In general, crisis intervention and acute stress management should form part of the curriculum for humanitarian and MHPSS professionals working in emergency and (post-)conflict settings such as of the Syria and Iraq crises on any layer of support [39]. Collaboration with multidisciplinary actors and referral paths for emergency cases are especially relevant in Psychological First Aid. Recognising people in need of immediate psychological assistance and delivering Psychological First Aid can in these contexts be an essential skill to be developed in trainings [22]. Particularly people working in other professions in the humanitarian field (such as WASH, food or shelter provision etc.) should be trained in identifying people in need, providing Psychological First Aid and referring to suitable MHPSS services.

Psychological First Aid (PFA) refers to the process of offering humane, supportive and practical assistance to fellow human beings who were recently exposed to a serious stressor. It aims at giving people in acute crisis a sense of safety and control by protecting them from further harm, helping them to address basic needs like food and water, comforting them and helping them to feel calm and safe, listening to people’s concerns if they themselves raise them and helping people connect to information, services and social support [22]. PFA should not be confused with professional counselling or a psychological intervention aimed at an individual’s mental healing from trauma and distress (even though it can be part of clinical care) [22]. It is a preliminary process for people in severe distress immediately after acute crises that serves to calm them down – but does not help them address or cope with the actual root causes and medium- to longer-term effects of the experience of violence, war and displacement. Some basic principles of Psychological First Aid should be part of the training especially for humanitarian workers who are usually the second ones (after local first responders) to encounter beneficiaries after serious stressors.

## Taking into account service users' belief systems

### Recommendations in short:

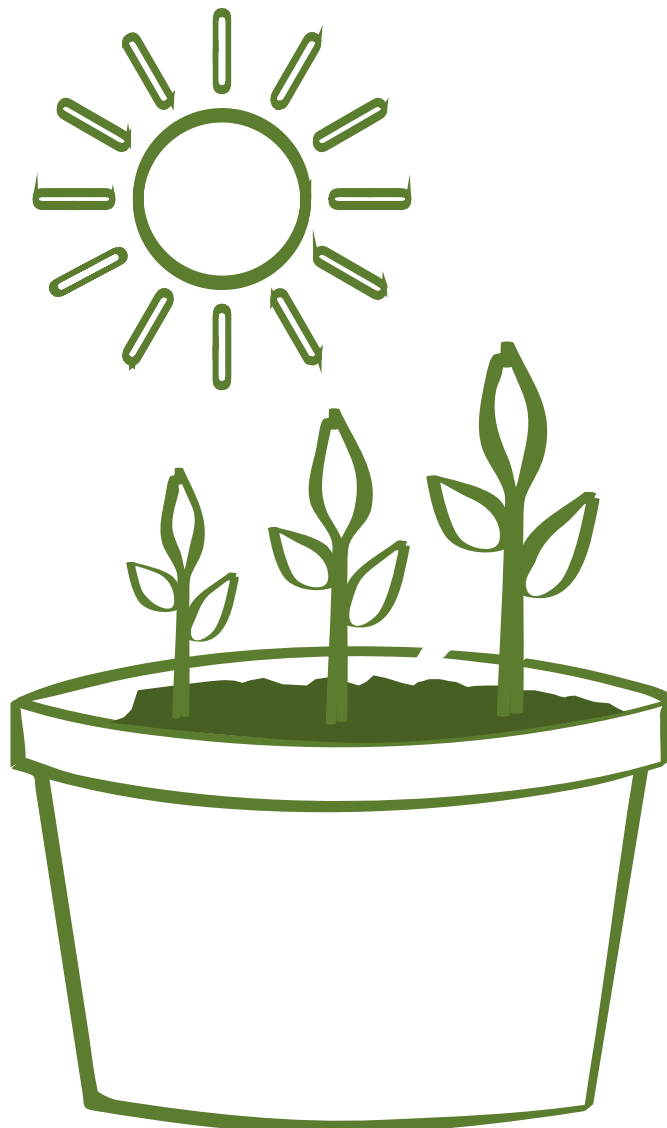
- Sensitise trainees to the fact that service users' belief systems can help or hinder the psychosocial support process.
- Enable trainees to build on service users' conceptions of the person as well as religious or other beliefs that can positively influence the way they cope with distress.
- Sensitise trainees to the fact that in order to take into account a person's beliefs and values, they have to thoroughly understand the individual's belief and value system and put their own beliefs and values aside to support the distressed person in regaining a sense of meaningfulness and a positive and coherent worldview of their own. Talking about beliefs and values should only happen if the distressed person is comfortable with this and wishes to do so.

Particularly in (post-)conflict or displacement contexts, MHPSS activities aim at stabilising and empowering distressed people and supporting them in regaining a sense of control and meaningfulness. How this can be done, however, also depends on the beneficiaries' personal conceptions of themselves, which are influenced by their socialisation as well as their value and belief systems. Value and belief systems can help or hinder the psychosocial support process and therefore need to be taken into account. Trainees should be sensitised to this factor and should be trained to constructively integrate a person's belief system into psychosocial support approaches in case this seems functional and appropriate [38].

According to Hassan et al. (2015), common Syrian concepts of the person can be categorised as 'socio-centric' or 'cosmo-centric', meaning that every individual is seen as linked to every other creature created by God – terrestrial or spiritual. The concept of qadar ('fate') in the sense of self-abandonment may enable patience in the face of helplessness and adversity [7]. Moreover, catastrophes and illnesses may be seen as an opportunity for growth and an occasion to strengthen one's faith [38]. In general, explanatory models for psychological distress often resort to religion. In some religious families, traumatic events might be seen as God's will. Culturally, suffering is often understood as a normal part of life, which people should learn to live with and which does not call for professional intervention except in severe cases ([7]; [49]). Distress may also in some cases be attributed to the existence of supernatural and spiritual powers (such as djinns, i.e. evil spirits – [7]; [49]).



Supporting distressed beneficiaries in creating meaning by reinforcing helpful conceptions of the person in the counselling process can be a promising approach to overcoming feelings of loss of control and is a key part of a resource-oriented intervention approach. At the same time, working with a person's belief system is highly sensitive and can be delicate. Naturally, it presupposes that the MHPSS worker thoroughly understands the service user's individual belief system and concept of the person, which might differ from the generally prevalent one. It is moreover known that in the face of adversity and loss (particularly in (post-)conflict-contexts involving human-made suffering), questioning previously held ideas, beliefs, and social norms is a common reaction. Being sensitive about this and not putting the service user into a religious or belief dilemma, which can break or impair normal rapport, is highly important. Should beneficiaries wish to talk about beliefs and norms, MHPSS workers should put their own values and beliefs aside and support the service user in regaining a sense of meaningfulness as well as a positive and coherent worldview of their own.



## 11. Theoretical background knowledge

### Recommendations in short:



Theoretical instruction needs to be adjusted to the trainees' future working environments and tasks and contain models and theories that are helpful to form a basis for their practical skills.

- Generally, theoretical instruction on psychosocial consequences of conflict and displacement, psychological models and theories that are relevant for their (future) field of work, significant legal frameworks, professional standards and ethical principles (Do No Harm, confidentiality etc.) will be relevant for many trainees.

