Field Report

Value-based counselling: Reflections on fourteen years of psychosocial support in Afghanistan

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Abstract

The psychosocial and mental health support system in Afghanistan has evolved significantly over the last decades. Inge Missmahl, founder and director of the International Psychosocial Organisation gGmbH traces the history of the sector over the last fourteen years and reflects on working towards the long-term integration of biopsychosocial mental health care in the Afghan Public Health System. Health system integration was accomplished through development and training delivery of a value-based counselling approach. The approach is based on six fundamental principles which consider the sociocultural origins and context of the individual's symptomatology, emphasises personal empowerment over pathologisation and promotes a symmetrical relationship between counsellor and client. Over 300 Afghanis were trained in this approach and qualified as psychosocial counselors and counselled over 10,000 clients in total. The work to date highlights the importance of designing long-term, applied training programmes which include self experience and qualitative supervision in psychosocial support provision.

Keywords: Afghanistan, conflict, cultural values, empowerment, gender, International Psychosocial Organisation, Kabul, online counselling, peer-to-peer approach, psychosocial counselling, psychosocial support, PTSD, supervision, trauma, value-based counselling

Introduction

Almost 14 years ago, in March 2004, I was nearing the end of my first assignment in Kabul. As a German psychoanalyst trained at the C.G. Jung Institute in Zurich on a sabbatical, I had been supporting the health staff at the National Mental Health Hospital in Kabul for 3 months. Little did I know that this stay would mark the beginning of a long journey including the creation of an organisation specialised in psychosocial care as well as a distinctive approach of psychosocial counselling based on the notion of values and individual empowerment. At that time, there were almost no structures for the treatment of psychological problems in Afghanistan (WHO and Ministry of Public Health, Kabul, Afghanistan, 2006). Today, a biopsychosocial treatment is available through the primary healthcare system in almost all 386 comprehensive healthcare clinics in the 34 provinces in Afghanistan. Practicing in these clinics are trained psychosocial counsellors who have participated in a 1-year applied training programme. They collaborate in a team with the medical doctors, all of whom also received a basic training in mental health support.

Today, I sit yet again in the office of our *'International Psychosocial Organisation'* (Ipso) in Kabul, looking out onto the snow-capped mountains enveloping the city and reflecting on 14 years of rewarding work in Afghanistan. The present journal issue shows how far the field of mental health and psychosocial support has come and led me to reflect on my experiences in supporting the development in this sector, starting very small in 2004. It all started by realizing that, firstly, diagnostic classifications of psychotherapy were often not applicable for our clients who presented with symptoms of depression, fear or anxiety and secondly, that Western psychotherapeutic methods were not always applicable to the psychosocial and cultural situation of the local context. Instead, we made the experience that people, seemingly stuck in hopeless situations and experiencing mental health symptoms, could regain their ability to function through well-structured talks, which allowed them to explore and understand their own situation. It also soon became clear that there would be a much greater impact in the prevention and promotion of mental health if we resist the temptation to treat social problems, which are being expressed through mental health symptoms of depression, fear and anxiety as a mental health pathology requiring treatment within the mental health sector. Instead we should understand them first

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and foremost as human responses to ongoing social issues. Clients expressed stressful experiences such as exposure to violence, loss and grief, difficult life transitions, issues of honour, shame and abuse in somatic and mental health symptoms. At the time, there were no well-trained psychotherapists in the country, and even if there had been, patients would not have been able to be compliant and attend as many sessions as needed within a Western treatment model.

In the Kabul hospital, I noticed each day that these socially rooted and conflict-related problems which were expressed through mental health symptoms of depression, anxiety and fear were regarded and interpreted by the medical doctor and other service staff as a personal pathology, as a mental health problem to be treated pharmaceutically. Doctors made a diagnosis based on presenting symptoms and, at that time, according to the Diagnostic and Statistical Manual of Mental Disorders Version IV-TR (American Psychiatric Association, 2000). That meant that a difficult or dysfunctional social situation was transferred to the mental health sector and reduced to an individual pathology. The person who expressed this high level of stress through mental health symptoms was thus victimised twice, first through her/his situation and then by way of diagnosis.

