PSYCHOSOCIAL WELLBEING SERIES



The Mental Health Needs of Vulnerable Children and their Caregivers in Low Income Areas

A Training Guide

Compiled by Brian Robertson

REPSSI
Psychosocial Wellbeing For All Children

REPSSI

Psychosocial Wellbeing For All Children

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Jonathan Morgan
Editor, REPSSI Psychosocial Wellbeing Series

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Few would deny the overlaps and common ground that exists both between "psychosocial wellbeing" on the one hand, and "mental health" on the other hand. Yet in practice, it often seems as if quite separate communities of practice surround these conceptual frames. For this reason REPSSI is happy to publish The Mental Health Needs of Vulnerable Children and their Caregivers in Low Income Areas, by Dr Brian Robertson within the REPSSI Psychosocial Wellbeing Series.

Noreen Masiiwa Huni
Executive Director,
REPSSI, May, 2008

About this Training Guide

This Training Guide was compiled for community-based HIV and AIDS workers, but may be useful for other individuals or groups. It is based on the premise that a significant proportion of vulnerable children and their caregivers in low income areas have unmet mental health needs that place them at risk for developing mental health problems and disorders. This premise challenges the assertion that there are only small numbers of such children, being those that require specialised mental health interventions. It also challenges the notion that 'love ("ordinary psychosocial care and support") is enough' for vulnerable children, motivating that educating caregivers and HIV and AIDS workers about the emotional development and mental health needs of vulnerable children is essential for their wellbeing.

As specialised child and adolescent mental health services are relatively inaccessible or non-existent in low income areas, this Training Guide has been designed for workers who do not have child and adolescent mental health training. Trainers, however, would need to have had some background or training in this field. This Training Guide relies on the availability of mental health referral facilities, or of electronic or tele-consultation for complex or severe mental disorders. Ongoing supervision for trainees after the completion of training is essential in order to develop the necessary skills for working with vulnerable children. Training is only the first step in skill development.

A further major premise on which this Training Guide is based is that the acquisition of book knowledge alone is not sufficient training for working with vulnerable individuals who are at risk for stress and mental health problems. Effective relief for such individuals takes place within a trusting and caring relationship. Self-knowledge and certain personal skills are essential requirements for workers likely to be involved in a helping role with vulnerable individuals.

This Training Guide has been developed in an African context, but with an eye towards adaptation in other low income areas. Trainers are invited to use or adapt whatever material is relevant to their own context and trainees' needs, and to construct their own training course. This Training Guide is not a Training Manual, and is not intended to be either all-inclusive or universally applicable, but rather to serve as an introduction to the mental health needs of vulnerable children. Trainers are expected either to omit sections of the Training Guide which are not relevant for their trainees, or to expand on sections which need more elaboration for their particular course. Trainers are also expected to provide more examples and exercises, or ones which are more applicable to their context, than are provided in this Training Guide. Trainees are encouraged to read further in the field of mental health and to take more advanced courses in selected aspects of mental health practice.

In designing and formulating this Training Guide, I have drawn freely on other published material, including publications in the field of Psychosocial Wellbeing, Support and Care. All sources are acknowledged in the Bibliography. My dual intentions have been to supplement, and to avoid duplication with, these resources.

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CHAPTER 1 Wellbeing, vulnerability and mental health

Childhood

In this Training Guide, *childhood* covers the whole period between birth and the end of adolescence/ onset of adulthood. What determines the end of adolescence will be discussed in Chapter 3. As there can be no universally applicable age for the transition between adolescence and adulthood, we will, for practical purposes, consider adolescence, and therefore childhood, to end with the teen years.

Vulnerability

Vulnerability literally means *liability to injury.* In broad terms, children are regarded as vulnerable if they are likely to suffer significant **injury** to their physical or mental health, or their social development.

What makes children vulnerable? What circumstances seriously threaten their physical or mental health, or their social development? These would include the following "*Difficult Circumstances*", defined as those circumstances in which children are exploited or denied their most basic rights (UNICEF 1990):

- Armed conflicts and forcible induction as child soldiers
- Rampant community and domestic violence

- Child abuse, prostitution, and trafficking
- Incarceration
- Street living and homelessness
- Child labour
- HIV and AIDS pandemic
- Societies which do not provide for children's basic needs for access to health care and education
- Societies which allow discrimination or condone the inhumane treatment of children

Richter, Foster and Sherr (2006) add the following points: "Children and adolescents living in communities seriously affected by HIV/AIDS are doubly vulnerable because typically they grow up under *difficult circumstances*, usually associated with poverty, as well as the dire effects of the HIV/AIDS pandemic. These effects entail multiple losses, including:

- ***health and vitality***, through infection, inadequate nutrition and poor health care;
- ***economic support*** through the collapse of livelihoods resulting from the illness and death of breadwinners and other adults in the extended family who were previously engaged in economic support and subsistence activities;
- ***parents*** and other primary caregivers to illness, death and abandonment;
- ***families***, as they are parted from caregivers and siblings following bereavements and poverty-induced migration;
- ***connections to social institutions*** as a result of stigma in the community and withdrawal from school because of poverty, work and/or care obligations in the home;
- ***human right to development*** in an environment that supports their basic needs for health, education, care and protection;
- ***opportunities to learn from caregivers and play*** with other children because parents may be too ill, because of stigma leading to exclusion, or demoralisation in the family environment;
- ***hope and opportunities*** for the future "

Many children and adolescents living in communities affected by HIV/AIDS also grow up amidst conflict and violence, whether at home, in the community, or in the country as a whole. This frequently involves experiencing violence to themselves or family members, and may include displacement and even separation from their families. So, children who are orphaned or vulnerable because of HIV/AIDS are often triply vulnerable due to HIV/AIDS, poverty or *Difficult Circumstances*, and conflict/violence. Therefore, we now see the HIV/AIDS pandemic in low income areas as part of, not separate from, the scourge of poverty and violence, although in most countries it is the most life-threatening and catastrophic of the three scourges. Getting medical treatment for all HIV/AIDS positive people is an urgent priority, but we need to remember that HIV/AIDS is part of a cycle or system which can't be broken by medication alone: see Figure 1 (Holden, 2003).

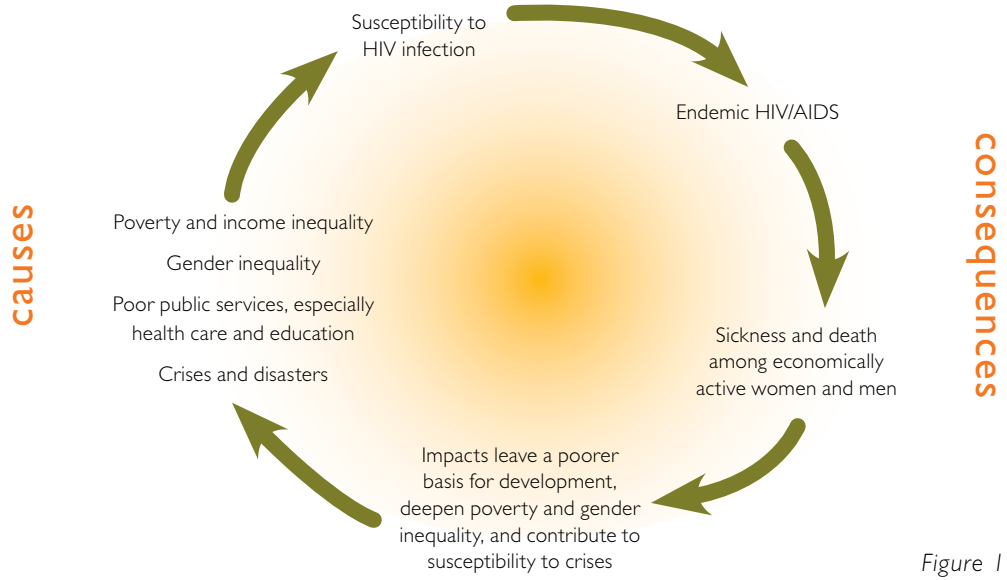


Figure 1

exercise

Trainees can be asked to discuss some of the following questions among themselves, and then report back and discuss with the whole group and the trainers:

1. Who are the vulnerable children and adolescents in your communities?
2. What *difficult circumstances* do children and adolescents in your communities have to deal with?
3. What losses do children and adolescents in your communities experience because of HIV/AIDS?

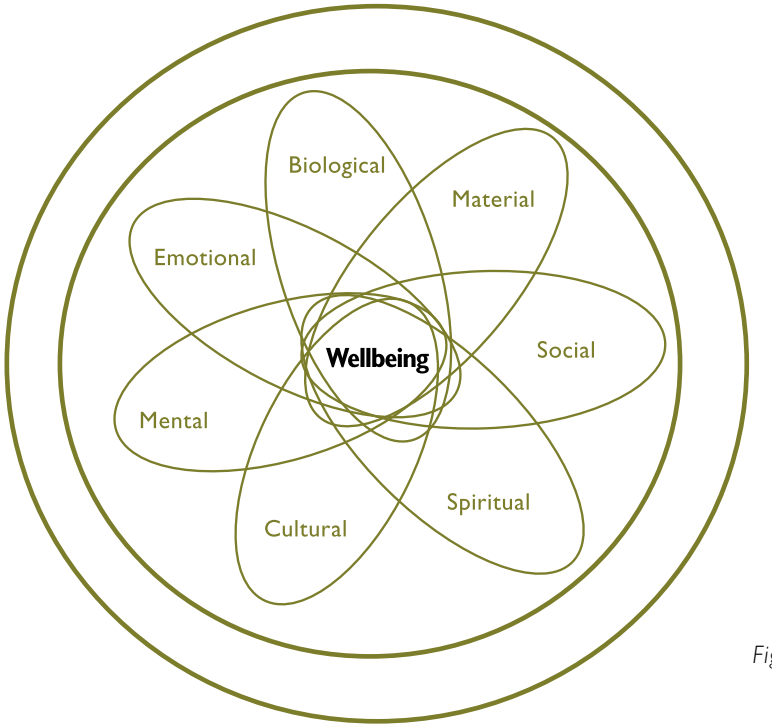


Figure 2

Wellbeing, Mental Health and Vulnerability

Psychosocial wellbeing is defined as the positive outcome of physical, psychological and social development, and is in constant maturation as individuals negotiate the successive stages of their psychosocial development through life (Richter, Foster and Sherr, 2006; REPSSI Psychosocial Wellbeing Series, 2007) (The stages of psychosocial development will be described in Chapter 3). A wellbeing model is provided in Figure 2 (Williamson and Robinson, 2005, as quoted in REPSSI, 2007)):

The various components are interdependent and overlapping to form a holistic entity. Wellbeing is determined by a combination of the individual's physical and psychological capacity, in interaction with their social and material environment. "As they grow, young children develop their emotional capacity, their relationships with other people, their intellectual capacities, and their hope and motivation for the future. These are best developed in nurturing and stable family environments with lifelong social connections, as these provide the necessary conditions for human development" (Richter et al, 2006). The concept of wellbeing can also be applied to households, families, communities and society as a whole.

Mental Health is a conscious, dynamic, evolving capacity, and not a pre-determined, unchangeable, all-or-nothing state. *Child and Adolescent Mental Health* is defined as the capacity to achieve and maintain optimal psychological functioning and wellbeing: it is directly related to the degree of age-

appropriate physical, psychological and social development achieved using available resources (South African Child and Adolescent Mental Health Policy Guidelines, 2003). Development is driven by genes, nurtured by loving, continuous and effective parenting, and shaped by the environment, which includes important physical, social, spiritual and cultural influences. Mental health is dependent on all these resources being available to the individual when required. As children grow and develop, their capacity actively to seek out and creatively use these resources increases.