As this recommendation paper focusses on capacity development in the context of the Syria and Iraq crises, qualification programmes and trainings will in most cases take place in a context of conflict and displacement. Practical skills to stabilise and support individuals and families under stress are from this perspective more important than theoretical background knowledge. Yet, some theoretical background is necessary to form a basis for the work of the future MHPSS professionals. Theoretical knowledge is also important for the sustainability of the qualification programmes: To ensure that trainees have long-term perspectives in MHPSS and will not only be able and qualified to work in the field as long as the crisis situation persists, they need a sound theoretical foundation for what they are doing. Theoretical instruction should generally be adjusted to trainees' future areas of work. However, modules on the following topics are generally recommended (this is a selection – others will become relevant depending on the individual training):

**Psychosocial consequences of conflict and displacement:** The necessity for context-sensitivity of trainings for MHPSS professionals leads to a need for an introduction to the dynamics of migration and the psychosocial consequences of conflict and displacement. This includes looking at psychosocial consequences of war, human-made violence, persecution and genocide, displacement and resettlement, impacts on and shifts in gender dynamics during and after conflicts as well as loss for individuals and societies [39]. In these contexts, trauma can be understood as an interaction between different sequences of traumatic experiences (war/persecution, flight, initial period after arrival, chronification of the temporary situation, which is often marked by discrimination and a lack of control over one's own life, etc.), rather than as originating from a singular violent event [47]. In light of the context of conflict and displacement, trainees on all layers of support should be familiarised with specific forms of distressing events that occur more frequently under those circumstances [39]. Sexual and gender-based violence (SGBV) against women and girls as well as against men and boys and LGBTI people significantly increases in conflict contexts and evidence suggests a high proportion of SGBV survivors also in the context of the crises in Syria and Iraq (e.g. [57]; [58]). Definitions and indicators for rape and sexual abuse, their physical, psychological and social impacts, the power dynamics underlying conflict-related sexual violence as well as effective ways of psychosocially supporting and protecting survivors of all genders and sexual orientations should be known to professionals working in the field of MHPSS ([39]; for a recommendation paper on working with female survivors of SGBV in the Middle East see [59]).

**Psychological background knowledge:** MHPSS trainings at all layers of support should include definitions, theories and types of trauma and traumatisation as well as the corresponding short-term as well as long-term reactions and consequences in both adults and children. Additionally, a basic theoretical introduction to fundamental psychological models and approaches to psychosocial interventions is advisable for those working in MHPSS on the second layer and a more profound instruction on layer three. This could include basic models of learning psychology, personality psychology and social psychology as well as clinical psychology and psychopathology. For the fourth, specialised layer of support, theoretical instruction on psychological theories, models and approaches should be more comprehensive and cover a wide spectrum of mental health conditions and therapeutic intervention techniques.

**Legal background knowledge:** Psychological and social issues cannot be regarded separately – this is the basic idea of a holistic approach to psychosocial support. As a fundamental condition for their psychosocial wellbeing, displaced people need a feeling of security, also for example with regard to their legal status. To this end, it can be advisable that (future) professionals on all layers of support have a basic understanding of relevant legal frameworks, such as the country of operation's asylum laws and relevant social laws or some relevant documents of international law (e.g. the United Nations Universal Declaration on Human Rights or the 1951 Convention Relating to the Status of Refugees) [60]. Legal counselling as such should, however, generally be done by legal advisors or suitable clerks and MHPSS professionals should refer to those professionals when it comes to legal questions.

**Principles and ethics:** During the training, professional standards in the field of MHPSS as well as ethical principles that should guide practice have to be introduced, including an understanding of the Do No Harm principle, confidentiality and integrity ([29]; [37]).

# Training didactics

12. How does learning happen in MHPSS? ..... 61-67



## 12. How does learning happen in MHPSS?

### Recommendations in short:

#### Creating a comfortable training atmosphere:

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- ➔ Ensure that there is time for getting to know each other / team-building at the beginning of the training. Give an overview of the course schedule and clarify trainees' expectations and goals before or at the beginning of the training.
- ➔ Trainings should always constitute a safe space: Assure and ensure confidentiality. If appropriate, set additional ground rules in a participatory manner.
- ➔ Inform trainees that sensitive and potentially distressing subjects will be addressed in the training. Throughout the training process, identify distressed trainees and stop or moderate discussions as appropriate.

#### Building on what trainees already know

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- ➔ Many trainees will already have worked with distressed populations in the given context (e.g. as non-formalised counsellors, health professionals etc.) and have much experience in this regard: Value trainee's expertise and build on their existing capacities.
  - Often, this only requires a systematisation, formalisation and theoretical underpinning of trainees' existing capacities.

#### Experience-based learning

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- ➔ Use participatory methods (e.g. role-play, field-based trainings).
- ➔ During theoretical inputs, also use methods in which trainees are learners and educators at the same time (e.g. presentations).
- ➔ Ensure that skills are always also put into practice during the learning process under supervision.

#### Supervised practice / on-the-job-coaching

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- ➔ All practical modules as well as (and especially) the time after the training should always be accompanied by supervision. This allows for guided reflection on one's own performances and challenges.
- ➔ The practical application of skills under supervision is where most of the learning happens in MHPSS.
- ➔ If possible, provide long-term external supervision for reflection on the work with clients and on cooperation with colleagues.

### Peer coaching

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- ➔ Peer coaching, i.e. a structured exchange among peers regarding their practice, is another helpful format to learn.
- ➔ Peer coaching formats like peer support groups should, however, be actively accompanied by the trainer or another expert.
- ➔ A good practice can be to let former trainees lead peer support groups after initial supervision by an expert.

### Long-term / multi-step trainings

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- ➔ Use long-term / multi-step trainings (self-reflection and supervision processes need sufficient time for putting skills into practice).
- ➔ Ensure continuity in the support structures (same supervisors/mentors throughout the learning process).
- ➔ Ensure that there is continuing support (supervision) between training sessions in multi-step trainings.

### Exemplifying the skills taught in the training

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- ➔ The interaction process between trainer and trainees during the training should be a model for interpersonal processes during psychosocial support processes (being friendly, respectful, warm, calm, empowering, etc.).

MHPSS trainings require the development of specific skills and competencies particularly in building and managing relationships and it is important to employ specific training methods that provide the best conditions to strengthen these competencies. It is nearly impossible to learn how to build trustful relationships or how to stabilise distressed people exclusively in a classroom setting. In MHPSS and particularly with regard to these skills, learning mainly happens through practical experiences that constantly need to be accompanied by professionally guided reflection on what happened during the practical sessions, especially on the relationship level [61]. In order to make a learning process possible, it is indispensable to consider, how such spaces for reflection can be organised and provided. The following training methods and types of training provision are recommended to strengthen the specific skills and competencies relevant for MHPSS.

**Setting the training framework:** Creating a training atmosphere in which trainees feel comfortable is essential to successfully conveying the training content. To this end, it is beneficial to get to know each other (for example through voluntary ice-breaker activities or team-building exercises) and clarify trainees' expectations and goals at the beginning of the training. Initially, giving an overview of the program's objectives and requirements and reviewing the training schedule can be helpful in providing structure for the trainees. It is also essential for a warm and fruitful training atmosphere to assure and ensure confidentiality: Trainees should be assured that what is shared and disclosed in training

sessions will not be communicated to third parties outside of the group of trainees and should themselves commit to confidentiality. Sharing and disclosing thoughts and experiences as well as participating in activities should always be voluntary. Above all, a private, secure and comfortable atmosphere is indispensable to allow trainees to open up, which is a condition for unreserved self-reflection. Allowing for and stimulating this openness also depends on the trainer's ability to transmit to trainees that all reflections are valuable, that anxieties are being taken seriously and that mistakes are an opportunity to learn. Trainees should be informed in the beginning that there is the potential for the training to touch on distressing subjects. It is the trainers responsibility to identify distressed participants at any point throughout the training and offer possibilities to work on highly distressing issues on an individual basis.