Principles of value-based counselling

Back in Germany, the insights I gained in Kabul stayed with me and motivated me to analyse carefully what I had learned. It seemed crucial to empower, rather than diagnose or pathologise, people suffering from these symptoms in a way that allowed them to be able to influence the social situation which had given rise to the symptom and enable them to reduce or cope better with the psychosocial stressor. Self-effectiveness, based on one's own values, was the key here. Therefore, when client and counsellor together jointly explored the meaning of the symptom in the given sociocultural context, considering the value system on which the client was perceiving the world and acting upon, positive results were obtained. The result was the development of a short-term, one-to-one talk-based psychosocial counselling approach that we call value-based counselling. It is guided by six important principles:

(1) Every person, regardless of their symptoms, is at any time able to act.
(2) Counsellor and client meet in a symmetrical relationship as equals.
(3) Each person has to be understood within his or her own frame of values.
(4) The meaning of symptoms needs to be understood within their given social and cultural context.
(5) The counsellor meets the client with authentic interest, unconditional regard and with an empathetic, non-judgemental attitude.
(6) Restoring self-efficacy, meaning and access to one's own resources are prioritised within the counselling process.

Within this value-based, resource-oriented counselling approach, the counsellor does not make a diagnosis based on symptoms. Instead, together with the client, she/he explores the meaning of the symptom in the given cultural and social context of the client based on the client's own perception. The counsellor is guided by the following questions: What is the person expressing with this symptom? What is the psychosocial stressor which is related to the symptom and what is their relationship to each other? In this process, the counsellor must change her/his perspective to take the perspective of the client and together with the client explore the situation: The client's perception, experience, their values and the values of the others involved in the situation. The aim is to reach a shared understanding of the inner situation of the client.

Within this understanding, the counsellor, together with the client, also explores the most dominant feeling tone present at that moment which is most hindering the client's everyday functioning in the present situation. Among others, these are very often feelings of guilt and shame, feelings of powerlessness and helplessness, fearfulness or low self-esteem. Based on these insights, the main complaint and the solution of the main complaint are defined. Then, steps are explored how the client can reach the solution. This solution usually opens a personal space for the client, however limited it might be, in which the client is able to influence the situation. After this definition of the solution to the main complaint, other psychosocial interventions such as reducing damaging behaviour or interventions helping to cope with loss and grief, reduction of hyper-arousal and skills in resolving conflicts have their place. These interventions are according to the best practises from different schools of psychotherapy. The client then should be able to leave the session with a homework and with the feeling of hope. The counselling is applied as a first intervention for individuals suffering from symptoms of depression, anxiety and traumatic distress, as well as for clients who are showing somatic symptoms which are related to a psychosocial stressor. Severe mental health cases of psychiatric illness, such as psychosis or severe depression, require referral to a psychiatrist.

Psychosocial stressors

The psychosocial stressors currently affecting many Afghans have the effect that the individual feels powerless and victimised. This originates partly in the ongoing war and insecurity, a situation one cannot influence at all. Poverty, insecurity, family conflicts, domestic violence, sexual abuse and exposure to traumatic experiences are all issues that arise day to day in our clinics.

Another important factor impacting the mental wellbeing of community members is the rapid transition from a rather traditional society to a society which is open and has access to global digitalisation, a change of values with a huge difference between rural areas and cities, traditional and modern ways of living. This is further compounded by the presence of the international community and the reflux of returnees from Western contexts. As a result, personal, social and cultural identities are challenged, basic assumptions about traditional

values are shattered and the reliability of social roles within the context of family and community is often disrupted.

It is a challenge to cope with this rapid change of values in a very short time and to find new models of how to live together and to integrate these new influences into the family systems. This can often lead to loyalty or ambivalence conflicts and inter-generational conflicts. The older generation often retreats to the perceived safety of traditional practices, something that has served them for generations. Forced marriages, child marriages and enforcement of strict gender roles are part of these restrictive practises. Therefore, changing gender roles are another topic with a huge potential for inter-personal and intra-personal conflict.

Family conflicts, domestic violence and symptoms of depression are often an indicator for traumatic experiences and post-traumatic stress disorder (PTSD) of one family member. We observed that, based on culture and tradition, the expression of traumatic distress differs according to gender, even if the distress was triggered by the same event. In general, we noted that women more frequently dissociate, retreat, avoid people and places and develop symptoms of depression and fear. Also, self-harming behaviour can be observed. Men, on the other hand, often suffer from hyper-arousal, and emotional numbness. Sometimes those traumatic experiences are not obvious in the narratives of the client, so that we sensitised our counsellors towards recognising these signs. Research by Miller and colleagues (2009) found evidence that although the clinical diagnosis of post-traumatic stress disorder (PTSD) has a good construct validity in the Afghan context, it carried little clinical relevance as a diagnostic construct. Miller *et al.* (2009) observed that the correlation between war-related experiences and depression as well as general distress was higher than the correlation between war-related experiences and PTSD.