Most people would agree that psychosocial and spiritual wellbeing, and optimal mental health are surely the first priority for each one of us, our children and our society. Obtaining optimal mental health is generally rated higher than physical health or social advantage, though they cannot be separated in reality as they impinge on one another.

Two critical realities underlie the concept of mental health:

1. Mental health develops, changes and grows as children, adolescents and adults develop, change and grow
   - The various areas of development are inter-related: for instance, an emotional problem can affect physical growth or speech development; and hearing difficulties or learning problems can affect emotional development. Therefore, mental health, like wellbeing, reflects the positive outcome of all areas of development
   - Development is a sequential process, and can be compared to putting one building block on top of another until the whole building is complete. In the area of psychosocial or emotional development, these blocks are called stages of development, and they follow one another in a definite order, and everyone has to go through the same stages (they will be described in Chapter 3). The stability and completeness of each stage depends on the stability and completeness of the previous stage. Therefore the earlier stages are the most crucial. The first stage can be considered to be the cornerstone.
2. The outcome of the developing process of child and adolescent mental health hinges on four main resources:
   - What genes the child inherits
   - What parenting the child receives
   - Schooling
   - Community and society

exercise

Trainees can be asked to discuss some of the following questions among themselves, and then report back and discuss with the whole group and the trainers:

1. What would you regard as the components of optimal mental health for yourself?
2. What would you regard as the components of optimal mental health for a 4 (or 6 or 8) year old child?
3. What would you regard as the components of optimal mental health for a teenager (take a specific age, e.g. 15 years old)?
4. What new insights did you gain about mental health from this exercise?

Indicators of Optimal Child and Adolescent Mental Health

Although mental health is developing all the time, it is possible to tease out the essential indicators of optimal child and adolescent mental health, which can then be evaluated at any age or stage of development. These general indicators are:

1. A good sense of self (who one is) and self-esteem (likes who one is)
2. Healthy, positive family relationships
3. Sound peer relationships
4. Productivity in learning and work
5. The capacity for managing change (either in one's own development, or imposed from the outside)

Wellbeing, mental health and vulnerability

As the definitions of *mental health* and *psychosocial wellbeing* are virtually identical, it is clear that the two concepts are the same, and the terms interchangeable. Similarly, the terms *emotional development* and *psychosocial development* are virtually synonymous, and can be equated with the *developing* aspect of *mental health* or *wellbeing*. How do *mental health* and *psychosocial wellbeing* relate to vulnerability? Vulnerable children and adolescents living in communities in low income areas affected by HIV/AIDS are usually exposed also to poverty, violence, and other *difficult circumstances*. Because of this, their physical or mental health or social development, often all three, are seriously threatened. As we have seen, both physical health problems and problems with social development (like lack of educational opportunities) can both cause and result from problems with *emotional* or *psychosocial development* or *mental health*. Mental health is integral to all aspects of health and development, hence the slogan: *"No Health without Mental Health"*. We function as integrated human beings: a threat to one part of our being, is a threat to all parts. We should not normally talk separately about physical and mental health, except when discussing illnesses which are predominantly physical or mental, and which require treatment directed mainly at one or the other area. The reason why we need to continue separating physical and mental health in discussion is to counter the still common practice among general health workers and policy makers of neglecting the mental aspects of health.

Exposure of children to the effects of HIV/AIDS, poverty and violence is a threat not only to their physical health and social development, but equally to their mental health and wellbeing. As large numbers of children living in low income areas affected by HIV/AIDS can be considered to be vulnerable in this way (Richter et al, 2006), so these same large numbers can be considered to be at risk for *mental health problems*.

> "Generally, at a community level, children are regarded as vulnerable when they are separated from caregivers, are malnourished, abused, neglected, out of school, disabled, ill, required to do excessive work, or lack access to services. By this definition, very large numbers of children are vulnerable".
>
> (Richter, Foster and Sherr, 2006)

Mental health problems should not be confused with the less common and more serious cases of mental disorder. Each is equally deserving of our attention, and of attempts to relieve them.

What do we mean by the term *mental health problem?* The term can be used in regard to anyone with a *significant impairment of psychological functioning or wellbeing*.

The impairment can arise directly or indirectly from

- stress
- substance abuse
- the effects of HIV/AIDS
- violence or displacement
- medical illnesses (including HIV/AIDS) or inadequate nutrition
- developmental disorders like intellectual disability, learning difficulties or deafness
- separation from loved ones, rejection, deprivation, abuse or neglect
- parent or family illness (physical or mental), death or dysfunction
- school or work maladjustment
- impoverished or high risk environments
- incarceration

This list of conditions is virtually the same as the list of conditions which we use as criteria to define *vulnerable* children, that is, children whose physical or mental health or social development is seriously threatened. It is therefore clear that most *vulnerable* children are *at risk* for developing a *mental health problem*, as defined above. Those at *highest* risk are likely to develop a mental health problem and perhaps even emotional or mental disorders like anxiety disorders or depression, given the current lack of knowledge in low income areas about the nature of mental health problems and where to get treatment; stigma; the lack of attention to mental health problems in existing Psychosocial Support resources, training programs and interventions; and the lack of general or specialised child and adolescent mental health personnel or services. Any *vulnerable* child or adolescent with *any* degree of risk for developing mental health problems deserves our concerted efforts to reduce the risk, as much as they deserve our efforts to reduce any threat to their physical health or social development.

A vulnerable child or adolescent at *high* risk for a mental health problem would be one experiencing a *severe* stressor (see examples below) or a *combination of lesser* stressors. The more stressors, the higher the risk. Age, innate coping ability and social support as well as the ability to seek this support also influence the outcome (these will be discussed in later chapters):

Severe stressors:

- Mother or Father or both with untreated or deteriorating AIDS
- Traumatic death of mother or father followed by difficult circumstances
- A child or adolescent who is HIV positive
- Sexual abuse
- Experience of severe violence and displacement
- Incarceration

Lesser stressors:

These would be the conditions listed on the previous page as causing significant impairment of psychological functioning (e.g. stress, substance abuse) and other similar conditions.

Trainees can be asked to discuss some of the following questions among themselves, and then report back and discuss with the whole group and the trainers:

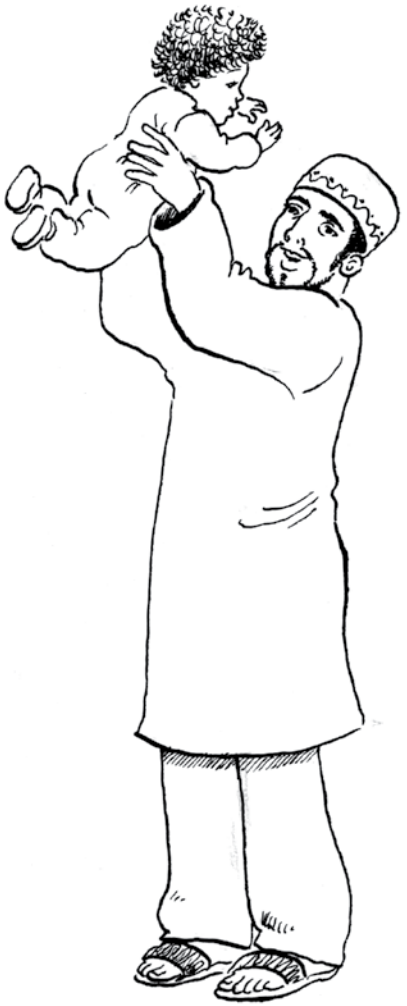
1. In your community or work situation, which stressors are the most common for children and adolescents?
2. In your community or work situation, what major stressors are of concern?

CHAPTER 2

Working with vulnerable individuals who are at risk for stress and mental health problems

Relief of stress and mental health problems is most effectively achieved within a trusting and caring relationship. Such a relationship makes it possible for the healing, sustaining, guiding and reconciling of individuals in physical, emotional or spiritual distress. The quality of this relationship is as important as any knowledge or techniques the helper may acquire. The emotions and life experiences of an individual in distress become a major focus in any helping relationship, so every helper has to be able to manage their own emotional reactions to them. For instance, working with someone who is stressed, anxious or depressed may make the helper feel stressed, anxious or depressed too, or irritated, or feel like not wanting to get involved. Helpers who are not emotionally affected to some extent by the problems of others, or who cannot manage their own emotions are not likely to be effective, and may even do harm. Everyone, even a mental health professional, has their own areas of vulnerability which are likely to be affected when working closely with vulnerable individuals.

For these reasons, *self-knowledge* and certain *personal skills* are essential requirements for working effectively with vulnerable individuals. Anyone can acquire book knowledge or helping techniques, but not everyone possesses or is able to acquire the required self-knowledge and personal skills, even with training. Furthermore, those who do have these essential talents are not automatically able to apply them effectively to children and adolescents. Working effectively with children and adolescents requires particular kinds of self-knowledge and personal skills. We can't all have every possible skill or talent. Inevitably, some people are more suited to certain kinds of work, while others are attracted to different activities. It is important to recognize both one's strengths and one's limitations (see section on Personality Functioning below).



Self-knowledge

The kinds of *self-knowledge* which are important when working with vulnerable individuals include:

- Knowing one's own vulnerabilities
- Knowing one's own strengths and limitations
- Knowing one's own personality functioning, i.e. one's habitual way of reacting, and of interacting with others, one's coping mechanisms, and how one comes across to others
- Knowing one's own values, and the effect of culture, religion and other influences on one's attitudes and behaviour
- Knowing how to identify one's own individual emotions, and how one deals with them
- Knowing one's own current stresses or mental health problems, if any

Many of the personal characteristics listed above are formed during our childhood. We are often less consciously aware of formative influences during childhood than we are of significant life-experiences during our adult lives, so reflecting on childhood experiences is a valuable way to increase self-knowledge for those working with vulnerable individuals. Although we all know what formative influences children ideally need in their upbringing, no-one experiences the ideal. Ideally, parents want their children to be happy and loving; to feel loved, affirmed and protected; to fulfil their physical, emotional, social, intellectual and spiritual potential; and to be able to master any challenges or stressors they encounter.

Before beginning this exercise the group needs to be reminded of the issue of confidentiality within the group. This exercise involves sharing some personal information. All trainees need to be aware that shared stories in the group need to remain confidential. Trainees are asked to write down the answers to the following questions privately, in a form that will make it easy for them to keep and refer to again. Discretion should be used about reporting back any personal information or experiences from this exercise to the whole group, and it should be every trainee's free choice what to share, if anything. Trainees should be warned that this exercise may rouse painful memories and feelings, and that they should speak to the trainer privately afterwards if they are experiencing any difficulties:

1. What were your main positive and negative childhood experiences regarding your relationship with your parents (or caregivers), the relationship between your parents, and other family relationships?
2. Have you experienced any difficulties with feelings as a result? If so, describe them and then indicate how you have dealt with them.
3. Describe any other negative effects of your childhood experiences, and indicate how you coped with them
4. Describe what impact both of the above have had on your life as a whole.
5. Describe any positive or negative childhood experiences that you have had outside of your family that may have compensated for or exacerbated those you described above
6. Describe what you would regard as your main areas of vulnerability today

Trainers need to observe the trainees carefully during and after this exercise for signs of distress, as not all individuals ask for support when they need it. The sensitivity and caring which trainers demonstrate during this exercise is a significant factor in reducing the risk of negative effects. The way the exercise is 'closed off' at the end is also important. Trainers can end with something like: "Please keep your notes of this exercise in a safe place. They are a short record of your own emotional history and make up which are important for you to have when working with vulnerable individuals: it will help you to keep separate your own and their emotional history and make up; it will enable you to use your own experiences to help others; and it will remind you to look after yourself and your own needs. We will return to these notes of yours later on."