**Building on trainees' existing capacities:** Trainings should build on the basic human skill for helping others and on trainees' existing capacities. This starts by helping the trainees recognise what they already know and which skills they possess without a specialist education. In situations of crisis and conflict, but also more generally in Middle Eastern societies, where professional (in the sense of having an academic education) mental health and psychosocial staff is rare, non-professional counsellors are active in various field, for example in local NGOs that work with survivors of gender-based violence or give support to refugees. These counsellors often have not received training in MHPSS, but possess rich and extensive experience in holistic counselling for individuals in situations of crisis and have developed (often very effective) ways of dealing with their distress. They thereby have abundant experience in community-based counselling and mediation techniques. Local staff working in related sectors, such as health, education or social services, often also necessarily take on the responsibility of meeting the psychosocial needs of their clients, because they are confronted with them every day given the immense demand for support. These experiences should be valued, built on and incorporated in MHPSS trainings. In many cases, existing knowledge only needs to be systematised, formalised and theoretically grounded, in order to formally professionalise the service providers' existing support strategies. Finding out together with trainees which MHPSS approaches they already use in their work that they have found to be useful for the people they work with and integrating and adapting those approaches in the training is highly advisable. This also strengthens trainees' self-confidence and context-sensitive psychosocial support practice.

**Experience-based learning:** Using teaching styles that require active trainee participation (role-play, simulations, case scenarios, practical homework etc.) has proved to be highly effective. Skills that are experienced by practicing them will be remembered much better. It is therefore advisable to use learning methods that facilitate the immediate and practical application of what was learned on a theoretical level. Moreover, role-play in which trainees themselves take the role of a beneficiary and experience the psychosocial support process from that perspective enhance their understanding of the role of various aspects that influence this process (such as a welcoming venue) for their (future) profession. Using field-based trainings to practice skills in locations that resemble the trainees' future working environment while providing on-the-job coaching is recommended. Some trainees might be shy in trying out role-play or simulations. Encouraging trainees to participate in trainings actively is therefore conducive when employing a participatory teaching style. Useful tips in this regard are [22]:

- Learning and using participants' names
- Being aware of very quiet or shy participants and gently trying to engage them without pushing them
- Ensuring a manageable number of members during group exercises
- Working in tandems/groups, which is often easier than performing in front of an audience alone
- Offering (voluntary) energiser games to engage participants
- Being encouraging and positive
- Introducing feedback guidelines
- Giving feedback in a sensitive and respectful way
- Inviting questions and allowing time for clarification
- Learning from feedback regarding the training style

Learning models in which participants are both learners and educators (e.g. when giving presentations about theoretical subjects) likewise increase memorability of the contents. In addition, linking training contents to trainees' previous personal or professional experiences in a participatory manner helps to transmit the training contents. Methods aimed at making the trainees active partners in increasing their knowledge and expanding their skills also implicitly convey the message that future service users can likewise be approached as active partners in the psychosocial support process in expanding the coping skills they already possess [23].

**Supervised practice / on-the-job coaching:** Since MHPSS trainings especially in crisis and (post-) conflict contexts mainly aim at strengthening and developing meta-skills in relationship-building and skills in managing a psychosocial support process, which need a lot of practice and self-awareness, and since interventions that are carried out poorly can cause a lot of harm, a thorough supervision during practical sessions should form part of any training concept in MHPSS.

The word "supervision" can provoke misunderstandings, as it is in some contexts (including the Middle East) understood as control through a superior. This, however, is rather the opposite of the idea of supervision as promoted in this paper. Supervision should be an opportunity to reflect jointly on one's own performance as MHPSS worker, on successes, challenges and deadlocks in psychosocial support processes as well as on mistakes and overwhelming demands in an open and honest way with an experienced MHPSS practitioner. Supervision should be a space for continuous reflection on the work with clients, the counselling relationship, methods that may be helpful as well as on inter-collegial cooperation. It can for example be used as a form of on-the-job coaching. Supervision is meant to be a mechanism to give trainees and less experienced practitioners an opportunity to reflect on their own role and attitude continuously. Seen as a process of guided reflection, it is thus the core method to ensure learning happens with regard to the central competencies that should be strengthened in a training as identified in the previous chapters. Providing for supervision will require a larger budget, but should be a precondition for MHPSS trainings as well as for volunteer and staff care support systems.



If the intention of a programme is to establish sustainable services, reduce risks of burn-out and to support psychosocial workers to develop a style of working that suits themselves as well as their tasks and the target group in the given context, as should be the case in MHPSS, continuous or repeated access to “external supervision” is advisable. The term “external supervision” refers to a space for reflection, which is facilitated and guided by an experienced external professional who is not directly known to the trainees or young MHPSS workers and is independent from hierarchical structures in their organisations. This type of supervision can be carried out for individuals, (often multi-professional) groups and for teams. Case concepts, possibilities of interventions and their limitations, counselling-relations and issues of cooperation in a team or network are reflected in a trustful atmosphere, supporting the trainees (or young MHPSS workers) in a continuous development of their skills and self-awareness in a resource-oriented way. Ideally, external supervision should always take place in a face-to-face setting. However, since external supervisors often do not find the time to stay in the given context for a prolonged period of time, online supervision can sometimes be an advisable alternative.

**Peer coaching:** In addition to supervision with an experienced professional, peer coaching – i.e. a structured exchange about successes, challenges and experiences among fellow trainees – can be a very effective format for learning, mutual support and staff care. A popular and very helpful form of peer coaching are peer support groups / “reflecting teams”: small groups of trainees who independently meet between sessions to practice their skills and discuss open questions with regard to their psychosocial support practice according to predefined steps and criteria. However, such forms of peer learning also pose specific challenges. Peer support groups and other peer coaching formats are not sure-fire successes, because trainees’ defences are often too strong to allow for unreserved self-reflection. Moreover, peer support groups, if unassisted, are usually initially not able to sufficiently create the safe space needed to enable a beneficial reflection and exchange. It is therefore recommended for trainers to support the initiation of peer support groups or other forms of peer coaching at the beginning of the training and actively accompany and supervise these groups for the initial period, until they themselves become able to conduct the reflection process. A good practice can be to let former trainees accompany the peer support groups from the start and after the initial supervision by the trainer or another expert take on the role of leading them. During practice-oriented modules between training sessions and when trainees are already working after the completion of the training, resorting to digital applications like WhatsApp or Skype for peer coaching can be helpful, if personal meetings cannot be arranged.

**Long-term / multi-step trainings:** Competencies relating to relationship-management, self-reflection, empathy, orientation towards service users’ resources, empowerment and self-care are hard to develop in just a few weeks or even days. Longer-term or multi-step trainings are necessary to achieve these objectives. Moreover, modules aiming at personality development require a trustful and safe space within the group of trainees. This can only be achieved if groups work together over a longer period of time. In order to allow for a trusting relationship between trainers/supervisors/mentors and trainees to build up and thereby create a space in which trainees can open up and in which self-reflection is possible, it is strongly advisable to have continuity in the support structures and have the same trainers/supervisors/mentors guide the trainees through the learning process over the complete period of time. Particularly for trainings in specialised psychological care, a longer time is needed for knowledge build-up to ensure

the trainees are equipped with the theoretical knowledge to deal with mental health conditions and not do harm. Furthermore, transferring skills acquired during the training into practical work is one of the most challenging aspects of capacity development. Multi-step trainings are therefore particularly advisable with regard to capacity building in MHPSS, since they allow trainees to use their newly-acquired skills and knowledge in their practical work between training sessions and in doing so also leave room for (professionally guided) reflection on successes and challenges, with the option to address them again in a subsequent training session [61]. For multi-step trainings, it is especially important to ensure that there is no gap between the training sessions in which trainees are not supported and supervised, but that there is a continuous mentoring available. For one-off trainings, at least a follow-up or refresher-session must be offered – otherwise the training will likely not have lasting effects.

**Exemplifying the skills taught in the training:** The interaction processes during the training should be a model for interpersonal processes during trainees' future service provision. Trainers should adopt a teaching method that demonstrates good verbal and non-verbal communication skills and conveys interest and enthusiasm. Being friendly, respectful, non-judgemental, warm and calm helps engage participants and create an atmosphere in which it is possible to learn and concentrate and trainees should be called on to display the same attitude among themselves. The skills a trainer should exemplify in the training for future MHPSS workers include creating safe spaces, developing trust, encouraging participants and meeting them at eye level.



