

Counselling skills training

in
adolescent sexuality
and reproductive
health

A facilitator's guide



Adolescent Health Programme • Division of Family Health
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COUNSELLING SKILLS TRAINING
IN
ADOLESCENT SEXUALITY AND REPRODUCTIVE HEALTH:
A FACILITATOR'S GUIDE

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The method described in this guide has been used with participants from more than 60 countries throughout the world since 1986, especially developing countries. Their experience and evaluation of the techniques has played a major role in refining it. They work manually in the youth and health sectors with non-governmental organizations such as those affiliated with the World Assembly of Youth and the International Planned Parenthood Federation, as well as in the public health and related sectors.

The countries and territories from which the participants to date have come include: Anguilla, Antigua, Argentina, Bahamas, Bangladesh, Barbados, Belize, Botswana, Brazil, Bulgaria, Chile, China, Colombia, Cuba, Fiji, Grenada, Guyana, Hong Kong, Hungary, India, Indonesia, Ireland, Jamaica, Kenya, Malaysia, Maldives, Mauritius, Mexico, Montserrat, Namibia, Nepal, Nevis, New Zealand, Pakistan, Philippines, Poland, Portugal, Romania, Seychelles, Solomon Islands, Sri Lanka, St Kitts, St Vincent, Surinam, Tanzania, Thailand, Tonga, Trinidad and Tobago, Turkey, Tuvalu, Uganda, Uruguay, United States Virgin Islands, Union of Soviet Socialist Republics (former), Vanuatu, Venezuela, Western Samoa, Yugoslavia (former), Zambia and Zimbabwe.

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PREFACE

Since the mid-1970s WHO has been actively involved in the promotion of adolescent health, particularly in regard to reproductive health of adolescents, with UNFPA support. The Adolescent Health Programme between 1990 and 1999 has developed an integrated approach to health promotion has been extended to all areas of adolescent health and development. Activities are undertaken in cooperation with other governmental youth serving organizations. The increased interest in adolescence as a priority period in life stems from a number of different factors.

More than 50% of the world's population is below the age of 25, 80% of whom live in developing countries. Improvements in public health such as immunization, clear water and sanitation have permitted greater attention to be given to health problems arising from behaviour, rather than from passively acquired infections. There is now a greater understanding regarding the importance of behaviour patterns for health and longevity. Most of these patterns have their origin in childhood and adolescence.

Changing social conditions which have in turn led to changes in sexual behaviour and relationships among young people include: accelerating urbanization; an earlier start to puberty together with a rise in the mean age of marriage; the rapid spread of mass media communication across cultural boundaries; and the decline of the extended and nuclear family. More and more young people are having sexual relations at an earlier age and generally do not protect themselves from pregnancy or infection.

This change in behaviour has caused new health problems. As well as the traditional problem – pregnancy and childbirth occurring too early among girls who marry young – many other problems arising from unprotected sexual behaviour have intensified. These include illness, injury and death among young mothers and children who become pregnant and give birth too early in life, or who undergo abortion; infertility arising from sexually transmitted infections (STI) and unsafe abortions, and infection from the immunodeficiency virus (HIV) and the likelihood of subsequent death from AIDS. In addition, adolescent motherhood usually means an end to education, training and economic opportunities for development of the female adolescent outside the home. The adolescent mother is usually not able to provide adequate childbearing, and usually does not have the support of the father of the child, who may himself be an adolescent.

The behaviours which lead to these problems are generally under the voluntary control of individuals, although there are many pressures which influence those behaviours. It is within the potential capacity of most adolescents to make decisions and take actions to protect their health. Most young people are fully aware of the prevailing moral and cultural norms in their societies; they generally know what adults want them to do. But they are often overcome by other influences and personal needs. Depending on their age and development, they are not always able to foresee the outcomes of their behaviour and to make the safe decisions for themselves. Counselling which contributes to their overall development will help them to clarify their feelings and thinking, and make more advantageous decisions. In many societies, however, “counselling” is highly directive, i.e. the counsellor tells the adolescent what to do. That form of counselling does not facilitate development nor strengthen the adolescent’s capacity to deal with other problems which may arise in the future. It may even be counterproductive if the adolescent feels rebuked or treated like a child. A style of counselling which is non-directive, i.e. helps young people make their own decisions, is of greater value to them in the long term, and it is that form which has been developed by the WHO Adolescent Health Programme.

One of the major obstacles to effective counselling is that adults (or other young people) who are in position to provide counselling, themselves lack knowledge about sexuality and find it difficult to discuss such subjects. Very few services are designed to meet the special needs of adolescents. Young people tend to stay away from services because they often feel unwelcome and misunderstood. When they do come, they tend to come too late for effective help resulting in higher avoidable tolls in death, illness and injury than adults, especially in problems arising from unprotected sexual relations. People who provide services are often not aware that helping young people make their own decision (rather than making decisions for them) will be more effective and enduring. The training in counselling skills described in this guide combines exposure to information about sexuality and reproductive health and principles of effective non-directive counselling with training in specific interpersonal communication skills, especially listening, in a week-long workshop which can be expanded as needed.

Training of this length, however intense, is not in itself adequate to create counsellors. It can be used to strengthen the knowledge, skills and understanding of those already working in a professional capacity, and to provide insight for managers and trainers. It is important that such training is followed up in a systematic way, preferably with monitoring and evaluation of its impact; sharing what has been learned with others through the systematic introduction of such training workshops; and, it is hoped, the expansion of services for adolescents which incorporate the principles of effective counselling. There is a worldwide need for existing services to be more accessible to young people, and for the creation of multisectoral services which meet the specific needs of young people, the most precious resource for the future of all societies.

INTRODUCTION

ABOUT THIS GUIDE

This guide is designed to help facilitators to run a 5-day workshop for training counselling skills in adolescent sexuality and reproductive health. It is divided into six sections. The first describes preparatory activities and the facilities needed for the workshop. The following five sections each provide a model daily programme, although some optional sections are suggested at the end, and by including those options and increasing the time devoted to practice, the training can readily be expanded to ten working days. In addition to general topics covered at the beginning and end of the workshop (G), each day is divided into three sequential segments: (A) Sexuality and Reproductive Health; (B) The Psychodynamics of Counselling; and (C) Micro-Communication Skills for Counselling.

Each day of the workshop is divided as follows, so that three key issues are addressed in turn: identification by participants of adolescent needs and problems associated with the development of sexuality and reproductive health (A); this segment is followed by a review and discussion of the basic psychodynamic principles of counselling adolescents, with special reference by participants to their adaptation to the cultural conditions in which they work (B); the third period of the day is devoted to practice of key components of communication skills for counselling in which the participants utilize the problems of interaction and communication identified in the morning session in the role plays performed in groups of three, called triads (C). Thus, while the overall principles and techniques of good counselling will be the same in all workshops, the specific problems and conditions will be drawn from the participants and be of relevance to their own cultures and the communities in which they work.

Throughout the manual reference is made to the overhead transparencies which may be used to accompany the presentations and discussions. Some should be presented in full, others are intended as guidance for the facilitator. The letter (G, A, B or C) and number of the transparency appears in the text in parentheses. Transparencies that are recommended for showing in full are indicated in **bold** lettering after the title of the transparency in the text, e.g. **(G2)**, whereas the others are, in ordinary type, e.g. (A2). References are also made (in brackets) within the text to transparencies relevant to the subject. It is not necessary to refer back to them in reading the text unless the facilitator wishes to. See the Introductory Notes in Appendix 1 for recommended use of the overhead transparencies. Photocopies of the transparencies are also found in the Appendix.

PREPARATION FOR THE WORKSHOP

Targets of training

The counselling skills training workshop is most appropriate for two kinds of participants: those engaged in providing services for young people, or those engaged in managing, supervising, or training service providers. The relevant services may be of any kind in which personal interaction is required including counselling, guidance, education, or clinical services. The focus is on skills useful in promoting adolescent development, appropriate sexuality and reproductive health, but the workshop design can be readily modified to include other topics of relevance which require sensitive interactions. The objectives of the workshop for each participant is to learn and to discuss special needs of adolescents in sexuality and reproductive health, but also to understand the feelings and perceptions of adolescent clients in counselling situation, through role playing.

Participant background

Participants may come from any discipline, although those with some background in psychology or related subjects are usually best prepared. They may be working for government or non-governmental organizations and be in any relevant sector such as health, social welfare, youth, education, religion and criminal justice. The participants themselves may be young, but should be at least 18 if the group includes adults. However, the workshop can also be organized for adolescents alone who are or will be working as peer counsellors.

The training workshop has been run successfully with participants of different cultural background, e.g. youth leaders from Asian and African countries; and participants from different disciplines such as clinical medicine, psychology, education and social work. It has been effectively conducted in multiple languages although this is a more difficult procedure. It can, of course, be run most appropriately within countries for those managing or providing services to young people.

Language

When participants and facilitators do not all share a common language, (this is often the case when a training workshop is run for the first time in a given country) the trainees must have at least a reasonably good understanding of the facilitators' language and some will need to be sufficiently fluent to role-play in that language in front of the group. However, much of the triad (groups of 3) practice can take place in the participant's native language. Participants will, however, lose the benefit of the facilitators' help during the triad practice. While it is obviously better for participants and facilitators to be fluent in the same language that is not always possible and the transfer of technology can still take place.

Participant preparation

Participants should be given the workshop objectives in advance and be told that they will be using participatory methods such as role play. They should also be told that while sensitive topics dealing with sexuality will be covered, they will not be expected to make any personal revelations. Nevertheless, spending a week dealing with topics related to adolescent sexuality may raise feelings that can be disturbing for people who are uncomfortable with aspects of their own sexuality, and participants should be forewarned. However the workshop may help the participants to recognize areas of special sensitivity for which they should seek subsequent help.

It is also important that participants be advised that they will be expected to attend all parts of workshop, since absences are disruptive for all concerned. This can be a problem for participants working in the city in which the workshop is held, so advance preparation on this point is essential. Travel arrangements should ensure that the participants arrive no later than the evening before the workshop is to begin.

Workshop size

Since the workshop would entail an active participation of the attendees, it is most effective with about 21 participants (approximately equal numbers of men and women), and with at least two experienced facilitators. For certain practice purposes the participants will be divided into groups of 3 (triads) in which each in turn takes the role of counsellor, client and observer, so it is most convenient to have a number divisible by 3.

Facilitator characteristics

At least one of the facilitators should have extensive experience in clinical psychology, professional counselling or psychotherapy and a broad-based understanding of human (especially developmental) psychology. The facilitators should have experience in working with young people, and above all, be able to respect and work well with people from different cultural background.

Travel

Travel is usually best arranged by a single organization. If participants must travel from other countries they should allow at least three months to secure visas for which they will usually require a formal letter of invitation. The letter should convey the following information: the objectives of the workshop, the dates and venue; a request that participants arrive no later than the evening before; which costs are to be covered by the conveners and how funds will be provided; where to procure airline or train tickets, if necessary; details of accommodation to be provided during the workshop; and how to get from the station to the accommodation or workshop venue. (This information should be provided even if participants are to be met, since meeting arrangements often fail). Tickets can usually be provided through travel agencies if they are paid for by the conveners, but it is usually best for participants to make their own reservations with the travel agency.

If feasible, flights should be met and transport provided, but minimally, participants should be given information in advance on the best local transport. Flight reconfirmation is usually necessary and it is best for the conveners to collect the tickets for reconfirmation early in the workshop (see “Day One” below).

Accommodation

Accommodation should be provided for the participants in the same place as, or near to, the site of the workshop, and transport, if necessary, arranged to and from the site of the workshop. Single rooms should be available whenever possible. It is usually best to provide the agenda and other local information for the participants on arrival.

Meals

Ideally, a communal midday meal should be provided at or near the site of the workshop. This saves time and facilitates a punctual return to the afternoon session. Care must be taken that special dietary requirements are met, including the possibility of vegetarian meals. Evening meals need not to be organized, unless the accommodation is remote from eating places in which case food must be available on the premises. Clean drinking water and appropriate sanitary facilities should be available at all times.

It is usual to have breaks mid-morning and mid-afternoon, and to provide tea, coffee or soft drinks, and a light snack. Ideally, these should be served just outside the workshop room.

Expenses

Different means of providing funds for the participants can be employed. Some agencies use a per diem system in which participants are given funds to cover their own expenses, other provide travel, lodging and meals with some small allowance for additional expenses. It is important to remember that people travelling from developing countries may need hard currency in advance to meet the cost of airport taxes, visa fees, etc.; and that they may have to stay for additional day or two because of a lack of connecting flights. Financial provision must be made to enable participants to stay for the duration of the workshop and arrangements made to disburse funds early in the week. These arrangements should be carefully explained during the discussion of administrative matters at the outset of the workshop (see “Day One” below).

Facilities

Minimum requirements

1. A large quiet room in which about 25 reasonably comfortable chairs (without tables or desks) can be placed in a semi-circle and easily moved about. There should be sufficient space for about 7 groups of 3 people to sit separated from each other and conduct role-plays undisturbed. One end of the room must be able to be

darkened so that transparency projections can be seen. The room should be at a comfortable temperature. It is helpful to have air conditioning in hot climates, but if it is excessively noisy, electric fans may be substituted.

2. An overhead projector, a screen, a supply of blank transparencies and coloured markers. If no screen is available, a white sheet attached to the wall with tape or tacks is an adequate substitute.

3. Photocopying facilities on the premises or nearby.

4. Some small tables for the use of the facilitators and for the display of material.

Optional facilities:

5. One microphone for the facilitator(s) if the room is large, or two mobile microphones which can be used for role plays conducted in front of the whole group.

6. One portable tape recorder for each 3 participants, with a blank cassette for each participant on which they will record their pre and post training interviews. Such tape recorders can often be borrowed since they are needed only on the first and last day of the workshop; however they should be in good working order and simple to operate.

7. A video camera and monitor for playback. This is useful for the afternoon session during which the triads practice communication skills. It is usually possible to rent video equipment on a half-day basis to minimize costs. However someone must be able to operate the cameras and playback equipment.

8. A slide projector. This could be made available for use of the facilitators, participants or outside guests.

9. An "easel" with flip-chart or a blackboard for occasional use, with the necessary crayons or chalk.

DAY 1

OPENING CEREMONY

Counselling for young people is a topic which is of growing interest in much of the world, not least in developing countries. To emphasize its importance, many workshops are preceded by an opening ceremony at which representatives from key Ministries such as Health or Youth, as well as UN agencies present in the country such as WHO, UNFPA or UNICEF, and non-governmental organizations (NGOs), speak. They are invited some time ahead of the meeting. And given a copy of the provisional agenda (G1). The speakers may express their views about the status of adolescent health, the needs which exist for the provision of strengthening of counselling services, and potential resources. At the conclusion of the opening ceremonies a break for refreshments is desirable, following which non-participants leave.

INTRODUCTION TO THE WORKSHOP

The conveners of the workshop may begin by welcoming the participants, introducing themselves and asking the participants to introduce themselves. An alternative is to ask the participants to spend five minutes in pairs to become acquainted with another individual whom they don't know, and then introduce that person to the group. This is useful way to encourage listening from the outset, help the participants know each other, and make it easy for each person to speak to the group as a whole early in the workshop.

Administrative arrangements concerning travel, lodging, food, expenses, etc. should then be discussed. During the plenary sessions, participants should be seated in comfortable moveable chairs arranged in a semi-circle without desks or tables; this encourages an informal, participatory atmosphere.

The overall objectives of the workshop should then be presented for discussion, as below:

OBJECTIVES (G2)

1. To become more knowledgeable and comfortable with topics of adolescent sexuality and reproductive health.
2. To become familiar with psychodynamic principles of counselling for behaviour change.
3. To learn and practise communication skills for counselling with a special emphasis on listening.

And, when participants are themselves responsible for training:

4. To be able to use the methodology of the workshop for the training of others for improving service delivery.

In discussion the objectives a number of points should be emphasized:

a) The primary purpose of the workshop is the training of communication **skills** rather than increasing factual knowledge. Nevertheless, some selected aspects of each subject deemed to be universally valid will be provided each morning on the substantive topic of the day. The communication skills to be trained are also of general utility and can be used in any setting. They are not designed to change cultural values but rather to enhance the communication process so that the difficulties young people face in any given society, can be expressed, clarified and resolved.

b) Each morning participants will be asked to identify what they consider to be the main adolescent problems in their culture. These will be used during the workshop to ensure the relevance of the subject matter to be used for training.

c) Participants are asked to bear in mind the adolescent's own point of view – as far as possible – throughout the workshop. This will be relatively easy for the younger youth leaders, but may be more difficult for older people in other professions.

d) The workshop alone is not sufficient to create counsellors, but should serve to identify and sharpen skills which can be used in counselling, or indeed any form of interpersonal communication. Its focus is primarily on individual counselling, with some attention to counselling of families and couples. It does not deal specifically with group counselling, although the skills used are also of relevance to that form of service.

e) Throughout the workshop, special attention will be paid to developing listening skills.

f) While role play and other participatory techniques will be used on very sensitive topics, participants will not be asked (or permitted) to reveal highly personal information about themselves. Nevertheless, role play can elicit feelings in the players which have been dormant and it is useful to have the facilitators available to discuss such feelings in private should the need arise. Before the first role play, participants should be shown the transparency called “Rules of Role Play” (G14). When role play is used participants are always asked to choose another name and age, and to “derole” immediately afterwards. This protects them from embarrassment and discomfort and reduces anxiety.

The group should then discuss the workshop objectives, with particular regard to how it fits in with their concepts of what counselling should be; what they hope to gain from the workshop; and how they hope to apply what is learned. At the conclusion of their discussion, the workshop methodology should be presented and discussed.

WORKSHOP METHODOLOGY (G3)

Each day is divided into three main sections, beginning each morning with session (A): review of sexuality and reproductive health problems, and session (B): the psychodynamics of counselling for behaviour change; these are followed in the afternoon by session (C): training in communication skills.

The Overall Programme (G1) for the workshop is thus a series of days in which the A, B, C pattern is followed. Participants will be given photocopies of each transparency used after discussion is completed (or on the following day) so they need not to copy them but only take notes in order to highlight any issues for themselves.

Although the workshop is usually held on five consecutive days, it can be adapted to suit local circumstances. For example, it can be held during a series of weekends. However, it is important that a certain intensity and comfort are achieved and these require a concentrated period of time dedicated exclusively to this activity. It is also important that the overall sequence suggested be used, i.e. the A, B, C pattern in which sexual and reproductive health issues are followed by psychodynamic principles, followed by the practice of counselling skills. However, during the first two days the content of each session may be adapted according to the needs of the participants. For example, those who have considerable experience in family planning services may require less information on contraceptive methods, and more on sexually transmitted infections (or vice versa). However it is essential that the issues of sexuality be dealt with thoroughly for all participants before other topics are taken up. Experience also suggests that it is generally better not to make too many changes in the planned programme. A sense of what to expect is helpful in

providing a “secure” atmosphere for the participants and enables them to deal with the important emotional aspects of the training.

WORKSHOP TOPICS (G4)

A Sexuality and Reproductive Health (A1)

At the beginning of each morning some general information will be *presented* on this subject, followed by group *discussion* as to how such issues manifest in their own cultures. Participants then select and enact *role play* to illustrate common problems that adolescents experience in interpersonal communication with adults or other young people.

Sexual Maturation

Sexual Behaviour

Sexual Difficulties

Sexual orientation

Sexual variation

Sexual dysfunction

Sexual abuse

Consequences of Unprotected Sexual Relations

Adolescent pregnancy

Induced abortion

Sexually transmitted infections (STI)

HIV infection leading to AIDS

Prevention of unwanted pregnancy

Prevention of STIs and HIV/AIDS

B The Psychodynamics of Counselling (B1)

In these sessions guiding principles will be *presented* and, where appropriate *modelled* by the facilitators for *discussion* regarding application in the local setting.

The Psychodynamics of Counselling

The Initial Interview

Difficult Moments in Counselling

Service Considerations

Counsellor Characteristics

Counsellor Training

Counselling Adolescents with Family

Optional:

Co-counselling

Couple counselling

C Microskills of Communication¹ (C1)

The skills of listening, as indicated below, will be *presented, discussed, modelled* and initially *practised in group*. After thorough understanding the participants will divide into groups of three (*triads*) in order to practise the skills more intensively. Each participant, in turn, will play the role of counsellor, client and observer with the client presenting problems identified in the morning sessions, the counsellor concentrating on the use of the skills introduced that day, and the observer taking note of the counsellor's behaviour. Participants will work with different partners each day except for the pre-training and post-training interviews which will consist of the same triads.

An overall model of interpersonal communication skills for counselling

Attending skills

The art of encouragers

Reflection of fact

Reflection of feeling

The art of asking question

The skill of summarizing

¹ Much of Section C is based on the work of Allen Ivey; however it has been significantly modified in some ways and should not be taken necessarily to fully represent the Ivey viewpoint. For that see Ivey, A.E. *International interviewing and counselling: Facilitating client development* (2nd ed.) Pacific Grove, CA: Brooks/Cole, 1988. Also, Hedlund, D.E. and Freedman, L.B. *Interactive skills program: Helping through listening and influencing*. Cooperative Extension, The New York State College of Human Ecology and the New York State College of Agriculture and Life Sciences, Ithaca, N.Y., USA, 1981.

Following a thorough discussion of the overall methodology of the workshop one of the facilitators will begin present:

**A THE WHO APPROACH TO
REPRODUCTIVE HEALTH IN ADOLESCENCE**

Presentation and Discussion

The overall WHO approach to the promotion of sexual and reproductive health is built on the concepts presented in overhead transparencies G6-G13, which are briefly outlined below. The set of eight overlays (G6-G13) should be presented by placing one above the preceding one (in order) until the full set of 8 are shown together on the same screen. Participants should be encouraged to discuss the relevance of these concepts to their own work setting.

DEVELOPMENT (G6)

Adolescence is a period of dynamic change during which the differences between boys and girls become more apparent, especially with regard to sexual characteristics and reproductive capacity. In all societies some form of courtship takes place during which young people may begin to form lasting relationship which commonly lead to marriage and family formation.

NEEDS (G7)

During the early, middle and late phases of adolescence young people have different needs. For example, early on they will need to understand the nature of changes which are taking place in themselves as well as the new demands and expectations placed upon them, and perhaps in that way be aware of anything which may be a cause for concern. As they move through later adolescence, as well having new kinds of relationship with adolescents and adults of both sexes, they need to have responsible and satisfying relationship with potential sexual partners and to be able to delay pregnancy and avoid STI if sexual relations should occur. Ultimately, in adulthood, they will benefit from the capacity to form lasting relationship and have good parenting skills.

RESPONSE TO NEEDS (G8)

In order to meet the natural needs of all young people, a response is required which is promotive or preventive in nature. In early adolescence this will include education and health screening; in middle adolescence it may include guidance and contraceptive services; and in late adolescence or adulthood, preparation for marriage – such as premarital counselling – and preparation for parenthood – including appropriate ante-natal care and guidance in child rearing.

IMPLEMENTING THIS RESPONSE (G9)

Those people in a position to help the young are likely to be those who are close to them and whom they trust; such people must be adequately prepared, whether formally or informally to provide help. In early adolescence, parents, other family members, and teachers, are important figures; in later adolescence youth leaders, adults outside the family such as employers, and popular figures, may become more salient; when marriage takes place, religious figures often have a role to play as well as family, and sometimes health professionals may provide screening services. Pregnancy and childbirth will also require the direct involvement of health providers. Those who determine policy in the key sectors such as health, education, religious affairs, youth and social welfare will be needed to facilitate appropriate training for adolescent health and development.

HEALTH PROBLEMS (G10)

If the natural needs of young people described above are not met, problems will arise. These may include, in early adolescence excessive anxiety, psychopathology, abnormal growth and development. In middle adolescence problems such as unwanted pregnancy, induced abortions, sexually transmitted infection (STI) and human immunodeficiency virus (HIV) infection leading to acquired immune deficiency syndrome (AIDS) may arise. If young people are not prepared for marriage and childbearing they will be at greater risk of poor marriages, too early pregnancy and childbirth with possible illness, injury and death to mother and child, lack of development of the adolescent parent, and poor childrearing practices.

RESPONSE TO PROBLEMS (G11)

Once problems arise, a curative, rather than promotive or preventive approach is necessary. This may require medical or psychiatric treatment in early adolescence to deal with problems of unhealthy development; medical treatment and care for the damage done by unprotected sexual behaviour (or too early marriage) leading to too early pregnancy and childbirth of hazardous induced abortions, treatment and control of STI and the consequences of HIV infection. Unpreparedness for marriage and childbearing may result in a need for psychiatric attention, legal action, social welfare and other mechanisms for dealing with suffering or abused individuals.

IMPLEMENTING THE CURATIVE RESPONSE (G12)

To deal with problems once they have arisen often requires specialists who are fewer in number, usually urban based and often costly. These may include psychiatrists, endocrinologists, genito-urinary tract specialists, obstetricians and gynecologists, attorneys, orphanage or adoption facilities (where they exist) etc.

THE WHO ADOLESCENT HEALTH PROGRAMME APPROACH (G13)

Given all these considerations, the WHO Adolescent Health Programme (ADH) emphasizes the importance of promotive and preventive action as the most humane and cost effective approach to adolescent reproductive health. In order to achieve this ADH emphasizes the importance of and facilitates research, training, action, evaluation and sensitization in all relevant sectors and disciplines, with the maximal involvement of young people themselves.

Following discussion of the overlays the first presentation of the B section will be made on Psychodynamics of Counselling for Behavior Change (B2-B4).