Values and personal skills

All our acts are value-laden, that is, they reflect the values we consciously or unconsciously subscribe to. There are no value-free acts, i.e., everything we do, we have chosen to do, because we believe that, in some way, they are good, or at least better than the alternatives. While we do not usually consciously think about the values we subscribe to, and are often not even aware of them, they are frequently obvious to other people, including those we are helping. This is one reason why it is important for helpers to become more aware of their own values, and to ensure that they cultivate the values they believe in, and not be unconsciously influenced to adopt unwanted values. Another important reason for helpers to think about their values is that certain values are necessary for the development of trusting and caring relationships.

exercise

This exercise can be done with the whole group. The trainees are asked the following two questions as a group, and their answers are written on a Board or Flip Chart. The trainer then discusses the answers with the group, and together two final lists are agreed upon:

1. What values are needed for effective work with vulnerable individuals (children and adults) who are at risk for stress and mental health problems?
2. What personal skills are needed for effective work with these vulnerable individuals?

The final lists should include some of the following:

VALUES	PERSONAL SKILLS
Compassion	Self-knowledge
Selflessness	Empathy
Respect for individuals irrespective of age, gender, religion, ethnic group etc	Keeping boundaries between self and others
	Flexibility
Being non-judgmental	Creativity
Confidentiality	Tolerance and perseverance
Valuing team members	Ability to learn from experience
Accountability	Communication skills
Professional ethics	Problem-solving skills
Self-development	Emotional stability
Caring for self	Integrity

At the end of this exercise trainees may be asked to write down privately 3 ***values*** and 3 ***personal skills*** of their own that they need to work on to improve, and to think about how they will be able to do this. If any trainees are unsure about how to develop certain values or personal skills further, they should be encouraged to raise this for discussion in the group. Training in personal skills will be discussed in Chapter 4.

Culture and other influences

Culture can be defined as the shared beliefs, attitudes, values and symbols of a group of people, which guide their behaviour and interpretation of the world. Although every individual has their own unique characteristics and make-up, much of the way individuals behave is influenced by their cultural background. However it is important to make the following two points:

1. Individuals from even very different cultures are more alike than they are different because of their common humanity.
2. Two individuals from the same culture may be different. No culture is homogeneous.

Culture influences almost every area of our lives: our worldview and spiritual beliefs; concepts of right and wrong, and of normal and abnormal; gender and child roles and status; marital relationship and sexual practices; childrearing practices; lifestyle; beliefs about causation of illness; the way physical or emotional distress is expressed; taboos, and so on. The term *cultural identity* acknowledges that I cannot be understood outside of my culture. It is important to recognize that many things contribute to our cultural identity, for instance: religion; socioeconomic status; language; age; gender; educational level; profession; family or tribe.

In a culturally diverse society it is crucial for helpers to fully understand not only the cultural identity of the individuals they are helping, but also their own cultural identity and how the two are perceived by and impact on each other.

exercise

1. As a group, trainees can be asked to name the different cultures encountered in their work, and to indicate which they do not have full knowledge about
2. As a group, trainees can be asked to name the different cultures represented among their group
3. Trainees can be asked to pair off with another trainee from a different culture, or with a different cultural identity. Each should tell the other how they perceive the other's cultural identity, and then the other corrects the perceptions

This exercise can be followed by some discussion about how little we know about each other's culture or cultural identity, even though we live in a multicultural society, and about our assumptions and stereotyping of others. Some action needs to be decided upon about how trainees can get more information about all the cultures we encounter in our society.

exercise

Trainees are asked to draw a picture of how they see themselves physically. They then pair up and share it with another trainee, and discuss their own perceptions of the other's appearance.

The trainer can discuss with the group that, just as you sometimes come across to others physically different to the way you see yourself, so your personality often comes across differently to the way you think of it.

Now the same pairs can be asked to write down a description of their own personality. then share and discuss it with the other.

The trainer can ask if anyone who was surprised at the difference between their own description and their partner's perception of their personality, would be willing to share this with the whole group. In our work with vulnerable individuals, we will often find that the way they depict themselves is different to the way we perceive them to be. For instance, vulnerable individuals often have a low opinion of themselves and their capabilities, and how they are perceived by others.

Trainees can be asked to write down as many strengths as they think they have in their personality, and how they have helped them in the past. The same pairs are asked to describe one incident to their partner where one or more of their strengths helped them in a certain situation and crisis. Then each trainee should write down some of the weaknesses they think they have (but this is not for sharing). They should think about how these weaknesses may have impaired their adult lives, for instance, in their marriage or intimate relationships, with their children, in school or their work. Then each trainee should put their lists of strengths and weaknesses together, and look at themselves as a whole person. They are encouraged to share this later with someone else who is close (not necessarily in the group), and ask them if that is how they see them. If not, they should try to work out why their own perception of themselves is different from the other persons. The trainer can point out that people whom they will be helping, are also made up of strengths and weaknesses, and trainees will need to assist them to become more aware of and use their strengths to help them resolve their problems. Everyone can change. Weaknesses can be worked on to strengthen or overcome them. Strengths should be nurtured and built up.

Trainees are then asked to write down all the things (resources) that are sustaining them at the moment, such as good relations with their family, good friends, religion, financial security, fulfilment at work. Then they should write down all the things that are causing them stress at the moment. They should put the two lists together and see which list outweighs the other. If they are under too much stress or have too few things sustaining them, it will make it difficult to help others with their stress. We can only give as much as we have got. Trainees can be asked if they are willing to volunteer examples of where they have found it difficult to give to others because of their own stress. The group as a whole can discuss ways of coping with stress and problems in general, and then each trainee is asked to write down their own usual coping mechanisms. A discussion can take place about helpful and unhelpful coping mechanisms. Examples of each are given below.

continued on the following page

exercise

Coping mechanisms

Helpful	Unhelpful
Problem-solving techniques (discussed in Chapter 4)	Ignoring the problem, and hoping it will go away
Talking to someone about the problem	Convincing oneself there is no problem
Prayer, or seeking emotional support	Keeping the problem to oneself
Having a good cry	Keeping a stiff upper lip
Having more realistic expectations	Avoiding difficult situations
Finding other sources of gratification, e.g. new interests, more relaxation	Looking for sympathy/solutions from others
Taking exercise	Drinking more, or taking drugs
Being more assertive	Blaming others, taking revenge

The Helping Relationship

It is important to bear in mind, when entering into a helping relationship, that it is always easier to cause harm than do good, especially if we do not have the self-knowledge, technical knowledge, values or personal skills required. For instance, with regard to

- Self-knowledge: for instance, if we think that what worked for us, must work for everyone
- Technical knowledge: for instance, if we work with children, but do not have the required knowledge about all aspects of child development
- Values: for instance, if we are judgmental about the efforts of those we are helping
- Personal skills: for instance, if we work with children, but do not have the appropriate communication skills

Trainees can be asked to break into small groups and list all the kinds of harm that we can cause in a helping relationship if we are not properly prepared or equipped. They should relate this to the kind of work they are doing (rather than talking in the abstract) and should be as specific as possible about the harm caused, i.e. what is likely to happen to the person being helped (the four examples above indicate ***how*** harm is caused but not ***what*** types of harm may be caused, e.g. if we are judgmental, the person may lose confidence in themselves, or they may not want to see us again). At the end, the small groups can present their lists to the whole group, followed by further discussion.

Working intimately with people in a helping relationship often rouses strong feelings and emotional reactions in the helper, which need to be recognized and managed, if they are not to do harm. Recognizing our own feelings also enables us to understand the feelings being experienced by the person we are helping. For instance, if we find ourselves feeling stressed, anxious, depressed or angry, it is possible that we are picking up these feelings from the other person. But we also need to do a self-check to make sure that our emotional reaction is not more related to something in our own present or past experiences.

exercise

The group as a whole are asked to identify feelings and emotional reactions which may be roused in helpers, and the trainer can write them up on a Board or Flip Chart.

The list should contain many of the following, which have been grouped into opposite pairs to indicate that emotions are experienced on a continuum between two opposite poles:

Approval – disapproval	Lightness – heaviness
Like – dislike	Alertness – tiredness
Love – hate	Feeling energised – feeling drained
Sexual attraction – physical revulsion	Relaxed – tense, stressed
Wanting to 'mother' – wanting distance	Interested – bored
Acceptance – rejection	Calm – agitated
Comfort – discomfort	Still – restless
Pleased – irritated	Confident – anxious
Joy – anger	Feeling focussed – feeling chaotic
Gladness – sadness, depression	Feeling in touch – feeling crazy

At the end of the exercise, the group can be asked which of these feelings or emotional reactions are good and which bad. After they have identified some as good or bad, the trainer can interrupt and point out that they are being judgmental because feelings are neither good nor bad. It is what a person does with the feelings that can be good or bad, e.g. if angry, physically attacks the person they are angry with. So all feelings must be accepted and respected, not judged. We can refer to feelings as positive or negative, but not good or bad. We often find it difficult to accept our own or others' negative feelings, and tend to judge them critically. The group may wish to discuss these concepts, if they are new to them.

In a helping relationship, it is not only negative feelings which must not be acted upon, but also some of the positive feelings. A helper needs to maintain a certain amount of neutrality in order to remain objective and be of real help. For instance, it is usually not helpful to 'mother' somebody, but rather to use the feeling to try to understand why you are feeling that way towards them: it could be that the person is unconsciously trying to get other people to solve their problems for them, or it could be that you need someone to mother or dominate at the moment.

exercise

As a group, trainees can be asked what harmful effects may result if they act upon their feelings. The trainer can select items from the list above for this exercise. Some examples are given below:

Like: The helper may not want to disagree with the person, even though it may be very important to get the person to see that they are wrong about something

Discomfort: The helper may interrupt what the person is saying and change the subject

Joy: The helper may feel so good that they miss the fact that the person is only looking at the pleasant side of things, and avoiding important negative realities

Bored: The helper may not respond with sufficient concern, so, for instance, may not provide sufficient follow up and after care

Some actions of helpers may not only be harmful, but also unethical, unprofessional or even criminal. For instance, entering into a sexual relationship with a client is unethical. Refusing to help a difficult client is unprofessional. Physically assaulting a client or sexually abusing a child is a criminal offence.

CHAPTER 3

The psychosocial wellbeing and development of children and adolescents

We have seen in Chapter 1 that the definitions of *psychosocial wellbeing* and *mental health* are virtually identical. *Psychosocial wellbeing* is defined as the positive outcome of physical, psychological and social development, and is in constant maturation as individuals negotiate the successive stages of their psychosocial development through life. *Development* is a sequential process, and can be compared to putting one building block on top of another until the whole building is complete. In the area of psychosocial or emotional development, these blocks are called *stages of development*, and they follow one another in a definite order, and everyone has to go through the same stages. The stability and completeness of each stage depends on the stability and completeness of the previous stage.

The terms physical, psychological and social development incorporate the various areas of development, such as physical growth, speech and language, cognitive, emotional and social (often combined as psychosocial), and moral and spiritual development. The components of each area of development are specific competencies or skills, such as toilet training, feeding, identity formation, the ability to love, and the ability

to learn and to work. The various areas of development are inter-related, more so when they are not yet fully mature, as in young children. For instance, babies who are neglected or abused may fail to thrive, that is, they do not feed well and fail to achieve their expected weight and physical growth milestones. In this example, a problem with emotional development is shown to have a major impact on physical development.