# Evaluation, monitoring and certification

- 13. How to tell whether a training was successful? ..... 69 -71
- 14. What are the opportunities and risks of certification? ..... 72-75



## 13. How to tell whether a training was successful?

### Recommendations in short:

- ➔ Monitor the training's impact on trainees' skills during the training, e.g. in supervision sessions (address uncertainties in the next training session).
- ➔ Evaluate the training's success (if possible by an external actor); the following indicators can be useful: acceptability, adaptability and comprehensibility of the training; impact on trainees' skills; impact on the trainees' organisations' services and impact on service users.
- ➔ Choose evaluation methods as suitable, e.g. case discussions or reports written by trainees, role-play, interviews and evaluation forms (with former trainees and agreeing clients), participatory observation etc. – use several evaluation approaches to validate findings (triangulation).
- ➔ Improve the training according to the results of the evaluation and share results with other training institutions.
- ➔ Choose well-trained context- and trauma-sensitive evaluation staff.
- ➔ Ideally, monitoring and evaluation (M&E) should be its own budget line in project proposals.

Evaluating and monitoring the success of a training are vital processes to ensure that the training effectively fulfils its purpose and sufficiently equips trainees with the skills necessary to psychosocially support distressed people and not do harm in this regard. At the same time, evaluating whether certain skills and attitudes have been strengthened can be extremely difficult – especially regarding personality development aspects of trainings: How can relationship-building skills or empathic capacity be validly and reliably measured? The classical evaluation sheet or final feedback round at the end of a training often do not sufficiently achieve the intended effect of understanding the success of the training in these regards. Instead, the evaluation of the training, including its methodology, should be adjusted to the specific competencies needed for psychosocial support in (post-) conflict settings.

Already during the training, a continuous monitoring of the training's impact on the trainees' skills, competencies and attitudes in the form of ongoing personal supervision/on-the-job coaching is essential. This gives trainers or supervisors the possibility to find out how the trainees have perceived the trainings, which training contents have been well understood and are being put into practice in a supportive way and which contents need further elaboration or modification [28]. Trainers and mentors should record observations regarding trainees' performance and make sure that uncertainties are addressed adequately in subsequent training sessions [29].

In addition to the continuous monitoring throughout the training period, an overall evaluation of the training after it has been finished is an important contribution to ensuring the training's quality, ascertaining that the training served its purpose and preserving insights and ideas for improvement for the next training. If possible, the evaluation should be carried out by an objective external actor directly after the training and ideally again as a follow-up a few weeks later, when trainees have had a chance to work in the field. The central question should be to what extent or on which dimensions the training was regarded as helpful or possibly harmful by the trainees and by those they ultimately serve.

The following indicators can be considered when evaluating trainings in the realm of MHPSS (compare [28]):

- Acceptability, adaptability and comprehensibility of the training methods
- The training's impact on trainees' skills; potential indicators include
  - Changes in trainees' knowledge and skills regarding MHPSS
  - Are effects maintained over time?
  - Trainees' ability for self-care (changes in stress level/ resource activation)
  - Do trainees themselves feel better equipped and more in control?
- The training's impact on the trainees' organisations' services; potential indicators include
  - Changes in the capacities of the trainees' organisations
  - Was it possible to expand the service's outreach?
  - Are staff care mechanisms being introduced/ implemented?
- The training's impact on service users; potential indicators include (if applicable)
  - Reduction of psychosocial distress
  - Improvement in physical and social functioning
  - Reduction of social isolation
  - Reduction in psychopathology
  - Reduction of obstacles to recovery
  - Positive progress in family and community processes
  - Positive progress in reconciliation processes
  - Satisfaction with services

Approaches to evaluating the training and assessing the above indicators must be selected carefully and suit the specific purpose of the evaluation. An evaluation of the training methods' acceptability, adaptability and comprehensibility can best be conducted by directly inquiring about these aspects with the trainees in oral or written form after the training – if possible when trainees have had a chance to put their newly-gained knowledge into practice. The training's impact on trainees' skills can theoretically and most easily be evaluated through written or oral context-adapted tests subsequent to the training (which is generally recommended for theoretical background knowledge, particularly for those who will work in specialised services). However, the quality of service provision and development of competencies in building and managing relationships can better be captured by an experienced MHPSS practitioner or the trainer himself/herself during case discussions or role-play with the former trainees. Insights regarding the training's impact on services can be gained by consulting the trainees' organisation's

policies (e.g. on staff care) or by inquiring at the managerial level regarding whether any changes were made at the organisational level as an effect of the training. Inquiries at the managerial level should, however, neither be used nor perceived to be used to ask whether a former trainee now performs better, as this can compromise trust both between trainers and trainees and within the trainee's organisation. Most importantly, a training should in the end benefit those who suffer from psychosocial distress. The training's impact on the trainees' future beneficiaries is therefore a highly relevant indicator that can best be assessed by inquiring about the trainees' services' helpfulness with agreeing beneficiaries themselves through short interviews or brief evaluation forms. Depending on the context and purpose of a psychosocial support process, the family or community can potentially also be included in the assessment [28]. Using several evaluation approaches is advised in order to validate findings.

The results of the monitoring and evaluation process should inspire improvements to the training concept. Results should ideally be shared with other training institutions, in order to disseminate lessons learnt and best practices. Given the relevance of a training's evaluation, it is important to choose well-trained monitoring and evaluation staff that acts in a context-sensitive and trauma-sensitive way – especially when interacting with people in distress [29]. Monitoring and evaluation should not be an end in itself or solely to receive funding and should likewise not take up too much budget and work time that could otherwise be spent on the services themselves. Ideally, monitoring and evaluation should have its own budget line to avoid using financial resources for this purpose that were originally meant for training implementation.



## 14. What are the opportunities and risks of certification?

### Recommendations in short:

- ➔ Before or at the beginning of the training, inform trainees about the expectations and conditions for certification, the kind of certificate they will receive and what it entitles them to.
- ➔ Always provide (at least) certificates for attendance, describing the training's content and length as precisely as possible.
- ➔ Only list skills and competencies developed in the training if they have been evaluated after the training and specify precisely for what they qualify the holder of the certificate.
- ➔ Find titles that describe the profession accurately but also suit designations used in the context.
- ➔ If trainers agree and if this does not put them at risk, include name and contact data of the trainer in the certificates.
- ➔ Work towards a reliable legal framework, which defines comparable standards and necessary competencies for certification, together with relevant authorities.
- ➔ Cooperate with accountable and reliable private and public authorities or state-structures when certifying.
- ➔ Do not undermine local certification structures by introducing parallel certificates.

In many fields and particularly in the health sector, professionals need to be able to show proof of their technical training both in order to be legally entitled to pursue their profession and also to be trusted to do so by beneficiaries. This is true in many contexts worldwide and also in the Middle East, where there is a very high esteem for certificates and titles. However, and as shown above, trainings can take a multitude of forms and last from very brief instructions of only a few days to a lengthy education of several months or even years. The question of which title or certificate is justified in a specific case is therefore highly relevant. In addition to the potentials of certification, issuing certificates or titles can also bear risks that should be kept in mind.

A certificate or title provides official evidence of what a person is capable of doing and is entitled to do in a professional way. This brings several advantages. Certificates that point out very precisely which skills and competencies have been developed in the training and to which professional practices the bearer of the certificate is entitled give all parties involved more security. For the trainees, a certificate means the security of



possessing proof of their newly gained skills, which is mostly necessary to pursue their profession. Generally, certificates and titles create trust for potential beneficiaries and give them the security that the service provider is a professional in the field for which they seek his or her support. Clients might only approach services if the service provider is able to give proof of their competencies with an official document. Certificates might therefore also convince a larger number of distressed people to seek professional support [13]. Especially in the Middle East, where people are often reluctant to use MHPSS services, this is an important aspect. In addition, certificates or titles give security to national authorities such as ministries of health as a verification mechanism. This might open up the doors to the public health care system for those who are trained as MHPSS practitioners. Ideally, training institutions should cooperate with authorities in order to ensure that relevant offices recognise their certificates so that trainees can pursue their profession within the public service system. The provision of certificates is also usually expected by trainees, especially in the Middle East, where certification is the norm. In fact, if no certificates are provided, many potential trainees will be sceptical and reluctant to participate.