B THE PSYCHODYNAMICS OF COUNSELLING FOR BEHAVIOUR CHANGE (B2 – B4)

Presentation and Discussion

The practice of “counselling” means many things to many people, and it is important that the participants discuss their views of what it entails. There is likely to be general agreement that it is a form of helping through interpersonal communication, but ideas on how that is provided, by whom and for whom, may differ widely. The facilitators should present an overview of the way in which the concept is used throughout this workshop, indicating that the training provided is meant for use with the general population of young people, who may be experiencing difficulty with some aspect of life, especially in relation to sexuality or reproductive health. The focus is particularly on the enhancement of communication skills for those providing counselling. It is not designed for counselling clients with serious psychopathological problems, nor is it meant as a process of long term psychotherapy which would deal with a deeper level of psychological processes. At the same time the provision of counselling requires professional training and differs from the kind of lay guidance or advice which might be offered by a friend or colleague. It also emphasizes a non- directive approach, i.e. one in which adolescent clients do much of the work as part of the process of helping them achieve greater maturity, and not a process in which the counsellor assumes responsibility for making decisions. Part of the counselling process is to reach a mutual understanding of the clients needs, reach agreement on the goals for the counselling process with a particular client, help the client reach those goals, and ultimately achieve a mutually agreeable end to the counselling process.

It is important that the counsellor, particularly in the initial interview, be able to exclude those clients who are inappropriate for the particular service being offered. This will mean being able to discern a degree of psychopathology in the adolescent which may require professional help of a different nature. While it is not possible in a workshop such as this one to provide training in that important task, it is an essential part of the professional preparation of counsellors. Those who will of necessity provide counselling without such training, will have to use their best judgement and be prepared in advance to refer to someone with whom they have good contact and who can help the individual in question. With this in mind the facilitators may then move on to the presentation of the points outlined below.

The following 21 points, should be followed by discussion in which participants are encouraged to identify any points with which they disagree, or feel are not appropriate to their own cultures, or to add key points. They can be presented one by one on an overhead projector with a sheet of paper obscuring points not yet mentioned by the facilitator. Discussion may take place during the presentation, but

it is generally more effective to complete the presentation before allowing full discussion to take place.

1. Adolescence is a period of transition from childhood to adulthood in which adolescents begin to take control of their own life and make decisions for themselves.
2. The counsellor's task in this process of change is to assist the adolescent to make informed choices.
3. The client/counsellor relationship is very important in the process of the client's transition to adulthood.
4. The relationship must be based on respect for the client as an individual.
5. Respect for the client involves the counsellor believing that the client can be helped to help him or herself.
6. The counsellor should have the skills necessary to demonstrate to the client respect and a willingness to listen.
7. The counsellor should be able to help clients believe that they have some control over their own lives, that they can make their own decisions, act on those decisions, and evaluate the consequences.
8. The counsellor should have the ability to enable clients to talk freely about themselves.
9. The counsellor should be able to help clients explore the feelings behind the facts.
10. The counsellor should understand that feelings are involuntary; that a person cannot choose how they feel and therefore should not feel responsible or guilty about the way they are feeling.
11. Equally, the counsellor should understand that behaviour is voluntary; that a person is usually able to choose how they behave and therefore is responsible for what they do; clients can begin to judge their own behaviour and be prepared for their behaviour to be judged by others.
12. Nevertheless, if a person does something that he or she considers is wrong it does not automatically make them a "bad" person.
13. It is important that the counsellor accepts the client as an individual even if the behaviour is seen as inappropriate.
14. It can be very rewarding for a client to be able to change their behaviour voluntarily, having talked through possible courses of action and the consequences of those actions.

15. The client will gain more confidence if they are able to make informed decisions for themselves.

16. The counsellor can help clients to feel more in control of their own lives, to feel successful and confident. Initially, this will be done by clients making small changes.

17. Rewards from feeling more confident have a far greater effect on the healthy development and behaviour change of adolescents than do punishments.

18. Internal reward is more durable than external reward.

19. Helping the adolescent to experience internal reward will motivate future self help.

20. Internal rewards will help the adolescent try to make greater changes in the way they live their lives and to wait longer for the reward.

21. The establishment of internal control over one's own behaviour, self-understanding and the capacity for longer term planning are characteristics of maturity, the pursuit of which is an objective of adolescent counselling.

C OVERVIEW OF COMMUNICATION MICROSKILLS FOR COUNSELLING (C2)

In this session an overview of a model of communication microskills for counselling will be presented and each of the skills briefly outlined. Discussion can take place during the presentation or at the end according to the mood of the group, but each point should be discussed at least briefly by the participants.

Presentation and Discussion

The purpose of counselling as presented here is to help a client achieve three things: self exploration, self understanding, and decision-making with consequent action. In order to help a client achieve these goals the counsellor uses skills of both listening and expression. In a non-directive approach the most important (and usually least trained) skills are those of listening and they will be the major focus of the training in section C. Expressive skills require clarity and simplicity in presenting information, alternative courses of action and directions, and it is assumed that those prepared to work in counselling already have these basic skills.

Effective listening is not passive. A number of techniques are applied to help the client talk in order to explore feelings as well as facts and circumstances. Good listening will show the client that the counsellor is interested, respectful, attentive, and able to understand, or at least be corrected, if something is misunderstood. It is not intrusive, it does not take control of the agenda for discussion away from the client, and does not stop change the topic the client has chosen to discuss. Below are some of the listening techniques, called “microskills”, because they are components of skills, which will be the subject of more intensive training in subsequent sessions. While, usually, we are not very conscious of using these skills, during this workshop we will pay close attention to them, and practise them separately. While at first this will feel somewhat artificial, it is a useful way for them ultimately to become part of the counsellor’s battery of skills.

The skills the counsellor employs move from the least intrusive, hence most desirable, body language, to the most intrusive, question asking, the least desirable. Body language has many components such as posture, facial gestures and the sounds of the voice; encouragers are simple nods or sounds which encourage the client to continue speaking; reflections are techniques of repeating back to a client what s/he has said in different words, which usually elicits elaboration; questions if asked appropriately, will give the client opportunity to expand on what s/he has begun to say (and not changed the subject); and summarizing is an opportunity to pull together the key points that the client has made. This is useful at the end of a session to pull together the key points that the client has made. This is useful at the end of a session or at a natural break in order to turn to another topic.

As clients talk they begin to have a clearer idea of what they think and feel, and of the choices they have in their lives. The counsellor may then help them examine logical alternatives from which to choose. When young clients begin to take action, they will feel more confident, understand that they have some control over their behaviour and are in a better position to learn what is best for them, an important part of becoming more mature.

These communication skills are wholly consistent with the principles of counselling for behaviour change as reviewed in Section B above, in which the client is helped to increase self development. S/he moves towards maturity by resolving difficulties through self-exploration, self-understanding, and ultimately acting on decisions.

PRE-TRAINING INTERVIEWS

To help participants evaluate their progress at the beginning and end of the workshop it is useful to tape-record and interview with a client prior to training. This is best done with a cassette recorder, in which each participant is given a cassette to record their initial and final interviews on sides a and b, respectively, of the cassettes. However if none is available, use of the same observer for pre- and post-training interviews can serve as an alternative.

G RULES OF ROLE PLAYING (G14)

Before beginning the session the rules of role play are discussed with the participants. They are asked to choose another name and age during the role-play and at the conclusion of the role play to "de-role" by saying "I am not X I am really Y" (their own name). This is an important protective device since role play can be a highly emotional experience and personal revelations may cause considerable stress and embarrassment. Participants are told not to discuss in advance the problem they will present as clients. It may be useful at this stage to demonstrate a brief role play in front of the entire group before the *triad practice*.

Triad practice (C9)

For the purposes of pre-training interview, participants are asked to divided into groups of three (triads) in which each, in turn, will role play client, counsellor, and act as observer. In other words they will conduct three interviews of no more than five minutes each. The client is asked to bring to the interview an adolescent sexual or reproductive problem appropriate to their own cultural setting, which centres in communication difficulties, while the counsellor is asked simply to help the client as best they can. The observer is asked to note what s/he considered most important about the counsellor's behaviour and to write that down; this is particularly important if tape recorders are not available as the notes will be used at the end of the workshop to examine any changes which may take place in the counsellor's skills. Participants are asked to form groups of three, as far away from other groups as practicable and to return to the semi-circle after about half an hour. The facilitators will circulate during the role plays to observe. If some participants

have never been engaged in interviewing or role play, it may be useful for two facilitators to briefly demonstrate what is meant by role play.

Plenary Session

When the participants return to the plenary session, begin by asking them a general question about their experience. Was it difficult or easy, in each of the three roles? What was most difficult? Who did most of the talking, client or counsellor? Was advice offered by the counsellor? Concentrate on the skills deployed by the counsellors (rather than the content of the problems the “clients” presented) informing them that the following morning will be devoted to those issues.

Before closing, ask participants for general feedback covering the whole day or any other issues they may wish to raise. Thank them for their efforts and indicate briefly what the programme will be for the next day, and remind them what time the session will begin.

DAY 2

After the group is welcomed the programme for the day is outlined and the methods of work to be used briefly reviewed. The topics under the three major headings will include: A Sexual Maturation and behaviour; B The Initial interview; and C Attending skills.

A SEXUAL MATURATION AND BEHAVIOUR

The main purpose of this session is to identify changes which commonly occur in adolescence and difficulties associated with them. These may differ between cultures. The presentation may be divided into physical, emotional, and sexual changes. A transparency is available for each but it is often better to begin by asking participants to identify the changes while one facilitator writes them on a transparency. If an important change is overlooked the facilitator may then wish to raise it for discussion.

Presentation and Discussion

Physical Changes (A2) In discussing physical changes the emphasis should be primarily on what the adolescent is likely to be aware of. One should also consider anxieties adults may have because of the new potential for pregnancy which comes with the development of the reproductive system and the risks of STI from behavioural changes. Both the physical changes and the attitudes toward them will differ in some respects between boys and girls as well varying considerably between individuals of the same sex. Puberty development follows successive stages in boys and girls, but the time duration for each stage varies considerably from one person to the other. The physical changes most evident to boys will be growth of facial, pubic hair and hair in the armpits, voice change, growth spurt and enlargement of the penis and involuntary penile erection and discharge; in girls it will include menstruation, breast development, pubic and armpit hair, enlargement of the body organs, broadening of the hips, increase in height and enlargement of sexual organs. Those changes might be a source of discomfort and the adolescent who has to adapt her/himself to the new body could feel embarrassed and behave with clumsiness or a certain diffidence. Both the occurrence of such changes and/or their absence in comparison with other young people may be a cause for anxiety and lead to tensions manifest in interpersonal communication with family, other adults and their peers.

Emotional Changes (A3) Concomitant with the physical changes adolescents may also feel powerful surges of emotion. Some are associated with

anxieties about what is happening to them and whether these changes are “normal” especially in comparison with friends their own age. Adolescents become more self-conscious, self esteem often declines, and feelings towards members of their own families and young people of the same and opposite sex may also alter in some way, sometimes mixed with sexual arousal. Their emotions are often quite volatile and excessive. They are often getting interest in the other gender and for sexual matter. But contrary to the courant impression, the main representations of girls and boys concerning sexual relationship are emotional aspects of the exchange such as tenderness, emotions or intimacy. Most of the adolescent have to experiment the end of a love affair, and feel despair or even have suicidal ideation at this occasion. and feelings of love and hate will sometimes alternate with each other in bewildering succession. Of course many of the feelings of adolescence are positive, exciting and exhilarating; this can be useful aspect of counselling. However, the focus of this discussion should be on the difficulties commonly experienced by adolescents in order to heighten the participants’ awareness.

Sexual Changes (A4) Sexual arousal will increase notably and some sexual activities are likely to begin. These may include masturbation and sometimes, sexual experimentation first with individuals of the same sex, and later with those of the opposite sex. Not only do adolescent attitudes to sexuality change at this time but the attitudes of other people toward them will also change. What might have been acceptable in childhood is no longer tolerated in adolescence. It is not unusual for sexual play to develop amongst friends particularly amongst the same sex. An adolescent will begin to explore his or her own body and may discover masturbation in this way, with more or less guilt. These changes will affect behaviour and relationships with friends, peers and parents. At first the adolescents may feel confused when a sexual reaction occurs. This new feeling is a part of the development process toward maturation of their own personality and autonomy. The adolescent may feel sinful and shy to discuss that with the counsellor who has to show her/him that a lot of people of her/his age feel and behave the same way. The way we behave is largely voluntary – and it is part of the adolescence process to improve the control of the individual on her/his behaviour. However, sexual drive in adolescent can be extremely strong. The adolescent may feel the urge to behave in certain ways and find the urge very difficult to control. The discussion should focus on difficulties which arise in the participants’ own settings.

Sexuality (A5) It is often useful at this stage to discuss sexuality in general, ensuring that participants are aware that sexuality exists throughout life from its very beginning to its end and that the sexual response system is different from the reproductive system which has a more finite time span. The capacity to procreate begins after puberty and ends with menopause in women and declines in older age for men. Some believe that boys are more quickly aroused sexually than girls who may be more responsive to emotional factors, and that while female arousal may be slower to begin it may be longer lasting. Sexual relationships are mainly interactive and the two partners have to communicate, to express themselves and to listen to the other, verbally and physically. To make decision, for example to plan to have sexual intercourse or to use a contraception, they have to negotiate. This could be an interactive process leading to a decision shared by both partners, or the negotiation

could be impossible if one is deciding for both of them, or if the other cannot express her/himself. The same might happen with sexual behaviour, gestures, sexual satisfaction or pleasure. Female and man have not exactly the same needs and expectations in a sexual relationship, and adolescents have to learn to establish a good relationship with the other, to express their own desires, to get and to give sexual pleasure. As there is considerable variation from individual to individual, however, such generalizations should not be made dogmatically but rather raised as questions for discussion.

Gender and Sex (A6) It is also useful to make distinctions between gender identity – the sex with which an individual identifies; gender role – the way in which a given society expects men and women to act; sexual orientation or preference – the sex to which one is attracted; and sexual behaviour – the degree to which one acts on sexual impulses. A review of these points can be a useful way to lead into a discussion of “normality” and pave the way for the following morning’s discussion of sexual difficulties.

Normality (A7) The discussion on Day 2 is likely to arouse some anxiety and possibly disapproval amongst some of the participants as to how sexuality in adolescence is being dealt with and what is regarded as “normal”. A useful way to examine this issue is to look at the concept of normality. Participants are asked how they use this word which generally falls into four (overlapping) categories – that which is: a) statistically most common, b) morally acceptable, c) natural and d) healthy or not harmful. Given the likely uncertainty of meaning when the word “normal” is used and the strong fear of “abnormality” amongst adolescents, participants are asked to be more specific and avoid its use altogether.

During the discussion of Sexual Maturation it is useful occasionally to remind the participants that the purpose of this session is to identify problems, and that raising issues of concern does not mean that one is necessarily expressing approval. At the same time it is appropriate to repeat a part of the previous day’s session on principles underlying the Psychodynamics of Counselling (T) which distinguishes between involuntary feelings and voluntary behaviour; and the importance of accepting and respecting the individual regardless of whether his or her behaviour is acceptable.

Role Play

This is an essential part of the morning session since it brings to life key issues raised by the participants and may lead to a change in some views expressed during the discussion. Before beginning it is useful to remind the participants of the Rule of Role Play (G14) presented on the previous day to ensure that they choose another name and age and derole after the discussion of the role play. Participants may also be reminded that role playing is voluntary, but a vital part of training. Participants should now choose two common examples of difficulties in communication or interaction experienced by adolescents on the subjects just discussed. Participants could be encouraged to choose different cultural characters.

For example, if the discussion identified masturbation as a subject which often arouses anxiety and anger, an appropriate role play might be the dialogue that takes place between father and son after the boy's mother has discovered her son masturbating and asks his father to talk to him. Masturbation is not exclusive to adolescents, it occurs in babies and adults as well, but orgasm is often first experienced through masturbation in adolescence. Participants should be reminded that a "typical" scene is sought, not an idealized one, and that the purpose here is not to solve the problem but to illustrate it. A second example of role play might revolve around a girl unprepared for menstruation who is frightened by it and talks to a friend who is also not very knowledgeable, or a mother or teacher who is embarrassed to talk about it with an adolescent who asks for information.

In reviewing role plays participants frequently discuss the factual content or what is said rather than the underlying emotions. A useful way to stimulate their capacity for emotional empathy is to put a blank transparency on the screen and ask them to use single words to describe the emotion experienced by a series of characters. This should not be done during role play but it can usefully be done after a role play is completed and the players have deroled. For example, in reviewing the case of the boy who has been taken to task for masturbating, although only two characters appeared in the role play, during discussion the participants could be asked to complete a table which might look something like the one below.

FEELINGS WHICH MIGHT BE EXPERIENCED BY:			
BOY	MOTHER	FATHER	BOY'S FRIEND
guilt	pity	anger	curiosity
shame	concern	concern	envy
fear	anger	embarrassment	arousal
satisfaction	embarrassment	pride	embarrassment
confusion	happiness		
	shame		
	a sense of loss		
	hostility		
	guilt		

A similar exercise can be done at any time during the workshop to help trainees identify their own feelings and strengthen their capacity to empathize with others. It is particularly important in debriefing the role players (whether as "adolescents" or as "counsellors") to help them identify their feelings.

B PSYCHODYNAMICS OF COUNSELLING

B THE INITIAL INTERVIEW (B5, B6)

The second half of the morning will begin with the important issue of the first meeting with an adolescent client. For this purpose a series of suggestions have been made which should be prefaced by the explanation that they embody certain principles but need to be adapted to local circumstances. To facilitate the transparency can be shown and explained item by item, discussion left until the presentation is complete. However, participants should be encouraged to interrupt for clarification.

Presentation

The first encounter with an adolescent is of great importance for a number of reasons. The adolescent is likely to be very sensitive to the counsellor's manner, looking especially to see whether it is friendly and non-judgemental. The first meeting will also set the style and tone for the kind of interactions which will follow. It is essential that both client and counsellor understand that they are entering into a professional relationship which is different from a social one, although personal issues will be discussed and feelings will be aroused in both counsellor and client. It is also important to manifest the principle of respecting the client, regardless of behaviours which the counsellor might not appreciate. As one of the major goals of counselling is to help the individual understand themselves better through self-exploration, the atmosphere created must be one in which young person feels free to talk about the most sensitive issues, even some of which they are not initially aware. Ways of overcoming difficulties in achieving these goals are also reviewed in the sections called Difficult Moments in Counselling 1 and 2 (B8, B9).

Timing: A key aspect if this is providing a "safe" environment for the young person. For this purpose consistency is important. This applies to the concept of keeping to time. When young people come, or are sent for help, they usually know little of what is to take place. They are frequently made to wait an indeterminate time, don't know how long they will be kept, nor when the visit will end. To the extent possible a counsellor should work differently. If it is possible to make an appointment for a specific time, that is best. If not, an approximate time will do. It is better to let the client know that you will be able to see him or her sometime between 9 and 10A.M. than simply sometime in the morning. Keeping an adolescent waiting engenders anxiety and sometimes anger. Some will not be able to tolerate this and will leave before you can see them. If they must be kept waiting, it is helpful for someone to let them know. Most adolescent clients will not know how much time they have with you, although they may guess. If, for example, only ten minutes are available, they should be told that at the beginning, and if possible, why that is so. If the counsellor has 45 minutes or an hour, again the client should be told at the outset. Ending a session "on time" is equally important. It is quite common for

an adolescent to wait until the session is about to end to reveal something of considerable significance. This is “safe” because they know they will not have to discuss it then. It is best to end the session on time, remarking on the importance of what the young person has said, but with arrangements having been made to meet again. These aspects of timing are consistent with the creation of a structured professional relationship with the adolescent, and a part of helping her or him to mature.

Client’s Comfort: The adolescent is likely to be anxious about this first meeting and probably expecting an interview along the lines of a medical model in which there is a considerable difference in status between doctor and patient, and in which the doctor does most of the questioning and makes the decisions. Because in counselling it is important that the adolescent learn to make responsible decisions, the setting needs to be somewhat different. Although the manner in which it is expressed will differ from culture to culture, respect and cordiality need to be shown from the start. Thus, the counsellor should rise when the adolescent comes into the room, introduce him/herself, ask for the client’s name (or how s/he likes to be called), offer them a chair, and thank them for coming. The latter point may seem unusual, but in fact, by coming to you the adolescent is showing considerable faith in (probably) a stranger and that merits thanks. It may also be appropriate to indicate about how much time you will have together and that confidentiality will be maintained, if that is the case (see Service Considerations (T) below for elaboration of this point). There is considerable advantage in sitting on similar chairs without a table or desk in between as this de-emphasizes difference in status. It is important that no one else is present in the room or, if that is not possible due to the lack of space, there should at least be a curtain or some divider available to maintain privacy.

Opening of the Session: It is best to begin by asking the client why they have come by saying something like “Perhaps you could tell me why you have come today”. The reason for this somewhat tentative opening is both to make it easier to reply and to leave room for the adolescent to say that he or she was sent and doesn’t know why. Very occasionally the client may have unintentionally come to the wrong service expected, for example, purely medical treatment for a STI in which case the nature of the service should be indicated and a referral arranged if the client agrees. On the other hand, it may be that the client feels more comfortable having come to a counsellor and is appropriately placed even if a referral for medical diagnosis and treatment is arranged. It is not appropriate to say “Tell me what problem is”. The purpose of counselling is to deal, primarily, with the person, not the problem, especially since the “problem” initially described may be best dealt with in an indirect manner, thereby having more impact on the underlying cause.

The Client’s Demeanour: Throughout counselling, one of the most important tasks is to be aware of the manner and emotions of the client and also what provokes a change. This is especially important at the beginning of the first session when rapport is established. Adolescents may come to a session manifesting some degree of anxiety, anger, sadness, or “jokiness”, or they may be quite expressionless. Part of the task of the counsellor is to reduce the extent to which

these feelings hamper self-expression. One of the most effective ways of doing that is to gently call attention to the mood of the client, and ask whether that is the case. For a client who is anxious it may be useful to say “Many young people who come to see me are a bit uneasy at first, I wonder if you feel that way too, John?”. For an apparently angry adolescent it may be all right to comment directly on it. Or, if the reason is clear, - for example, the adolescent was sent to the counsellor but didn’t want to come – the counsellor could say “I wonder if you’re a bit annoyed about having to come here when you didn’t see the need for it?” The client’s anger should be acceptable to the counsellor and this is a way to show that it is a legitimate feeling. A client who is manifestly sad also needs permission to be that way, and perhaps some reassurance from the counsellor that in the circumstances it is natural to feel sad. Commenting on the adolescents’ feelings and helping them to acknowledge them goes a long way toward reducing the level of tension, showing the acceptability of their emotions to you, and helping them to acknowledge their own feelings.

Silence: Effective counselling calls for more action on the part of the client than is customary in the medical setting. However, it may be the client’s first experience of this way of working. How can you as a counsellor make it clear to your client that you have confidence in the client’s inherent ability to solve their difficulties and mature well? How can you put clients at their ease? An important aspect of this is to keep direct questions to a minimum and wait for the client to speak some of the time. Unaccustomed silence can be uncomfortable to both client and counsellor, but some exposure to it in the first session can be valuable. Too long a silence is not appropriate since the client will not understand why, but waiting a bit longer than usual can helpfully illustrate the point that the client is expected to take some initiative. The client may break the silence by asking what the counsellor wants to know, in which case an appropriate reply is to say that part of the purpose of the session is to help you talk a bit about yourself. If the counsellor breaks the silence a similar comment is in order to be followed by another wait. As time goes on it will seem more natural to the client and greater and greater self-exploration will take place helping the counsellor understand the source and nature of the difficulties being experienced. Sometimes the client may be unwilling or unable to talk at the first session. This does not mean the session has been a complete failure. There are many reasons why a client may not want to talk; they may be frightened or need time to trust the counsellor. Thank them for coming and indicate that they have taken an important first step. Suggest and arrange another meeting. Even if they say they do not want to come back, make the appointment, ask them to think about it and say you will hope to see them.

Appropriateness of Question and Reply: Sometimes a question put by the client is inappropriate. For example a personal question, or a question which the counsellor is not able to answer because of a lack of information (see Difficult Moments in Counselling below for a review of these points). In the former case it is important to indicate why the question is not appropriate and not to evade the issue; in the latter it is best to indicate that the counsellor doesn’t have the information but will either get it or refer to someone who can provide it. Clients often want to be comforted about a problem they have. While it is appropriate to reassure them that

you can help in some way, not least by spending time with them, it is not appropriate to mislead with false reassurance. For example, if a young person is concerned about homosexual feelings, it is not appropriate to say “don’t worry it will go away in time” since it may not. However you can certainly help them in other ways. The principle of being honest with the client is an overriding one and the clearest way to manifest respect and establish a trusting atmosphere.

Ending the Session: It is important to bring the session to a close when the time you have allocated to the client has come to the end. It is useful to make a brief summary of the session (see Summarizing Skills in Section C below) especially indicating some positive achievements made by the client and the value you place on his or her willingness to work out their difficulties. Then ask how the client feels. Arrange a further appointment or discuss how the situation will be followed up. If only one session is necessary, say that the client is welcome to come back whenever he or she wishes and you will be glad to see him or her. If client starts to leave in anger or despair before the session is complete ask them to stay for a few moments more to discuss their feelings, and at least advise them that although they are leaving in an unhappy frame of mind, the door remains open to them and you hope they will come back. This “lifeline” is important since while their behaviour may be very provocative the usual reaction is one of rejection. The counsellor’s response is a different one and it may enable the adolescent to return. As noted above under “Timing” don’t extend the session because something of significance has just been raised by the client. This takes the “safety net” away of knowing that they will not have to discuss it further that day. This principle applies to threatening subjects such as suicidal intentions – see “Difficult Moments (T)” below for a review of that issue.