The developmental changes that are constantly taking place in children and adolescents make it more difficult for helpers to know whether they are developing normally or not, especially if they are from a very different culture to that of the helper. Therefore it is essential for helpers to have a sound knowledge of all areas of normal child and adolescent development, of norms for each age or stage of development, and of the factors that can impact on or modify these, such as physical or mental ill-health or disability, or gender, parenting, environment (see below) culture and socialization. Vulnerable children are those likely to suffer significant injury to their physical or mental health, or their social development. Helpers need to be familiar with the signs of such injury, i.e. when development is not proceeding normally, and how to get vulnerable children back on the track of normal development.

This Training Guide focuses on emotional or psychosocial development. There are many other texts which provide detailed information on the other areas of child and adolescent development, e.g. Kibel and Wagstaff (2001) or REPSSI Psychosocial Wellbeing Series (2007). Trainees need to acquire basic knowledge in all these areas of development, from infancy to old age.

There are many aspects to emotional development, which are fully described in psychology texts. This Training Guide will rely mainly on Erikson's Theory of Psychosocial Development, which is a useful tool for understanding some of the main aspects of emotional development (Erikson, 1963).

Healthy Psychosocial Development

"All children must have at least one person who uniquely loves them and has a deep vested, future-oriented interest in their wellbeing" (Richter, Foster and Sherr, 2006). Research has shown that a loving, continuous and effective caregiving relationship with at least one parental figure is essential not only for healthy psychosocial development, but even for survival. Babies who are not engaged in a strong ***attachment*** relationship to a mother figure fail to thrive, and may die. A breakdown in ***attachment*** in older children and adolescents will not have such dire consequences, but may have very serious negative effects on psychosocial wellbeing and development. The outcome depends on what the alternative care and circumstances are, especially crucial in the case of younger children, and on the resilience of the child or adolescent. "A child's age, caregiving and family background, temperament and coping ability, and the supports available to the child at the time of the stress – especially closeness to trusted and familiar caregivers – are all known to lessen adverse effects on children…..Child vulnerability results from the absence of stable and affectionate adult care and protection, as well as from multiple risks or unabated stressful situations" (Richter et al, 2006).

Studies of babies and young children show what every mother knows, namely that within a few weeks of birth, babies are reacting emotionally to people around them, and in their own unique way. Their personality is already developing. Children's interactions with people at one year of age are already complex and varied, and it is clear that they think and feel far more than they are yet able to communicate. The ability of young children to communicate and express deeper feelings and concerns develops much more slowly than their ability to experience them, especially when attachment is poor, or when they are not encouraged to communicate, or when they feel threatened. This leads some adults mistakenly to believe that young children do not think or feel deeply, or that they are less affected by hurts and trauma than adults. Children aged three or four years are often able to express their innermost thoughts and deeper feelings very clearly, if encouraged and supported, and have reason to trust. Without strong early ***attachment*** and enduring love and support, children are not able to achieve optimal psychosocial development and wellbeing, no matter how good their material circumstances are. **No amount of stimulation,**

education, physical care or social advantage can replace a child's need for a loving, continuous and effective caregiving relationship with at least one parental figure.

In the following section the stages in the healthy development of the capacity for loving relationships will be briefly described from infancy to old age, as well as the stages in the healthy development of the capacity for learning and work (Robertson, 1996). Sigmund Freud believed that the hallmark of an individual's mental health (or wellbeing) is the capacity for love and for work. Important areas such as adolescence and self-esteem will be discussed in more detail. Trainees should be encouraged to read up other aspects of psychosocial development about which they need more information.

The Development of the Capacity for Loving Relationships

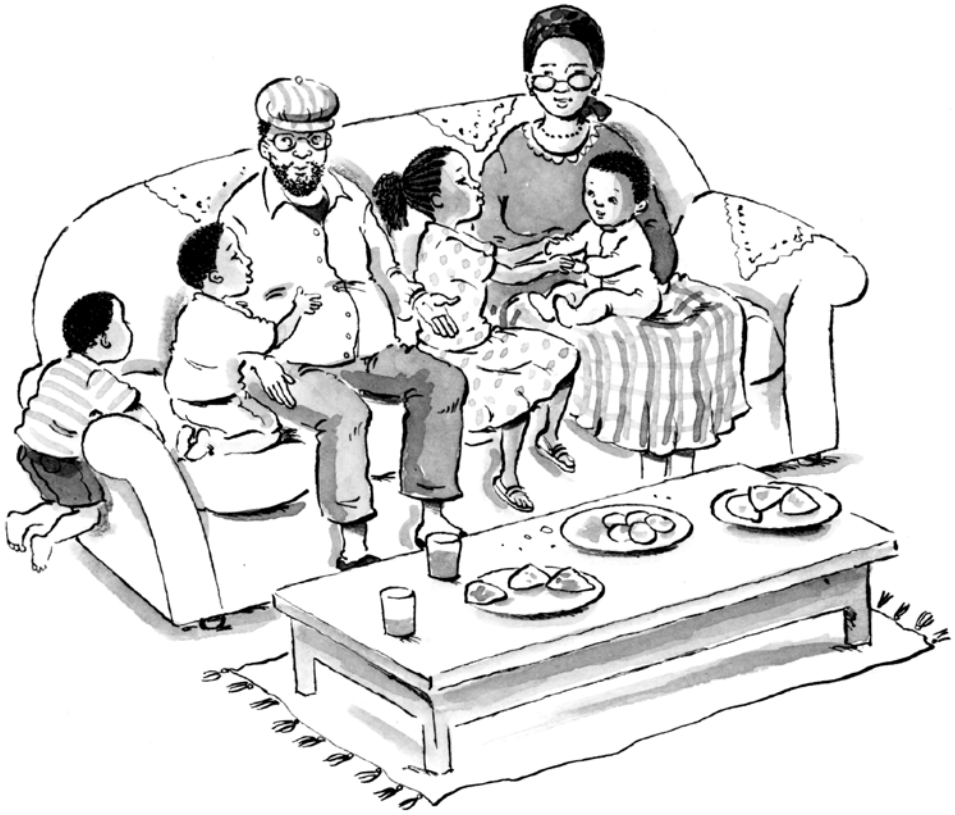
The capacity for loving relationships develops stepwise, like a child learning to walk by taking one step after another. Each step would represent a new achievement on the road to mature loving. We can also use the building block analogy, in which each block that is put on top of another represents a new achievement and a foundation for the next block. We call these blocks stages of development. The psychosocial achievements they represent, and the approximate time period over which they are developing, is given in the Table below, followed by a brief explanation. These time-periods may vary a little from individual to individual, or from culture to culture, and girls develop faster than boys. A fixed time period for each stage is indicated for simplicity only. In reality, successive stages overlap each other.

TABLE 1: Stages in the development of the capacity for loving relationships

1.0	Basic trust	0-18 months
2.0	Autonomy	18-36 months
3.0	Assertiveness	3-6 years
4.0	Socialisation	6-12 years
5.0	Personal and sexual identity	12-20 years
	5.1 through the peer group	12-16 years
	5.2 through intimate relationships	16-20 years
6.0	Commitment to intimate relationships	20-30 years
7.0	Consolidation of intimate relationships	30-40 years
8.0	Re-alignment of identity and relationships	40-50 years
9.0	Intergenerational leadership	50-60 years
10.0	Intergenerational wisdom	60- years

The baby who experiences warm nurturing and effective care during the early months develops a sense of well-being and *trust* in the world that will serve as the basis of trust for future relationships. Another important foundation laid at this stage is the beginning of the development of concern for others. Rapid development of language and motor skills during the second year of life makes toddlers ready to want to manage for themselves: increasing success leads to a sense of *autonomy*.

Between 3 and 6 years of age the child has the opportunity to learn how to become *assertive* but cooperative within the small circle of family and friends. Without the achievement of basic trust, autonomy and assertiveness the child is ill prepared to meet the demands of *socialisation* as required in the classroom, within the peer group and in early contacts with the larger community. This relatively quiet and orderly period of development comes to an end with puberty, which heralds the onset of the more turbulent stage of adolescence, during which *personal and sexual identity* are forged.



By the end of early adulthood a *commitment* to intimate relationships has usually been achieved, and is followed by approximately thirty years of middle adulthood characterised successively by *consolidation*, *re-alignment* ("mid-life crisis") and family *leadership*. By late adulthood, or old age, the drive to love has been fulfilled, and this fulfilment in the elderly is manifest as *wisdom*.

Children who do not experience continuous love, and are not guided and supported (positive parenting skills) through these stages of development can become untrusting, aggressive or fearful, destructive, insecure in themselves and in their relationships, lacking in self-esteem, sexually inhibited or promiscuous, and rebellious. When these significantly impair the child or adolescent's psychological functioning, we consider the child to have a mental health problem. This will be discussed more fully in Chapter 4.

Anger and *aggression* should not be thought of as independent negative emotions or emotional reactions, but as closely related to loving relationships, because they assist us to overcome obstacles in the way of love. When used constructively for this purpose, we describe them in positive terms such as *assertiveness*. It is only when anger and aggression are used destructively, that they become harmful.

The development of the capacity for learning and work

The capacity for learning and work develops stepwise in a way similar to that described for loving relationships. Each achievement and stage is represented in Table 2.

TABLE 2: Stages in the development of the capacity for learning and work

1.0	Transitional play	0 – 18 months
2.0	Constructive and symbolic ('fantasy') play	18-36 months
3.0	Task orientation	3- 6 years
4.0	Formal learning	6-20 years
	4.1 primary school	
	4.2 secondary school	
5.0	Occupational training and commitment	20-30 years
6.0	Consolidation of career skills	30-40 years
7.0	Career leadership	40-50 years
8.0	Community leadership	50-60 years
9.0	Retirement	60- years

The baby's initial preoccupation with their own and the mother's body gives way to play with *transitional* objects that are usually soft materials associated with mother. This helps infants negotiate the transition from the mother's world to their own world, which is initially peopled with cuddly animals and dolls. The emerging ability of the infant to play out with these toys fantasies about interpersonal relationships is called *symbolic* play, which develops through the stages of solitary, parallel and co-operative play with peers.

At the same time the child is exercising and developing perceptual and motor abilities through activities like filling and emptying containers, and opening and shutting doors. This leads on to building and moulding activities and to the expression of ideas and fantasies through drawing and painting. Interest develops, not only in the play and activity themselves, but also in the product which has been created. This is the crucial stage of *task orientation*, the ability to focus on activities which have aims other than simply play or self-gratification. It is an important component of schoolreadiness and prepares the child for the *formal learning* requirements of primary school. Ultimately, with entry into secondary school, young teenagers should be well on the way to taking personal responsibility for their own education.

Commitment to a career is followed by *consolidation* of career skills and the subsequent development of a *leadership* role, firstly in the formal career setting and subsequently in the wider community. Similar stages of adult development apply to those who work mainly within the home and family. Retirement from formal career commitments takes place soon after 60 years, although leadership activities may continue long after retirement.

Children who are not lovingly guided and supported through these stages of development may not learn how to play, or how to express their ideas and feelings in play, which can affect the development of speech and language; and they may have difficulties with visuomotor development and coordination. These in turn may slow the development of intelligence and schoolreadiness, and lead to learning difficulties. The outcome may be school dropout or underachievement, and subsequently work-related problems.

Adolescence

Adolescence can be defined as the stage of development between childhood and adulthood. The beginning is easier to demarcate as it is determined by the physical changes of puberty, but the ending is determined by the completion of psychosocial tasks and merges into the next stage of young adulthood. Adolescence can be divided into two parts, early and late adolescence, corresponding to the two stages indicated in Table 1, approximately from 12-16, and 16-20 years respectively.