On the other hand, the trust created through official documents and titles can of course be misused. Since the proclamation of professional abilities goes hand in hand with employment and remuneration, the risk of misuse of certificates is high. If certificates do not narrow down precisely which competencies have been acquired, the scope for interpretation is opened up and people might take on tasks and professions they are not trained to perform. This may lead to poor and potentially harmful practices. Conversely, certification requirements that are not adapted to the context might also exclude very skilled and successful counsellors from working as such, which is especially a problem in contexts characterised by scarce human resources. The process of certification, while very important, should therefore be approached in a highly responsible way and with as much precision as possible. Furthermore, designations and titles used in certificates can also carry risks in another way: Training design has to take into account the trainees' (future) role within the public service system [28]. Designations that are unfamiliar or deterrent for the target population might prevent those who need support from approaching services. For example, if the term "psychotherapist" is met with reluctance or suspicion, awarding this title might be counterproductive (e.g. as opposed to "mental health practitioner"). Thus, while titles and certificates must mirror the skills and competencies acquired during the training as precisely as possible, they should also create a working environment in which the future MHPSS professionals can effectively fulfil their tasks.

This leaves the question of on which basis a title or certificate should be awarded. Generally, handing out a certificate that confirms attendance is advised in any training. It is essential, however, what exactly the certificate or title states or implies. Certificates that only prove participation should point this out clearly and describe the training content as well as the amount of training hours as precisely as possible. Only if the actual competencies and skills developed in an individual trainee have been evaluated in the course of or after the training should the certificate explicitly state them. Given the above risks of certification, it is crucial to be as precise as possible in explaining which competencies the trainee has acquired in the training and for which tasks or professions he or she is thereby qualified. Ideally, the name and contact data of the trainer(s) as well as of the training organisation should be included in certificates to allow for potential queries

and clarifications. However, this should only be done if the trainer agrees to it and if it does not put him or her at any risk. Before the training or at the latest during the first session, trainees should be informed about the expectations and conditions for certification (e.g. attendance rates). Trainees should also be made aware of the kind of certificate they can receive and what exactly it entitles them to do. Many training organisations are not able to provide a “full” certificate according to international standards due to budget restraints and due to the adaptation of the training to the local context. Even if full certificates can be provided that allow participants to work in certain positions as MHPSS professionals, they will be useless if there is no budget available for hiring those professionals. For certification to be effective, it is therefore also necessary to strengthen the psychosocial support system on a structural level and ensure that trainees will be able to work in their professions.

Particularly given the importance of certificates in creating trust and the risks this entails, it is advisable to work towards a trustworthy, reliable legal framework that defines comparable standards and necessary competencies for the awarding of certificates (while keeping in mind that existing local certification structures should not be undermined by introducing parallel certification structures). Certification should in this sense ideally happen in cooperation with reliable, accountable private and public authorities or state-structures, who co-sign the certificates. This would simultaneously promote the cooperation and coordination between MHPSS training institutions and state structures and thereby the promotion and in the long term the sustainable installation of a psychosocial care system at the national political level.



# Sustainability: How to ensure the sustainability of capacity development initiatives?

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Trainings in the context of development cooperation aim at a sustainable development of capacities. Sustainability should therefore be included in considerations about MHPSS capacity development from the beginning. In order to work towards sustainability, possibilities for upscaling of the training can be considered. Most importantly, however, sustainability of MHPSS capacity development largely depends on the existence or installation of a functioning and comprehensive sustainable psychosocial care system at the national level.

## 15. How to upscale capacity development initiatives?

### Recommendations in short:

- ➔ Consider different upscaling formats to spread and increase the impact of the training.
- ➔ When establishing Training of Trainer programmes,
  - ensure that the future trainers are aware of the need to adapt each training to the context and not to use the same blueprint without consideration in different contexts.
  - ensure that there is sufficient time for reflection and an extended period of supervised practice before the participants offer trainings by themselves.

While the need for psychosocial support markedly increases in conflict-situations [22], resources for MHPSS services and qualified MHPSS workers offering psychosocial support are often missing. This is a significant problem in the Middle East, which is exacerbated by the often-prevailing unfamiliarity with the concept of psychosocial support and the stigmatisation thereof. A relevant question when offering trainings in such contexts therefore relates to multiplication: How can capacity development initiatives be scaled up in order to train more people offering services in (post-)conflict contexts in MHPSS or to qualify more people to become MHPSS practitioners?

Upscaling can work on several levels. Informal upscaling can for example mean that trainees pass on their newly-gained knowledge or skills to colleagues. More formal upscaling approaches are based on different degrees of professional guidance and mentoring for certain trainees, who will later train others with different degrees of professionalism. A hybrid form of upscaling could for example be to engage former trainees to support and accompany a subsequent training as co-trainers, before becoming lead-trainers themselves. The most common formal method for upscaling capacity development initiatives in conflict and emergency contexts is the concept “Training of Trainers” (ToT), which aims at quickly qualifying many people in a kind of cascade model in order to meet an acute need. If implemented well, ToT-programmes can effectively lead to a significant enhancement of the MHPSS service landscape. However, training counselling skills and competencies to support people who have experienced trauma also poses challenges and can potentially lead to harm if blueprints taken from the ToT-programme are simply

passed on from context to context or if ToT-programmes only superficially train the trainers without sufficiently developing personal meta-skills. When scaling up capacity development initiatives, e.g. through ToT programmes, it is important to always keep in mind that trainings have to be context-sensitive and cannot just be transferred from one group to the next. Simply duplicating a training's content and methods will not be successful in this field. Furthermore, major elements of an MHPSS training should be directed at competencies in handling relationships and emotions – those of future service users as well as of future service providers – and strengthening these competencies requires specific methods and an approach based on experience-based learning from the trainer's side. Preparing people to accompany such processes as trainers usually takes a long time and involves parallel mentoring. Unfortunately, neither factor is provided in many ToTs. When multiplying counselling knowledge and competencies via ToTs, it is important to set up a strong coaching and mentoring structure in which trained trainers have the possibility to actively put into practice what they have learned in the ToT while reflecting regularly with their mentors on their challenges and experiences when training others. If this mentoring structure is given, ToTs leave room for future trainers to work on their difficulties while transforming their learning knowledge into active teaching knowledge. Only after participants in ToT programmes have gained substantial practical experience in training others under supervision are they fit to offer context-adapted trainings by themselves.

## 16. How to work towards an improved and sustainable psychosocial care system at state-level?

### Recommendations in short:

#### Advocacy for MHPSS

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- ➔ Engage in public outreach to policy-makers and lobbying for MHPSS and disseminate quality standards or principles, which might create an incentive for political authorities to use them.

#### Structurally anchor MHPSS in (state) institutions

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- ➔ Implement trainings within existing local structures and assess which institutions could be suitable cooperation partners for the training.
- ➔ Encourage and support the establishment of MHPSS focal points in relevant ministries and lobby for the inclusion of MHPSS in relevant ministries' policies.
- ➔ If appropriate, include relevant political authorities/ministries in sensitisation workshops, but be aware that this can also disrupt the workshops and/or intimidate other trainees (consider separate trainings).

- ➔ Look for or establish and support networks for professionals (e.g. MHPSS Cluster Groups / Roundtables / Task Forces) for joint action, reflection and learning.
- ➔ Support the establishment of a representation for psychotherapists and counsellors at the national level.
- ➔ Establish complaint mechanisms with regard to trainings.