Discussion

For many participants in developing countries and those who work in institutions with an authoritarian style, this somewhat non-directive style of counselling is uncommon and it is likely to raise issues of cultural acceptability. Experience over the years has suggested, however, that the principles are valid in all settings although the way they are manifested may differ. Furthermore, the practice training sessions over the week often serve the key purpose of demonstrating, even in role play, the value of using them in any cultural setting. Discussion following the presentation should help to raise all of these issues and participants should be encouraged to be frank.

Modelling

It may be appropriate during the discussion for the facilitator to model some of the issues discussed above, such as the welcoming and opening of the initial session with an adolescent client. This should be brief but it is best to stay with the rules of role play. Thus, a volunteer from among the participants will choose the name, sex and age of the young client who is coming to see a counsellor (played by the facilitator under another name) for the first time. Experience suggest that the facilitator should work in a way appropriate for his or her own culture at the same time exhibiting the points presented.

C MICROSKILLS OF COMMUNICATION

C ENCOURAGERS AND OTHER ATTENDING SKILLS (C3)

The focus of this session will be on a key groups of listening skills needed by counsellors called “attending skills”. All of these behaviours are exhibited by everyone who engages in conversation but usually without conscious awareness. By separating them into individual components of communication (“microskills” is the term used by Allen Ivey who originated the system in the U.S.A.) and providing practice these skills can be sharpened and better employed to achieve effective listening, which is essential to counselling. At the same time the trainees will become more aware of these behaviours in the client, often the most valuable indicator of the client’s emotional state. Practicing components of skills separately will feel somewhat unnatural, especially as these are normally done without conscious intent, but it is the best way to strengthen these skills which ultimately will be naturally integrated into active listening.

Presentation

At the beginning of the session it is useful to first show the Transparency of the “V Model” (C2) and indicate the place that attending skills (non-verbal listening skills) have as the least intrusive of the listening skills. Again, emphasis should be placed on helping the client talk, rather than the counsellor. The Attending Skills Transparency can then be shown, item by item, with the use of *Modelling* by the facilitator and *Group Practice* by the participants.

Eye contact Good interpersonal communication requires appropriate eye contact which can readily be modelled by the facilitator with a role play, although there will be some cultural differences. Somewhere between an unwavering gaze (staring) and total aversion of the eyes, lies a comfortable degree of eye contact. An anxious, angry, embarrassed or depressed adolescent may avoid eye contact, but the counsellor should keep his or her face turned toward the client as an important way of manifesting interest. Often a turning point in the first session is signalled by the establishment of eye contact.

Body Language One of the most significant forms of communication is *by the body*. When a role play is video taped, e.g., and the sound turned off, most participants will be able to describe much of what is going on between the counsellor and client simply from the body language. This behaviour can be used effectively by drawing attention to its component parts. One way to illustrate the overall importance of body language is to ask one volunteer (privately) to “freeze” in the middle of a conversation begun with another role play. Very soon the other person will come to a halt illustrating the vital importance of body language in communication. This will also illustrate the fact that while the specifics of body language may differ from culture to culture, communication depends on body

language in all cultures. Another important aspect of body language is *the distance* between two people. The facilitator can have this modelled by calling for two volunteers to have an ordinary conversation about any subject while standing up. The facilitator then asks one of the volunteers (privately) to move continuously toward the other person during the conversation. Inevitably, during the role play, the second person will take a step back each time the first player takes a step forward indicating what is a comfortable distance between two people.

Another aspect of body language is *the synchrony* of movement between two people. When one person leans forward, if good rapport exists, the other will lean forward too. Leaning away from someone tends to be seen as rejecting. People tend to mimic the body language of their conversational partners. If one folds his arms, the other is likely to follow the gesture and so on. Again these can be illustrated in brief role plays.

Vocal qualities also play a role in communication. Raising the volume of one's voice or its pitch, is often associated with anger, speaking more quickly with anxiety, lowering the loudness and speed of a voice may indicate sadness, etc. Some variety, rather than monotony, is called for in speaking. The facilitator can model such changes with a volunteer placing themselves sufficiently distant from the group so that their actual words will be indistinct, and ask the group to identify the emotion being expressed. Participants should be asked to continue their observation of body language after they leave the session that evening.

C ENCOURAGERS (C4)

This is the second in the group of listening skills shown in the "V Model" (C2). It is a simple, but powerful, form of active listening closely akin to body language in which nearly non-verbal signals are given to encourage the client to speak or continue speaking. Such signals include a nod of the head, or, in English, a sound such as "mm hm" or words such as "I see", "go on", etc. These small signals are vital, if unobtrusive, indicators to the client that you are listening, interested and pleased that he or she is expressing themselves. This skill can be easily illustrated by listening to some one in a role play, when the signals are deliberately omitted, and then observing the effect encouragers have when they are reintroduced during the same role play.

Encouragers exist in every language, and participants should be asked to illustrate this truth in the language in which they normally work (if it is other than English) through brief role plays in front of the group.

It may be useful at this stage to do **an exercise "Roses and Daisies"**. In this case the facilitator will ask the participants to count off, but instead of calling the numbers out they should alternately say either "Rose" or "Daisy". Since they will work in pairs there must be an equal number of "Roses" and "Daisies". Then one of the facilitators will lead the "Roses" out of the room and explain their task by saying that the exercise is aimed at developing listening skills; the "Daisies" will bring up a certain subject, and the "Roses" will keep silence and behave as if they were not listening at all until the facilitator claps his/her hands. Since now on, "Roses" should

be all ears to whatever “Daisies” say. At the same time another facilitator inside the room will explain to the “Daisies” that while teaming up with a “Rose” they should tell him/her about the most wonderful day in their lives. A “Rose” will not intervene or ask questions and will just keep listening. A “Daisy” should continue the story until the facilitator says that the time is up. When the exercise is done, it is important to discuss feelings of the participants from both groups which were experienced by them in the course of doing the exercise.

Once the facilitator feels that all the participants have grasped the microskills covered in this session, through presentation, observing them being modelled and through group practice, it will be time to turn to the next session, *Triad Practice*. Before that a coffee break is usually advisable.

Triad Practice

Participants are now asked to divide into groups of three (triads) working with someone they had not worked with on the previous day. They should be asked to move their chairs into groups of 3, as far away as possible from other groups. The facilitators will circulate amongst them. Where possible, the facilitator should sit through one role play in each triad before moving on to next. Each of the participants will in turn play “client”, “counsellor” and “observer”. The role plays should last about 5 minutes each. Those role playing clients are asked to choose a situation of the kind discussed or role played in the morning session covering Sexual Maturation. They are not to discuss it in advance but simply behave as they would if they were the young person in question. As always with role play, they are to adopt a name and an age appropriate to adolescent in their culture. The Counsellor is asked to make use of what has been learned in section B of this day and the previous one – Psychodynamic Principles of Counselling (B2, B3, B4) and Initial Interview (B5, B6), but to concentrate on the use of attending skills including eye contact, body language and encouragers. Participants are asked not to give advice to the clients in these practice sessions and to try to avoid asking many questions. The main task of the “counsellor” consists in encouraging the “client” to speak, making him understand that whatever he says is important and valuable, and in establishing good rapport with the use of encouragers. The observer will note when and how the attending skills are used and the client’s reaction. Participants should be reminded that becoming a good observer is also an important part of training.

On completion of each role play in the triad practice sessions, the observer should first comment on the use of the counsellor’s skills and then turn respectively to the client and counsellor. It is important that observers comment on positive aspects of what the counsellor has done and not simply be critical. However, emphasis should be on the counsellor’s use of skills rather than the “problem” presented by the client. Then they derole and repeat the exercise so that each person has had the opportunity to practice each role. About 15 minutes will be needed for each role play and discussion, so that a total of a 45 minutes to one hour should be made available. Upon completion of the role plays the participants should return their chairs to the group in a semi-circle for a final plenary section.

During the triad practice, it is useful to have a video camera record parts of some of the role plays for playback in the plenary session. However, for sound recording to be adequate it may be necessary to provide the two role players with hand-held microphones. Too heavy reliance should not be placed on the use of video and playback, although it can be a considerable asset when used appropriately.

Final Plenary Session

The group should first be asked a general question about their experience in the triad groups including any difficulties they may have encountered. Remember to focus the discussion on the skills used and **not** on the content of the client problems. The participants should first be asked about their experience as observers. Then, they should be asked about the ways in which they were or weren't able to use their skills as "counsellors", and what the participants as "clients" felt during the process. What has encouraged a "client" to speak and what has been in the way of being en rapport? The facilitators may also wish to contribute their own observations, citing particular instances they may have observed in the *triad practice* which illustrate the principles and skills reviewed. If the video is of reasonable quality playback may be judiciously used for this purpose.

The last few minutes of the day should be used for some general feedback from the participants on the day activities. Questions about what was most and least helpful are usually a good way to stimulate a frank discussion. Before closing, thank the participants for their efforts and provide a brief reminder of the programme for the next day.

DAY 3

Outline the programme of the day and briefly review the methods of work to be used. Welcome any feedback from the previous day. Unless changes in the programme have been agreed upon the major topics will be: A Sexual Difficulties; B Counselling Service Considerations; and C Reflections of Fact, Reflections of Feeling, Summarizing and Verbal Following.

A SEXUALITY AND REPRODUCTIVE HEALTH

SEXUAL DIFFICULTIES

While on the previous day anxieties common to most adolescents were reviewed, today attention will be turned to problems which may be relevant to a minority of adolescents but which may be equally, or more, likely to come to the attention of counsellors. Sexual difficulties might lead to suffering and real psychosomatic disturbances for her/-himself; They might interfere with her/his sexual relationship and emotional aspects of interaction with her/his partner. Sexual orientation and sexual violence are not only personal difficulties, but are inserted in the familial and social environment, and their disclosure might have consequences in the different environments where the adolescent is living. They will be discussed under three headings: Sexual Dysfunction, Sexual Variation, and Sexual Abuse. Again special attention will be given to the adolescent's perspective within the cultures represented in the workshop. Some situations will then be selected by the participants for role play to illustrate existing problems of interaction and communication.

Presentation and Discussion

Sexual orientation

The development and acknowledgement of the sexual orientation plays an important role in the formation of an adult identity. Sexual orientation is defined as the persistent pattern of physical or emotional attraction to members of the same (homosexual attraction), the opposite (heterosexual attraction) or both (bisexual attraction) sexes. Sexual fantasies, emotional attraction, sexual behaviour and self-identification are considered to be dimensions of sexual orientation.

Clear distinctions need to be made between attraction, fantasies and affiliation in order to help the adolescent deal with his or her feelings. Some teenagers might not yet have come to terms with the process of the acknowledgement of their sexual orientation. And sometimes it takes years before the adult should inform their family and friends about their sexual affiliation through the so called "coming out". Information, support and possible contact with the homosexual community could help these adolescents to accept their feelings and to understand what is best for them. Professionals could help an adolescent distinguish between his or her feelings and the meaning of sexual relationship and prior activity. There are two essential points of which participants need to be reminded – that sexual preferences are not chosen and are exceedingly difficult – if not impossible – to change, and that many people who might be appropriately described in this way do not necessarily engage in homosexual behaviour. The converse is also true, i.e. that young people living exclusively with members of their own sex may engage in homosexual behaviours without having a homosexual orientation. It is also the case that not all such homosexual or bisexual behaviours are necessarily harmful, a point the group might wish to discuss.

Since in virtually all societies this is seen in a negative light it will inevitably mean that the adolescent with a homosexual orientation will face difficulties and sometimes will think about suicide or happen to kill themselves. Given these problems and since homosexuality – heterosexuality lies on a continuum, many of those with strong homosexual inclinations will suppress that part of their nature and do their best to lead primarily heterosexual lives. They may marry, without losing the homosexual feelings and lead a bisexual life in fantasy or reality. (An adolescent with a profound homosexual orientation may at the same time have an equally profound wish to be purely heterosexual. This can be the source of great misery since one cannot intentionally change sexual orientation although it may evolve over time.) Others with a homosexual orientation may be content with that but recognize that they will have to deal with antagonism from some others perhaps within their own families. An important task of counsellors is to help young people through these difficulties.

Sexual Dysfunction (A8)

The initiation of sexual activity may be difficult and young people need to be reassured about their own capacity to develop their knowledge and skills in that matter. A lot of young people don't feel satisfied after their first sexual intercourse, but very few dare to tell it to others because efficiency is necessary in that matter especially among boys. Female sexuality shows a different maturation with a sense of intimacy and an important role of emotional arousal and passion interacting with sexual satisfaction. Sexual behaviour is also an interactive process where each person has to deal with negotiation and power relationship. Individual counselling is a special occasion to discuss these issues.

The term sexual dysfunction is usually used to some form of impairment of the ability to achieve sexual satisfaction during intercourse. Thus it is not considered a problem unless it is perceived as such by one or both partners. Some dysfunctions are more common in adolescence than others. In this session it is usually best to

explain how you are using the term and to indicate briefly the working definitions of the terms described below. The words used by adolescents will usually differ from the technically “correct” term. Some discussions of the words which are used will be valuable. While some participants may find it embarrassing, they should be reminded that they will be hearing such terms in the counselling situation. If the language used by some of the participants in their own settings is different from the language used in the workshop, ask them to write down the technically correct terms and the words more likely to be used by the adolescents in their own cultures.

Impotence (or erectile dysfunction) – an inability to achieve or maintain an erection of the penis. Primary impotence is defined as never having achieved an erection. This is rare and usually the result of organic problems. Secondary impotence is much more common and is usually caused by anxiety about the situation or about the erection itself. It is likely to be temporary if the anxiety is dealt with. A young man who is anxious about sexual intercourse or its consequences may experience secondary impotence. If he isn’t aware of the cause of its commonness it may lead to long-standing sexual problems and an immediate loss of self-esteem.

Premature Ejaculation – an inability to control ejaculation so that it occurs soon after arousal and before either the adolescent boy or his partner wishes it to occur. Because of the quick arousal experienced by the adolescent boys this is likely to be a fairly common problem.

Retarded Ejaculation is the reverse, i.e. it occurs later than desired.

Vaginismus – Spasm of the vaginal muscles which prevent penetration.

Dyspareunia – Pain experienced on penetration of the vagina for which there are multiple causes. This can cause considerable psychological stress as well as have an adverse impact on long term relationships.

Lack of Sexual Desire – a perception by the young person that they are not sexually aroused when they think they ought to be and perhaps especially in relation to a sexual partner.

Excess Sexual Desire – the perception that sexual arousal occurs more often or more strongly than they wish. This is not an uncommon complaint expressed by boys who may find their concentration on other things lapsing because of sexual thoughts and desires.

Anorgasmia – an inability to experience orgasm when desired. Given the greater likelihood of rapid arousal in boys and a somewhat slower (but longer lasting) arousal in girls, there may be anxiety (in either partner) that the girl hasn’t achieved orgasm. However, many people enjoy sexual experience without experiencing orgasm, and simultaneous orgasm is probably not the rule, but rather the exception. Young people may not be aware of this.

The discussion should focus on what participants believe to be the most common difficulties experienced by young people, and on the problems which arise

when they attempt to communicate with others on these subjects. The participants should be encouraged to consider at least one of these situations for role play.

Sexual Variation (A9)

Sexual variation is more commonly referred to as sexual deviation since, narrowly defined, it means being able to achieve orgasm **only** through stimulation of the kind described below. Some variations are not necessarily harmful to the individual or sexual partner. Participants should be encouraged to discuss their views on this subject. However, the amount of time spent on this subject depends on its relevance to the adolescent community served by the participants. The counsellor needs to be an able and sympathetic listener to any such problem, and it is precisely the more unusual ones which are likely to have been kept secret and for which the adolescent may be in greatest need of help.

Sado-Masochism – the achievement of orgasm only by giving (sadism) or receiving (masochism) pain to or from a sexual partner.

Transvestism – Dressing in the clothes of the opposite sex as the sole means of achieving orgasm. This is not usually related to sexual orientation although many participants may assume that it is an expression of homosexuality.

Voyeurism – Observation of people engaged in sexual acts or those which may have sexual overtones, as the sole means of achieving orgasm.

Exhibitionism – Achieving orgasm exclusively by displaying sexual organs, usually to strangers in a public place.

Fetishism – Arousal by an object or material such as shoe, or rubber, as the exclusive means of experiencing orgasm.

Transsexualism – Feeling trapped in the body of the wrong sex, a relatively rare but powerful phenomenon which is usually present from early in life. It does not correspond to homosexuality but in recent times has come to be recognized as a phenomenon which is sometimes treated by surgical means.

Paedophilia – sexual arousal through sexual interaction with children (also see Sexual Abuse, below).

Sexual Abuse (A10)

The purpose of this discussion is to help the participants recognize situations which are harmful or distressing to the adolescent, arising from the behaviour of other people toward them, either against their will or without adequate consent because of their immaturity. Sexual victimization can describe two kinds of situation: sexual abuse or aggression by an older person during childhood or adolescence; and violence in the context of a sexual relationship during adolescence. This is often referred to as violent date, violence in sexual interaction being another situation of sexual aggression; when an adolescent eventually might be the perpetrator. Sexual abuse or harassment can take many forms and may differ

considerably between cultures. It is appropriate for the facilitator to explain how the term is being used and ask the participants themselves to provide examples of what they see as sexual abuse. Just as sexual behaviour may take many forms and is not restricted to sexual intercourse, sexual abuse covers a wide range of behaviours. It may, for example, be purely verbal rather than physical; it may overlap with the previous topic as in case of the practice of paedophilia. Sexual abuse can have short- and long-term consequences, especially apparent at the time of adolescence because of the development of adult sexual life and personality. Many abusers have a history of being sexually abused themselves, which doesn't mean that sexually abused adolescents are going to become abusers themselves. Following the discussion the transparency can be shown, although it is more useful to elicit behaviours identified by the participants and record them on a transparency during the discussion. Some of the more frequently cited kinds of abuse are listed below.

Incest – This can be defined operationally as sexual relations which occur between two people in the same family such as father and daughter or mother and son, but situations which are almost as disturbing may involve those who are not blood relations such as a step-father and step-daughter. Again, for purpose of the discussion on sexual abuse, incest may include sexual activity which falls short of intercourse. Incest is almost universally censured and under-reported. Some participants will find the subject shocking and may begin by saying that it is extremely rare in their own cultures. However that opinion may be somewhat modified in the group discussion. Incest is a particularly difficult subject for the adolescent to raise for reasons which include shame, embarrassment, often a sense of guilt that they have somehow consented or encouraged it, fear of the reaction of the mother, for example, if it has occurred between a girl and her father or step-father, fear of consequences to herself such as being sent away, and the possibility that the family will be broken up, anxiety about legal implications, etc. The family system is connected to the incest history and the adolescent could not be helped without an active effort toward the whole family in a coordinated network of services or persons. Role playing a girl who tries to tell her mother of an incestuous situation will help to illustrate some of these difficulties.

Rape – the forcing of sexual intercourse on an unwilling male or female. Rape may be particularly traumatic for an adolescent with no prior experience of intercourse and may be accompanied by additional physical (as well as psychological) abuse. In that case, post traumatic stress syndrome might lead to immediate needs of debriefing and psycho-somatic specific care. In many countries sexual intercourse with a minor – however defined – is treated as statutory rape, even if the minor consents, since the young person is not considered to be mature enough to make an informed judgement. Incest may also occur when a young adolescent doesn't feel able to refuse the attentions of an older member of the family.

Prostitution – the involvement of adolescents in exchanging sex for money or other favours is often seen as sexual abuse since some adolescents are forced into this, some will do it out of desperation, and others will be too young to make mature voluntary choice. The different conditions leading to prostitution involve social,

legal, economic and psychological factors that often prevent to help the young person only with an individual approach. A multidisciplinary network might be crucial in that matter. In many developing countries it is most prevalent in tourist zones. In some countries young people are being sought out by adults on the assumption that they are more likely to be free of the AIDS virus.

Paedophilia – as in the above categories a child or young adolescent may be either obliged or persuaded to have sex with an older person to fulfil the latter's sexual desires and is a form of sexual abuse because of the immaturity of the child (also see Sexual Variations above).

Sexual Harassment – this may take many forms including repeated teasing or embarrassment often, but not always, by boys or men toward girls. How that is constituted in the cultures of the participants should be discussed.

Violence in dating relationships – sexual victimization may happen between adolescents in intimate relationships when one partner, more often the boy, forces the other to do sexual things she/he doesn't want to do or forces her/him to have sex. An important task of counsellors is to help young people, victims and perpetrator, to disclose their difficulties, to react and to prevent violence in their present and future sexual relationship.

Role Play

The subjects covered under the broad heading of Sexual Difficulties, including sexual dysfunction, variation and abuse offer many problematic situations in which a young person may try to communicate with another, or will express their anxieties in some manner which may be partially hidden. These situations lend themselves to role play, and on this third day of the workshop the group should be encouraged to take on some of the more difficult and sensitive issues such as incest and homosexuality. The purpose of this session is to illustrate the problems and help the group to understand the experience, especially of the adolescent, when faced with these difficulties. It will enable them to avoid being shocked or embarrassed to the detriment of their claims. It will empower them to understand the impact of culture and society on the representation of sexual violence and gender roles and implicitly to help young people to talk about such subjects if they are troubled by them. Moreover it will allow them to talk about the attitude of other professionals in the network of services in their country, and to exchange their ideas to deal with the obstacles and difficulties. Overt sexual behaviours should **not** be role played but scenes such a girl trying to tell her mother about an incestuous occurrence, or a boy trying to express his anxieties about a homosexual experience can be usefully demonstrated. Again, the role players should be volunteers but those who have not yet taken part should be encouraged to do so without calling upon them individually. The usual rules of role play apply and are especially important in this session when sensitive and often somewhat repressed topics may be brought to the surface.

Note: The topic of sexual difficulties in adolescence is fairly extensive and it may not be possible to deal adequately with it in the first part of the morning. However, the facilitator should see that not too much time is spent on topics of

minimal relevance to adolescents. If more time is needed to review problems, it should be continued the following morning in Session A. These subjects may also recur in Difficult Moments in Counselling (days 4 and 5) and may be used as the subject matter of role plays during the afternoon triad counselling skills practice sessions.

B PSYCHODYNAMICS OF COUNSELLING

B CONSIDERATIONS IN COUNSELLING SERVICE PROVISION

The main purpose of this session is to explore the best ways within any cultural context to apply the principles of counselling as outlined in Sessions B on the first day in The Psychodynamic Principles of Counselling (B2, B3, B4) and as exemplified in The Initial Interview (B5, B6) presented on day 2. The main issues addressed in this session will be the assurance of confidentiality and privacy, and the boundaries of the counsellor's role. As before, it is vitally important that the views of the participants be expressed on each of the key topics both in terms of their views of what is appropriate, and the best ways of achieving confidentiality in their own setting. It may be useful to present the topics only as headlines and ask the participants to help define their meaning. The comments below are to help the facilitators in their management of the discussion.

Presentation and Discussion

Counselling Service Considerations (B7)

Counsellor's Responsibility – While counselling skills remain common in many different situations the role of a counsellor in a particular setting may have some special characteristics. This workshop focuses primarily on the skills needed rather than the discipline of the counsellor. Thus people who are performing as counsellors may come from many different disciplines such as medicine, teaching, nursing, social work, psychology, religion, youth work, criminal justice, etc. When they are working as a counsellor however, it is almost always desirable that it be separated from their usual role. For example, the manner in which medical histories are (appropriately) taken is very different to the way in which a counsellor helps a client to explore themselves. If a doctor is offering a counselling service to a patient it is probably best to do it at a different time and, if possible, in a different place where medical consultations are held, in order to distinguish between the roles of doctor/patient and counsellor/client. Similarly, a counsellor who is not working in an STI clinic and is not equipped to diagnose or treat in these conditions may effectively counsel a client suffering from an STI. In this case, arrangements need to be made for appropriate diagnosis and treatment elsewhere. When someone with moral responsibility, such as a minister of religion engages in counselling, the rule of separation also applies, i.e. it is essential to be non-judgemental in the role of a counsellor and help the client to make their own moral choices.

Appropriateness of Services to the Needs of Client – As indicated in The Initial Interview (B5, B6) it is important at the outset of the first session to help the client say why he or she has come, and to have a clear idea of her/his demands and of her/his needs. It may be for reasons such as a request for financial assistance, or legal help in which case an appropriate referral will be needed. But one must be

careful not simply to refer a client, and has to try to help her/him to clarify her/his own need. Adolescent may hesitate to tell their difficulties at the first interview with the counselor and confusion, especially in delicate matter as sexual issues, is frequent. At the same time it can be confusing for an adolescent if too many people are involved in helping. Therefore, an early decision should be made as to what are the objective of the counselling (needs clarification, help in multiple difficulties, help to access to other services, etc.) in order to decide whether or not it is appropriate to take on the individual as a client. An adolescent seeking help will often ask the counsellor to identify the individual person, his gender or his social position or psychological attitude, and not only the discipline. It is important to respect the right of the client to choose the person she/he want to speak with, but also the right to get the best quality in services.