The early phase (the younger adolescent)

Coming after the quieter primary school phase, this is sometimes a turbulent phase, characterised by evident sexuality, rebelliousness and strong peer group identification. The major characteristics of the first half of adolescence are:

- sexual interest and experimentation
- preoccupation with own bodily and emotional changes
- emotional lability
- dependence-independence issues
- peer group identification

The late phase (the older adolescent)

During the second half of adolescence preoccupation with physical and sexual identity is gradually superceded by an interest in spiritual matters, ideals, morals and philosophies which eventually leads to the adoption of a personal belief and value system. It is also at this time that the adolescent has developed sufficient confidence in his or her own identity and is mature enough to begin to handle intimate relationships with others.

The major characteristics of the second half of adolescence are:

- idealism and interest in abstract ideas
- developing intimate relationships

The tasks of the parent or caregiver of the adolescent are to promote and support the mastering by the adolescent of their developmental tasks (see below). Many parents and other involved adults find it very difficult to begin making a place for the adolescent in their adult world, instead trying to control them or continue treating them like a child. It is also useful to bear in mind which stages of adult development the parents themselves are negotiating at the time. As most parents of adolescents are between 40-50 years old, many are themselves dealing with the "mid-life crisis" (the stage of *realignment of identity and* relationships) which may increase their difficulties coping with and supporting the adolescent. Parents who are younger and still involved with consolidating their own relationships and their career may find themselves in competition with the adolescent's needs. Older parents may be relatively inflexible in their responses to all the changes and adaptations required as parents of an adolescent.

The developmental task of the adolescent is to successfully negotiate the stage of adolescence. The criteria for the resolution of adolescence are

- the achievement of a stable gender identity and the acceptance of
- the capacity for stable intimate relationships
- emotional independence from the parents
- the capacity for productive work
- the development of a personal value system

Self-concept, self-esteem and sense of self

One of the most important keys to happiness and wellbeing is a favourable self-image. Children who like themselves are confident. They feel they can cope with obstacles, and are not burdened with self-doubt. They solve problems in original, innovative ways. Their success renews their self-respect and makes it easy for them to respect and love others, and, in turn, they are respected and loved.

On the other hand children who do not feel good about themselves are convinced that they cannot succeed, and do not try very hard, resulting in a downward spiral of lack of confidence and lack of success. They may try very hard to please others, or be destructive both of material things and of other people's feelings. Because of their self-doubts they are not much fun to be with, and so have trouble making and keeping friends.

Children can recognise themselves at eighteen months, and develop a sense of self toward the end of their second year. By the age of three, children are thinking of themselves mostly in terms of external characteristics - what they look like, where they live, what they're doing. Not until the age of six or seven do children begin to define themselves in psychological terms. They now develop a concept of what they are like (the real self) and also of what they would like to be (the ideal self). Their evaluation of themselves results in their self-esteem. Our self-concept is developed from four bases:

- The way we feel we are loved and approved of
- Competence in performing tasks we consider important
- The attainment of moral and ethical standards
- The extent to which we influence our own and others' lives (Papalia and Olds, 1989)

Risk and Protective Factors in Psychosocial Development

The previous sections in this chapter have described healthy psychosocial development in general. In reality, every child has their own unique developmental trajectory which is different to others in their culture, and even their own siblings. Similarly, no two children with developmental or mental health problems are alike. For instance, poor self-esteem or depression will not have the same appearance from one child

to another, or even among siblings. No two children can be fit into the same mould, and therefore assessment of their individual psychosocial development and wellbeing requires some understanding of the factors and circumstances which have shaped their unique characteristics. These factors and circumstances, as indicated in Chapter 1, can be divided broadly into four areas, namely the child, the parents/family, the school, and community and society. We can use a biopsychosocial framework, i.e. physical, psychological and social, to ensure that we have considered all possible factors and circumstances. The main ones, with some examples, are listed briefly below. When they promote and support healthy psychosocial development and wellbeing, we call them ***protective*** factors, and when they may adversely affect them, we call them ***risk*** factors. Further reading in this area should be encouraged.

1. Gender
   - Girls develop at a faster rate than boys
   - In general, girls tend to be more verbal, and boys more active and aggressive
2. Temperament/personality
   - Young children differ according to activity level, intensity of their emotional reactions, and their response to new experiences
   - These and other characteristics produce different ways of being, doing and reacting as children grow older
3. Intelligence/learning ability
   - High intelligence and good learning ability are protective factors, whereas learning problems and intellectual disability are risk factors
4. Wellbeing and health
   - Wellbeing and good physical and mental health are protective factors, whereas serious physical ill-health, disability, stress and mental health problems are risk factors
5. Parenting/family functioning
   - Developmental issues of parents, e.g. career problems, overprotectiveness, neglect, abuse, parental illness (physical or mental), and marital discord are risk factors for children
   - A healthy marriage is one of the strongest protective factors for children, whereas marriage breakdown or death of a parent are risk factors
   - Family size, communication, discipline and sibling relationships may be protective or risk factors
6. Schooling
   - A happy and successful school experience is a very strong protective factor
   - Lack of schooling, learning problems, academic failure, and being bullied are risk factors
7. Peers/community/society
   - Poor peer relationships, or relationships with antisocial peers are risk factors
   - Community support and active participation in faith-based or other community activities are protective factors, whereas poverty and growing up in a violent or bad neighbourhood are risk factors
   - Civil war, displacement, natural disasters and epidemics are risk factors
   - Societies which do not respect human rights, or provide safety and security, or basic services put children at risk

If possible trainers should come to this exercise with one or more case - histories (ideally taken from their work situation or experience) that they can present and work on with their group. The trainees are asked to indicate as many risk and protective factors as they can identify, to estimate the child/adolescent's stage of psychosocial development (loving relationships, as well as learning and work), and to comment on their self-esteem and, for adolescents, their progress with their developmental tasks. The exercise is intended to help trainees apply the knowledge gained in this chapter to real situations, not to discuss interventions.

CHAPTER 4

Stress and mental health problems in vulnerable children and their caregivers in the context of HIV/AIDS

Stress is the response of individuals to the circumstances and events (called "stressors") that threaten them and tax their coping abilities (Santrock, 1999). Different individuals may perceive or appraise the same circumstances and events differently. Some that are felt to be stressful by one individual, may even be felt to be invigorating by another. As soon as stress is felt, we consciously or unconsciously appraise our coping resources. When harm or threat of harm are appraised as high, and coping resources perceived to be low, marked stress is likely to occur. When harm or threat of harm are appraised as low, and coping resources high, stress is more likely to be moderate or low. Note that it is also the perception of harm, and not only the reality, which determines the outcome.

Because children are not yet intellectually and emotionally mature, and their coping resources not fully developed, they are more likely to appraise harm or the threat of harm to be greater than adults facing the same stressor. The younger the child, the more likely they are to feel overwhelmed by a stressor, and also more likely to be influenced in their appraisal by their parents' (or other adults') and older siblings' reactions (appraisal of) to the stressor. The more confident and resilient the parent, the less likely it is that the child will feel stressed. Adolescents will be influenced by the reactions of their peers. Adolescents generally tend to ignore, play down or deny threats to their coping ability, so may not engage with a stressor, or not until the risk of personal danger is immediate.

exercise

Trainees can be asked to recall and discuss situations

- which they expected to be stressful, only to find later that they were not
- which they found stressful but others did not
- where they underestimated their coping abilities

Causes of stress

Stress may arise from both ***daily hassles*** and ***life-events***. It may seem that the daily hassles of some individuals are fairly minor, but with stress, everything is relative, and perception and preparedness to cope strongly influence outcome. These so-called minor hassles could include jealousy, arguments, change, pressure, and living in a multicultural society. For others, daily hassles are more challenging, such as financial worries, coping with ill-health in the family, separation from loved ones, conflicts with in-laws, school or work-related stress, and coping with poverty, e.g. inadequate housing, lack of food and other basic commodities, and poor delivery of public health services.

Life-events can be divided into those that most people experience, and those that are more extraordinary. All life events are stressful to some degree, even when they are fulfilling and ultimately enhance wellbeing. For instance, moving house or getting married are known to be potentially very stressful. For children, the birth of a sibling or starting school can be stressful, and for teenagers, starting high school and the normal process of puberty and adolescence are stressful. Everyone recognises the stress caused by marital breakdown and divorce, loss of housing, death of a loved one, loss of job, and being mugged or burgled. Extraordinary events like rape or other personal experience of violence, a life-threatening illness like HIV/AIDS, and incarceration are very stressful. For children, the dying or death of a mother (and sometimes other family members) is frequently much more stressful, and for a much longer time, than is recognised. Being in the middle of a war or a severe epidemic like HIV/AIDS, or being exposed simultaneously to multiple stressors are considered to be some of the greatest causes of stress. It is important to remember that adults have more choices in relation to avoiding or reducing exposure to stressful events, whereas children are either too young to exercise choices, or are obliged to accept the decisions of their parents or caregivers.

Effects of Stress

The body responds to stress with an increase in heart rate, blood pressure and breathing rate, and the muscles tense in readiness for *fight or flight* (Atkinson, Atkinson, Smith and Hilgard, 1987). The mind is cleared and the ability to concentrate enhanced. These changes are essential for coping with physical danger, but are not all adaptive for psychological stress, and may lead to physiological as well as psychological exhaustion when stress is chronic, as it so often is. Physiological exhaustion, due to overactivity of the hormones and other chemicals in the body, can cause medical symptoms and illnesses, such as loss of energy, aches and pains, headaches, irritable colon, high blood pressure and peptic ulcer, as well as psychological symptoms or problems, and mental disorders like psychosomatic disorders and depression. These are some of the signs of chronic stress.

Psychological or emotional symptoms of chronic stress include feelings of anxiety or panic, irritability or anger, and apathy or withdrawal, as well as difficulty concentrating and organising thoughts. Anxiety and anger may help to mobilise the individual's coping resources to respond to stressors in the short-term, but if they persist or are out of proportion to the stressor, they can lead to impairment of psychological functioning (mental health problems), and eventually emotional or mental disorders like anxiety disorders, depression, substance abuse and antisocial behaviour. In Chapter 1, a mental health problem was defined as a *significant impairment of psychological functioning or wellbeing.* This definition can now be further elaborated as

> A behavioural or psychological pattern (a persistent way of thinking, feeling, acting or interacting) that is associated with personal distress (e.g. due to anxiety, anger or sadness), or with the inability to function normally (in the personal, social, or academic/occupational domains), or in children and adolescents, with impairment of normal development.

Because children are not always able to articulate, or communicate, their thoughts and feelings, we often refer to mental health problems in children as emotional or behavioural problems. For the same reasons, children's reactions to stress, compared to older individuals, are likely

to be more disorganised, more behavioural than verbal, with more regression (showing behaviour typical of younger children) and more physical symptoms, e.g. abdominal pain. Prolonged severe stress, for instance due to ongoing abuse, emotional deprivation or severe trauma, may impede normal physical, emotional or social development, especially in young children. Such *developmental problems* may manifest either as delayed or as abnormal development.

When mental health/emotional/behavioural/developmental problems reach sufficient severity and persist continuously for a significant period of time, they may be diagnosed by health professionals as mental or psychiatric disorders. Mental disorders may roughly be divided into *common (usually milder)* and *serious mental disorders*, and will be described below. Mental health/emotional/behavioural problems are relatively common in low income areas because of the multiple stressors individuals are exposed to, the lack of knowledge about mental health, the lack of facilities for mental health support, and stigma. Although it is difficult to estimate the number of individuals who have mental health problems or are at risk for them in low income areas, it would be safe to assume that the numbers are large.