#### Ensure long-term professional perspectives for MHPSS staff

- ➔ Train local staff and work towards the provision of sufficient local funding for MHPSS.
- ➔ Try to negotiate the integration of adequately-trained MHPSS professionals into the public health, education, and social care systems and into community mental health services.
- ➔ Try to ensure that trainees can work in a field related to MHPSS (during and) after the training in order to ensure that they do not forget what they have learned.
- ➔ Work towards the establishment of a comprehensive staff care concept within trainees' organisations.

Especially in contexts of conflict, psychosocial work is often carried out by civil society organisations or in the realm of internationally led humanitarian work or development cooperation. While this is in many cases necessary as a first step for the short- or even medium-term, it is crucial to keep in mind that from a human rights perspective, it is mainly the responsibility of a state to ensure the provision of health care, social services and MHPSS services (consider [62]). For the sake of sustainability and guaranteed provision of MHPSS services, it is therefore vital to address the existing institutional health, social care and education infrastructures. To promote an improvement of the psychosocial care system at the national level, initiatives for capacity development in MHPSS should be accompanied by the following interlinked measures:

**Advocacy and information campaigns:** Action in any field first and foremost requires awareness about corresponding needs and shortfalls. Public outreach and sensitisation work regarding affected people's concerns and needs in the realm of MHPSS on a political level should therefore be part of training organisations' work as well as of the trainees' future work as MHPSS practitioners. This can for example take the form of dissemination work, networking, information/de-stigmatisation campaigns and lobbying. Ensuring regular contact with policy makers and informing them about MHPSS needs in the society, lacks in service provision and the strong link between mental health and possibilities for reconciliation can be helpful in inspiring state action in this field [28]. Quality standards or principles should be defined and disseminated within professional networks (preferably with the inclusion of the political level), which might create an incentive for political structures to follow these standards/principles [61].

**Structural anchoring of MHPSS:** During and after conflicts and emergencies, the interest in and recognition of the relevance of MHPSS services increases dramatically. This provides an entry point for the structural anchoring and the enhancement of MHPSS in state structures [61]. Several options can be considered in this regard:

- Implement trainings within given local structures (if possible including local training organisations, relevant ministries and certification structures).
- Assess carefully which institutions – e.g. universities – would be suitable cooperation partners for MHPSS trainings (which synergies are most promising? Which approaches to psychosocial intervention does the institution promote? Which resources can the institution potentially supply? etc.). This might ensure the training's long-term linkage to existing, sustainable structures. In turn, for academic programmes at universities, a cooperation with NGOs provides them with the opportunity to allow their students to gain practical work experiences, e.g. through internships.
- Encourage and support the establishment of MHPSS Focal Points within relevant ministries (such as the ministries of health, social and family affairs, education etc.). Assigning this particular function will ensure that knowledge regarding MHPSS will stay in the Ministry even if already-sensitised staff leaves. Organising information events about MHPSS for supervisors of the Focal Points helps create an environment in which the latter can work effectively.
- Lobby for MHPSS's inclusion into the relevant ministries' overall political strategy and programmes. This secures MHPSS's status within the respective institution and facilitates the allocation of budget from the national government [24]. A challenge in this regard is that institutional responsibilities for MHPSS are often not clear. In many cases these responsibilities are fragmented and lie with the ministries of health, education, and social affairs simultaneously, which can impede a coordination of MHPSS initiatives (especially in case of competition between the ministries).
- Inform political structures such as the responsible ministries about the existence of the trainings and, if appropriate, allow for their participation in sensitisation workshops. This can also ensure their cooperation with regard to the advancement of MHPSS. However, before deciding to include political authorities, carefully consider the effect that their participation could have on other participants and the dynamics in the training (and if indicated consider training/sensitising political authorities separately).
- Support the establishment of a representation for psychotherapists and counsellors at the national level; look for, support or establish networks, lobby groups and professional boards (e.g. a national umbrella organisation that can negotiate with policy makers).
- Support MHPSS technical working groups / roundtables / task forces to coordinate and support measures in the field and formulate (national) roadmaps and action plans. Ideally, these technical working groups should not only take national, but also regional experiences and lessons learnt into account.
- Support the implementation of complaint and improvement bodies for trainings in order to be able to ensure training quality. Particularly in (post-)conflict contexts, there is the risk that due to too little oversight, MHPSS services and trainings can be offered that do not actually help beneficiaries cope with their distress and instead cause harm.



**Creating long-term professional perspectives for staff:** In order for trainings to lead to sustainable MHPSS structures in the countries of concern, it is essential that locals are trained as trainers and as MHPSS workers and that long-term professional perspectives are offered for them locally. For the foreseeable future, in most cases financial resources and sufficient long-(enough-)term funding from international donors are needed in order to build up local infrastructures, since their costs exceed the capabilities of most states hosting refugees and IDPs in the Middle East. Yet, if MHPSS is not integrated into the national health care, social services and education systems (including the provision of sufficient funding), but is only regarded as a short-term emergency measure to respond to the acute humanitarian crisis, long-term professional perspectives for local psychosocial staff will be scarce and the psychosocial care system will stay dependent on international help. It would therefore be optimal to negotiate with policy makers and relevant authorities to ensure that adequately trained and certified MHPSS professionals are integrated into the primary health care system, educational facilities (e.g. as school counsellors), social work departments or, if available, into community mental health services ([13]; [29]). With regard to training design, it is in terms of trainees' professional prospects also important to look into what trained counsellors can use the training for in the long term after the crisis is over and to incorporate corresponding modules into the training. Since skills that are not practiced will easily be forgotten, it is moreover essential to ensure that trainees can actually work in a related field, apply their newly acquired skills and gain work experience after the training under supervision. This is sometimes for example a challenge when including Syrian refugees in trainings. Including refugees would help build capacities that will at some point be available in Syria and is thereby highly desirable. However, in Lebanon or Jordan for example, Syrian refugees have very limited access to employment and will most likely not be able to work in any related field after completing the training. Many organisations therefore refrain from including Syrians, because they fear that the costly training will not produce a lasting learning effect, given the lack of opportunities for practice. Lobbying for a change in those policies or ensuring other ways for Syrians to practice their skills (e.g. within refugee camps) is recommended. Furthermore, future counsellors' and therapists' ability to work in MHPSS in the long term will require a thorough staff care concept in order to prevent high drop-out rates and maintain staff health (for a context-sensitive approach to staff care for MHPSS staff's with a focus on the Middle Eastern region see [41]). This, too, makes a multi-level approach necessary: All hierarchic levels within the trainees' organisations need to be made aware of the importance of an effective staff care concept and support its implementation in order to provide the conditions for the future counsellors' and therapists' own wellbeing and thereby the long-term sustainability of their services.