Confidentiality/Information for Others – This is one of the most important issues to be addressed by a counselling service and in many respects one of the most difficult. Adolescents are often extremely anxious about revealing feelings, thoughts or acts which they have thus far kept secret. They may feel ashamed, guilty, embarrassed or simply confused. A skilled counsellor can help a young person talk about such things but will be severely handicapped if the adolescent believes that what is said will not be kept in confidence, or isn't sure that confidences will be kept. Bearing in that one of the principles of counselling is to help the young person achieve the capacity to make their own decisions about their behaviour, the need to break a confidence should arise only very rarely. But the limit of confidentiality must be explained at the beginning of the counselling. Anyway, the need for adolescent not to be alone with her/his difficulties has to be emphasized by encouraging her/him to communicate with parents or confident.

There are three separate issues to be reviewed under this heading. 1. What do we mean by confidentiality? 2. How can an adolescent know that confidences will be kept? and 3. What is the best way to break a confidence if the counsellor feels it is absolutely essential to do so?

1. What does confidentiality means? Absolute confidentiality means that no one apart from the counsellor and the client will be aware of the identity of the client nor the content of the counselling session. Most services have some form of reporting system in which the name of the client is recorded and seen by others within, and sometimes outside, the service. This may be acceptable if they are other professionals who are trained to keep such information strictly within their working guidelines. While the identity of the client may be known, information about the content of the session should remain confidential. However records are often seen by staff such as clerks, secretaries etc., who may not have been trained in confidentiality. It is essential that such training be incorporated as a part of the service provision. If it is necessary to provide information in terms of statistics or service use, a coding system may be employed to provide information whilst protecting the identity of individual clients.

2. How will the adolescent know whether confidentiality will be kept? Most adolescent clients will not be sure as to the degree of confidentiality kept by the counsellor, but may not feel able to ask. One solution is to have a notice displayed in

a prominent place stating the rules of confidentiality. Another is to inform the client at the beginning of counselling how the confidentiality is assured. A third, less effective, approach is to inform only when asked, but that runs the considerable risk of missing those too anxious to ask.

3. What if the counsellor feels confidentiality must be broken? There are certain circumstances when some (but not necessarily all) participants will feel that other people either ought to be informed or feel constrained by policy or legal matters to break confidence. Some will cite examples such as the situation of a young adolescent who is pregnant and may intend to seek an abortion; an adolescent who has an STI but is unwilling to go for treatment; an adolescent involved in an incestuous situation but unwilling to have it revealed for fear of the consequences; and an adolescent who in some manner is breaking the law. While each example should be discussed by the group on its merits and according to local circumstances, it is appropriate to remind the participants that it is extremely difficult to force anyone to do anything. For example, a pregnant adolescent may seek an abortion in a dangerous way if an attempt is made to force her to keep the pregnancy; a boy with an STI may simply run away if a confidence is broken; revealing incest to other parties may result in compounding the damage done or in violence against the adolescent, etc.

The counsellor's prime responsibility is to the welfare of the client and it is rarely helpful to break confidence. However, if the counsellor feels it is in the best interest of the client for others to know of the problem, she/he should first help the client to understand why and try to get agreement. If that fails and the counsellor still feels it is essential to divulge information, the client must be told to whom, how and when the step will be taken. Breaking a confidence, however, may not only damage the relationship with the counsellor beyond repair, but it may also inhibit other young people from coming for help once word spreads that the counsellor may break confidences.

Note-taking – Participants sometimes ask whether it is appropriate to take notes during a session. For two reasons this is usually undesirable. First, it takes attention away from the client. For example eye contact is impossible, and the body language used is focused on the note pad not the client (see Attending Skills (C3)). Secondly, it immediately arouses suspicion that whatever is said will not be kept in confidence, even if the client doesn't ask. Given the nature of the counselling the counsellor should not need detailed notes and any reminders – to be kept in a confidential place – can be noted immediately after the session.

Communication Outside the Session – Confidences can sometime be inadvertently broken by, e.g. sending letters to an adolescent which may be seen first by others or by telephoning a client at home. It is helpful to discuss the best way of communicating with a client outside a session if that should become necessary.

Privacy/Where to Meet – Closely allied to confidentiality, is the issue of privacy. Ideally, a client should be able to come to a service without necessarily revealing to others that he or she is there for counselling. For example if the service is provided in a general health care clinic or in a youth centre, entering the main

building doesn't reveal the purpose of the visit. However this may not be wholly practical. Having a sign which reads for example "Youth Service" might be better in this regard than one which reads "Youth Counselling Service" as long as it doesn't cause confusion.

Privacy during the session is of paramount importance and can always be achieved to some degree. Ideally, counselling should take place in a room with no one but counsellor and client(s) present. If that is literally impossible, a screen or curtain to shield the client(s) from view, and sufficient distance from others so as not to be overhead, are basic requirements. It is important that the session not be interrupted by others, and it is best to ensure that telephone calls are not put through. If this is not possible, then the caller should be advised at once that you cannot speak now and an arrangement made for the call to be made at another time.

Services may be provided on premise used for other activities, such as a clinic, school, hospital, youth centre or some other public function. However, the venue should be easily accessible by foot or public transport; counselling sessions should be held during hours when it is feasible for young people to come; and the premises be pleasantly decorated and provide a place to wait which, if at all possible, does not reveal the purpose of the client's visit if others are present.

Duration and Frequency of Sessions – Some 30-45 minutes is a comfortable duration for a counselling session. Too short and it is difficult to establish rapport, - too long and it becomes overly exhausting and demanding for the adolescent. However, it is not always possible to provide that much time and quite a bit can be accomplished even in 5 minutes, as the participants will discover in their role plays in *triad practice* and in the *modelling* performed by the facilitators. However, this depends not only on the skill of the counsellor, but the understanding of the client as to the duration of the session (see Initial Interview (B5, B6)). Ending a session when it is not expected can be damaging in that the client may feel rejected or that he or she has said something "wrong". Prolonging a session can also be disturbing because it takes away the "safety net" or agreed rules and may cause the client to feel that the counsellor has panicked because of something brought up at the last moment.

The frequency with which sessions are held will be a matter of judgement and feasibility, but is generally useful to provide at least a few days for the client to absorb the counselling session and perhaps act on some decision made. If there are to be a series of sessions, the time should be fixed in advance whenever possible so that the client feels she/he "owns" a specific time, as well as a sense of structure, so important for the young person.

Bringing Counselling to a Close – Deciding when counselling is no longer needed is an important part of the service. (see Evaluation of Counselling (G15)). Ideally, it should be a decision jointly arrived at both counsellor and client. If a client chooses to cease coming before the counsellor believes she/he is ready, it should be discussed and the door left open for a return by the client if in need. Excessive pressure should not be brought to bear on the adolescent to continue against their wishes but the counsellor needs to understand why and provide the

maximum possibility for the client to make a success of the (albeit) premature departure. Adolescents may, however, simply not return without warning or they may miss one session but come for the next. Rules and structure are important for adolescents and it may be appropriate to write to them (assuming that this can be done without breaking confidentiality) expressing regret that they were not able to come to the session, and asking them to make contact with you. Irregular attendance is damaging and may be a way of unconsciously trying to manipulate the counsellor. It needs to be discussed and not tolerated in the longer run.

If the counsellor feels that counselling has achieved its purpose but the client does not agree, something has not worked well in the counselling. It may be that the client, instead of becoming more mature, has become overly dependent on the counsellor. If the counsellor has applied the principles suggested here, it is unlikely that that will occur. A counsellor may come to feel that he or she is no longer able to help the client and wish to end counselling for that reason. While that may be a valid reason for ending, it is extremely important that the young person is helped to understand why, that alternative arrangements are made if that is appropriate, and that the positive side of what has been achieved is strongly emphasized. The client should not be made to feel that the failure is entirely their fault, rather, they should be helped to understand that while some things have been accomplished, it may not be of value to continue together beyond this point. It is extremely important that advance notice be given of this, however, so that at least one or two sessions more can be used to bring the counselling to an appropriate conclusion. Sometimes, considerable progress can be made in those last sessions.

The points outlined above are intended primarily to provide guidance for the facilitators, and should not be used in the form of a lecture. It is far better for the group to reach similar conclusions through their own discussion. However, any points that are not raised by participants should be introduced by the facilitators and the recommendations indicated above expressed at the appropriate time.

Role Play and Modelling

Role playing of one of the situations related to confidentiality for example could be useful to the participants. Before bringing the session to a close it may be useful for the facilitator to model appropriate behaviour in relation to some of the above-mentioned points, asking participants to volunteer as “clients”. Examples of model issues could include: how a counsellor might go about enlisting the agreement of the client if a confidence is going to be broken; or how to deal with termination of counselling if the client doesn’t want it to end. These are Difficult Moments (T) for the counsellor, and will be addressed, with others, in Session B on day 4.

C MICROSKILLS OF COMMUNICATION

C REFLECTIONS, SUMMARIZING and VERBAL FOLLOWING (C5)

Begin the session by showing the V Model (C2) and indicate that the place of reflections are somewhat more intrusive than attending skills and encouragers. Reflecting back the meaning of what the client has expressed, either in regard to facts or feelings, is a useful technique for encouraging the client to continue talking. It is sometimes more effective for this purpose than a direct question and it reinforces the idea that it is up to the client to engage in self-exploration and not to depend entirely on the initiative of the counsellor. Summarizing is similar in that it is feeding back what the client has said, but will cover more. Participants should be reminded that while the skill is a valuable one, it will feel somewhat artificial when it is practised on its own. Nevertheless, the practice will enhance the skill so that it can be incorporated more effectively into overall counselling. Both *modelling* by the facilitator and *group practice* can be effectively used in this session.

Presentation and Discussion

Reflections of Fact (C5) Like the use of effective attending skills and encouragers, reflection is another way of showing the client you are interested and are listening carefully this time by mirroring the sense of what the client has said in slightly different language. This is different from interpretation by which the counsellor might expand the meaning of a statement. It is meant to be simply an accurate restatement. Reflection is a deceptively simple skill. In fact it is not so easy to master and requires considerable practice.

It is useful to introduce some examples at this point. Participants are asked to make a statement, on any subject, as an adolescent might make it. “Yesterday, at school, I was asked to do some extra homework.” The facilitator might respond – “So you were asked to do some additional schoolwork at home yesterday.” A few more practice statements are converted into reflections by the facilitator, following which the conversion after each statement is done by the participants, perhaps providing several versions of each statement. The person who volunteered the initial statement is asked whether they accurately reflect what was said. The practice should then continue with statements which might be made by adolescents on the topics of sexuality and reproductive health. These statements are likely to be more laden with emotion but the task remains one of reflecting the facts expressed by the client.

For example, a statement such as “Last night my boyfriend tried to get me to do something I didn’t want to do but I told him I wouldn’t and he stopped trying.” Might be accurately reflected by “So when you were with your boyfriend yesterday

you convinced him not to press you to do something you didn't want to do." An inaccurate reflection might be "Last night after your boyfriend made some sexual advances you convinced him to stop." This is inaccurate on two counts, the girl did not say that "sexual advances" were made and she said only that he "tried" to get her to do something she did not want to do, not that he succeeded and subsequently stopped. It is best to encourage the participants to identify the inaccuracies themselves but if not the facilitators should point them out. Once there is clear understanding of this skill, and everyone in the group has had an opportunity for some practice, the facilitator can turn to the next category.

Reflections of Feeling (C5) In this case what is reflected is the emotional, rather than the factual, content of what has been expressed by the client. In the example given above, if the girl had gone on to say: "I was scared at first but when he stopped trying I felt okay again", an accurate reflection of feeling might be: "I understand that you were a bit frightened at first when your boyfriend was pressuring you to do something you didn't want to do but when he didn't persist that feeling went away." An inaccurate reflection would be: "So you were annoyed with your boyfriend last night because of what he was trying to get you to do, but you felt all right when he stopped." The client did not say that she was annoyed but that she was scared. Again, practice should be continued in the group for some time until the skill has become adequately clear to everyone.

Reasons for Reflecting Back to Client (C6) Once both skills are clear the facilitator should review the rationale for reflections. Reflections are valuable active listening skills in that they:

1. Show that the counsellor has been listening
2. Oblige the counsellor to listen
3. Enable the client to correct the counsellor if the counsellor has misunderstood
4. Encourage the client to continue talking because when the counsellor reflects what the client has expressed it indicates that expressing it was acceptable
5. It leaves the choice of the topic to the client thus helping them to understand their role in the counselling session and to achieve greater self-exploration

These consequences will become more apparent during the *triad practice* and as the workshop progresses.

Summarizing (C5) Akin to reflection, but covering more of what has been said by the client, summarizing is a useful skill for the same reasons as reflecting. However, it is also a useful way to close a topic, and change the subject in the least disruptive way. Summarizing will include both reflections of fact and of feeling. By definition, it avoids repetition, and is more concise than the client's statement. However, it must include the important points expressed, especially those that have been emphasized by the client. Thus, it may help to give a clearer expression of the client's experience, without moving beyond it into an interpretation.

Group practice

Group practice should again be employed to strengthen the skill of summarizing. A video play-back of a role play during the workshop, in which a “client” tells the “counsellor” about an experience, can provide the raw material for making summaries. Alternatively, a transparency which incorporates comments made by a client during a session can be shown. It is usually in the form of a brief story and is most effective if it is drawn from one of the role plays already performed in front of the group. It should therefore be prepared in advance of the session. One example of such a “story” is provided in transparency (C7). When the transparency is on the screen one of the participants should be asked to volunteer to read it to the group as if she or he was the adolescent making the statement, taking on the character and age of the client as usual role play. The facilitator may then summarize what has been said to the client trying to cover all the salient points. It is sometimes more instructive to provide a summary which, while essentially accurate, does not truly reflect the spirit of what has been said, thereby provoking comments for participants.

Thus if the example provided (see (C7)) were used in **inaccurate** summary would be the following “So after the dance you went to your boyfriend’s home even though you didn’t know whether you would be alone or not, and you know that your mother would not approve. You allowed him to make sexual advances to you and it was only after you left that you began to worry about the consequences. Then you waited a while before telling your mother.” If this summary is made to the “client” who has read the statement to the group, she is likely to react indignantly and say that is not what she said. Although the facts are essentially correct the tone and implications are pejorative and don’t capture the ambivalence and anxiety of the girl. A more **accurate** summary would be something like the following: “I understand that after the dance you were pleased that your boyfriend asked you to go to his home because you like him very much and thought it would be all right because you expected other people to be there. When you realized you were alone you and he made some sexual advances you first tried to stop him but then let it go on for a while. By the time you left, however, you became more frightened and began to think that you might even be pregnant. After a few days of anxiety you decided to tell your mother what had happened.” This summary is likely to lead to a more favourable spontaneous reaction from the “client” and the group will recognize that the second summary more accurately reflects both the facts, and the client’s emotions. Participants should now be encouraged to attempt overall summaries of the story themselves, to see how the volunteer client responds.

Verbal Following (C5) Until now emphasis has been placed on the importance of allowing the client to guide the subjects as the best way of achieving self-exploration and understanding. This is sometimes called “verbal following” and is an important skill for trainees to practice. It is especially useful in preventing direct questions from the counsellor which almost always change the subjects the client has raised. However, there are certain occasions when it is appropriate to change a subject. If the client has become very repetitive and the counsellor has the sense that he or she is uncomfortable about moving on a change of subject may be

helpful, although the change should be slight and should follow a brief summary. Thus, if a client has been talking about his mother, mentioning his sisters and brothers, but not his father, it might be appropriate to say: "David, you've very open about the fact that there have been some disagreements at home between you and your mother about how much freedom to make decisions you should now have, and you've described the differences about the way you and your older brother and sister are treated, but you haven't yet mentioned your father. I wonder, now, if you might like to talk a bit about him?" Changing the subject by introducing a summary first gives the client an opportunity to correct any misunderstanding and is also positive, since the implication is that the client has done the right thing in saying what he has said thus far. Note also the tentative and "open" question used (see The Art of Asking Questions (C8) in Day Four). It is open since the counsellor does not David currently has a father, or why no reference has been made to him as yet. It may be that the adolescent has some underlying anxiety about his father in the family relationships but has not yet been able to raise the issue. The open question about the father is likely to be relevant to the topic and stays with the main theme of what the adolescent has just been saying. For example, it would **not** be appropriate to change the subject in order to ask how the adolescent has been doing at school, or about his plans for the future, etc.

Allow the group to practice changing the subject by using summaries. Ask for a volunteer to provide a statement which recaptures something said by a client in a previous role play. Members of the group will then try to feed back brief summaries and introduce a change of subject. The facilitator should see to it that the subject remains close to what has been presented.

Triad Practice

Participants are now asked to practise the skills of reflecting and summarizing, especially, in *triad practice*. As on Day 2 they are asked to divide into groups of three, comprised, if possible, of people who have not yet worked together. Each assumes the role of client, counsellor and observer, in turn. As clients, they are asked to choose a problem from the subjects covered in the morning sessions including sexual maturation, sexual behaviour and sexual difficulties, without advance discussion of the role play with the counsellor or observer. On discussion, the counsellors are asked to concentrate on the skills of reflecting fact, reflecting feeling and summarizing, and on introducing a change of subject after summary. The observers will record and categorize the statements of the counsellor and try to observe their effect on the client. The facilitators should sit through one complete role play with as many groups as possible. The video camera may be employed with several of the triads to provide examples for discussion (as long as the sound recording is functioning well). About one hour should be allowed for the *triad practice*, after which participants are asked to return to the semicircle for a *plenary discussion*.

Plenary Session

Begin by asking the group for feedback from the observers about the use of reflecting and summarizing skills. If reflections of fact predominate over reflections

of feeling, discuss with the group the importance of words which express emotion. Ask the “clients” about their reactions to the reflections and summaries. Ask the “counsellors” if they felt they were able to use reflections effectively. Some may complain about the artificiality of the exercise especially if they believe that clients want advice, and may have difficulty simply feeding back what has been said. The more successful counsellors in the *triad practice* however are likely to have discovered the powerful effect reflections can have on the degree to which the client is forthcoming. Video playback may be used here to provide examples. Some discussion should be held on the capacity of the counsellors to change subjects following summaries, and its effect on the client. Once again, in this session, primary emphasis should be placed on the use of skills rather than on the content of the problems presented by “adolescents” in the role plays. Before ending the session ask for any general feedback from the day, briefly review the next day’s programme, and thank the ~~clients~~ participants for their efforts during the day.

DAY 4

Begin by outlining the programme for the day and the methods of work to be used. By Day 4 some changes in the programme may be necessary. For example, extra time may need to be devoted to topics that have not been covered fully, or alternative topics introduced. Day 4 of the “Model Programme” (G1) is outlined below. The topics to be covered will be: A Consequences of Unprotected Sexual Relations; B Difficult Moments in Counselling (1) and Counselling Adolescents with Family; and C The Art of Asking Questions, Focus and Tense. It should be emphasized that the consequences of unprotected sexual relations may include both unwanted pregnancy and STIs, HIV/AIDS. Hence, Day 4 will be devoted to discussing issues related to unwanted pregnancy and its prevention, while the problems of STIs, HIV/AIDS will be scrutinized on Day 5.

A SEXUALITY AND REPRODUCTIVE HEALTH

A CONSEQUENCES OF UNPROTECTED SEXUAL RELATIONS (A11, A12)

This morning’s focus is on some of the untoward consequences which may occur when an adolescent has sexual relations without protection against pregnancy and STI/HIV infection. Because sexual intercourse among adolescents is often unplanned, and both the information and methods required to prevent pregnancy and STI are often inaccessible, adolescents run a high risk of medical and psychosocial health problems. The primary focus of this session should be on the adolescents’ perspective, in particular as to how it affects their behaviour, and how others react to them. Participants will be asked to use role play to elucidate some of the problems of interaction faced by adolescents on these subjects.

Presentation and Discussion

Some Unfortunate Consequences of Unprotected Sexual Relations (A11)

It is best to introduce the topic by first asking the participants for their thoughts about the consequences of unprotected sexual behaviour in adolescence. In this connection, it is useful to start discussing with the participants the differences between protected and unprotected sexual behaviour by touching upon various aspects of relationship in couples, including the feelings of love, mutual respect and care. It seems advisable to cover the subject by presenting contrast situations, i.e. how a couple would feel under favourable conditions (by enjoying the feelings of pleasure, joy and happiness), and, on the contrary, what complexities are associated with inconsiderate acts and chances (disappointment, disease, conflicts). The

participants are asked to divide into 2 groups and to do the following exercise during 2-3 minutes: group 1 would list positive characteristics of sexual relations and group 2 would list the negative ones (provided it is an unprotected sexual intercourse). Then the facilitator will offer the participants to provide summaries of these characteristics by paying attention to the fact that sexual relations should bring about positive emotions, and after making some key points he/she may present an overhead transparency (A 11). This shows the potential consequences of unprotected relations. These include too early and unwanted pregnancy, abortion, forced marriage, and damage of both a physical and psychosocial nature to mother and child. Furthermore, STI may lead to infertility, and HIV infection to AIDS and death.

Prevention of Unwanted Pregnancy (A13, A14) The medical risks of pregnancy amongst adolescents, below the age of 17 are considerable. The younger the adolescent, the greater the risks. They include complications of pregnancy and childbirth, a higher risk of spontaneous abortion, still-birth, premature birth, and babies of low birth weight. In many cultures, the psychological impact will depend on whether the conception took place within marriage, and was planned or, at least, wanted. While these concepts are likely to be familiar to the participants, they may not have thought much about the particular anxieties faced by an adolescent who thinks she might be pregnant, and the sequence of thoughts, feelings and events which follow. It is useful to guide the participants through this sequence.

A helpful first step is to ask the participants to attempt to describe the initial feelings and thoughts experienced by an adolescent when she first suspects that she might be pregnant. A transparency can be used to list the feelings identified by the group in order to strengthen their awareness of emotional responses. List them in a single column headed "girl" or "adolescent"; subsequently, the feelings of the other parties concerned can be listed in additional columns. Emotions attributed to the girl often include shame, guilt, embarrassment, pleasure, curiosity and fear.

How does the adolescent respond to the pregnancy as time goes by? Do her feelings change toward the pregnancy and toward the changes taking place in her body? What sort of emotions does she have? Is she happy or sad, if she trying to deny the possibility of being pregnant?

A second useful question is "What is likely to happen next?" It is important that the group consider the issue in detail. Saying that she will have a pregnancy test or arrange antenatal care is **not** an adequate response to this question. Rather, the next step may be that the girl will confide in her best friend, or perhaps her boyfriend. If she does what is the friend likely to say or do? How will her boyfriend react? Will he deny the possibility and accuse her of having sex with someone else? What will follow? and so on. Each step along the way presents an opportunity for the adolescent, although it usually compounds the problem. It also provides material for the subsequent role plays.

At some point in the likely sequence of steps, the girl's mother will either be told, or question the girl if she suspects something is wrong. This may be followed by mother telling father, and perhaps ultimately mother and daughter going to see a

doctor or someone else for care or possibility for an abortion. The feelings of these individuals can also be listed on the transparency. All of these interactions lend themselves to role play which will enhance the group's understanding of the experience. The transparencies indicated above may be used if some of the points are not covered, but it is generally best to elicit the key issues from the group.

Spontaneous Abortion (Miscarriage) The group should be reminded that adolescent (more often than adult) pregnancy may end in spontaneous abortion; this usually occurs within the first twelve weeks. This will be of little significance to the adolescent if it happens very early on, but if it is preceded by bleeding and severe cramping pains it may be alarming, especially if the adolescent is not aware that she is pregnant. She may be in need of counselling in such circumstances.

Induced Abortion (Pregnancy Termination) (A15) is a very important topic in adolescent reproductive health, since adolescents are less likely to be married than adults and more likely to want abortions. At the same time adolescents have less information about services, procedures and legislation, less knowledge about the health consequences, less experience in dealing with health workers and fewer resources. They often anticipate negative reactions from health professionals and adults in positions of authority such as teachers or their own families. For these reasons they are more likely to wait longer before taking action and are more likely to try to self-abort or to seek clandestine abortions which may put their health and, indeed, their lives at risk.

The participants should be taken through the feelings and sequence of events likely to follow when an adolescent decides to seek an abortion. What does she feel? What does she think? To whom does she turn for help? What is likely to happen when she does? Of course, the circumstances differ from society to society so that the content of the discussion will be directed to a large extent by the situations of the participants in their own countries. The transparency can be used but it is best to encourage the group to develop their own through discussion.

Childbirth/Childrearing Childbirth itself can be very traumatic, particularly in adolescence. The adolescent may be very frightened by the experience. If the baby is born early or is born on time but is very small it may need special care which the adolescent feels unable to provide. Time and patience is needed for the mother to become confident, and supporting her to become so will be essential for the safety of the baby and the mother's health. Some adolescents cope well with a child, especially if they are married and living in a society where an extended family is available to help. However, their own development may be limited. For example, they may have to forego the education, experience and training that would otherwise help them to develop and lead fuller and more productive lives as women. Sometimes this leads to resentment towards the child. Babies born to adolescents are sometimes clandestinely abandoned or even killed by the young mother if she has been able to keep the pregnancy secret from the family. If the child stays with a parent or parents who are immature the child may grow up without the kind of psychological and social support that he or she needs in the first years of life. Because they may be short of money the parents may not be able to provide an adequate diet for the family or afford the medical services they need. Anyhow it

should always be remembered that a childbirth is a heartwarming event in the life of each family. So, if a pregnant adolescent girl (and possibly her family as a whole) makes a decision to “keep” the baby, irrespective of any difficulties in the future the emphasis should be put on positive emotions associated with the forthcoming event. This will help reduce the risk of unfavourable consequences faced by the young mother to-be and her baby.