On the other hand, mental disorders are less frequent. Studies suggest that at least 15 % of individuals (one in seven) develop a mental disorder at some point in their lives. This percentage would certainly apply to adolescents, whereas young children would be lower and adults higher. For instance, 25% of all women and 10% of all men develop depression at some point in their adulthood, often present (but not necessarily diagnosed) by the end of adolescence. The percentages may be higher in low income areas, and are rising because of increasing poverty, violence and drug abuse, pandemics like HIV/AIDS, and the breakdown of family and societal structures and values. A recent study in South Africa showed very high rates of mental disorders in AIDS orphans (Cluver, Gardner and Operario, 2007). Mental disorders are often not diagnosed in young children, unless specifically looked for, and unless children feel safe to disclose their feelings, but they can be detected through close observation and sensitive questioning. Mental disorders tend to become more obvious in adolescence, when teenagers are more articulate, or act out their feelings, although teenagers typically do not like to admit having problems. By adulthood, individuals are generally more

aware and accepting of their emotional problems and more ready to seek help, or at least to talk to someone about them. Mental disorders require referral to health professionals for assessment and treatment. Some of the main mental disorders are listed below.

The Natural Course of Stress Reactions

Typically acute stress reactions remit spontaneously after the stressor has stopped and the individual has found a way to cope with it. However, often the stressor is ongoing, as in sexual abuse, or there are multiple stressors such as with civil conflict or the effects of HIV/AIDS; and sometimes an acute stressor is so severe (or perceived to be severe), or the individual's coping skills are not sufficiently developed (or perceived not to be), that stress reactions become chronic. Chronic or repeated stress may result in greater resilience, or lead to ***mental health or developmental problems***, and in certain cases to ***mental or developmental disorders*** (see Table 3 and 4 below). The factors that determine these outcomes include genetic vulnerability, the nature of the stressor (severity, ongoing or multiple), previous exposure to stress, current physical and mental health, coping skills (see Chapter 2), and social support from family or community.

TABLE 3: Examples of mental health/emotional/behavioural and developmental problems

Poor attention span
Low self-esteem
Aggressiveness
Excessive worrying
Sleeping difficulties
Promiscuous behaviour
Stealing
Alcohol misuse
Developmental problems, such as slow physical, speech or intellectual development; emotional immaturity; relationship problems

Three factors help children to become resilient to stress (N.Garmezy, quoted in Santrock, 1999, p 270):

1. Reflectiveness, cognitive skills (e.g. intelligence, attention, information processing), and positive responsiveness to others (temperamental trait)
2. A family marked by warmth and cohesion, and the presence of at least one caring adult, and
3. The presence of some source of external support, such as a teacher, parent of a friend, or church.

exercise

Trainees can be asked to break up into small groups to discuss the following questions, and then report back to the whole group:

1. Which mental health/emotional/behavioural and developmental problems of children and adolescents are common in your community or work situation?
2. Which mental health/emotional/behavioural and developmental problems of children, adolescents and their caregivers do you associate with HIV/AIDS?

TABLE 4: Examples of Mental/Psychiatric and Developmental and Personality Disorders*

Common mental/psychiatric disorders

Anxiety Disorders, e.g. Separation Anxiety, Social Anxiety, Post-Traumatic Stress Disorder
Depressive Disorders
Attention-Deficit Hyperactivity Disorder
Conduct Disorder of Childhood
Somatoform (Psychosomatic) Disorders
Alcohol abuse

Serious mental/psychiatric disorders

Autistic Spectrum Disorders
Drug abuse, and alcohol/drug dependence, e.g. tik (methamphetamine), heroin
Bipolar Disorder
Schizophrenia
Dementia

Developmental disorders

Failure to thrive
Speech and Language Disorder
Specific Learning Disability (e.g. dyslexia)
Intellectual Disability (Mental Retardation)
Borderline or Antisocial Personality Disorder (adults)

* *Further information about these disorders can be found in books, e.g. Robertson 1996, Robertson Allwood and Gagiano 2001, Patel 2003, documents, e.g. World Mental Health Day 2003: Emotional and Behavioural Disorders of Children and Adolescents (published by the World Federation for Mental Health), or websites, e.g. website of the World Federation for Mental Health* (www.wfmh.org), *or of national mental health associations (e.g. South African Federation for Mental Health: www.safmh.org), or general mental health websites (e.g. Mental Health Information Centre of South Africa: www.mentalhealthsa.co.za).*

Skills needed for working with stressed individuals

When stress has a significant impact on psychological functioning, i.e. leads to mental health/emotional/behavioural problems, helpers need to offer relief within a trusting and caring relationship. To do this effectively, the following three skills are essential. Detailed descriptions of these skills, together with appropriate exercises, can be found in counselling manuals (e.g. Gibson et al, 2002; Sterling & Lazarus, 1995)). A number of Psychosocial Care and Support manuals describe communicating and playing with children, e.g. REPSSI Psychosocial Wellbeing Series, 2007.

Empathy

Empathy is understanding and accepting another person's thoughts, feelings and behaviour. It depends on an ability to recognize or elicit unexpressed thoughts and feelings, and to put yourself in their shoes - to identify with their situation. It includes acknowledging their freedom to make their own choices, and respecting the choices they do make. It is the opposite of being uncaring and judgmental. It is different to *sympathy* which is feeling *for* others, which implies recognizing but not necessarily understanding and accepting their thoughts, feelings and behaviour. Too much sympathy may lead a helper to lose objectivity and become overinvolved, which is not helpful to the client.

Communication skills

These comprise *verbal* and *non-verbal communication skills*, and include *listening skills*. Table 5 lists some characteristics of 'good' and 'bad' listening.

TABLE 5: Some characteristics of good and bad listening

GOOD	BAD
Providing privacy and a quiet space	Allowing distractions and interruptions
Making eye contact	Looking away from the client
Giving full attention	Being preoccupied with other things
Appearing interested and empathic	Looking or acting bored or critical
Listening without interruption	Interrupting
Looking for unspoken feelings	Taking words at face value
Picking up non-verbal cues	Ignoring non-verbal cues
Being aware of your own feelings	Ignoring your gut feel

Individuals in distress, including children and adolescents, often hide their deepest feelings and 'edit' their verbal communication, either consciously or unconsciously. Sensitive listening and questioning will usually help them to share their innermost thoughts and feelings, but much insight into them can also be gained from careful observation of non-verbal cues in:

- Facial expression, e.g. sad, angry, anxious
- Body posture, e.g. tense, listless
- Body movements, e.g. restless, lethargic
- Rate of speech, e.g. rapid (anxious) speech, slow (depressed) speech
- Tone of voice, e.g. high (anxious), low (depressed) tone
- Behaviour, e.g. withdrawn, aggressive, self-destructive behaviour. If behaviour is at odds with what the person tells you they feel, their behaviour is more likely than their words to reflect their true feelings. People act the way they feel.

Non-verbal cues play a very important role in understanding children's feelings, because in general, they find it harder to identify and/or express their feelings verbally. Communicating with children and adolescents includes helping them to identify and express feelings verbally, which they are demonstrating by their behaviour or play. Children who are too young or distressed to express their feelings verbally may need to be engaged in play: play serves as an outlet and a healing medium for distress, and as a source of information for the helper about underlying feelings, and it allows the helper to establish a trusting relationship with the child. Drawing is a useful form of play, and often provides the helper with an insight into the child's thoughts and feelings, besides being an indicator of general development. An important *caveat* when communicating with children in a therapeutic context is to avoid the use of *authority* as far as possible: telling children that they must or mustn't do this or that is likely to prevent them communicating openly with you.

Adolescents may not want to play or draw. They can also be quite challenging and they are usually quite verbal they tend to engage in conversations and discussions more then younger children who still want to play. A useful way of connecting and communicating with them is by talking about the things that **they** are interested in, music or TV programs or sports or books. This will help build a trusting relationship between you and the adolescent making it easier for them to open up more about their feelings should they wish to.

Problem-Solving skills

Problem-solving involves a number of steps, including helping the person to:

- Define the problem clearly, and possibly reframe it more positively
- Identify possible solutions, using available resources
- Select one solution, and make a plan
- Overcome obstacles to implementation
- Evaluation of the implementation of the plan

CHAPTER 5

HIV/AIDS

It is essential for HIV/AIDS workers to have the latest scientific information about HIV/AIDS at their fingertips. If this has not been provided elsewhere, it should be arranged as part of this training course. Updates can be found in publications or on the internet, but it is often more beneficial to invite a local expert to do a presentation on this topic for the trainees. This ensures that the local context of the pandemic is taken into account, and the opportunity for discussion provides a good learning experience.

It is recommended that a scientific presentation or update on HIV/AIDS covers the following areas:

- Latest scientific information about the disease
- Information about the nature of the epidemic in the country where training is occurring
- Special focus on children, adolescent, family and caregiver issues
- Information about evidence-based prevention and treatment measures

As some countries responses to HIV/AIDS, especially in low-income areas, frequently fall short of essential requirements, it is useful to include, for trainees, information about national HIV/AIDS policies and plans, and a situational analysis of the extent to which essential requirements are being met. Trainees should be encouraged to actively engage in activities to promote and advocate for better services.

CHAPTER 6

Wellbeing, Mental Health and HIV/AIDS

Psychosocial wellbeing is the positive outcome of physical, psychological and social development, and is in constant maturation as individuals negotiate the successive stages of their psychosocial development through life. *Mental Health* is a conscious, dynamic, evolving capacity to achieve and maintain optimal psychological functioning and wellbeing. Wellbeing and mental health develop, change and grow as children, adolescents and adults develop, change and grow.

We have seen that children growing up in low-income areas affected by HIV/AIDS are triply vulnerable, due to the combined interactions of HIV/AIDS, poverty and difficult circumstances, and conflict/violence. Many of these children and adolescents will develop *mental health/ emotional/ behavioural* problems (see Chapter 4 for definitions). A smaller number will go on to develop mental disorders requiring assessment and treatment by health professionals. Noteworthy compounding factors in low-income countries are that, due to ignorance, stigma and lack of accessible and effective health services, mental health problems and disorders are often not detected, or effectively treated, resulting in worsening of the problems/disorders and poorer outcomes. High rates of medical conditions, including HIV/AIDS, contribute to the raised mental health burden in low-income countries.

There is an inter-relationship between wellbeing/mental health and HIV/AIDS. Individuals with mental health problems or disorders are at increased risk for contracting HIV/AIDS and having poorer outcomes, and individuals with HIV/AIDS are at increased risk for developing mental health problems and disorders (Collins et al, 2006; Freeman et al, 2005)

The effect of HIV/AIDS on Mental Health

HIV infection may result in mental health problems or disorders through direct action (infection) on the brain, or indirectly through emotional reactions to being HIV +, or to its effects on family and community, from the time of diagnosis through to the advanced stages of AIDS. Some of these effects are indicated in the tables below:

TABLE 6: Mental health/emotional/ behavioural ***problems*** due to HIV infection

Impaired concentration
Impaired memory
Coordination problems
Irritability
Mood swings
Personality change
Suicidal behaviour

TABLE 7: Mental and developmental ***disorders*** due to HIV infection include*:

Delirium
Dementia
Depression
Anxiety
Attention-deficit Hyperactivity Disorder
Bipolar Disorder
Psychosis
Developmental disorders in children, e.g. failure to thrive, speech and language disorder

TABLE 8: Mental health/emotional/ behavioural and developmental ***problems*** resulting from emotional reactions to the effects of HIV/AIDS on self, family or community

Worrying, sadness and guilt
Low self-esteem
Anger, and blaming and hurting others
Withdrawal, or overactivity
Aggressive, reckless or irresponsible behaviour
Misuse of alcohol
Developmental problems in children, such as feeding or sleeping problems in younger children, relationship or learning problems in older children, and problems with negotiating adolescence in teenagers

TABLE 9: Mental and developmental ***disorders*** resulting from emotional reactions to the effects of HIV/AIDS on self, family or community*

Depression
Anxiety
Conduct disorder of childhood
Somatoform (Psychosomatic Disorders)
Substance abuse and dependence
Worsening of pre-existing disorders such as intellectual disability, bipolar disorder, and schizophrenia
Developmental disorders in children, such as failure to thrive, and attachment disorders

Even individuals on anti-retroviral treatment may develop (usually milder) mental health problems, such as impaired concentration and memory, and mental disorders, such as depression and anxiety. HIV/AIDS is likely to undermine parenting functions and the quality of the parent-child relationship, especially when mothers are affected (Brandt, 2005)

These mental health problems and disorders arise in relation to HIV/AIDS in its various stages and effects, as indicated in Table 10:

TABLE 10: Experiences associated with HIV/AIDS which may lead to the development of mental and developmental problems and disorders

Diagnosis of positive status
Marital/family conflicts in relation to disclosure of positive status
Fear of contracting HIV infection from HIV+ family members
Fear of loss of HIV+ family members
Stigma and rejection
Loss of own health and vitality
Inability to work/attend school
Withdrawal/loss of spouse/parent/child due to illness/ abandonment/death
Child/adolescent heading a household/caring for sick adults
Economic hardship
Loss of home/belongings
Exploitation and abuse

It is important to recognize that some of these experiences have chronic effects, and continue to act as stressors over many years, e.g. stigma, loss of a mother, exploitation and abuse. Individuals affected by such experiences may need long term support, in addition to reversal of the stressor, where possible.