## Literature:

- [1] GIZ Regional Programme „Psychosocial Support for Syrian and Iraqi Refugees and IDP“ (2018): Guiding Framework for Mental Health and Psychosocial Support (MHPSS) in Development Cooperation: As exemplified in the context of the crises in Syria and Iraq. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.
- [2] INEE – International Network for Education in Emergencies (2012): Minimum Standards for Education: Preparedness, Response, Recovery. Online: [https://inee.org/system/files/resources/INEE\\_Minimum\\_Standards\\_Handbook\\_2010%28HSP%29\\_EN.pdf](https://inee.org/system/files/resources/INEE_Minimum_Standards_Handbook_2010%28HSP%29_EN.pdf) [accessed on 17.07.2019]
- [3] [National Comprehensive Cancer Network (1999): NCCN practice guidelines for the management of psychosocial distress. In: *Oncology* 13(5A), pp. 113-147.
- [4] Herriger, Norbert (2014): *Empowerment in der Sozialen Arbeit: Eine Einführung*. 5th edition. Stuttgart: Kohlhammer.
- [5] UNHCR (2019): Syria emergency. Online: <http://www.unhcr.org/syria-emergency.html> [accessed on 17.07.2019].
- [6] UNHCR (2019): Iraq emergency. Online: <http://www.unhcr.org/iraq-emergency.html> [accessed on 17.07.2019].
- [7] Hassan, G. / Kirmayer, L.J. / Mekki-Berrada A. / Quosh, C. / el Chammay, R. / Deville-Stoetzel, J.B. / Youssef, A. / Jefee-Bahloul, H. / Barkeel-Oteo, A. / Coutts, A. / Song, S. / Ventevogel, P. (2015): *Culture, Context and the Mental Health and Psychosocial Wellbeing of Syrians: A Review for Mental Health and Psychosocial Support staff working with Syrians Affected by Armed Conflict*. Geneva: UNHCR.
- [8] Onyut, Lamaro P. / Neuner, Frank / Schauer, Elisabeth / Ertl, Verena / Odenwald, Michael / Schauer, Maggie / Elbert, Thomas (2004): *The Nakivale Camp Mental Health project: building local competency for psychological assistance to traumatised refugees*. In: *Intervention* 2(2), pp. 90 – 107.
- [9] Bittenbinder, Elise / Patel, Nimisha (2017): *Systemische Praxis in globalen Zusammenhängen – zwischen Solidarität und Abwehr*. In: *Familiendynamik* 42(1), pp. 18-26.
- [10] Kleefeldt, E. (2018). *Resilienz, Empowerment und Selbstorganisation geflüchteter Menschen – Stärkenorientierte Ansätze und professionelle Unterstützung*. Fluchtaspekte, Vandenhoeck & Ruprecht Verlage.
- [11] Weissbecker, Inka / Leichner, Ashley (2015): *Addressing Mental Health Needs among Syrian Refugees*. Middle East Institute. Online: <http://www.mei.edu/content/article/addressing-mental-health-needs-among-syrian-refugees> [accessed on 17.07.2019].

- [12] Shoeb, Marwa / Weinstein, Harvey / Mollica, Richard (2007): The Harvard Trauma Questionnaire: Adapting a Cross-Cultural Instrument for Measuring Torture, Trauma and Posttraumatic Stress Disorder in Iraqi Refugees. In: *International Journal of Social Psychiatry* 53, pp. 447-463.
- [13] International Medical Corps (2015): Mental Health and Psychosocial Support (MHPSS) Needs Assessment of Displaced Syrians and Host Communities in Jordan. Online: <https://data2.unhcr.org/en/documents/download/44261> [accessed on 17.07.2019].
- [14] WHO, Regional Office for the Eastern Mediterranean (2017): Mental health care in Syria: another casualty of war. Online: <http://www.emro.who.int/syr/syria-news/mental-health-care-in-syria-another-casualty-of-war.html> [accessed on 17.07.2019].
- [15] IRIN (2017): Iraq's growing mental health problem. Online: <https://www.irinnews.org/feature/2017/01/16/iraq%E2%80%99s-growing-mental-health-problem> [accessed on 17.07.2019].
- [16] The Hashemite Kingdom of Jordan (2011): National Mental Health Policy. Online: <http://www.mhinnovation.net/sites/default/files/downloads/innovation/reports/National-Mental-Health-Policy-Jordan.pdf> [accessed on 17.07.2019].
- [17] MHIN – A global community of mental health innovators (2013): Mental Health System Reform in Jordan. Online: <http://www.mhinnovation.net/innovations/mental-health-system-reform-jordan?mode=default> [accessed on 17.07.2019].
- [18] Ministry of Public Health of the Republic of Lebanon (2015): Mental Health and Substance Use: Prevention, Promotion and Treatment. Situation analysis and strategy for Lebanon 2015-2020. Beirut: Lebanon. Online: <http://www.mhinnovation.net/sites/default/files/downloads/resource/MH%20strategy%20LEBANON%20ENG.pdf> [accessed on 17.07.2019].
- [19] Karam, Elie / El Chammay, Rabih / Richa, Sami / Naja, Wadih / Fayyad, John / Ammar, Walid (2016): Lebanon: mental health system reform and the Syrian crisis. In: *The British Journal of Psychiatry International* 13(4), pp. 87-89.
- [20] WHO, Department of Mental Health and Substance Abuse (2011): Mental Health Atlas 2011 – Turkey. Online: [http://www.who.int/mental\\_health/evidence/atlas/profiles/tur\\_mh\\_profile.pdf](http://www.who.int/mental_health/evidence/atlas/profiles/tur_mh_profile.pdf) [accessed on 17.07.2019].
- [21] International Medical Corps (2017): Mental Health and Psychosocial Support Considerations for Syrian Refugees in Turkey. Sources of Distress, Coping Mechanisms, & Access to Support. Online: <https://internationalmedicalcorps.org/wp-content/uploads/2017/07/Mental-Health-and-Psychosocial-Support-Considerations-for-Syrian-Refugees-in-Turkey.pdf> [accessed on 17.07.2019].
- [22] WHO (2013): Psychological first aid: Facilitator's manual for orienting field workers. Geneva: WHO Press. Online: [http://apps.who.int/iris/bitstream/10665/102380/1/9789241548618\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/102380/1/9789241548618_eng.pdf) [accessed on 17.07.2019].

- [25] Van der Veer, Guus (2006): Training trainers for counsellors and psychosocial workers in areas of armed conflict: some basic principles. In: *Intervention* 4(2), pp. 97-107.
- [24] Ingabire, Chantal Marie / Kagoyire, Grace / Karangwa, Diogene / Ingabire, Noella / Habarugira, Nicolas / Jansen, Angela / Richters, Annemiek (2017): Trauma informed restorative justice through community based sociotherapy in Rwanda. In: *Intervention* 15(3), pp. 241-253.
- [25] Bubenzer, Friederike / Tankink, Marian (2017): Introduction to Special Issue: linking mental health and psychosocial support to peacebuilding in an integrated way. In: *Intervention* 15 (3), pp. 192-198.
- [26] Austin, Beatrix / Fischer, Martina (2016): *Transforming War-Related Identities – Individual and Social Approaches to Healing and Dealing with the Past*. Berlin: Berghof Foundation Handbook for Conflict Transformation.
- [27] MISEREOR (2018): Positionspapier Traumaarbeit: “Verwundete Beziehungen brauchen Heilung” – Zur Traumaarbeit als zentralem Bestandteil von Friedensarbeit und Entwicklungszusammenarbeit. Online: <https://www.misereor.de/fileadmin/publikationen/positionspapier-traumaarbeit.pdf> [accessed on 17.07.2019]
- [28] Weine, Stevan / Danieli, Yael / Silove, Derick / Van Ommeren, Mark / Fairbank, John A. / Saul, Jack (2002): Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings. In: *Psychiatry* 65(2), pp. 156-164.
- [29] Inter-Agency Standing Committee (2007): *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. Geneva: IASC. Online: [https://interagencystandingcommittee.org/sites/default/files/iasc\\_guidelines\\_on\\_mental\\_health\\_and\\_psychosocial\\_support\\_in\\_emergency\\_settings.pdf](https://interagencystandingcommittee.org/sites/default/files/iasc_guidelines_on_mental_health_and_psychosocial_support_in_emergency_settings.pdf) [accessed on 17.07.2019].
- [30] WHO (2005): *Human Resources and Training in Mental Health*. Online: [https://www.who.int/mental\\_health/policy/Training\\_in\\_Mental\\_Health.pdf](https://www.who.int/mental_health/policy/Training_in_Mental_Health.pdf) [accessed on 17.07.2019]
- [31] WHO (2016): *Problem Management Plus (PM+). Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity*. Online: [https://www.who.int/mental\\_health/emergencies/problem\\_management\\_plus/en/](https://www.who.int/mental_health/emergencies/problem_management_plus/en/) [accessed on 17.07.2019]
- [32] WHO (2018): *WHO Mental Health Gap Action Programme (mhGAP)*. See in particular the mhGAP Humanitarian Intervention Guide (mhGAP-HIG) and the mhGAP Training Manuals. Online: [https://www.who.int/mental\\_health/mhgap/en/](https://www.who.int/mental_health/mhgap/en/) [accessed on 17.07.2019]
- [33] Pinzker, Inge (2017): Dolmetschvermittelte Personenzentrierte Psychotherapie mit Flüchtlingen. In: *E-Journal für biopsychosoziale Dialoge in Psychosomatischer Medizin, Psychotherapie, Supervision und Beratung*, 5(1), pp. 56-74.