Adoption Another alternative sometimes considered is to give up the baby after it is born to be raised by someone else, possibly family living elsewhere, or a more formal adoption. Such a step can be extremely traumatic for a mother, and how such decisions are made, and by whom are important issues for discussion

Role Play

Following the discussion, it is useful to ask the group to role play two or three of the situations adolescents face, especially with regard to pregnancy and pregnancy termination. One of the most effective ways to use role play for this purpose is to create a sequence using the same characters (albeit different participants for each role play) in a mini-story. For example, the first role play might be of a girl whose mother confronts her daughter with the suspicion that something is wrong perhaps because her daughter (who thinks she might be pregnant) has been sick in the mornings, or seems especially anxious. Once that is completed the group can be asked what they think would happen next and might agree, e.g., that mother would tell father. This scene can then be role played. In the scene with her daughter mother might be angry (along with other feelings), whereas in the scene with father she might be more protective of her daughter. This might set the stage for a third role play when mother and daughter (and possibly father) go to a doctor, or someone else. As in each session A, the purpose of role play is to elucidate the problems faced, not the solutions. Thus, if a role play includes a doctor (or someone else in a professional capacity) being confronted with a potentially pregnant unmarried adolescent, the role player should try to emulate the most likely **immediate** reaction of such a person in their culture. While the health worker might be quite concerned to help the girl he or she might, nevertheless, have an immediate reaction of shock, or disapproval, or embarrassment. It is important that such feelings be noted since it will be of significance when the participants are role playing counsellors later that day.

A PREVENTION OF UNWANTED PREGNANCY (A13, A14)

The focus of this session is on prevention, and the emphasis should be on the problems associated with preventive approaches. Thus attention will be given to contraception as a means of preventing too early and unwanted pregnancy, but the focus will be on the obstacles to obtaining and using contraceptive techniques (as well as difficulties in promoting abstinence) by adolescents.

Presentation and Discussion

Begin the session with the Figure showing the Outcomes of Unprotected Sexual Activity (A11) and ask the participants to focus first on the issue of

preventing pregnancy by describing the different ways in which that can be achieved. If abstinence from sexual intercourse is not mentioned it should be introduced. Similarly, the group may need to be reminded that sexual activity is far broader than sexual intercourse, and that abstinence does not necessarily mean no contact with the opposite sex. As the participants list methods of contraception they can be put on a transparency for the group to see. These methods may include some which are not appropriate for all adolescents as in Some Methods of Pregnancy Prevention (A16). The next step in the discussion can be to ask the group what they consider to be the requirements for effective contraception (A17). These ought to include issues of accessibility and availability of sound information, services, products and counselling.

The group may then examine each of the methods which have been mentioned to see how well they meet the requirements of effectiveness within their own settings. Below is some discussion of major methods, for the facilitator's use in stimulating discussion, if necessary. As always the preferred approach is for the facilitator to elicit the thinking of the group rather than pressing information or ideas to them, much as we are asking them to do in their roles as counsellors. Below some of the advantages and disadvantages of various contraceptive methods are briefly outlined, but as with STI, the discussion should centre on the perspective of the adolescent and the obstacles likely to be encountered in the use of any method.

Requirements for Effective Contraceptive Services and Methods (A17)

Services:

Availability – A necessary, but insufficient, condition is that the method, product or service be available within the adolescent's society.

Accessibility – For a service or product to be made use of by an adolescent it must be not only available but feasible for use by the young person. The service needs to be advertised in such a way that young people will be aware of it, informed as to how to use it and believe that they will be welcomed as it. The location needs to be one that can be reached on foot or by public transport; any financial costs must be quite small; the hours of opening need to be such that the adolescent doesn't have to leave school or work for a major part of the day; the procedures for getting to see the relevant person, or obtaining the product must be simple enough so that there is a minimum of frustration, embarrassment, and delay; and it should be possible for him or her to use the service without a referral.

Confidentiality – One of the most essential conditions is that a service must not only be confidential but also that adolescents believe it to be confidential. As discussed earlier (Counselling Service Considerations (B7) these are different issues. Young people have no way of knowing whether the people they see at a service will inform others about their problem, request, or visit, unless the service provider informs them directly, through a sign in the room, or by advertising the fact outside the service setting. Many people consider their services to be confidential yet report the names of their clients and type of problem to others within their system.

Methods:

Ease of use – The use of some contraceptive methods require planning in advance of sexual intercourse which is a disadvantage for adolescents who typically have unplanned and sporadic sexual relations. For example, the pill must be used on a regular basis even though sexual intercourse may be irregular, the diaphragm must be inserted in advance of sex, the condom must be purchased in advance and be available at the time of intercourse.

Minimum embarrassment and skill – Methods such as the diaphragm and the condom require the adolescent to touch the genitals which some find embarrassing. A method may also require considerable skill – inserting the diaphragm, timing withdrawal, etc. These are factors which work against their efficient use.

Communication between partners – Ideally, the use of any method should be discussed by the sexual partners and the decision made jointly. In practice, this is exceedingly difficult. Adolescents (like many adults) find talking about sex a difficult matter. For a girl to raise the subject in advance of intercourse suggests she has been planning it, and this remains taboo to some degree in many societies. Some contraceptive methods can be used without the knowledge of the partner – taking the pill, the insertion of an IUD (though not recommended for nulliparous women), vasectomy and tubectomy (again, neither for adolescents). However, while these methods may protect against pregnancy, they do not protect against STI, including HIV infection. For that the condom, abstinence, or sexual relations without intercourse, are required. Communication between partners is important for these reasons, but it remains a typical obstacle to protection in adolescents.

Safety for health and minimal side effects – Not only must the method not have any deleterious effect on the health of the users, but unacceptable secondary effects, for example, on body weight, menstrual bleeding, complexion, sexual anxiety will work against the likely use of the method. The fear of side effects, or the fear of long term effects such as cancer, however inaccurate, will also interfere with the use of methods, so it is important that prevailing myths among adolescents are elicited.

Positive Individual characteristics – Having high self-esteem, clear aspirations for the future, the capacity for planning, and the ability to withstand social pressure, means that the adolescent will be more likely to use effective contraception and protection against STI, while the lack of such qualities works against good practices. At the same time, the ability to make own decisions turns out to be the factor of utmost importance which predetermines a stable behaviour towards using a selected contraceptive method.

Methods of Preventing Unwanted Pregnancy / Methods of Contraception (A16)

The following list is not comprehensive, but includes most of the more commonly used methods.

Abstinence – Avoiding sexual intercourse until the adolescent is able to have a fully responsible and emotionally fulfilling relationship, and not merely capable of achieving orgasm, is an important principle in helping a young person to delay the beginning of sexual intercourse, though not necessarily all forms of physical contact. The young person also needs to know what the consequences of sexual intercourse can be both in biomedical terms, including pregnancy and STI, and the ways in which it might affect their relationships and their future. Furthermore, both adolescent females and males need to know and have access to protective measures if they are to begin to have sexual intercourse.

What are the obstacles to abstinence among adolescents? What pressures exist for each sex to have intercourse? What are the counter-pressures? How is such conflict currently dealt with? What is sexual behaviour considered to be by the young person and what are their views about the morality of such behaviour? What do they think adults want, and what are adults views? The answers to these questions, which the group should discuss, may be widely different from culture to culture, for the two sexes, and for different age groups among adolescents.

Natural Methods – These are methods of contraception which are based on a knowledge of how the female body works in order to judge when the ovulation is and is not possible. These methods are sometimes called **rhythm, periodic abstinence, or fertility awareness**. Using such a method is simplest if the adolescent girl has an established and regular menstrual cycles which is often not the case, especially in early adolescence. More sophisticated techniques can be used such as recording basal body temperature (**BBT Method**) and observing cervical mucus (**Billings Method**), but that is not likely to be feasible for most adolescents. But even if an adolescent is given the knowledge and perhaps tools for determining a “safe” period, it also requires cooperation with a partner which suggests not only good communication but a good relationship. As sexual intercourse in adolescence is often unplanned and sporadic, and even at best natural methods are not highly reliable, it is not likely to be useful for most adolescent, despite the fact that it costs no money and avoids using any contraceptive device.

Withdrawal or Coitus Interruptus - This method requires the male withdraw his penis from the vagina during sexual intercourse before ejaculation occurs. However, sometimes there is leakage of semen before ejaculation. If used properly it may be 75 – 85% effective, but it requires great self control (as well as knowledge) and the willingness of both partners. As male adolescents are often quickly aroused, it is especially difficult for them to use the withdrawal method effectively. On the positive side, however, there is no cost involved, it is always available and perfectly safe, although its practice may lead to anxiety in sexual relations.

Diaphragm or Cap – This is a soft rubber cup with a stiff but flexible rim around the edge which, when correctly inserted into the vagina, covers the entrance to the uterus and combined with the use of a cream blocks sperm movement. It should be used with a **spermicide (contraceptive foam, jelly or cream)** which helps to kill sperm if it gets past the diaphragm. It also provides protection against some STIs and, if used correctly, may be 80 – 90% effective in preventing

pregnancy. However it has a number of drawbacks for adolescents especially in developing countries. The diaphragm has first to be fitted by a health worker which means the adolescent girl must admit to someone that she is engaging in or (planning to) engage in sexual intercourse. She may also need to tell that to her sexual partner and worry what he will think of her. It needs to be inserted before sexual intercourse and kept in for some six hours afterwards. As sexual relations are often unplanned this is a considerable disadvantage. Adolescents may also find the method messy and embarrassing to use. It needs to be kept safely, and cleaned, and that may be especially difficult for an adolescent who wants to keep its use secret from family members. It is not especially costly but it requires access to a health service for it to be used effectively and checked periodically for fit.

Intrauterine Device (IUD or IUCD) – This is a small plastic or metal device inserted into the womb by a trained health worker. Again for an adolescent girl this may be difficult since she needs to know about the method, or feel able to consult a health worker and take risk of a negative reaction to her revelation that she is sexually active. Once inserted it is an effective protection against unplanned pregnancy but it is not recommended for women who have never given birth, which will be the case for most adolescents, especially the younger ones. For some there will also be unpleasant side effects. There is a risk of pelvic inflammatory disease (PID) with serious potential consequences which may affect future fertility.

Oral Contraceptive (“OC” or “The Pill”) – This method of contraception is one of the most widely used and highly effective in preventing unwanted pregnancy if taken regularly, most commonly for 21 days a month. This means commitment and attention to the calendar. It may mean finding a place to hide the pills for some adolescents. In many countries it requires a prescription from a doctor, who must therefore be informed of sexual activity, and it usually requires some expenditure. The pill is often useful in regularizing the menstrual cycle, and providing some protection against PID. Alone, it is not an adequate protection against STI, but because it is effective against pregnancy the need for prophylaxis may too easily be ignored. Therefore, special attention should be paid to the so-called double Dutch method according to which the condom inevitably turns out to be the second line of defence for such protection.

Emergency Contraception – In case of unexpected sexual relations without using contraceptives (“unprotected” sexual intercourse), rape or any contraceptive failure, one may resort to the use of emergency contraception which can minimize the risk of developing unwanted pregnancy. To this end, not later than in 72 hours after the sexual intercourse special hormonal pills should be administered provided mandatory medical advice had been given prior to doing so. Of prime importance is that this method is absolutely unacceptable for regular use.

Moreover, within 5 days after an “unprotected” sexual intercourse an IUD can be inserted but the use of the latter by adolescent girls should comply with the same rules as those applicable to the use of IUDs in the ordinary course of events.

The Condom (Sheath) – A sheath of thin rubber/latex put on before intercourse when the penis is erect. It collects the semen at the time of ejaculation

and prevents it from entering the vagina. It must be removed carefully after intercourse but before the erection is lost to avoid the spillage of semen. This is an efficient, cheap, and reliable method both for preventing pregnancy and at the same time as the sole method of protection against STIs, including HIV/AIDS, if used invariably and properly and so can be an optimal method for the adolescent. However it requires some knowledge, a little skill, some expenditure, a means of obtaining it with a minimum of embarrassment or censure, and some forethought before intercourse takes place. It has no side effects but some feel that its use reduces sexual sensation slightly. If the latter argument is predominant, it is recommended to resort to persuasion by emphasizing that, on the contrary, the condom use is associated with a number of advantages. For instances, one may indicate that a lubricant drop squeezed onto the balanus inside the condom will augment the sensation, while the condom itself will prolong sexual intercourse. Because the girl is vulnerable to pregnancy as well as STI (or HIV infection leading to AIDS) she has more at stake and may be more concerned about the consequences of unprotected sexual intercourse than her partner. It would be a considerable advantage if girls found it feasible to obtain condoms but in most societies that is especially difficult. The vaginal sheath currently being developed may ultimately be of considerable value for this reason.

The condom can be combined with any contraceptive. Condoms can be used with water-based lubricants (lubrication). One must be careful that oil, grease or oily lubricants do not contact with condoms because these substances may compromise its integrity. If medicinal drugs are used intravaginally or applied on the penis, one should initially consult a doctor or a pharmacist. The condoms should not to be stored ever so long, and special attention should be paid to the expiry date on the package. The condoms should be kept in a dry cool place protected against sunlight. All condoms are meant to be disposable.

How to use a condom:

1. A condom should be put on an erect penis only.
2. A condom should be put on before starting sexual intercourse since the sperm can be produced even before ejaculation.
3. Carefully open up the package along the tear-off line and extract the contents. When opening the package up, putting the condom on or using it, avoid any tear of the condom with sharp objects, like fingernails, teeth, rings, jewellery, etc. since a damaged one will be unable to provide proper protection.
4. Prior to putting the condom on, make sure that the foreskin is retracted. While putting the condom on, take hold of the condom tip with your fingers to prevent an air bubble inside. Make sure that the condom tip is empty (to be later filled with semen).
5. Unfold the condom all the way along the shaft of the penis down to its base. The condom should not be pulled but put on the erect penis by holding its tip with your fingers and by gradually unfolding it.
6. Immediately after sexual intercourse, the penis should be slowly extracted from the vagina and the condom put off. Hold the condom in such a way as to prevent the spillage of semen.

7. Do not dispose of a used condom into a water-closet pan since it may lead to sewage choking. Condom disposal should be done so that nobody is exposed to risk of infection.

Spermicides – chemical substances destructive to spermatozoa before the latter enter the uterine cavity. These agents are manufactured in the form of cream, suppositories, tablets or foam aerosol. Spermicides are administered vaginally before starting a sexual intercourse. The mechanism of action of spermicides is pretty simple but, as compared to other modern contraceptives, their efficacy is low (50-70%), and in consequence many people would prefer to use them in combination with barrier methods (for example, with the condom). Spermicides can lower the risk of being infected with STIs due to nonoxinol 9 as one of their ingredients. One dose of spermicide is potent for about an hour. If it is elapsed before the onset of a sexual intercourse one more dose should be administered. Another dose of spermicide is required every time a sexual intercourse is about to happen.

Injectable and Implantable Contraceptives – A variety of new methods are being developed and tested which have the advantage of procedures which, although requiring administration by a trained health worker and thus requiring revelation of sexual activity by the adolescent, require no further action on the part of the adolescent for a period of several months to several years. However they vary in the length of time required for a return of fertility which can cause problems for an adolescent who marries and some have considerable side effects. For the most part they have not been fully tested on the adolescent population.

Vasectomy (Male Sterilization) and Tubectomy (Female Sterilization) – Vasectomy is a permanent method of contraception which prevents the movement of sperm from the testes to the penis so that sperm does not become the part of the semen which is ejected. Similarly, tubectomy, a sometimes reversible method, prevents the egg from travelling through the fallopian tubes to meet the sperm where fertilization would otherwise take place. Neither method is appropriate for adolescents because they are not mature enough to make a decision which is likely to have permanent consequences, and because they may change their minds in the future and be unable to do anything about this.

Role Play

Following the discussion of methods of pregnancy prevention and the particular obstacles which many young people face in practice, ask the group to select one or two situations which exemplify these problems in their own societies. For example, they might wish to role play an adolescent trying to purchase a condom for the first time; a girl trying to ask her boyfriend if he has any way to protect her from getting pregnant; a girl trying to ask her mother, or a boy his father, what he should do if she or he has sex with someone; or an adolescent trying to talk to a teacher about the subject. Again the emphasis should be on depicting the problems of communication and interaction which exist in the most typical fashion.

B PSYCHODYNAMICS OF COUNSELLING

B DIFFICULT MOMENTS IN COUNSELLING (1) (B8)

The main purpose of this session is to help participants deal with particularly difficult moments experienced by counsellors when working with adolescents, by illustrating techniques for dealing with them consistent with both the principles as defined in the Psychodynamics of Counselling (B2, B3, B4) on Day 1, and the practices as described in the Overview of Communication Microskills (C1) also on Day 1. Below is a review of a number of different Difficult Moments for the benefit of the facilitator. It is not expected, however, that more than two or three will be illustrated in a single session. *Modelling* Difficult Moments can also be interspersed through out the week when ten or 15 minutes become available and it is relevant to the topic at hand.

Presentation and Discussion

As noted earlier in the week, participants have been asked to identify moments in counselling which are particularly difficult for the counsellor, rather than the client. In this session (and a similar one the next day) the facilitator(s) will attempt to *model* the best ways in which to handle such moments consistent with the principles and practices advocated in this workshop. Although a sample transparency is available (B8) it is best to compile a list from the participants themselves throughout the week to which some can be added at the beginning of this session.

What follows are some typical “Difficult Moments” raised by participants.

Silence – the client is unwilling or unable to speak for some time. This is a common phenomenon among adolescents who are very anxious or angry, usually because they have been sent against their will. If it happens at the very beginning of a session it is best for the counsellor after a little while gently to call attention to it saying perhaps: “I can see that it is a bit difficult to talk. It’s often that way when someone first comes to see me. I wonder if you’re not feeling a bit anxious?” Or, alternatively, if the silence seems an angry one – (e.g. the adolescent is looking away from you) you might say “You know sometimes when someone comes to see me who doesn’t really want to be here they decide not to say anything. I wonder if that’s how you’re feeling?” These statements should be followed by another period of silence, with the counsellor looking at the adolescent and maintaining body language which indicates a sympathetic interest.

Sometimes silence will occur in the middle of a session. In those circumstances the context is very important, and the counsellor will have to judge why it has occurred. It may be because the adolescent is finding it very hard to make an admission of a secret, or that he or she is unhappy with how the counsellor has

just reacted to something. Generally it is best to wait, as it is crucial that the young person makes the effort to express his or her feelings or thoughts, even though the counsellor may initially find it uncomfortable. There are times when a silence is the result simply of thoughtfulness on the part of the adolescent. There is no need to break the silence nor to indicate in any way that it is not acceptable.

The Client cries – A client who starts to cry or sob may make the counsellor uncomfortable. A natural response is to try to stop it perhaps by comforting the client, but that is usually not best in the counselling session. Crying may occur for different reasons. For some it is a very helpful release of emotion and an appropriate response is to wait for a while, and if it continues say that it is all right to cry, it's a natural reaction when you feel sad. This gives them permission to express their feelings. The crying will usually cease in a little while. Crying, however, sometimes occurs for another reason. It can be used to elicit sympathy or to stop any further exploration. It may be a way in which the client is trying to manipulate the counsellor much in the way she or he will do it at home, or with other adults. Again it is best to let the client cry indicating that although you are sorry they feel sad, it is nevertheless a good thing to express their feelings. If the client is being manipulative it will soon come to an end and the lesson learned that the counsellor cannot be manipulated in the same way that other adults have been.

Some counsellors in some cultures will want to comfort the client by touching him or her. While it may be appropriate, touching a client, especially of the opposite sex, should be treated with extreme caution. There are several reasons for this. Often the difficulties an adolescent is experiencing are sexual in nature and touching a client, even in a relatively non-sexual way, such as on the hand, or on the shoulder, it may be misinterpreted and frighten the adolescent. The decision will be appropriate to the culture as well as to the gender and age of the counsellor and client, but it is important that a professional relationship is established, and not a social one.

The Counsellor Believes there is No Solution to the “Problem” This is an anxiety often expressed by trainees and results in their becoming “stuck”, i.e. not knowing how to proceed. It is important to remember that the primary focus of counselling is on the person, not the problem. Even the most intractable of difficulties, including the recognition by an adolescent that he is homosexually orientated when he doesn't wish to be; a young girl wanting to have an abortion when it is impossible to obtain one; or even a person facing untimely death in the knowledge that she/he has become infected with the HIV virus, do not mean that the counsellor cannot help the client. One of the most appropriate ways to deal with a client who insists on a solution to the problem as he or she defines it, is to say that while you may not be able to change some things, in your experience getting to know the person better is always helpful, and sometimes the perspective on things change. In practice sessions it is not uncommon to see a participant role playing a counsellor quickly make some mistaken assumptions. A girl is anxious about what has happened with her boyfriend. The counsellor quickly jumps to the conclusion that she is pregnant. An adolescent hints at incestuous feelings; the counsellor assumes sexual intercourse has taken place; etc. The more the client is able to

explore him or herself, the more possibilities will exist for dealing with the difficulties including the underlying causes of it.

The Client Threatens Suicide – This is perhaps the most anxiety provoking situation for a counsellor. Most young people who threaten suicide do not commit suicide, but nevertheless desperate enough to cry out for attention in this way. There are some things on needs to remember. It is virtually impossible to stop anyone from committing suicide who wishes to do so. A panic reaction on the part of the counsellor may be more frightened to the adolescent than a more measured one. It is appropriate to say that while no one can stop a person from taking their own life, you would feel terribly sad if that were to happen. You are just getting to know each other and you see much that you like and admire in the adolescent. Those who commit suicide are often hopeless. They feel that they have no relationship with anyone who cares. The lifeline that the counsellor throws to the adolescent is that he or she does care and that may give them sufficient hope to continue.

Some young people threaten suicide in a manipulative fashion to get their own way. They are equally in need of help but must be shown that there are other ways to get the attention and concern they need. An adolescent who was very little self-esteem will not believe that anything but a threat of suicide will matter to others – perhaps it has worked in the past, but it should not work in the same way with the counsellor. A comment indicating positive feelings about the client, not about the threat, is the most valuable approach.

It is not uncommon for such a threat or hint of suicide to occur just at the end of a session (see Initial Interview (B5, B6). The reason for this is that the client feels “safe” enough to raise it because s/he knows the session is about to end and will not have to talk about it at that time. It is best for the counsellor to indicate that what the young person has said is very important, that you are glad he has been willing to share his feelings with you on such an important issue, and that now that it has been raised it should be looked at together when the adolescent comes to the next session. It is then important to confirm the next session with the adolescent. An inappropriate reaction is to panic and say – well you feel that way, don’t go, we had better do something about it right away. Even if you prolong the session at that point, it may communicate panic and not be as helpful as the measured reaction that expresses concern and faith that the adolescent will return.

Because suicide is so tragic in the young, each counsellor will have to make his or her judgement as to the best way to deal with it. The better the rapport with the client, the less likely it is to occur, so that much emphasis needs to be placed from the very outset of the first session on the establishment of that rapport. It is the best protection against suicide in the client.

The Counsellor Makes a Mistake – There are many ways in which the counsellor can make a mistake. He or she may make a factual error about something the client has said earlier. The counsellor may become inappropriately embarrassed or angry at something the client has said. The single most important rule in establishing a good relationship with the client, the kind of relationship that you want him or her to have with other people, is to be honest. Basic respect for the

client is one of the key principles of counselling (see Psychodynamic Principles (B3, B4, B5)). That respect and confidence in the client can be best demonstrated by admitting that you have been mistaken. An apology is appropriate if you were wrong. Factual errors are easiest to deal with. You might say: "I am sorry, I'd forgotten that you told me you had a younger brother." If you do something which you regret – perhaps getting angry at a client who is being provocative, it is also appropriate to acknowledge that. You might say: "You know, a moment ago when you said that you didn't see how I could help anyone your age because I was too old to know how a young person feel, I was very angry for a moment. Perhaps you noticed it. It's natural way to react, but it's not really fair for you. After all why wouldn't you think that. I have a different idea about that since I think that people have the same kinds of feelings at any age, although the things they care about may be different. Would you like to talk about that?" You can be sure that any emotional reaction you express unwittingly or otherwise, will be perceived by the client in some manner even without being fully aware. The more openly you can deal with your feelings when it is appropriate (without making personal revelations about your life outside the session) the better example you will be providing to the client to do the same thing. The counsellor's mistake can be turned to the good of the client.

The Counsellor Does Not Know the Answer to a Factual Question – This is a common anxiety expressed by counsellors, but, as with the above circumstance, it is perfectly appropriate to say that you don't know the answer but will try to get the information for the client if it is appropriate for you to do so, or alternatively identify another source of that information for the client. Evading the question or answering without adequate knowledge will do far more harm to the all-important relationship you are establishing with your client than simply admitting your lack of knowledge.

The Client Refuses Help – Gently probe as to the reason. In discussing the Initial Interview (B5, B6) it was noted that one of the most important first tasks is to establish why the young person has come. Many adolescents are sent for help when they may not want help. Helping the young person say why they are there will usually open the subject up. It is then appropriate to say something like: "Well, I can understand how you feel. I'm not sure whether I can help, but perhaps we could take a few minutes just to see what you think, and together we can decide whether it might be worthwhile talking a bit more." Often the client will say that something like "My father thinks I have a problem with this boy at school, but I really don't. He just won't listen when I tell him." The adolescent may be quite right, but she may instead be experiencing difficulties in her relationship with her father, and the skilled counsellor may be able to help her remain in counselling to deal with that. If the adolescent is completely unwilling to talk, stress the positive, that at least he did come, you've met each other now, and maybe he might like to reconsider. Suggest another appointment and try, if possible to leave it open. The adolescent then has a "lifeline" and may indeed return.