The effect of mental health on HIV/AIDS

In addition to resulting from HIV/AIDS, mental health problems or disorders also increase the risk of contracting HIV/AIDS, and of having a poorer outcome. Mental health problems or disorders may lead individuals into behaviour which increases their risk of contracting HIV/AIDS, e.g. promiscuity or unprotected sexual intercourse or use of contaminated needles in drug abuse, or their risk of being exploited and abused. Some of these individuals have poor coping skills. Mental health problems or disorders may cause them to avoid or refuse testing, or if tested positive, to try to infect others, or to refuse treatment. There is increasing evidence that stress, and mental health problems and disorders decrease the CD4 count and increase the viral load, even in individuals on antiretroviral treatment (Mental Health AIDS, 2006). Depressed, suicidal or psychotic individuals are likely to have difficulty adhering to strict treatment regimes.

In summary, HIV/AIDS is associated with an elevated risk of mental disorder in infected individuals and their children, which is likely to persist for at least another generation after the introduction of antiretroviral treatment and psychosocial care and support programs. Mental disorder is associated with an increased risk both of contracting HIV infection, and of undermining the body's response to the infection, even in the presence of anti-retrovirals. The implication is that mental health, like stigma or food and nutrition, is a significant mediator in the success of antiretroviral and psychosocial care and support programs in low-income countries.

For further information on the nature of these disorders, consult the references by table on page 28.

CHAPTER 7

Managing the Mental Health needs of vulnerable children and their caregivers in the context of HIV/AIDS

ASSESSMENT

Assessment of mental health needs

The first step in managing mental health needs is to assess them. As children's mental health, in the case of young children, is dependent on the parenting they receive, and, in the case of older children and teenagers, hugely influenced by it, the assessment of children's mental health needs is not complete without assessment of their caregivers' mental health also. Schooling also plays a very important role in determining the outcome of children's emotional development, both through the provision of formal education, as well as through promoting prosocial development: school maladjustment and school dropout are recognized as major risk factors for children's mental health. The community and social environment in which children grow up is another significant influence on children's mental health, whether through difficult circumstances like poverty or violence, or social factors like peer influence and social support.

Therefore, the initial assessment of children's mental health needs has to be fairly wide-ranging, even when carried out by workers who do not have specialised mental health training. It does not need to be lengthy or exhaustive, but does need to provide an overview of the key domains involved in the development of wellbeing and mental health. Table 11 lists these domains. Where possible, the assessment needs to be carried out with both the primary caregiver (e.g. a parent) and the child/teenager, using good communication skills (verbal and non-verbal), including observation, and play where necessary. Some time spent alone with a teenager is essential, and is often also valuable with younger children, when feasible.

TABLE 11: Key domains to be assessed as part of a mental health assessment

1. **Any mental health/ emotional/ behavioural/ developmental problems or disorders that have already been identified as a possible cause for concern**
2. **Current physical and mental health**
3. **All areas of development, including emotional (psychosocial) development**
4. **The family**
5. **School or workplace**
6. **Community and social environment**

If some mental health or developmental problems or disorders have already been identified, the worker needs to try to identify their cause (e.g. medical illness, inadequate parental care, child heading a household, negative school experiences, peer relationship issues, difficult community circumstances), and in particular, whether they are directly or indirectly related to HIV/AIDS. If the child has consulted a mental health professional, the worker needs to request a report with the written permission of the guardian (e.g. parent), and with the knowledge of the child/teenager.

The assessment of current physical health includes medical conditions like HIV/AIDS, TB, malaria, and malnutrition, as well as physical disability (e.g. due to birth injury; blindness) and intellectual disability. Note should be made of any medication being taken, and of any problems related to the medication. A report on the child's current medical condition or disability should be obtained from the relevant professional, with the written permission of the guardian (e.g. parent), and with the knowledge of the child/teenager.

The assessment of current mental health (in addition to any problems already recorded under item 1 of Table 11) includes the temperament or personality of the child/teenager, any stressors and stress reactions, and any mental health/ emotional/ behavioural/ developmental problems or disorders, and their likely cause. Examples, or common symptoms (e.g. symptoms of depression or post-traumatic stress disorder) may need to be provided in order to illustrate what is being looked for, as many parents in low income areas are not familiar with mental health problems and disorders, especially in children. Traumatic experiences, including abuse, must always be inquired about directly, as parents are sometimes unaware of them, and children/teenagers may not volunteer the information. Workers will need to be familiar with the way in which mental health problems or disorders may manifest (whether due directly or indirectly to HIV infection). Some information about their manifestation is provided in previous chapters of this Guide, including the books and websites listed at the end of Chapter 4. It may be useful for trainees to have a lecture from a child mental health professional on this subject. The exercise below will help trainees to become more skilled in detecting mental health problems and disorders.

All areas of development, including physical growth, speech and language, cognitive, emotional and social development, need to be checked. Pregnancy and birth complications, and any past medical problems or surgery, and feeding and sleeping difficulties must always be inquired about directly. An assessment needs to be made about whether the quality of the child or teenager's current parental care (if any) is sufficient for their emotional needs (see Chapter 3). Each child or teenager will have particular emotional needs stemming from their unique past and current circumstances, in addition to their universal need for a loving, continuous and effective caregiving relationship with at least one parental figure.

Effective caregiving must provide:

- Protection
- Shelter, Nourishment, Clothing
- Self-actualization
  - Physical
  - Emotional/social
  - Intellectual
  - Moral and spiritual
- Teenagers' caregiving needs can be summed up as follows:
  - Connection (an ongoing relationship with someone who cares for them)
  - Autonomy (being encouraged to become increasingly autonomous)
  - Regulation (appropriate supervision and controls)

In assessing the current mental health and psychosocial development of children and teenagers, the following indicators of optimal mental health and development described in Chapter 1 can be used as a yardstick:

1. A good sense of self (who one is) and self-esteem (likes who one is)
2. Healthy, positive family relationships
3. Sound peer relationships
4. Productivity in learning and work
5. The capacity for managing change (either in one's own development, or imposed from the outside)

Children and teenagers who have mental health problems will manifest difficulties in one or more of the above areas, e.g. they may appear unhappy with themselves as evidenced in depressive, aggressive or antisocial behaviour; they may not be coping with the social or academic demands of school life; they may have difficulty with peer relationships; there may be troubled relationships at home; and they may not cope well with new situations or demands. If none of these are present, and the children or teenagers appear to be coping and developing well, but the helper is still concerned, the only recourse is to ask the child or teenager confidentially about their situation. If there is still no hard evidence of problems, then the child or teenager should be carefully observed over the next few months to see if any problems emerge.

Assessing the quality of family life is an important part of the mental health assessment, as children's protection from harmful experiences, and their recovery from mental health problems depends on healthy family functioning. Assessment should include the items listed in the previous paragraph, as well as the emotional atmosphere in the home, the respect shown between family members, and the discipline and guidance given to the children. In addition, it is essential to note what difficult experiences, e.g. death of a mother, or heading a household, the child or teenager has endured, and to look for or enquire sensitively about other stressors that may be hidden, such as abuse or alcoholism. Some possible family stressors are listed at the end of Chapter 3, in the section: *Risk and protective factors in psychosocial development*. Difficult experiences related to HIV/AIDS are discussed in Chapter 6. The discussion about family life provides a good opportunity to ask the primary caregiver about how they are coping, and to evaluate their mental health needs.

The mental health assessment is concluded with assessment of the positive and negative aspects of the child or teenager's school experiences, and their community and social circumstances.

Finally, it needs to be remembered that children or caregivers are not always able or willing to talk about painful or shameful experiences, and this needs to be respected. At the same time the worker must avoid taking everything the child or caregiver says at face-value, and must use their own instinct and powers of observation to draw their own conclusions.

Example of an assessment matrix – this is a visual guide for gathering the information that you need when making an assessment. Please see the above text regarding all the detailed information that you would need to fit into the matrix. This matrix can be adjusted to suite you and the work that you are doing.
N.B. Be aware of who is giving you the information when doing an assessment

Assessment Matrix

Family/Household				
Members	(name)	(name)	(name)	(name)
Head of family				
Working				
Schooling				

Home Environment	
Physical Shelter	
Protection from harm or risk	
Nourishment	
Clothing	
Caregiving (who is the cargiver at home?) (what is the quality of caregiving?) (what is the caregiver's physical and mental health??)	

Community and Social Environment	

Family Member	(name)
Age	
Physical Development (problems/concerns, eg illness)	
Emotional Development (problems/concerns)	
Social Development (problems/concerns)	
Physical Health	
Mental Health	
Schooling (problems/concerns)	
Relationships with family members	
Relationships with friends	
View of self	

exercise

With the assistance of a mental health professional, trainers should

1. Draw up some case histories of children, teenagers or caregivers with mental health problems, typical of the culture and area, e.g. HIV/AIDS, in which the trainees are working. Trainees can discuss these case-histories in small groups, and then present their findings and get feedback on how well they did in detecting the stressors and mental health problems and disorders reflected in the case-histories
2. Arrange role-play sessions in which the trainees play out a mental health assessment with a 'client' (e.g. one of the trainers acting the part of a caregiver). If a mental health professional is available, he or she could demonstrate an interview with a local child or teenager, who is willing to take part in such an exercise. During these role-play sessions, trainees would have the opportunity to put into practice the skills discussed in Chapter 4.
3. If need be use the assessment matrix as a guideline. Remember it may be adjusted to your own needs

Assessment of need for intervention

A good assessment is 'half the cure'. Once trainees have confidence in their ability to detect the presence of mental health problems in their clients, they will find that it is often obvious what they need to do about them. The nature of the intervention, and the intensity of the intervention will depend on how severe the problems are. Some problems are obviously severe, e.g. abuse, war and displacement (see list of severe stressors in Chapter 1), but other problems affect people differently: some people cope better than others. One way to find out how severely a person is being affected by a problem, is to determine how much their daily functioning is being affected. Most people cope with every day hassles and ordinary life-events with some tension and distress, but it is temporary and their daily functioning is not affected. Others become so distressed, consciously or unconsciously, that they cannot continue to function normally. Daily functioning is assessed by looking at the following areas:

- Personal functioning, i.e. going about everyday activities at home, eating, sleeping, planning, making decisions, etc
- Social functioning, i.e. relationships with family members, as well as functioning in the community
- School or workplace functioning

With children and teenagers, an assessment of the severity of mental health problems includes seeing whether their development is being affected, e.g. whether infants are failing to thrive, or young children failing to develop trust and confidence or becoming aggressive instead of well-adapted, and teenagers showing excessive disregard of authority or indulging in seriously risky behaviour. Particular attention to the negative impact on their emotional and social development needs to be paid to children or adolescents heading households.