- [34] Bittenbinder, Elise (2018): Vorwort. In: Schriefers, Silvia/ Hadzic, Elvira (Ed.): Sprachmittlung in Psychotherapie und Beratung mit geflüchteten Menschen: Wege zur transkulturellen Verständigung, pp.13-17. Göttingen: Vandenoever & Ruprecht.
- [35] Charlson, Fiona / van Ommeren, Mark/ Flaxman, Abraham / Cornett, Joseph / Whiteford, Harvey / Saxena, Shekhar (2019): New WHO Prevalence Estimates of Mental Disorders in Conflict Settings: A Systematic Review and Meta-Analysis. Online: <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2930934-1> [accessed on 17.07.2019]
- [36] Charité – Universitätsmedizin Berlin / Jiyan Foundation for Human Rights (2019): Assessment of specialized MHPSS interventions in the context of the crises in Syria and Iraq. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.
- [37] Deutsche Gesellschaft für Beratung e.V. (DGfB) (2010): Essentials einer Weiterbildung Beratung / Counseling. Online: <http://www.dachverband-beratung.de/dokumente/weiterbildungsstandards.pdf> [accessed on 17.07.2019].
- [38] Al-Krenawi, Alean / Graham, John R. (2000): Culturally Sensitive Social Work Practice with Arab Clients in Mental Health Settings. In: *Health & Social Work* 25(1), pp. 9-22.
- [39] Center for Mental Health and Psychosocial Support Services, Koya University (2017): The Psychosocial Support Services (PSS) Training Program. Online: [https://www.seedkurdistan.org/Downloads/PSS\\_Training\\_Program.pdf](https://www.seedkurdistan.org/Downloads/PSS_Training_Program.pdf) [accessed on 17.07.2019].
- [40] UNRWA – United Nations Relief and Works Agency for Palestine Refugees in the Near East (2017): mental health and psychosocial support framework. Online: <https://www.unrwa.org/resources/about-unrwa/mental-health-and-psychosocial-support-framework> [accessed on 17.07.2019].
- [41] Jacobi, Josephine / Becker, David / Langer, Phil / Maier, Luise / Sheese, Kate / Schumann, Frank / Ahmad, Aisha-Nusrat (2019): Developing Staff Care. An Introductory Guide for Organizations Working in Emergency Settings, in Areas of Protracted Conflict and its Aftermath. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit.”
- [42] Wheaton, Wendy (2008): Training of trainers on mental health and psychosocial support in emergencies, Africa. In: *Intervention* 6(3/4), pp. 298-303.
- [43] Johnstone, Lucy (2017): Psychological Formulation as an Alternative to Psychiatric Diagnosis. In: *Journal of Humanistic Psychology* 00, pp. 1-17.
- [44] Harper, David, & Moss, Duncan (2003): A different chemistry? Re-formulating formulation. In: *Clinical Psychology* 25, pp. 6-10.

- [45] Butler, Gillian (1998). Clinical formulation. In: Bellack, Alan S. & Hersen, Michel (Eds.), *Comprehensive clinical psychology*, pp. 1-23. Oxford, England: Pergamon.
- [46] The Center for Victims of Torture (2011): *International Healing Services. Building Local Mental Health Capacity*. Online: [accessed on 17.07.2019].
- [47] Keilson, Hans (1992): *Sequential Traumatization in Children*. Jerusalem: Magnes Press, Hebrew University.
- [48] Das, Veena (2015): Beyond trauma, beyond humanitarianism, beyond empathy: a commentary. In: *Medicine Anthropology Theory* 2(3), pp. 105-112.
- [49] Afana, Abdelhamid (2012): Problems in Applying Diagnostic Concepts of PTSD and Trauma in the Middle East. In: *The Arab Journal of Psychiatry* 23, pp. 28-34.
- [50] Gurrus, Norbert / Wenk-Ansohn, Mechthild (2013): Folteropfer und Opfer politischer Gewalt. In: A. Maercker (Ed.): *Posttraumatischen Belastungsstörungen*, 4th ed., pp. 477-499. Berlin: Springer. 525-553.
- [51] Flatten, Guido / Gast, Ursula / Hofmann, Arne / Knaevelsrud, Christine / Lampe, Astrid / Liebermann, Peter / Maercker, Andreas / Reddemann, Luise / Wöller, Wolfgang (2011): S3-Leitlinie Posttraumatische Belastungsstörung. In: *Trauma und Gewalt* 3, pp. 202-210.
- [52] Agger, Inger / Raghuvanshi, Lenin / Shabana, Shirin / Polatin, Peter / Laursen, Laila. (2009): Testimonial therapy: A pilot project to improve psychological wellbeing among survivors of torture in India. In: *Torture: quarterly journal on rehabilitation of torture victims and prevention of torture* 19(3), pp. 204-217.
- [53] Clancy, Mary Alice C. / Hamber, Brandon (2008): Trauma, Peacebuilding and Development: An overview of key positions and critical questions. Online: <http://www.incore.ulst.ac.uk/pdfs/IDRCclancyhamber.pdf> [accessed on 17.07.2019].
- [54] Hart, Barry / Colo, Edita (2014): Psychosocial peacebuilding in Bosnia and Herzegovina: approaches to relational and social change. In: *Intervention* 12(1), pp. 76-87.
- [55] Braithwaite, John / Nickson, Ray (2012): Timing Truth, Reconciliation and Justice after War. In: *Ohio State Journal on Dispute Resolution* 27(3), pp. 443-476.
- [56] Gierlichs, Hans Wolfgang / Wenk-Ansohn, Mechthild (2005). Behandlungsbedarf, Prognose und Suizidalität bei komplexen chronischen Traumafolgestörungen. In: *Zeitschrift für Ausländerrecht und Ausländerpolitik* 25, pp. 405-415.
- [57] Anani, Ghida (2013): Dimensions of gender-based violence against Syrian refugees in Lebanon. In: *Forced Migration Review* 44, pp. 75-78.
- [58] UNHCR (2017): "We keep it in our heart": Sexual Violence against Men and Boys in the Syria Crisis. Online: <https://www.refworld.org/docid/5a128e814.html> [accessed on 17.07.2019].

- [59] medica mondiale (2019): Mental Health and Psychosocial Support (MHPSS) with female survivors of SGBV in the context of the crises in Syria and Iraq: A guiding and recommendation paper for actors in the MHPSS sector of the German development cooperation. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.
- [60] Mollica, Richard F. (2014): The New H5 model. Trauma and Recovery: A Summary. Cambridge, Massachusetts: Harvard Program in Refugee Trauma.
- [61] GIZ Programme „Stärkung psychosozialer Unterstützungsstrukturen für palästinensische Flüchtlinge“ (2017): Stärkung psychosozialer Kapazitäten im Rahmen von Entwicklungszusammenarbeit im Kontext von Konflikt, Fragilität und Gewalt. Eschborn: Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH.
- [62] European Network of Rehabilitation Centres for Survivors of Torture (2018): Refugee survivors of torture in Europe. Towards positive public policy and health outcomes. Online: [http://www.baff-zentren.org/wp-content/uploads/2018/08/Euronet\\_Publikation\\_English\\_online.pdf](http://www.baff-zentren.org/wp-content/uploads/2018/08/Euronet_Publikation_English_online.pdf) [accessed on 17.07.2019]

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