Modelling

The facilitators should practise in advance of the workshop, if they feel it would be helpful to prepare themselves for *modelling* difficult moments such as the

ones above. For this session, and the similar one on the next day the facilitators should begin with a review of the transparency on which the difficult moments have been recorded. Then one of the facilitators will volunteer to role play a counsellor faced with one of those “Difficult Moments”. He should then leave the room while the other facilitator decides with the group which one they would first like to see. The facilitator is then called back into the room and begins a role play with a volunteer “client” who will present the Counsellor with a “Difficult Moment”. The counsellor does his or her best to help the client and may be able to demonstrate a useful way of doing so. The usual rules of role play apply, with the second facilitator debriefing the role players at the end of the role play before turning to the group. For training purposes it may be useful for the facilitator who has role played the counsellor, to wait until the group has responded before commenting. It is important that the group be encouraged to be candid in their comments on the facilitator. It is best for the facilitator, of course, to be candid in judging his or her own performance pointing to both what was helpful and what mistakes may have been made.

B COUNSELLING ADOLESCENTS WITH FAMILY (B10, B11, B12)

Many young people who appear for counselling are in fact sent by their families, and it is not uncommon for them to be seen, at least initially, with one or more members of the family. While the same basic principles apply to family counselling as to individual counselling, some special considerations are necessary because of the complexity of the situation. These include attention to differences in responsibility and authority which reside in different members of the family and the need to help not only the individual, but the family as an effective unit.

Presentation and Discussion

Ask participants whether in their work they currently deal with the families of adolescents or plan to in the future. Review the major reasons which bring families in for help and ask participants how they manage the situation. For example do they generally see all family members together or separately? Do they continue to see the family together after the first session? Following this discussion present the three transparencies which illustrate some principles, following which a discussion may be held on the relevance of these points for their work, and how it can best be adapted to their conditions. Below is an elaboration of some of these points. These should not substitute for the group discussion, but rather be used by the facilitator during the discussion if necessary.

The Decision – As with an individual it is important to ascertain first who made the decision to come, how was it made, and why. It may be that it was done without consulting the adolescent or against the adolescent’s wishes. Or that may be true of another crucial member of the family who may or may not be present.

Counsellor’s Role – It is especially important to emphasize at the outset that the chief task of the counsellor is to clarify the situation and help the family reach their own decisions. It may be noted that it is very common for families not to listen so carefully to each other since they know each other so well, yet things change, and those changes are not always clearly perceived. This is also a good moment to

commend the family on coming together for this purpose which itself is an important step toward resolving any difficulties.

Family Seating – A very useful indication of relationship in a family is how they choose to seat themselves. Place the chairs in the room in such a way that they can be easily moved and allow the clients to seat themselves. Notice how they have arranged themselves. Important information will be provided about alignments within the family and whether they are positive or negative. For example, mother may pull two chairs close together and motion for her daughter to sit beside her, while her husband takes a chair and perhaps turns it a bit away from them. Father and mother (or other adults) may sit together to face the counsellor while the adolescent takes a chair as far away from every one as possible. The more flexibility the counsellor allows, the more will be learnt from the seating arrangement. The counsellor may wish to point out how they have seated themselves later in the session if it is relevant to the discussion.

Together or Separately – At the first session, it is best if the group waiting to see you come in together. The usual introductions are made and then the Counsellor asks the group how they arrived at their decision. If it appears that the adolescent is unhappy about being there, it is sometimes useful to say “I find it helpful, sometimes, to meet for a few minutes separately with the young person and the adults in a family when they first come just to help clarify the situation since sometimes it is difficult for people to talk together. Would that be all right with you?” If the parents or adults agree, the counsellor will then ask the adolescent to wait outside for a few minutes and escort the young person out to a chair. After a few minutes with the older family members, in which they give you their perspective, guide them courteously outside the room and ask the adolescent to come in. Once the adolescent has spoken his or her mind, ask the adults to come in again. Thank them for expressing the difficulties as they see things, and then summarize (see Summarizing (C5) what each party has said in a neutral fashion. Once the family has been brought together, however, if you are going to continue to see them as a family, **they should not be separated again**. This is important since separating them will suggest that counselling has not enabled them to communicate and that there may be secrets between different members of the family and the counsellor. This can be very harmful to the overall process.

It may be that at the end of this first session, it is felt by all concerned that counselling the whole family together will not be the best procedure. It may be sufficient to see the adolescent alone, or the parents may need help in their own right and the adolescent does not. If the latter is the case it must be stated tactfully, and the agreement of the parents sought to that procedure.

From the Adolescent – If the adolescent is seen separately early in the first session, the most crucial task is to help the adolescent express his or her own view and how he or she sees the problem, if there is one. It is not uncommon for the view of the adolescent to differ considerably from that of the accompanying adults. The adolescent may feel that there is no problem but the fact there is a disagreement about this, is a sufficient reason for having counselling.

Helping the Family Listen to Each Other – One of the most crucial tasks of the counsellor is to help each member of the family listen to every other one. Because of long-standing habits, assumptions are often held which are no longer valid, especially when adolescents are rapidly developing. The counsellor may use the techniques of reflection of fact and feeling and summarizing (C5) very usefully for this purpose since it helps *model* effective listening for each member of the family, it provides an opportunity for correction, and an opportunity to state the feelings of each individual in the least provocative manner.

Observing Changes and Feedback – As with individual counselling, it is important that the counsellor be sensitive to changes in each person which result from something another has said or done in the session. Some remarks, for example, may be hurtful, or arouse anger, or be comforting. Yet those feelings may be expressed simply by body language, and may not be noticed by the person who has made them. It can be very helpful if the counsellor is able to indicate such reactions and give the family a chance to discuss them.

Counsellor Neutrality – Throughout the sessions it is essential that the counsellor does not take sides, bearing in mind that the role is one of clarifying, not deciding. The key to achieve this is to help each member express their views and their feelings, and to help the others perceive them.

Family Roles – Remember that individual members of a family have different roles and responsibilities. The adolescent does not have responsibility for or authority over the adults in the family while they are, to some degree, responsible for the adolescent. As the young person matures the relative balance of responsibility needs to change. In most families major school or work decisions will be made for the adolescent by the parents, although in a well functioning family it will be in consultation with the adolescent and gradually those decisions will be made primarily by the young person. But most day-to-day minor decisions and actions within that framework are taken autonomously by the adolescent. It is important that the counsellor helps the family to readjust to the changes which are more rapid in the adolescent than in the adult. But the counsellor should not usurp the authority within the family.

Adolescent and Fairness – What often appears to be a major disagreement may be not so much about a particular decision, but about the way it was reached. Adolescents are particularly sensitive to being consulted and feel the need to be part of decision-making as a sign of their growing maturity. They will be more willing to go along with a decision if they feel they have been consulted and if the reasons for one they don't like are made clear to them. If they can be brought to feel that it has been fairly arrived at, much of the disagreement may dissolve and a pattern set to defuse future differences of opinion. This will apply not only to differences between the adolescent and parents but to disputes between siblings. It is not uncommon for one of the children in a family to be in a "scapegoat" role taking the blame for the problems which are generated by others.

Father's Role – In many societies the father is expected to be the final authority in the family and responsible for its major decisions. There are many

exceptions to that, and it may be that in a particular family it is not the father, but the mother, or the grandmother, or some other adult, and it will be important to ascertain who is in control in a particular family. Nevertheless the “father” role needs special consideration by the counsellor in order to be effective. It is often true (whatever the reason) that women are more able to express their feelings generally, and more accustomed to expressing them verbally, than men. It is thus usually much more common for the mother to come with an adolescent than for them to come together with the father, or for father and adolescent to come without mother. Thus if the father has come, the counsellor needs to acknowledge the fact, compliment the father on his willingness to help the family by clarifying issues and reassure him that you are not usurping his authority.

Arguments During the Session – Anger is often expressed in family sessions. After all, it is often rancorous and seemingly insoluble disagreements that bring them for help. As with the expression of feelings in an individual counselling session, it is best to let it occur, at least for a little while, rather than attempt to stop it. It will help you to observe the family as it really is, it will help you to provide feedback once it is over as to how each behaves during an argument, and it will show them that you accept the expression of their true feelings during the session. However the argument should not go on indefinitely and once each of the individuals have made their views clear, you may wish to thank them for that but suggest that they might like to hear what you, as an outsider, have noticed.

Bringing the Session to a Close – As with individual counselling, it is important to close the session appropriately. Before ending summarize each person’s point of view as clearly and neutrally as possible, and highlight the achievements made during the session. The first achievement has been their willingness to come together. The second achievement may be the fact that they have all been able to communicate their respective points of view, and that they have been able to listen well to each other. In the course of doing this they may have expressed some understanding, sympathy and positive feelings that are new. That should be especially noted. The achievements may, of course, go beyond that, if some issues have been resolved, and plans made for the future. The fact that some differences remain, however, should neither be ignored nor treated as a failure since changes, to be enduring, need practice and time. As with any session confirm the next meeting unless it is the final session, in which case a review of the plans should take place, and the counsellor should indicate his or her willingness to see the family again should the need arise.

Modelling

Once the discussion is completed, it is useful for the facilitator to model a part of a session with volunteers from the group making up a family using one of the problems raised in earlier sessions.

C MICROSKILLS OF COMMUNICATION

C THE ART OF ASKING QUESTIONS / FOCUS AND TENSE (C8)

A primary aim of counselling is to assist adolescents in the process of maturation by helping them to explore their feelings and thoughts, understand themselves better and make and evaluate their own decisions. Effective listening by the counsellor is central to the skills that assist the adolescent in this process. In the preceding days listening skills, including the attending skills, and the use of encouragers, reflections and summarizing, have been practised. These are less intrusive than asking questions. Questions are the most common form of active listening but the way questions are often used may run counter to what is needed in the counselling setting. In this session the distinction is made between “open” questions which encourage self-exploration, and “closed” questions which discourage it, and practice provided. In addition to exploring question asking, the recognition of the focus of statements and the tense in which they are made will also be discussed.

Presentation and Discussion

Begin the session with a display of the V Model (C2) showing the place of questions in the array of listening skills, asking the group to describe briefly the ones previously covered. Explain that asking questions has a role to play in listening but is more intrusive than attending skills, reflections or summarizing. However questions can be more or less intrusive depending on their nature. The difference between open and closed questions is here defined by the extent of freedom the person responding has in choosing a response. Thus an open question is one which permits a broad range of responses while a closed question usually calls for a single word response such as “yes” or “no” or a number. The open question thus allows the client to exercise some control over the direction of the conversation which is consistent with the best practice, while the closed question narrows it to the counsellor’s choice. There is a third kind of question preceded in English by “why?” which, while apparently open, is often a closed question in disguise, or not a real question but an implicit accusation.

Open Questions – allow for a wide range of response. In English they frequently start with words such as: What? Could? Would? How? For example: “How do you spend your leisure time?” or, “Would you like to tell me more about your family?” The client can then choose how to answer that question from among a wide array of possible responses. Thus, in answer to the first question an adolescent might say: “I have so much schoolwork and I have to help with chores at home so I don’t really have any leisure time!” or “I like sports best, especially football. My friends and I have a game every Saturday. We belong to a League and I help to organize the schedule for our games. It’s really my favourite sport. I’m even thinking about becoming a professional. But since I’ve had this problem with my

father, I'm afraid he won't let me play any more." An open question may elicit a great deal of importance to the adolescent and will help the counsellor to help the client. The open question gives a signal to the client that he or she is free to make choices about what they will discuss, although by posing the questions certain limitations are placed on the client, unlike a "reflection" which simply feeds back what has already been said.

The open question should, however, follow the rules of "verbal following" as previously discussed. In other words, the question should be posed on a subject which is under discussion and has been raised by the client. Thus it would be appropriate to ask the question above about the leisure time if the client has already raised subject by saying something like "I've been having a problem with my father. He wants me to get a job after school but if I do that I won't have enough time to be with my friends." It would **not** be appropriated if the client has just been saying "What I'm really worried about is how my girlfriend will react when I tell her what happened at the party last week."

Closed questions – usually call for a response from a very narrow range of choices and frequently elicit one word answers followed by a silence in which the client will wait for the next question. In English, closed questions often start with words such as: Is? Are? Do? Did? How many? For example: "Did you tell your girlfriend what happened?" or "How many brothers and sisters do you have?" or "Do you go to school?" The answers to the first and third question are likely to be either "yes" or "no", and to the second, simply a number. Closed questions are commonly used in medical settings when the health worker is trying to obtain information to help him or her make a decision about treatment which the health worker will provide. It is perfectly appropriate in that context. However, in the counselling context the first need is for self-exploration which means that the client must exercise the choice of what to express, and ultimately the decision for action is in the client's rather than the counsellor's hands.

Closed questions also contribute to a more authoritarian atmosphere of the kind an adolescent is used to when being questioned by a teacher, a doctor, a nurse, a religious minister, a parent, etc. It leaves the authority and responsibility with the questioner not the responder. As this is more common the adolescent may not be prepared for open, rather than closed questions. Part of the counselling process is to help the individual learn to strengthen capacity for making appropriate decisions in partnership with others. Closed questions can also be dangerously misleading as they may take the client in an inappropriate direction based on mistaken assumptions on the [art of the counsellor.

Questions beginning with "Why" are in a special category. In principle the response to a why question can be chosen from a wide range making it an open question, but in practice it is often a very difficult question to answer and sometimes it is used in an accusatory fashion. For example, "Why didn't you tell your mother what happened at the party?" may be taken by the adolescent to imply that she should have done so. "Why do you keep thinking about this girl all the time?" That may be the question the adolescent is posing and it doesn't help him when the counsellor poses it.

Whichever questions are posed the principle of **verbal following** as discussed on the previous day should be maintained. The question should not be used to change the subject unless a **summary** has first been provided and checked for accuracy with the client. If a question is going to be used to open a new subject, it is important that it be an open question for the reasons described above.

Group Practice

Once the concepts have been explained and discussed participants can practise posing questions in the following manner. The facilitator asks anyone to state a question. The group then indicates whether it was an open or closed question. This can continue until it is clear that all participants have grasped the difference. The facilitator then asks that the participants continue the process but now also try to convert closed question into open ones and vice versa. Closed and open questions are not mirror images of each other but practice in “conversion” from one to another will elucidate the difference.

For example, “Did you tell your girlfriend what happened?” (closed) can be converted into “Have you thought about whether to discuss this with your girlfriend?” (although strictly speaking a closed question, it is much “softer” and more likely to lead to a fuller response than one word). Or, “How do you feel about whether to share this with your girlfriend?” (open). “How do you spend your time?” (open) to “Do you go to the cinema?” (closed). “Would you like to tell me about your family?” (open) to “How many brothers and sisters do you have?” (closed). The group should continue with practice until it is clear that most participants are able to both identify the type of question and convert one from the other. More practice, however, should be devoted to converting closed questions into open ones, since the closed question is both less appropriate in counselling and more commonly used. While this exercise can be done orally with a reasonable sized group, it can also be helpful to use *written group practice* in which each participants writes the correct response and then discusses it with the group.

Presentation and Discussion

Following the group practice with questions, the facilitator presents the skills of identifying and using the focus and tense of statements made by the counsellor.

Focus – In this context the focus of a statement of any kind (reflection, question, or other remark) can be divided into five categories indicated by pronoun:

“You” = Focus on the client

“I” = Focus on the Counsellor

“We” = Focus on Client and Counsellor

“They” = Focus on others

“It” = Focus on the main theme

You – In keeping with the overall aims of counselling, the focus should generally be on the client. “You were saying when you first thought you might be pregnant” (reflection, focus on the client). “I wonder how you are feeling at the moment?” (open question, focus on client despite the fact that the counsellor is included in the statement). “Could you tell me more about yourself?” (open question, focus on the client).

I – Occasionally it is appropriate to focus on the counsellor. For example as described in Difficult Moments (B8) above, when the counsellor makes a mistake it may be appropriate to acknowledge it and apologize “I’m sorry, I’m afraid I’d forgotten that you told me you had an older brother” (neither reflection nor question, but direct response to the client correcting the counsellor). Or, in response to a personal question put to the counsellor “In my experience, I find it best for the I’m trying to help not to talk about myself and so I’ve made it a rule not to do so.”

We – Sometimes it is appropriate to refer to the relationship which exists between counsellor and client. Thus, “I’m glad you came to see me and that we’ve been able to talk together about things that are important to you.” (Particularly useful at the close of a session since it emphasizes the positive and makes reference to the relationship that has been established).

They – The client may have raised many issues about his family, e.g., without mentioning his father. You may wish to say, “Brian, you’ve told me about your mother and brothers. Is there anything more you’d like to say about your family?” (open questions, focus on others, following the subject raised by the client).

It – The client may have been talking about a subject which makes him anxious. The counsellor may then say something about the subject such as “As far as we know, it is quite common for a boy to stroke his penis for sexual release, what we call “masturbation” or “There are a number of places where a young person can go if she wishes to find out whether she has been infected with a sexually transmitted infection.” Generally speaking when the focus is on the overall subject or on people not present, it tends to lose the immediacy of what is happening in the room between client and counsellor and becomes more abstract.

In the practice sessions, the participants should be asked to concentrate more on the client focus, but also to practise the “I” and “we” focus and to de-emphasize practice of focus on “it” and “they” with which they are more likely to be well versed.

Tense – This refers whether the statements made by the counsellor are in the past, present or future tense. It is useful for the participants to identify this since there will be a tendency to talk about the past and future and ignore the more difficult present tense, especially in relation to emotions being experienced during the counselling session. The facilitator can then ask participants to make a few statements which are usually sufficient to illustrate differences of tense. For example: “How are you feeling now?” (present); “How did you react when your boyfriend told you what happened?” (past); “Have you thought about how you will break the news to your mother?” (future).

Choice of tense also influences or reflects the emphasis of the discussion. The past tense is generally used by the client to explore how they came to have a problem. The present tense focuses on what is happening in the session. The future tense is used more when clients are beginning to think ahead as to how they will resolve their difficulties.

Group Practice

Once it is clear how the term “tense” is being used, the facilitator can get the group to practise all the skills discussed in this session. Thus the group is asked to pose questions, say whether they are open or closed, and identify the focus and the tense of the question. For example, “How are you feeling just now?” (open question, focus on the client, present tense). “I understand from what you’ve said Maria, that you’re quite worried about how the other girls feel about you” (reflection of feeling, focus on the client, present tense). “So your boyfriend was eager to get you to go a little further than you had before” (reflection of fact, focus on other, past tense). “Many young people who come to see me find it difficult to talk at first.” (Statement, focus on “it”, past tense implied even though the statement is made in the present tense).

In this *group practice* session the participants can be asked to observe the nature of statements made by the counsellor, including whether the statement was an open or closed question; whether it was a reflection of fact or feeling; what was its focus, what was its tense; and whether verbal following was adhered to or violated. This should then be used by the observers in the *Triad Practice* to follow.

Triad Practice

Again the participants from groups of three, and try to work with someone they have not yet worked with. When role playing clients, the participants are asked to bring to the role play the kinds of sexual or reproductive health problems faced by adolescents which have been raised in earlier discussions. When role playing counsellors, the participants are asked especially to practise the art of using open questions, but to mix it with reflections (especially reflections of feeling which tend to be neglected). The observers are asked to continue to observe the attending skills of the counsellor including body language, gestures and the use of encouragers. If a video is available with adequate sound recording, it is useful in this session to record segments of role plays from a number of different triads. The facilitators should circulate among the triads staying for at least on full role play and feedback in each triad.

One more option of developing these skills can be suggested since as against the above practice, it requires less time. The participants are requested to divide into 3 groups which, in their turn, have to be subdivided into even smaller groups of two (client-counsellor). Group 1 counsellor will have a dialogue by using closed questions, Group 2 counsellor will ask open questions and that of Group 3 will use combined questions (both open and closed ones).

Plenary Session

Ask for the participants' experience first as observers, followed by what they felt as clients and then as counsellors. The video may be used to show scenes in which the counsellor posed questions and asking the group to critique the use of this skill. Again it should be remembered that it is important to comment on the positive aspects of the counsellors efforts and not simply errors made. This is also an important aspect of providing supervision and training which needs to be absorbed by the participants for future use.

As always, before the session close ask for comments about the day as a whole, briefly outline the next day's programme and thank the participants for their efforts and progress made.

DAY 5

As in previous days, begin by outlining the programme for the day, noting any changes which may have been introduced in agreement with the group. Below is an outline of Day 5 as it appears in the “Model Programme” (G1). As this is the last day the workshop evaluation and follow-up action, as well as a closing ceremony are included. The topics of the day are: A Prevention of Pregnancy, STI and AIDS; B Selection and Training Considerations, Evaluation of Counselling, Difficult Moments in Counselling (2) (B9); C Overall Integration of Skills, Post Training Interviews; and G Workshop Evaluation, Follow-up Action, Closing.

A SEXUALITY AND REPRODUCTIVE HEALTH

A CONSEQUENCES OF UNPROTECTED SEXUAL RELATIONS (A11, A12)

A SEXUALLY TRANSMITTED INFECTIONS

Sexually Transmitted Infections (STI) The primary purpose of this discussion is to focus on problems adolescents face in dealing with STIs, rather than on the specific medical issues. These are often problems of communication and interaction. It is useful to remind the group that sexual intercourse in adolescents is often unplanned and sporadic, and may result in STI or in pregnancy. A list of common STIs (A18) may be presented, as a reminder that there are many kinds, followed by a discussion on the various symptoms of an STI, however, **without tying the symptom to a specific disease**. After eliciting symptoms of which the group is aware, the list of symptoms may be presented (A19). The reason for not typing specific symptoms to specific diseases is that unless the counsellor is specially trained to diagnose and treat STI, he or she should not try to guess the nature of the infection. For example, saying that a particular symptom is associated with gonorrhoea, may lead the adolescent to seek out a friend who has been treated for this disease, in order to obtain the same medication, without consulting a trained professional. This may have disastrous consequences. It should also be pointed out that STI can exist without outward signs, especially in females, reducing the likelihood of diagnosis and treatment.

Again it is helpful to ask the participants to identify the feelings of a boy and of a girl each of whom is afraid that they may have contracted an STI. A transparency can be used for this purpose as was done for pregnancy (see Day 4,

Session A). One scenario that usefully stimulates discussion is for the participants to begin with a situation in which an adolescent boy thinks he might have got an STI. This can usefully be dealt with in the same manner as the suspected adolescent pregnancy above. What are his feelings? Who does he speak about it? What does he do next?, etc. This might include a subsequent confirmation that that he has an STI with a request that he tell his girlfriend. How does he react to that? If he does tell his girlfriend how does that happen? What are her feelings? What does she do? Who else will find out? Will family members learn of this? If so how? What will they feel? What will they do? Again, a transparency can be used in which the participants indicate the feelings, in successive columns, of the boy, his friend (if he tells a male friend), the girl, her parents (perhaps) and so on for the key figures.

There are special reasons why STI is particularly hazardous for adolescents in comparison with adults (A20). One of the key issues in the control of STI is the issue of confidentiality (see Day 3, Session B) – to what degree is it practised by health workers? What do young people believe or know about the practice of confidentiality? These problematic issues should be raised during the session with emphasis on the perspective of the adolescent.

HIV/AIDS (*Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome*). Once the STI discussion is completed the facilitator can raise the issue of HIV infection leading to AIDS, if it has not already been introduced by the participants. Frequently, the group will not have mentioned AIDS in the previous discussion and more significantly it may not have appeared in the role play of the boy talking with friends about his suspected STI. If that is the case the point can be made that such topics are often compartmentalized by health workers and by young people. The same applies to the separation of pregnancy from STI and HIV infection. It may be useful to reintroduce the initial figure (A11) showing the chains of problems emanating from unprotected sexual intercourse.

AIDS is different in two major ways from most other STI; there is no known cure for it; and it is believed always to be fatal although the time between HIV infection and the appearance of AIDS related diseases is very uncertain. **HIV**, the virus that causes AIDS, **can be passed** from one person to another **via infected semen, blood and vaginal fluids**. It can be passed from man to man, woman to woman, man to woman and woman to man, **as well as by a mother to the child through pregnancy, childbirth and breastfeeding**. However, there is often a great deal of uncertainty among the adolescents (and many adults) about how HIV infection can be transmitted.

In this connection, it is useful to do an exercise “Measure of Risk” that would enable the participants to have an idea about the degree of risk associated with different contacts. For this purpose, four Whatman paper sheets should be made available in advance and clearly entitled as follows: “High risk”, “Low risk”, “No risk”, “Unable to define the degree of risk”. These sheets should be fixed on the walls of the room in the above sequence, and spaced out so that the participants can easily approach them. There must be enough room under these sheets for sticking post-it notes. The participants will use these notes to put down one of the following types of contacts: *French kiss, *Vaginal contact with the condom, *Swimming in

the swimming pool, *Handshake with HIV-infected person, *Sex between man and wife, *Insect bite, *Visit to a dentist, *Breastfeeding by HIV-infected mother, *Using someone's toothbrush, *Using water-closet seat in the public rest room, *Needlestick injury inflicted by the used injection needle, etc. Post-it notes will be handed out to the participants (who may either work in small groups or compete in two teams). The participants are asked to stick their post-it notes to the wall under the Whatman paper with the given risk category selected by them as the one associated with a specific contact. (Scotch-tape and scissors may be needed for that). The final results are discussed. Prior to presenting the transparencies with listed major modes of HIV transmission (A 21), the participants can be requested to share their information on these topics.