Individuals whose daily functioning is being affected by mental health definitely merit intervention directed at the causes of the problems. Individuals with mental health problems which are not significantly affecting their daily functioning also merit intervention to restore wellbeing and get their development back on track, so as to prevent the problems getting worse. All individuals, even those with mild problems will benefit from support, and the offer of advice.

The way in which individuals are given feedback about their mental health assessment is crucial to their agreeing to receive help, and their future compliance. Most individuals will hold back from the decision to receive help, preferring to believe that things are not that bad, and that the problem will right itself. Fear is largely behind this reluctance; and ignorance and stigma increase fear. It is therefore important to explain to caregivers (with a modified explanation to children and teenagers) what mental health problems you have detected, and to explain what mental health problems are; explanations need to address ignorance and stigma, and to cover causes, manifestations, outcome and the nature of the treatment of

their mental health problems. It is usually helpful to indicate how the individual will benefit from intervention, and it may be necessary also to indicate what future difficulties they are likely to experience, if they don't receive intervention. This process is called *psychoeducation*. Once individuals have fully understood and accepted their problems, they are more likely to comply with treatment or advice

INTERVENTION

In order to be effective, interventions for mental health problems need to be comprehensive, empowering and sustained over time. Many mental health problems include patterns of thinking or reacting that have been acquired in childhood, and have become entrenched over the years. Replacing them with healthier patterns takes time, during which individuals often need ongoing support; so once off interventions are seldom enough, even for children and teenagers. Improvement is likely to be sustained when individuals take personal responsibility for the process; mental health is something which develops from within, much more so than physical health which is often restored simply by undergoing treatment. The more individuals are empowered to care for their own mental health, the more successful will the intervention be. Helpers therefore need to encourage individuals to be active ***partners*** in the treatment process. This applies also to older children and teenagers.

By comprehensive, is meant that all aspects of the problem need to be addressed. Mental health problems have many roots, including ignorance and misperceptions, developmental issues, relationship problems, difficult community circumstances, and lack of basic social services. Comprehensive intervention means that it is not enough only to provide specific measures for a mental health problem, such as assistance with self-esteem or coping, or medication for a mental disorder, but all the other roots must be treated, otherwise the problem is likely to 'grow back'. For an intervention to be comprehensive, it needs to have the following four components: *mental health prevention, promotion, care and rehabilitation*.

Mental Health Prevention

Mental health problems have a tendency to recur. Prevention means minimising the risks of the problem recurring. The most important preventive action is identifying and treating a problem early before it becomes entrenched, when it is still a possible concern rather than a definite problem; for instance when a bereaved child is beginning to show signs of not coping, or a bereaved teenager is becoming antisocial, or a caregiver is beginning to get depressed. In such cases, encouraging the individual to talk about their difficulties and what caused them, and working with them to look for solutions (or providing solutions, e.g. for young children) may be sufficient to rectify the problem.

In other cases, where there are longstanding patterns of maladaptive thoughts or behaviour, or developmental problems, it will be necessary to get development back on a normal track before interventions for mental health problems will be effective. For instance, using the examples given in the previous paragraph: the bereaved child may have no attachment figure, the teenager may have longstanding problems with social relationships, the caregiver may continually underrate her coping ability. Unless these underlying problems are also addressed, the primary presenting problem may not improve.

The first and most important thing helpers need to do is to encourage and support their clients to talk about their problems (or provide an opportunity for children to play – see REPPSI, 2007), in a setting of trust. Many individuals only become fully aware of their problems when they talk about them. Often it is only when talking about them that they can consider them objectively and not be overwhelmed or frightened by them. This is why it is so important for helpers to have good listening skills. It is often only when talking about their problems that individuals begin to look for solutions. This is where the helper can assist with problem-solving skills. Not only does talking about problems provide tremendous emotional relief, and an opportunity to begin doing something about them, it also changes the individual's attitude and they become more positive and more hopeful about the future. This change of attitude can even change and correct chemical processes in the brain, demonstrating the influence of mind over matter. The greater the change of attitude and the more sustained it is, the greater the likelihood that even longstanding patterns of thinking and behaviour will change.

Assisting young children in this way cannot replace their need for a continuous attachment to a parental figure. Fathers, or other adult males should also be drawn in as caregivers, if necessary, as they may be able to provide very effective nurturing. If caregivers are not available for older children or teenagers, helpers should try to identify, in discussion with the child, one adult in the community who can be that child's confidante. This confidante is someone to whom the child can talk about their feelings and struggles, and their developmental challenges, and who will provide support, guidance and protection.

Although many children, teenagers and caregivers will be helped simply by expressing their problems in a caring environment – especially if they are given the opportunity to do this over time until their problems have resolved – particular mental health needs may emerge from the discussions which require particular interventions. For instance, children and teenagers may require help with self-esteem or social skills issues, or anger management, or how to be assertive and say "No" to personal abuse or to substance misuse. They may need help with understanding and handling their own difficult feelings in times of great stress and trauma, and they may need preparation for bereavement. Group interventions are often useful to address these concerns, and examples of these can be found in manuals and on websites, e.g. www.reppsi.org. Sometimes with children and teenagers, counselling of parents or caregiver is necessary about how to provide more effective nurturing care, or cope with behaviour problems, trauma or bereavement. Parent training courses may be helpful.

Parents and caregivers may benefit from training in better coping mechanisms, or problem solving skills. Counselling them about their own relationship issues may be necessary, and many excellent books are available for this.

If there are ongoing problems in the home, at school, in the workplace, or in the community, that are contributing to an individual's mental health problems, then attempts need to be made to address these, or at least to help the individual to cope better with them.

Mental Health Promotion

Mental health promotion is about increasing positive mental health and wellbeing through interventions directed at creating individual, social and environmental conditions that enable optimal physical, psychological and social development. Mental health promotion addresses communities or nations rather than individuals, but with the ultimate aim of benefiting the individuals in society. It includes broad-based activities such as providing legislation that protects human rights, providing safe

environments, providing universal education and providing social benefits for the disadvantaged.

The relevance of mental health promotion in regard to vulnerable children, is that vulnerability is intimately related to inequitable social conditions like poverty and gender inequality. Unless these adverse conditions are addressed, attempts to assist vulnerable children will be undermined. More will be said below about large scale efforts to promote mental health by reversing adverse social conditions, but there are a number of smaller scale, local interventions that helpers can organise to promote mental health. Public education and information is probably the most important one. Helpers can ensure that there is information readily available to the public, and especially those affected by HIV/AIDS, on child psychosocial development and parenting issues, on mental health issues (e.g. positive mental health, the nature of mental health problems and disorders and where to get help), and on the inter-relationship between mental health and HIV/AIDS (see WHO Mental Health and HIV/AIDS series, No 1)). This information can be disseminated by TV, radio, CD ROM, brochures, or by lectures in the community or to special groups such as teachers and students. Counteracting stigma is an important aspect of community education.

Mental Health Care

Mental health care refers to care or treatment provided for mental health problems or disorders, when these have gone beyond just being a possible concern (as discussed in the section on Prevention) and are clearly established. The same general principles as in Prevention are advocated as the first line of care, namely encouraging the individual to talk about their problems, to try to understand them, and to look for ways of coping. The same interventions need to be considered, e.g. help with self-esteem, social skills, coping mechanisms etc. In addition, more complex or specialised interventions may be indicated, such as bereavement counselling, trauma counselling, personal abuse counselling, violence counseling and substance abuse counselling. Where appropriate, helpers should be encouraged to undertake training in these types of counselling, as these situations are so prevalent and much can be achieved by lay counsellors. Training courses and manuals for such counselling are becoming increasingly available, e.g. WHO Mental Health and HIV/AIDS Series No 2 & 4, 2005; and SAT Counseling Guidelines. Otherwise, these individuals will need to be referred to mental health professionals, if available.

Lay counsellors may also be able to acquire skills, under supervision, to counsel those with anxiety or depression, but it is advisable to refer affected individuals first to a health professional for an assessment, diagnosis and treatment plan, and, in particular, to check whether the condition is related to HIV, requires medication, or there is any suicide risk.

Conditions like Attention Deficit Hyperactivity Disorder, psychosis, schizophrenia and bipolar disorder always need to be referred to a health professional, as medication and specialised psychiatric treatment will be required. Specialised psychiatric treatment is carried out by a mental health professional, and includes modalities like individual psychotherapy, marital therapy and family therapy. Hospitalisation may be indicated.

Mental Health Rehabilitation

Mental health rehabilitation refers to achieving and maintaining the highest possible quality of life in individuals with established mental disorders, e,g, depression, alcohol dependence, schizophrenia. These individuals will have a diagnosis and treatment plan given by a health professional, which usually includes medication. The lay helper's role is not only to assist the patient to remain compliant with treatment, but also to support the patient in the everyday challenges of living so that they can achieve and maintain the highest possible quality of life despite their 'disability'. Health professionals seldom concern themselves with these everyday challenges of their patients, and yet failing to cope with these challenges can cause worse impairment than the mental disorder itself. These challenges include coping with stigma and rejection, even within the family; inability to find employment or even a meaningful occupation or hobby – or in the case of children and teenagers, not being able to access schooling; and inability to find suitable accommodation.

POLICY DEVELOPMENT AND ADVOCACY

Individual workers can only do so much. In most low income areas affected by HIV/AIDS, the needs of vulnerable children and their caregivers far exceed what individual workers can do. While it is important for individual workers to do whatever they can, they need to consider the fact that far more can be achieved if an effective national plan for HIV/AIDS has been devised, and is being implemented. An effective national plan is one which integrates mental health into all aspects of HIV/AIDS care. Few, if any, national HIV/AIDS plans in low income areas do this. Workers who are convinced of the importance of mental health in HIV/AIDS are urged to unite with advocacy groups to pressure governments to integrate mental health into their national HIV/AIDS plans.

Integrating mental health into HIV/AIDS will require strengthening of local mental health services. The mental health services in most low income areas are insufficient for current needs, let alone for the requirements of an integrated HIV/AIDS plan.

SUMMARY OF KEY MESSAGES

- Most vulnerable children and their caregivers in low income areas affected by HIV/AIDS will experience mental health problems at some time. They deserve to be offered support and relief for these, and the chance to prevent them developing into longstanding, disabling conditions. Caregivers need to be given special knowledge and skills to enable them to care effectively for vulnerable children – "ordinary psychosocial care" may not be enough.

- To be effective, interventions for mental health problems need to have a strong preventive component, i.e. they need to look beyond the current problem, and strengthen the underlying personality, as well as addressing negative environments. This frequently implies ongoing support over months or years to ensure that the desired improvement is taking place.

- To be effective, mental health interventions should be integrated with all activities of the national HIV/AIDS Plan (see WHO Mental Health and HIV/AIDS Series, No 1, 2005). This implies mental health training for all HIV/AIDS workers, and the strengthening of mental health services.

- At all times, workers need to work within ethical and professional boundaries. Recognizing the limits of their competence is a basic principle. Working within a team, or in partnerships, safeguards workers against errors and increases the effectiveness of the intervention

- Training is the beginning, not the completion, of skill development. Skills only become well developed and consolidated when practised under supervision. Supervision is not a luxury. It is essential for safeguarding against errors, and for consolidating skills.

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