In the expression of traumatic distress, we found that hyper-arousal and avoidance are well –hidden underneath the concept of dignity, honour and shame. The fear of losing control over the own situation and feelings by being exposed to memory flash backs and hyper-arousal are disguised in exerting compensatory control within the social space which can be controlled, often the family, which again fits very well into the cultural concept of the responsibility of a man to protect his family and ensure that the woman's honour is not endangered.

Window for Life, HOSA, the Mental Health Department and Ipso

Based on the experiences I had gained with clients in Kabul I spent the remainder of 2004 developing the above detailed counselling approach together with a first curriculum for the development of a training course. Caritas International was willing to support a training of 30 Afghan men and women in this approach and funded their placement in small counselling centres all over Kabul. For this project, I returned to Afghanistan in 2005 and, together with Dr. Fareshta Quedees, created a first Afghan team. We called the project *'Window for Life'*, trained 30 women and men during 1 year and opened 15 counselling centres all over Kabul to support the local population through individual counselling and support groups. After working with the 10,000 clients in individual sessions, we analysed the statistics we had gathered from the ongoing client documentation of our sessions and realised that there were too many issues which were not addressed in sessions. For instance, an evaluation of our client case statistics showed a high percentage of family conflicts as a psychosocial stressor, yet our routine client documentation showed very little reports of domestic violence within families by the counsellors.

It became evident that in their sessions, the counsellors were avoiding topics which they themselves were affected by; social taboos and issues of honour and shame prevented our counsellors to address these issues in their sessions. We responded by revising the training curriculum and increasing the self-experiential training part by 50%, up to 60 group sessions and 10 individual self-experience sessions, to enable the counsellors to first better understand and possibly overcome their own difficulties to then be able address these issues in their counselling, without unconsciously identifying with the inner situation of the client. Regular professional supervision, both individual and in groups, was and remains a cornerstone of our quality assurance and duty of care for the counsellors. Today, each counsellor working for Ipso has a personal supervisor and participates in a weekly group supervision. In the personal supervision, the counsellors' difficulties are discussed, whereas in the group supervision, understanding of different cases and interventions is deepened. Quantitative statistics of new cases, of follow-up cases and the qualitative case documentation also are review enduring supervision. Over many years, we have noted sustained benefits from this structure for our service quality.

From this initial project, two Afghan non-governmental organisations (NGOs) emerged in 2007: One was *'Window for Life'*, which continued the counselling service delivery in the counselling centres; the other was called *'HOSA'*, which took the responsibility of training future counsellors. I supported both NGOs on a technical level and after a second round of training counsellors through HOSA in 2007 and 2008; we conducted a research study (Ayoughi, Missmahl, Weierstall, & Elbert, 2012) to evaluate the effectiveness of our counselling approach. The randomised controlled trial was led by Sarah Ayoughi, PhD, who had joined us in 2008. The study compared treatment as usual, in this case routine medical care, to the delivery of five to eight psychosocial counselling sessions on a group of Afghan men and women in a community setting. A widely used screening instrument for anxiety and depression was used to assess severity of symptoms at baseline. We found that post-treatment, the counselling group showed a significant reduction in symptom severity of depression and

anxiety, compared to the control group. Except for the stressor of poverty, our counselling clients also showed a significant decrease in various psychosocial stressors they had reported pre-counselling, such as family conflict. Encouraged by the positive results of the study, I founded Ipso - which means 'self' in Latin- in 2008. Through Ipso we trained up to today over 453 men and women of all regions and ages as psychosocial counsellors in our 12-month training course with a strong focus on supervised practice and self-experience. From 2008 till early 2010, I served as a technical assistant to the Mental Health Department in the Ministry of Public Health. Dr. Sarah Bernhardt, who was then the responsible person for health at the European Union Delegation in Kabul, believed that *'we have to keep the flag for mental health in Afghanistan flying high'*?. Dr. Alia was the Director of the Afghan Mental Health Department alongside Dr. Azimi, who, as an Afghan psychiatrist had the deepest insight into mental health issues affecting the country before, during and after the reign of the Taliban. In 2009, our counselling approach became obligatory for all counsellors working within the local health system. The National Mental Health Strategy[1] (2009–2014), which we developed in the Mental Health Department, gave priority to the inclusion of a biopsychosocial treatment model for mental health in primary health care. The counsellors trained by Ipso are now placed mostly in the Comprehensive Health Care Clinics within the basic package of Health Care Services of the Afghan Primary Health Care System or are working with other organisations such as HealthNet TPO, the UN or with Ipso. This integration into mainstream health care was invaluable. All this was made possible only through the support and engagement of the Afghan Ministry of Public Health, the European Commission in Kabul, the German Foreign Office and the committed team of Ipso in Afghanistan and Germany who has been working together since 2004.