The issues surrounding the diagnosis of HIV infection are complex. There is a blood test which shows whether a person has come in contact with HIV but it is not accurate until three months after infection. Those infected may be unaware that they have contracted the virus and so can pass it on others. Considerable stigma is attached to HIV infection and AIDS by many people perhaps because it is often associated with homosexuality or drug abuse (neither of which is a necessary precondition for becoming infected) both of which are also stigmatized. People with HIV infection or AIDS can suffer from isolation and loneliness because of the fear of being found out or because of other people's reactions to them.

As with STI and pregnancy, it is important that the participants try to anticipate the emotional reaction of adolescents to this subject which (as with adults, but perhaps more so) will be a major determinant of their behaviour. For some, fear may predominate but the consequences, paradoxically, may be denial of the risk. For others so much publicity has been given to the danger of AIDS that it becomes simply background noise and is ignored.

But there are also problems of interaction common to pregnancy prevention, STI and AIDS which is the difficulty of communicating about it between young people who may engage in sex, and between young people and their elders on these subjects.

There may be some discussion around the advantages and disadvantages of testing.

B PREVENTION OF SEXUALLY TRANSMITTED INFECTIONS, INCLUDING HIV

Presentation and Discussion

Many of the same considerations which present obstacles to the prevention of pregnancy by adolescents apply also to STI prevention. There are however a few differences. While a number of different methods of contraception exists, prevention of STI is essentially limited to abstinence from sexual intercourse, an exclusive relationship between two people who are free of disease and the use of the condom. The group may be reminded of what was said about these issues for adolescents in the discussion on prevention of pregnancy. Most STIs are treatable and curable if

they are caught early. However adolescents are usually the group that present latest for treatment. Generally the information they have is clouded with rumour and is inaccurate. Girls, especially, may feel anxious or guilty about having had a sexual relationship and these feelings of guilt increase if they are frightened about having caught an STI and afraid of the reactions of parents and health workers. They worry about who they should tell first, or whether to tell anyone, so that they delay seeking help.

The first course of action of many adolescents is to try self-medication by buying disinfectants or pain killers from a chemist or borrowing medication from friends. Disinfectants and pain killers from a chemist will often mask the symptoms of the disease without curing it. If they buy antibiotics these may well take symptoms away but they may not be strong enough or of the correct type to cure the disease. During the time of self-medication the adolescent is especially vulnerable. They may spread the disease, thinking that they have cured themselves, by having sex with another person. They may remain infected and suffer the consequences. STI are often without symptoms in the female so that the disease may not be infected and untreated, leading ultimately to sterility as it spreads to the reproductive system. As she is unaware of an infection she may pass on the disease to another person. STI in a woman can be transmitted to the foetus in her womb and can result in mental impairment, blindness or death of the baby. Clearly, accurate information and the reduction of unrealistic fears are essential in the prevention of STI and HIV infection, but there are obstacles to achieving this.

Obstacles to the Prevention of STI/HIV (A22)

When discussing this topic, it seems important to enable each participant to assume his or her attitude to the issues of sexuality, STIs and HIV-infection, and to emphasize the need for showing respect to the opinions of other group members, just as the counsellor will respect for the client's opinion. To this end, it is advisable to do *an exercise "Four Corners"*. Four signs which read "Agree", "Don't agree", "Don't know/not sure", "Own opinion" should be attached to the walls of the room. Before starting to do the exercise, it is vital to discuss its goal/objectives, and to point out that such things, like "correct" and "incorrect" opinions, should not exist at all. The facilitator will read the statements given below, whereupon the participants will approach the sign bearing their viewpoint. Representatives of each group are requested to substantiate their attitudes. The participants are then offered to join another group if their opinions have been reconsidered. The purpose of this discussion is to try to understand those attitudes which differ from the counsellors' viewpoints, as well as to think over the ways these differences may influence the efficiency of counselling.

Possible statements could be as follows:

- Sex without sexual intercourse is not a true sex.
- Having just one sexual partner will prevent STIs and HIV-infection.
- It is essential that drug users are given clean needles and syringes free of charge.
- Homosexuals may change their sexual orientation, if they want to.
- HIV-infected women are counterindicated to have children.

- Condoms should be accessible to ALL people, irrespective of their age.
- The problem of AIDS is magnified by the reporters, but in fact it is restricted to a small and not the best part of the society.
- It is acceptable to maintain concurrent sexual relations with several sexual partners.
- I hate the idea of having an HIV-infected child in the same class with my child.

Attitude to STI – The attitude toward the presence of an STI in males and females may be different both among adolescents and adults. In some communities having an STI may even be regarded as a mark of pride among boys, indicating sexual experience. If the adult attitude is pejorative, particularly toward girls, however, this will deter young people from seeking help and so act as a major obstacle to diagnosis and treatment.

Symptoms of STI/HIV – As noted, an STI in the female is more likely to be without obvious symptoms than amongst boys. This prevents diagnosis and treatment unless the young woman becomes informed about this. HIV will be asymptomatic in both.

Diagnosis and Treatment of STI – Most STIs can be treated once diagnosed. However an adolescent may be anxious to avoid admitting that they have had sexual relations. The adolescent may be concerned about the negative attitude of the health worker, a possible lack of confidentiality, and an attempt to inform the sexual partner(s) of the adolescent. They may also be concerned that they may have broken the civil or religious laws of the land. These anxieties may or may not be justified, but unless they are dealt with they will serve as a deterrent to accurate diagnosis and ultimate treatment. If adolescents don't go for professional help, they are more likely to self-diagnose and treat themselves with considerable hazard to their health and those of their sexual partners.

Diagnosis and Treatment of HIV/AIDS (Acquired Immune Deficiency Syndrome) – Unlike most STI, HIV infection or AIDS cannot be treated and is believed to be ultimately fatal for all who are infected although the time from HIV infection and AIDS disease is uncertain. Thus the diagnosis of HIV infection does not lead to treatment and cure. It is likely to be profoundly disturbing to an adolescent to learn that he or she is HIV positive, since it may be perceived as a “sentence of death” and discourage them from all sexual activity, marriage and child bearing. Those who are married may have good reason for wanting to be tested, although the blood test can only determine whether one has come in contact with the HIV three months or more prior to the test. Knowing that one is infected may help protect others, but the same protective measures need to be taken to protect oneself from becoming infected and may serve as an even greater motivating force. They must prevent their semen and blood in the case of man, or vaginal fluids and blood in the case of woman, from coming into contact with another person. If they are sexually active it calls for the practice of safe sex which can include hugging, stroking and kissing, and the careful use and disposal of a condom every time they have sexual intercourse.

Thus while testing for STI is to be encouraged, whether or not a test for HIV infection is appropriate requires careful thought in each individual case, and readiness for counselling afterwards. There is a need for a better understanding of HIV infection and AIDS not only for the adolescent, but for society as a whole to avoid stigmatizing those infected, avoid the dangers of driving underground such knowledge, and enable people to speak more freely of preventive measures. Stigma breeds secrecy, and secrecy breeds fear and ignorance which are the greatest obstacles to the prevention of HIV/AIDS in adolescence.

Reducing the Hazards of STI/HIV (A23)

The group, having reviewed the obstacles to the prevention of STI and HIV infection among adolescents, should now turn briefly to what can be done to reduce these obstacles and the extent to which they can feasibly be achieved with and for adolescents including:

Provision of Information – to young people and adults about how diseases are contracted, how that can be prevented, how they are diagnosed and how they may be treated and the adolescent helped.

Provision of Counselling/Clinical Services – in an accessible and sympathetic manner.

Consequences of Untreated STI – potential consequences to the adolescent male, female, their sexual partners and children.

Abstinence – the value of delaying sexual intercourse until the young person is ready for a mature and responsible relationship.

Safe Sexual Practices – including sexual interaction without intercourse, the careful use and disposal of a condom, and sexual relations in which both partners are free of disease and have sexual relations with no one else.

At this point, it is worth doing an exercise on proper use of the condom. For this purpose, the participants can be asked to volunteer to demonstrate how a condom should be put on properly by making comments on one's actions. This exercise goes well as a competition between the participants with the observers assessing the adequacy of the task performed and discussing the mistakes made.

Role Play

The group should now choose at least one problematic situation to role play. For example, they may wish to role play a male adolescent who suspects (or knows) that he has an STI. He may be talking to a male friend, his girlfriend, a member of his family, or a nurse. The reactions depicted should be as typical (not necessarily helpful) as possible. A common role play is of a boy who believes that he contracted an STI from a prostitute rather than his girlfriend, but in order to warn her he will have to admit that. It might also be a typical discussion between two adolescent boys about whether or not one of them might have been infected with the "AIDS virus"

and what they should do about it; or a boy and a girl trying to tell a parent that he or she thinks she might have “caught AIDS”; or a young person talking with a friend after a positive diagnosis of HIV infection has been made. The role play will raise the issues related to what is believed about testing and the implications of knowing about one’s disease. Bear in mind that it is important to role play the most typical reactions which are likely to occur in order to strengthen the understanding of the group concerning the obstacles to the prevention of STI and HIV among adolescents in their own communities.

B PSYCHODYNAMICS OF COUNSELLING

B COUNSELLOR CHARACTERISTICS (B13) AND TRAINING (B14, B15, B16, B17)

The selection of counsellors is a crucial task in the management of counselling services. While it is often not possible to recruit new staff it remains important to consider what characteristics are desirable and to do whatever possible to foster those traits

Presentation and Discussion

Counsellor Characteristics (B13)

Begin by asking the participants what qualities they think are important in counsellors. This may relate to their background characteristics, their personal qualities, and the kind of groups which they are expected to serve. Some of these are discussed below, but it is best if the transparency is generated by the participants and listed by a facilitator during the discussion, rather than using a prepared transparency. During the discussion, it is important to note that every counsellor should contribute to the teamwork of specialists who are doing their best to provide integrated services, and as a consequence close attention should be paid to exercising interdisciplinary approach to their training.

Service Factors – In considering the qualities to be sought in counsellors it may be useful to consider first the nature of the service itself. What kind of staff are currently available? Will they be sufficient to meet the service needs? What are the special characteristics of the adolescent population they will be serving? Are they, for example, of both sexes; will younger or older adolescents predominate? What sort of educational level and language(s) skills will they have? Will they be largely urban or rural based? What kind of problems can be anticipated? Might they be problems of early marriage; of sexual promiscuity; or of drug use in combination with sexual behaviour? Will they be largely school-goers or out of school? etc. How many clients are anticipated per day or week and how much time is likely to be available for each client. What are the service objectives? Will it include specialized services in family planning or STI detection? If so, what role will the potential counsellor be expected to play in that part of the service? What will the working conditions be (including pay, setting and working hours)? Will there be a role for unpaid volunteers? If so, they must be prepared to observe the same principles and rules regarding counselling of adolescents as paid staff.

Personal Qualities – If this discussion occurs during the 5th day of the workshop it is likely that participants will cite personal qualities first, and agree that they are the most important characteristics of a counsellor. When this discussion is held earlier in the week, education and training are often cited first. Experience

strongly suggests that personal qualities are, in fact, the most important in effective counselling. The qualities cited often include: commitment to their clients, respect for others regardless of circumstances, responsibility, warmth, intelligence (but not necessarily intellectual achievement), self-awareness, self-understanding and self-acceptance, humour, balance, patience, maturity, friendliness, initiative, open-mindedness, a pleasant manner, capacity to listen well, tolerance, honesty, and empathy. The group should discuss the ways in which such qualities are manifest in the cultures in which they work.

The subject of appearance and dress is often raised. A key principle of counselling is that attention should be focussed on the client, anything which detracts from that, such as extreme dress or a markedly untidy appearance, is to be discouraged. Otherwise, it is important that the counsellor feel comfortable in dress and does not necessarily dress in a special way to please clients.

Background Characteristics – How relevant are the age, gender, ethnicity, language skills, education level, previous training and experience of the potential counsellor to the service he or she is expected to deliver? Generally, counsellors should have achieved a level of education at least equivalent to the majority of their clients, and be appropriately trained for the task, but differences in age, gender and ethnicity can generally be overcome by positive personal qualities. They will need to be able to communicate well (both understand and speak) in the language spoken by the majority of their client, but it may not be possible to be knowledgeable in all client languages especially if the population they serve is highly diverse. When the counsellor needs to use an interpreter great care should be taken to preserve confidentiality and ensure that the person doing the interpreting is acceptable to both client and counsellor. It may be useful for the participants to discuss how this can be achieved if it is a problem they are likely to face. Ask the group to discuss the issue of differences between counsellor and client. How important are they? Should a counsellor attempt to talk using slang that the adolescent uses? Generally it is best for the counsellor to be the same with all people, using language which is clear and understandable, but not trying to be like the client. Just as the counsellor will respect the client, however different the client may be from the counsellor, the reverse should also be (or become) true.

Recruitment – If staff are to be added to a counselling service, even if they are to be drawn from existing employees, attention must be given to how they are to be recruited. Ask the group to consider how people find out about jobs in their communities. How will the task be advertised so that it will be seen by appropriate potential applicants/ would it be useful to use local radio or newspaper for this purpose? Or will it be restricted to a local notice board in which case the applicants are likely to be restricted to those in the local service.

Because the personal qualities of the counsellor are so important, it is essential that a “probationary” period be used before a final decision is made either by the applicant or the employer. For this purpose a period of observation is needed. This may be taken place in a variety of ways (see Training Programmes for Counsellors (B14-B17) including the use of role play, sitting in with an applicant during an interview, observation through a one-way mirror if such device is

available and the client agrees, or co-counselling when the applicant works together with a trained counsellor. In many settings it is very difficult to use a probationary period, but an effort should be made to make it relatively easy for the applicant to understand that continuation will depend on mutual agreement. Not everyone will feel comfortable with the rules of the service or the style of work called for, so it is best for both to allow some time before making a final decision.

The Training of Counsellors (B14, B15, B16, B17)

Closely allied to the issue of recruitment, is that of training. In the workshop a number of training techniques were demonstrated. In this session issues of importance in planning training programmes should be considered from multiple perspectives including: service needs, training logistics, content of training, methods of training, trainee characteristics and needs and the characteristics of the trainers available. Again, as much as possible should be generated by the participants. Below is an elaboration of some of these points for the facilitator to share with participants, as needed.

Presentation and Discussion

Service Factors – For whom is the service intended, i.e. what are the characteristics of the adolescent population which will be seen by the successful trainees? What are the overall objectives of the service? Will it include specialized tasks? What will the working conditions be like? Will pay, hours, location, privacy and comfort be adequate for staff and clients? If there are weakness with respect to any of these conditions, can training help to minimize the anticipated problem? When trainees are accepted will they have to meet any requirements with regard to the background characteristics or personal qualities? (see Recruitment above).

Content of Training – What kind of knowledge will be the trainees need to acquire? Will it include adolescent development, sexual maturation, biomedical issues of health and development? Psychosocial aspects of behaviour? Pathology in young people? Contraceptive methods? Basic knowledge of sexually transmitted infections? Will training explore and help them deal with their own sexuality; their moral codes and values regarding appropriate behaviour; their attitudes toward young people, adults and families, the religious community and other service providers? The trainees will need factual information in order for them to feel confidently informed and ready for the subjects raised by their clients. Clear and up-to-date biomedical, psychosocial and developmental information needs to be provided with discussion by the trainees and the opportunity to ask questions. It must be stressed that they do not need to know everything. They will be able to say when they don't have answers to particular questions, but the training period is a good time to help them identify gaps in their knowledge that they would like to fill. This may well include information about other services, and how to refer. Reading material, films, video and other kinds of recordings can assist the learning process by presenting information in a clear and lively way.

Service Procedures and Principles – This type of service should be invariably characterized as accessible and client-friendly. Therefore, the training

should help the trainees understand and comply with the basic principles of the service such as confidentiality, respect for the client as an individual and putting the client's needs first, how to deal with specific problems such as those elaborated under Difficult Moments in Counselling (B8, B9) and other service policies. The training period should also be used to help the trainee to meet other people who work in the service at all levels including receptionists, guards, clerks all of whom have a role to play in assuring a good service to adolescent clients.

Training in Skills – To what extent will interpersonal communications skills, capacity to work well with young people, and counselling skills of a professional nature be part of the training programme? Trainees need to learn to communicate effectively, especially to listen well. They may also need to overcome personal anxieties about some of the subjects which form part of adolescent counselling in sexuality and reproductive health. This can be achieved best by involving them actively in the process of learning. Role playing both clients and counsellors followed by discussion and feedback can help uncover some of the difficulties counsellors are likely to face.

Training Methods – What techniques will be employed? This workshop has used presentations by lecturers, group discussion, modelling by facilitators, role playing by participants, group practice, the use of video and tape recorders to observe trainees, triad practice and background reading, among others. However many other techniques can be useful including: written exercises; videos of trained counsellors at work (although the identity of the client must be hidden); the substitution of a facilitator for a trainee who has just role played a counsellor to demonstrate a particular technique; the presentation and discussion of a session which took place with a real client; having the trainee sitting in on another counsellor's session; working with another counsellor (co-counselling); and supervision after seeing a client. It is clear that the most effective methods are experimental, i.e. involve the trainees in action such as role playing both counsellor and client and practicing the microskills of communication in group exercises.

Another essential element of effective training is the reaction of trained observers, as well as those role playing clients, to what has been demonstrated. Trainees need to feel involved in their training course. They should be able to discuss possible changes and additions and help determine the content of the course. They should also be asked to evaluate the training immediately after the course as well as some months after beginning work as counsellors. This will help the trainers to modify later training programmes.

Training Logistics – Where can training take place with adequate space and privacy at appropriate times for an adequate period of time? The structure of the training programme will depend largely on the time available, the facilities available to train the counsellors and the timing of the programme. If the trainees are working full-time at another occupation, training sessions may have to be run in the evenings or at weekends. If the sessions are using the facilities of a clinic or school, the time of availability of rooms may be restricted. As with clients, it is best if the location and the timing of sessions can be kept constant and predictable.

The above issues should be addressed by the participants with emphasis placed on the practicalities of applying training to meet the needs and constraints in their own situations.

B DIFFICULT MOMENTS IN COUNSELLING (2) (B9)

This is a continuation of the review of Difficult Moments experienced by counsellors which was begun on Day 4. Again, it is best to use those selected by the participants throughout the week. Selected examples are given below, for the guidance of facilitators. The methodology is derived from the basic Psychodynamic Principles of Counselling (B2, B3, B4) and Communication Microskills for Counselling (C1) presented on Day 1.

Presentation and Discussion

The following are some additional Difficult Moments experienced by the participants of previous workshops. It is best, however, to use the list generated by your participants, before introducing others that have not been mentioned, and asking the group if they are relevant for them.

The Client is Uncomfortable with the Counsellor's Gender – This difficulty may be made explicit if the client says, "I don't think I can talk to a woman (or man) about this" or "I was expecting a woman (or man)". It may not be stated but sensed by the counsellor. If this is the case, it is best for the counsellor to raise the issue by saying something like – "I wonder if you were expecting to see a man (or woman)?" Once the issue is in the open it is appropriate to say something like "Some young people are, at first, more comfortable with someone of the same (or opposite) sex, but in my experience that usually becomes less important once they get to know each other. Why don't we try to continue, and see how we get on?" The client will usually accept that and the problem is likely to vanish if the counsellor is attentive, respects the client and is non-judgemental. The use of encouragers and reflections are particularly helpful since they give the client a sense that what he or she is saying is acceptable. If the client, from the outset is adamant that they wish to see someone of the other sex, and it is possible to arrange that before going any further, it may be necessary to try. But, in fact, it would probably be better for the client to learn to work with a person of the sex which makes him or her uncomfortable. The counsellor should therefore first see if the client can be given sufficient confidence to try.

The Counsellor is Short of Time – As noted in Initial Interview (B5, B6) it is always of benefit to the client to know approximately how much time he or she will have with the counsellor, and it is best if that amount of time remains more or less constant. On occasion, it may happen that the counsellor has less time than usual. It is then extremely important to say so at the outset, provide the reason, if that is feasible, and apologize, indicating that she or he will hope to meet the client again at a specific time. A great deal can be accomplished even in a few minutes as it has been demonstrated to the participants by now in the role plays. It is best to make use of that time rather than send the client away.

The Counsellor Cannot Establish Good Rapport – Sometimes it may be very difficult to establish satisfactory rapport with the client. This is not necessarily a reason for ending counselling or referring to someone else. Rather the counsellor should ask for help from others in reviewing the sessions to understand better where the difficulty may lie. If there is something about the client which the counsellor finds himself rejecting it is essential that it be dealt with, if at all possible. One of the important aspects of training is for the counsellor to learn what may make him or her uncomfortable and try to deal with those issues before beginning counselling, or, at least, seek help while working with someone with whom it is difficult to establish rapport.

If, after discussing it with an experienced counsellor, the difficulty appears to be that the client has never been able to have a close relationship with anyone, sending the client away or to someone else will not help, but is likely to damage the client. It is far better to try to communicate especially by helping the client to feel better about himself.

The Counsellor and Client Know each other Socially – It is quite common in small communities that an adolescent client will know who the counsellor is and may know him or her quite well. If the relationship is a casual one, it may be possible to serve as a counsellor, but it must be made clear early on that confidentiality will be totally respected, and that the way you will relate to your client is quite different from the way you would relate to a friend or acquaintance. If, however, you are well known to each other, it is not possible to serve as a counsellor. It will be necessary to explain that to the client and arrange for someone else to help. The counsellor must indicate that in his/her experience it is not helpful to work with someone he or she knows socially because it is a different kind of relationship. While a friend might want to be comforting or one might get angry or be embarrassed by something he doesn't like, the role of a counsellor is a different one. It isn't possible to change roles when meeting outside the counselling session, and this will inevitably give rise to confusion and hurts feelings.

The Client Talks Continuously and Inappropriately – This is the opposite of a client being unduly silent or refusing to talk, but it may arise from the same kind of anxiety which makes talking difficult. If a client persists in talking continuously and saying things that are essentially trivial (to the client) and repetitive, it is appropriate to interrupt after some time, and say e.g., "Excuse me Mary, but I wonder if you realize that for some time now you have been repeating the same thing? Are you feeling a bit nervous or finding it hard to talk about other things?" This may help to alter the focus of the conversation from something outside the session to the client herself which may be sufficient to halt the flow of inappropriate talk.

The Client Asks a Personal Question of the Counsellor – A counsellor/client relationship is a professional one, not a social one. That is a valuable aspect, because it enables the counsellor to react in different ways from the other people in the young person's life, and can help them to learn more constructive and rewarding ways of relating to people. This may be difficult for the client to understand at first, especially if the counsellor is being warm and caring at the same

time. One hazard to this relationship is responding to personal questions from the client about oneself. This is almost never advisable for several reasons. It takes attention from the client. It may lead to a series of questions which while starting innocuously may end with very private matters which the counsellor then refuses to answer. This gives the wrong message to the client suggesting that something is wrong either with the counsellor, or with the client for being concerned about such things. Sometimes the client will want to know if the counsellor has the same problem. Saying “yes” may make the client feel that the counsellor cannot help because she or he has not “solved the problem”; saying ‘no’ may make the client feel the counsellor does not understand the problem. It is far better to respond to a personal question by saying that it is not helpful to the client if the counsellor talks about herself and that is why he or she makes it a rule not to. The client will accept that rule. It is far better than either answering some but not all questions, or, worse, evading the issue which will destroy the honesty of the relationship.

The Counsellor is Embarrassed by the Subject Matter – It may happen that something the client says embarrasses the counsellor. The more training he or she has had in sensitive subjects, the better he or she will be able to identify areas in which they feel most vulnerable and the less likely they are to be unprepared. Nevertheless they may be embarrassed. It is always best for the counsellor to be honest with the client especially if they have responded emotionally since the client will anyway be aware of it. This can be turned into advantage, by acknowledging having had such a feeling and then returning to the subject if the client has raised it. The counsellor may wish to say something like: “You may have noticed that when you mentioned the fact that you were masturbating, for a moment I was taken aback. That sometimes happens when people aren’t expecting something but in fact, I’m glad you brought it up and maybe it would be useful to talk about that.” After the session it may be helpful to talk with whoever is providing supervision about what happened, and see if such uncomfortable feelings can be overcome.

Modelling

As in the previous session, it is best for one of the facilitators to leave the room while the group chooses a Difficult Moment which they would like to see demonstrated. After a volunteer offers to role play the client, the facilitator is called back and the role play begins without the facilitator being told which Difficult Moment is being demonstrated. The counsellor then does his best to deal with the client for 3 to 5 minutes. The other facilitator debriefs the role players, turns to the group for their reaction and comes back to the two role players for final comments before they de-role. By now the group should be able to discuss the principles applied as well as the techniques used, and their effects. An alternative procedure, which may be feasible at this point in the week, is to ask one of the participants to serve as the facilitator who debriefs the role players and runs the discussion. This is good practice and will enable the group to comment on the volunteer facilitator as well at the end of the discussion. At least two Difficult Moments should be *modelled* in this session, time permitting.

B TERMINATION AND EVALUATION OF COUNSELLING (G15)

Before concluding training the issue of how counselling can be evaluated should be raised. Below is an outline of some of the key questions that need to be addressed.

Presentation and Discussion

The facilitator should ask the group to reflect on when it is appropriate to terminate counselling, how such a decision should be reached and what would determine whether counselling had been successful. Before beginning the discussion it may be useful to refer the participants again to the Psychodynamic Principles of Counselling (B2, B3, B4) and the V Model of Communication Skills for Counselling (C2) with reference to what is expected of the client.

Termination of Counselling

It is clearly best that this be by mutual agreement between counsellor and client. Counselling should not end abruptly, it's more helpful if it is discussed in advance. Some counsellors find it useful to agree on the number of sessions at the outset of counselling and might say during the 5th session (if the agreement was for 6) "Next week will be our 6th session together. You remember we agreed to stop after six, how do you feel about that now?" If both feel more sessions are needed, the reasons for that should be reviewed.

If an adolescent client terminates counselling by simply not returning, an effort should be made to contact the client without violating confidentiality. The counsellor should indicate that when someone decides to stop counselling, it is usually best to have a session in which that is discussed, not necessarily to continue counselling, but possibly to bring it to an appropriate close. Another appointment should be suggested and the adolescent asked to confirm it.

If a counsellor feels counselling should end, but the client does not, something has gone wrong. It indicates that the client has become overly dependent on the counsellor and efforts should be made to deal with that issue before ending counselling.

Criteria for the Evaluation of Counselling (G15)

Self Exploration and Self Understanding – One of the purposes of counselling is to help the adolescent learn more about him/herself by talking about their feelings, thoughts and experiences with the help of the counsellor. To what extent has that been achieved?

Termination of Counselling – Did the counselling sessions come to an end by mutual agreement of client and counsellor, or was one more eager to end than the other? If so, what was the reason for that?

Action by Client – Did the adolescent make some changes in his/her behaviour or circumstances as a result of a better understanding of self and

relationship with other key people? Does that action seem appropriate and constructive? Is it likely to lead to other steps which will be helpful to the young person? Was the decision to take action reached by the adolescent in a more mature way than would have been done before counselling?

Changes in Relationships – Does the adolescent see him/herself somewhat differently now? Have there been changes in relationships with other people? Are those changes likely to endure? Has the way in which the client relates to the counsellor become more mature?

Client Satisfaction – Is the client satisfied with the outcome of counselling? Has the issue which brought the young person for help been resolved in a satisfactory way?

Satisfaction of Referrer – If the client wasn't self-referred, to what extent are those who referred him/her satisfied with the outcome?

Future State – Is it likely that the client will be able to avoid such difficulties in the future, or deal with them in a healthy way should the need arise? Has the client left with positive feelings toward the counsellor making contact likely in the future if it is needed?

Participants may have other ideas to discuss. It may be noted that solving the "problem" which precipitated counselling, has been somewhat de-emphasized. While the problem needs to be dealt with in some constructive way, it is often the case that underlying difficulties of self-esteem or of relationships generally, have led to the problem. The more important issue may be to help the adolescent to mature and in so doing avoid future problems or deal better with those that arise. The emphasis throughout this training workshop has been on the person rather than the problem, and evaluation should take that into account.

C MICROSKILLS OF COMMUNICATION

C INTEGRATION OF SKILLS

The final session on communication skills will include a review of all the skills and some *modelling* of how they are used in an integrated fashion.

Presentation and Discussion

Begin with a display of the V Model of Communication Skills (C2) and ask for participants to give a brief description of each of the listening skills, and the issues of focus and tense. Remind the group that “less is more” in the sense that the least obtrusive measures – body language and encouragers, can be more powerful in enabling the young person to speak and in so doing learn about themselves, than more intrusive actions by the counsellor such as asking questions. Remind them of the value of reflections and summarizing, the importance of generally not changing the subject, and the harm that can result from the use of closed questions. The participants should be asked about each of the skills, how they feel about their ability to use them, and what they found to be effective during their practice sessions, and given the opportunity to ask any remaining questions about them.

C POST-TRAINING INTERVIEW (*Triad Practice*)

Participants should now be ready for their final triad practice session. For this purpose they will be asked to use all that they have learned during the week and do the best they can to help their clients when they role play the counsellor. As far as possible, the triads should be identical to the one in which each participant did their Pre-Training Interview. The observers are now asked to take careful notes. As usual, each participant will in turn play counsellor, client and observer. The role plays should be no more than about 5 minutes, and the situations of the clients should not be discussed in advance, but presented as they would be in a real-life situation. The facilitators should circulate as usual among the triads, sitting through one complete role play and feedback to the extent possible. Upon completion of the session the participants should, as usual, return to the semicircle for the plenary review.

Plenary Session

This plenary session should be devoted first to a review of the Post-Training Interview with a focus on what has been learned and whether any changes have taken place in the style and effectiveness of the counsellor. Begin with the views of each of the participants as observers. Once an observer has commented, it may be appropriate to get reactions from the “client” and “counsellor” on the role play being discussed. There should be an opportunity for each participant to receive feedback on the performance relative to the pre-training interview. Once that is complete

attention should be given to the observation skills, and whether they feel there has been any improvement in them and, if so, how.

G EVALUATION OF WORKSHOP FORM (G16)

NOTE: Before going to lunch, the participants should each be given a copy of the workshop evaluation form (G16) to be completed before leaving the session. They should be asked to be completely frank, and not put their names on the form unless they wish to. The form should be put face down in a stack at the facilitator's table. Once they have been completed the facilitators should read them during the break, tally the findings, and prepare an overhead transparency form which the summary findings can be fed back to the group for discussion.

G EVALUATION OF WORKSHOP (G16)

The previous discussion of the post-training interviews performed by the participants will naturally lead into an evaluation of the workshop by the participants.

Presentation and Discussion

The discussion should begin with a presentation by one of the facilitators of a summary of the findings from the evaluation forms completed by the participants before the lunch break. The presenter should try to address the key questions including: What features were most commonly liked and disliked about the workshop; how well were each of the three main objectives met in the views of the participants; and what was gained for service provision and for the training of others. The “Other Comments” section is often the most illuminating since the participants will highlight the issues they felt most strongly about. However, it should be remembered that individual comments may not represent the majority view. The evaluation form provided is a very simple form calling for qualitative (rather than quantified) answers. Experience suggests that this is probably the most useful method with a relatively small group of participants.

It is also possible, of course, to prepare a much more elaborate evaluation form. This could include separate questions on the content of the three main sections (A, B and C); questions which regard to each the methods used for training; questions about adequate preparation of the participant for the workshop and the materials provided; the adequacy of the facilitators and logistical issues, as well as the extent to which the overall objectives were met. A rating scale can be provided for the responses to these questions. It is generally best to use an even-numbered scale or there may be a tendency to overuse the middle rank. For example, such a scale might be 1 = very much, 2 = somewhat, 3 = a little and 4 = not at all. Despite the apparently greater rigour of such an approach, the nature of the information gleaned from a simpler qualitative response sheet will probably be more useful in that it allows the participants to place emphasis on what they feel is most important rather than responding equally to all aspects of the workshop. This form of eliciting through open questions parallels the style which has been promulgated throughout the workshop, and is recommended for the evaluation.

Once the overall findings have been presented (remember that each of the participants will not otherwise know what the participants thought) the participants should be given the opportunity to express any additional thoughts, elaborate on comments that have been made, suggest changes which might improve future training workshops and discuss ideas for other possibilities for training.

The group will inevitably ask the facilitators what they thought, not only of the workshop, but of the participants themselves. Once the group has had its say, it

is appropriate for the facilitators to express their views. Needless to say, it is important (as it is in counselling, in training and in supervision) to emphasize the positive aspects. At the same time it is useful for the facilitators to say what they feel were strengths and weaknesses of the workshop, and mention areas which they feel may need more work by the participants

G FOLLOW UP TO THE WORKSHOP (G17)

Presentation and Discussion

The evaluation discussion will naturally lead to the question of how are the participants planning to follow up the experience of training in this workshop. This is an extremely important issue if the training is to prove of lasting benefit and relate to the key objectives of the workshop (G2). The facilitator may wish to begin the discussion by mentioning several areas of potential follow up including the following which can be displayed on a transparency:

- Starting or expansion of a counselling service for adolescents
- Introduction or enhancement of training of counsellors for their own or others' service
- Modifications of the supervision of counsellors in their service
- Recruitment of new staff for the service
- Introduction or strengthening of evaluation of existing counselling services
- Research needs to help strengthen their services
- Enhancing information about their services to help young people use it
- Modifying the service to make it more effective
- Helping to advocate counselling services among influential groups
- Meeting resource needs
- Plans for further interaction among the participants and facilitators

One of the most important functions of the counselling skills training workshop is to help participants lay firm plans for future follow-up. The first step is a thorough assessment of their existing services in the light of what they have

learned. The second is a specific plan of action to strengthen or expand what exists including an indication of the kinds of resources needed. As far as possible this should be elaborated during this discussion, with plans made for appropriate follow-up.

Before the discussion ends the facilitators should ensure that the final list of participants and facilitators is available to everyone and each knows how to contact the others. It is a good idea for the facilitators to ask that at some future date, perhaps within 6 months or one year, the participants write to the workshop conveners providing a further assessment of the utility of the training, and stating the extent to which they have been able to implement follow up action.

G CLOSING CEREMONY

It is customary in many societies, and often helpful to the local conveners, to invite one or two figures from, for example, the Ministry of Health or Youth, or a major non-governmental organization to be present at the closing ceremony, and to comment on the workshop. It is also generally much appreciated if Certificates of Participation are prepared with the names of the Organization(s) which convened the workshop, and the signature of the head of that organization and the facilitator(s). They are then awarded individually to each participant to the applause of the group. It should, however, be emphasized that these are certificates of participation only, and do not constitute professional qualification. It is also customary for one of the participants to thank the conveners and the facilitators on behalf of the group, and for the facilitators to return the compliment. The facilitators will certainly have gained from the experience of working with a group interested skills, and it is appropriate that they express their gratitude for that opportunity at the end of the workshop.

OPTIONAL SESSIONS

B PSYCHODYNAMICS OF COUNSELLING

B CO-COUNSELLING (B18, B 19)

Co-counselling refers to joint counselling by two or more counsellors at the same time. It can be particularly useful in family or couple counselling, especially when the two counsellors are of different sexes. With one client, especially an adolescent, it is not recommended as it can be rather overwhelming and inhibit the adolescent from talking. Below are some suggestions for co-counselling if it is to be used.

Presentation and Discussion

First ask the participants whether they currently work with anyone else (or intend to) when counselling adolescents. Discuss those circumstances and clarify whether the role of the two counsellors is meant to be the same, or different. If the roles are different, ask whether it is feasible for both to apply the principles and practices propounded in this training workshop. The facilitator may then present some suggestions under the headings contained in Issues in Co-Counselling (B18, B19) which are elaborated below.

Preparation – It is essential that the counsellors discuss in advance the objectives of the counselling, the particular needs of the clients (if the adolescent has already been seen) and the roles each counsellor will play (if differences are intended). There may be some disagreement between the counsellors on a given issue. It is important, however, that the overall objectives are the same, or it will be damaging to the clients. Differences of style or approach are not necessarily harmful as long as basic principles of respect for the client and good listening practices are adhered to. An amicable relationship between counsellors is essential, or otherwise attention will focus on the relationship between the counsellors, to the detriment of the clients.

During the Session – The counsellors need to be sensitive to each other's feelings and needs during the session as well as to those of the clients, and to notice any differences in the way the clients react to each of them. It may be useful to comment on such differences in they are particularly relevant to problems the adolescent may be having in his or her relationship. For example, if the counsellors are male and female and a female client reacts somewhat differently to the same kind of comment made by the two counsellors, it may be useful to raise the issue by reflecting on it and asking the client if that is an accurate reflection. This can be a valuable way of focusing in the present tense on what is happening during the

session, which often has greater power because of its immediacy than a more abstract discussion about events outside the session.

It is also acceptable for one counsellor to express a difference of opinion with the other if it is done in a courteous, respectful and non-dogmatic manner. Showing how a difference can be dealt with in a good relationship may be helpful to the clients. It also will help to confirm the honesty of the counsellors and their ease with each other. It must be done sensitively, however, and should not be raised during the session if it is likely to confuse or disturb the clients. For example, it might be helpful for Counsellor 1 to say to Counsellor 2: "You know Sam, when you said a moment ago that you thought Peter was angry when his father said he often made that mistake, I wondered if Peter was feeling more hurt than angry, what do you think, Peter?" It would not be appropriate to say: "Sam, I don't think you are treating Peter's father with the respect he deserves." In the first example it may help to clarify Peter's feelings and also help his father learn something about his son without harming the credibility of the second counsellor. In the second example, Counsellor 1 is seriously undermining the relationship between Counsellor 2 and Peter's father, which may damage the counselling process. If Counsellor 1 believes that his partner is not being adequately respectful, however, there are two other kinds of action which would be more appropriate. Counsellor 1 might say to Peter's father "You know, I realize that sometimes when we work with families, a father can feel a bit left out, after all it is your family. I wonder if you might feel that way Mr Shah?" This may help the father to regain respect if he feels threatened, and it also gives a signal to Counsellor 2 that he may overstepped the mark. In addition, since Counsellor 2 feels that a difference has arisen between the two counsellors, it should be brought up in their discussion after the session.

It may also be appropriate to support the other counsellor if he or she comes under attack inappropriately without, however, making it seem that the counsellors are on one side of an argument and the clients on the other. Counsellor 1 might say "You know, Mr Shah, I think perhaps Sam was trying to clarify what had been said, rather than implying that you were at fault." Similarly if Counsellor 2 is experiencing a Difficult Moment, it may be appropriate to help him or her out. If Counsellor 2 suddenly becomes embarrassed at something one of the clients has expressed, it might be helpful for Counsellor 1 to say: "Sometimes, when we hear something unexpectedly we can be a bit taken aback, but I'm very glad you brought that subject up, Peter. Now that it is out in the open I think we will be able to deal with it better."

Counsellors who work well together will soon be able to detect very minor signals when one thinks the other may be on the wrong track. But bearing in mind that the clients will also be sensitive to body language, tone of voice and other such forms of communicating, it may be better to make a comment openly to the co-counsellor rather than giving a covert signal.

Follow up to the Session – It is best if the co-counsellors can discuss the session immediately afterwards. They should consider together the conclusions to be drawn from what was said, especially with regard to the welfare of the clients. But they should also be attentive to any difficulties that occurred during the session, and

any differences which arose between themselves. It is often valuable to review a co-counselled session with an experienced third person, but a good relationship between the co-counsellors will ensure that potential problem will be raised quickly and dealt with amicably. As with counselling, supervision and training, the co-counsellors should not forget to comment on the positive things which their co-counsellor may have achieved during the session. They should then think ahead to the next session and discuss any particular issues which they feel need special attention.

Modelling

Following the discussion it is very helpful for the facilitators to model co-counselling, illustrating difficulties that may arise and ways of dealing with them. The examples provided in the text above can serve as the kind of raw material for modelling. For training purposes it would be best if the illustration could encompass both the model session, and the follow-up discussion between the two counsellors. Sometimes participants learn as much from bad examples as good ones, so the facilitators may wish to illustrate an example of how **not** to work together, ask the group to comment and then provide a better model of co-counselling.

B PSYCHODYNAMICS OF COUNSELLING

B COUNSELLING COUPLES (B20)

Adolescents who come for help will not usually be part of a stable couple relationship so that counselling of couples may be uncommon in many services. However, when it is appropriate, couple counselling can be a very valuable way of helping the maturing process of adolescents. It is often helpful for a couple to be counselled by two counsellors, male and female, working together, but it is by no means essential.

Presentation and Discussion

The facilitator should begin by asking the group for their experience in counselling couples, and whether those have included adolescent partners. It may then be useful to present Some Issues in Counselling Couples (T) whose major points are elaborated below. As always, the discussion should centre on the participants reaction to these suggestions and their relevance to the settings in which they work. Many of the issues in couple counselling are similar to family counselling and cross reference to Issues in Family Counselling (T) may be useful.

Opening – The counsellor should thank both for coming, introduce him or herself, and ask them how they would like to be called. Explore with them how the decision was made to come for counselling and how each person perceives the need for help. It may be that one partner is more reluctant than the other, and if so, it will probably be the male. It is helpful to react to that by saying that it is often difficult for people to discuss their difficulties with outsiders, but coming to see someone together is a step in a right direction.

The “Problem” – The reasons for coming may also be different for the two partners. The counsellor should make it as easy as possible for each to say what they see as the problem for which they are seeking help. For example it may be that the young man feels that the young woman is not sufficiently responsive to him sexually. It may be that the young woman feels that the young man doesn’t care enough about her. While these are apparently different reasons, in fact they are both derived from aspects of their relationship which should become clearer during counselling.

The Counsellor’s Role – As with families it is important that the clients see the counsellor’s primary function as helping to clarify the situation so that they will be in a better position to make appropriate decisions. People who live together often stop listening carefully to each other and conflict sometimes comes from misunderstanding which can be removed by effective counselling.

Together or Separately – There should be no need to separate the couple at the outset in order to ensure that each person is able to speak their mind. It is far better to exert influence in the first session so that each is enabled to listen to the other. Reflecting back what each partner has said is one of the best ways to ensure that this happens. There may be a difference in status between the two, however, especially if the male is older and he is expected to appear to be more dominant. The counsellor must then work tactfully to help the young woman express her point of view. This may not be feasible at the very outset, and forcing someone to speak is not a good idea. But the counsellor must remain aware that one of the pair has not yet been able to be open.

Arguments – Some couples may be able to express their differences openly by having an argument during the session. It is best for the counsellor to let it happen, at least until each has made their main points. As with families, this will help the counsellor see how they deal with each other in the heat of the moment, and help the counsellor feed that back to the clients. What is said during an argument may be more revealing than a less heated discussion. At some point, however, it is appropriate for the counsellor to ask them to stop for a moment to let the counsellor describe what seemed to him or her to be happening between the two clients.

Crying and Silence – As described in *Difficult Moments in Counselling* (B8, B9) both crying and silence serve a purpose, and should not be abruptly stopped by the counsellor. The same techniques suggested for individuals can be applied to couples, but it may well be that the partner will intervene first. The nature of that intervention should be observed. If it is counterproductive it may be useful for the counsellor to comment on it gently as part of the process of helping the two to relate differently. For example, if the male partner gets angry or irritated when the female partner starts to cry it may be typical of their relationship. It may be that the young woman is unable to confront her partner with what she feels, and he becomes increasingly frustrated and helpless when she cries instead. She interprets this as meaning that he doesn't care about her feelings, whereas he thinks she uses tears as a weapon to stop him from getting what he wants. Helping the young couple to express their own feelings by reflecting on how they deal with them may be an important first step in helping them to have a more fulfilling relationship.

Ending a Session – As with family therapy it is important to end session with a neutral summary which captures as accurately as possible the respective viewpoints of the two partners, and emphasizing positive achievements. Perhaps one of the partners has indicated that he now understands better something he hadn't seen before, the other partner says that she realizes that he does care for her more than she thought. These points can be reiterated at the end. The couple should also be praised for having come together for help and asked how they are feeling at the moment. Before they leave arrangements should be made for the next session, unless it is the last one, in which case the counsellor should remind them of his or her willingness to see them in the future should the need arise.

Modelling

It is helpful for participants to see an example of how the facilitator or facilitators work with a couple. Volunteers from the participants should be asked to role play a young couple with a fairly typical difficulty which might arise in relation to sexual or reproductive health issues. The role players will, as always, adopt different identities and ages, and should not discuss the difficulties the couple will bring to the counsellor(s) very much in advance. The role play will take on a life of its own and that is often more illustrative than a highly planned scenario. If both facilitators engage in the role play demonstrating co-counselling with a couple, and the session occurs toward the end of the week's training, it will be useful to ask one of the participants to serve as the "debriefed" of the role play. The facilitator will first ask the role players for their reactions during the scene, then obtain those of the group, finally returning to the role players for any additional comments before they derole. The group may also comment on the effectiveness with which the participant facilitator debriefed the role play, always remembering that any criticism should be balanced with praise for the positive aspects demonstrated.

WHO COUNSELLING SKILLS TRAINING
IN
ADOLESCENT SEXUALITY AND REPRODUCTIVE HEALTH:
A FACILITATOR'S GUIDE

APPENDIX 1

OVERHEAD TRANSPARENCIES
(PHOTOCOPIES)

APPENDIX 1

COUNSELLING SKILLS OVERHEAD TRANSPARENCIES (PHOTOCOPIES)

G **GENERAL**

- G1 Workshop Programme
- G2 Objectives
- G3 Methodology for One Day
- G4 Topics of the Workshop
- G5 Methods of Work
- G6 - Reproductive Health in Adolescence
- G13 (Continued)
- G14 Rules of Role Play
- G15 Termination and Evaluation of Counselling
- G16 Workshop Evaluation
- G17 Potential Follow-up Action

A **SEXUAL AND REPRODUCTIVE HEALTH**

- A1 A List of Topics
- A2 Some Physical Changes in Adolescence
- A3 Some Emotional Changes in Adolescence
- A4 Some Sexual Changes in Adolescence
- A5 Sexuality
- A6 Gender and Sex
- A7 Points for Discussion (Normality)
- A8 Some Sexual Dysfunctions
- Sexual Orientation
- A9 Sexual Variation
- A10 Some examples of Sexual Abuse
- A11 Possible Consequences of Unprotected Sexual Relations (figure)
- A12 Possible Consequences of Unprotected Sexual Relations
- A13 Some Issues in Adolescent Pregnancy
- A14 (Continued)
- A15 Some Anxieties in Relation to Induced Abortion
- A16 Some Methods of Pregnancy Prevention
- A17 Some Requirements for Effective Contraception
- A18 Some Sexually Transmitted Infections
- A19 Some Symptoms of Sexually Transmitted Infections
- A20 Hazards of STI for Young People
- A21 Major Modes of HIV Transmission
- A22 Obstacles to the Prevention of STI/HIV
- A23 Reducing the Hazards of STI/HIV in Adolescents

B ***PSYCHODYNAMICS OF COUNSELLING***

- B1 B List of Topics
- B2 Psychodynamics of Counselling for Behaviour Change in Adolescence
- B3 (continued)
- B4 (continued)
- B5 The Initial Interview
- B6 (continued)
- B7 Counselling Service Considerations
- B8 Difficult Moments in Counselling (1)
- B9 Difficult Moments in Counselling (2)
- B10 Issues in Counselling Adolescents with Family
- B11 (continued)
- B12 (continued)
- B13 Counsellor Characteristics
- B14 Factors to Consider in Planning Training Programmes for Counsellors
- B15 (continued)
- B16 (continued)
- B17 Some Methods for Training of Counselling Skills
- B18 Issues in Co-Counselling
- B19 (continued)
- B20 Issues in Counselling Couples
- B21 (continued)

C ***MICROSKILLS OF COMMUNICATION***

- C1 C List of Topics
- C2 Counselling Paradigm (V Model)
- C3 Attending Skills
- C4 Encouragers
- C5 Reflection of Fact / of Feeling / Summarizing / Verbal Following
- C6 Reasons for Reflecting Back to Client
- C7 Client Story for Reflection Exercise
- C8 Questions / Focus / Tense
- C9 Training of Communication Microskills

INTRODUCTORY NOTE

The primary purpose of the overhead transparencies is to provide backup material to the facilitators. Those in the G and C series should be shown to participants while in the A and B series, **some are best elicited from, rather than shown to**, participants. Below are those recommended for full display, the others to be used at the discretion of the facilitator.

G GENERAL (all to be shown in full)

The series G6 – G12 are overlays, i.e. each succeeding one should be carefully laid upon the previous one so that the cells match. This produces a cumulative effect so that g12 completes the information in all the cells. G13, combines in one, all the information in G6 through G12.

A SEXUALITY AND REPRODUCTIVE HEALTH (only these to be shown in full)

A1 – A List of Topics

A8 – Sexual Dysfunction so that definitions can be provided

A9 – Sexual Variation, to provide some definitions

A11 – Figure showing the chain of consequences which can arise from unprotected sexual relations

A21 – Major modes of HIV transmission for information purposes and discussion

B PSYCHODYNAMICS OF COUNSELLING (only these to be shown in full)

B1 – B List of Topics

B2, B3, B4 – Psychodynamics of Counselling for Behaviour Change in Adolescence, for an overview of the underlying principles espoused in this training

B5, B6 – The Initial Interview, for suggestions as to how such principles can be manifested

B7 – Counselling Service Considerations, for service issues which relate to psychodynamic principles

B10, B11, B12 – Counselling Adolescents with Family, for a general outline of key principles and practices

B17 – Methods for Training of Counselling Skills, to be used as a checklist of techniques for discussion

Optional Sessions:

B18, B19 – Issues in Co-counselling

B20, B21 – Issues in Counselling Couples

C Microskills of Communication (all to be shown in full)

Amongst the others in the A and B series, it is generally best to elicit the views of the group, and supplement missing elements from the transparencies. It is helpful to have a second facilitator list the ideas of the group on a blank transparency during the discussion for all to see, and correct, if they wish. The group will usually be well able to generate appropriate material of their own. It may be useful for the facilitator to make use of the major headings in the transparency B13 is divided into groups headed: Personal Qualities, Background Characteristics, Service Factors and Recruitment Factors. These should all be considered by the group so that if one heading does not arise spontaneously, the facilitator should introduce it as a question. The use of the transparencies is left to the discretion of the

facilitators, but in our experience, apart from those listed above, the less use made of prepackaged materials and the more generated by the group, the more successful the training.