In 2014, Ipso took the next step and launched a secure, video-based online counselling platform (www.ipso-ecare.com) to provide access to counselling for all Afghans in need of help. This service remains especially important for those who live far away or do not want to risk their anonymity – or even their lives – by going to a health facility to see a counsellor. For those for whom an in-person appointment is considered too much of a social stigma, the online service offers a way to break the isolation of persons in need. Access to the service is facilitated through various internet points, closed rooms with a PC station and access to the website. We established such internet points in eight provinces, hosted by other organisations and projects. Increasingly, we find that clients log into the system with their personal smart phones at their convenience.

Barriers and opportunities

In implementing our particular approach the primary challenge in successfully service delivery, especially within the public health system, was meeting the high need for continuous qualitative and skilled supervision for the practising counsellors. The second challenge is the recruitment and selection of suitable future counsellors. Suitable candidates require a certain level of life experience to be able to cope with all these difficult life stories. They further need to be able to authentically embody the qualities of non-judgemental, unconditional regard, of authentic interest in the other and of empathetic understanding. These qualities are necessary pre-conditions to be able to enter the professional counselling relationship on a symmetrical level.

Throughout all these years, we all were and still are convinced that this non-pathologising counselling approach was and remains meaningful for people who suffer from mental health symptoms due to a dysfunctional social environment or the exposure to a high level of stress in everyday life. The positive results of the counselling – being able to witness how people are regaining access to their personal potential and their resources and are able to influence their lives and ready to take personal and social responsibility – continue to motivate myself and our team until this day to continuously lobby on a health policy level for this approach.

It is the mandate and aim of Ipso to constantly improve the counselling approach and their services through our Psychosocial and Mental Health Centre in Kabul. In doing so, we try to foster local ownership and leadership. All Ipso staff in Afghanistan is local, our country office is led by a female doctor, and at the time of writing, 47% of our staff are women. Today, our counsellors work in the public health system and in different projects[2] for internally displaced people, returnees and all people in need. Moreover, we currently disseminate this value-based counselling approach to other countries, most recently Germany and Ukraine. Since early 2016, we have trained over 80 counsellors from 17 countries who now help their fellow countrymen and – women through our online platform, wherever the clients may be, in Syria, Lebanon or elsewhere.[3]

After my first visit, I would never have thought that this country and its people would become the centre of my commitment for the next decade. I am grateful to the wonderful people I have had the honour to work with, all of whom driven by the same commitment to help those in need. I am forever grateful to the Ipso team in Afghanistan under the lead of Dr. Fareshta Quedees, to our whole team in Afghanistan, to Dr. Sarah Ayoughi in Germany and to the Afghan Mental Health Department under the lead of Dr. Bashir Sawari. Thank you.

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Conflicts of interest

There are no conflicts of interest.

References

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). doi:10.1176/appi.books.9780890423349.

Ayoughi, S., Missmahl, I., Weierstall, R., & Elbert, T. (2012). Provision of mental health services in resource-poor settings: A randomised trial comparing counselling with routine medical treatment in North Afghanistan (Mazar-e-Sharif). *BMC Psychiatry*, *12*(1), 14.

Miller, K. E., Omidian, P., Kulkarni, M., Yaqubi, A., Daudzai, H., & Rasmussen, A. (2009). The validity and clinical utility of post-traumatic stress disorder in Afghanistan. *Transcultural Psychiatry*, *46*(2), 219-237.

WHO and Ministry of Public Health, Kabul, Afghanistan. (2006). *WHO-AIMS report on mental health system in Afghanistan*.

[1]http://www.mhinnovation.net/sites/default/files/downloads/innovation/research/National-Mental-Health-Strategy.pdf.

[2]See https://ipsocontext.org/projects/current-projects/.

[3]See https://ipsocontext.org/wp-content/uploads/2018/03/DOKU_LIBANON_FINAL.pdf.