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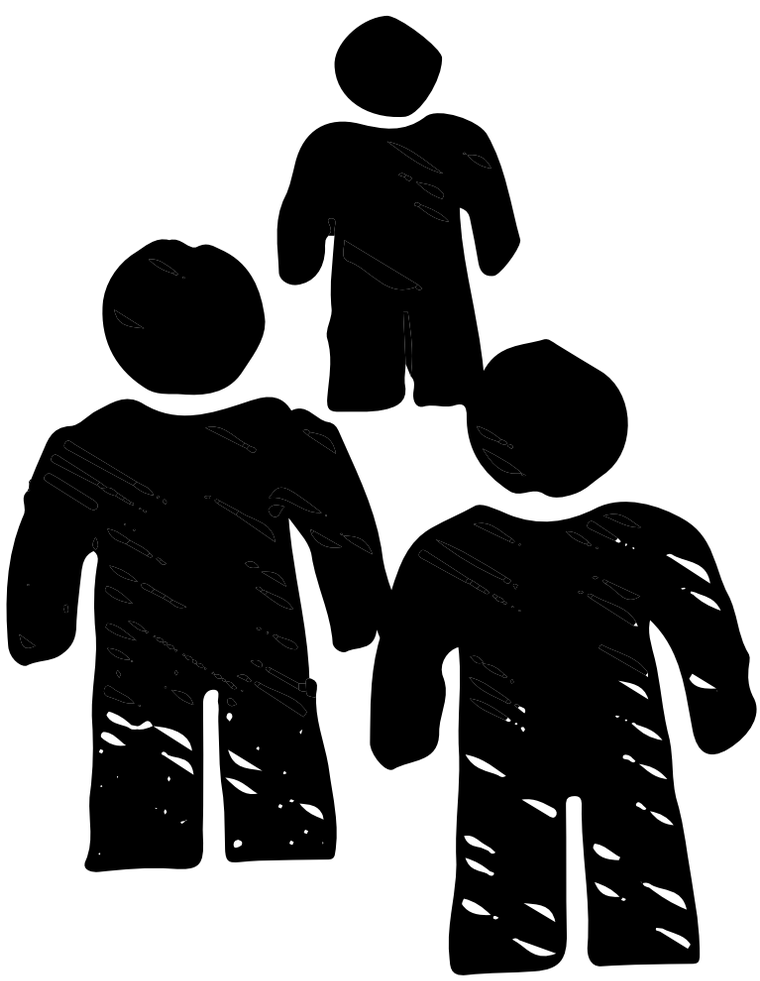
COUNSELLING

GUIDELINES FOR SPECIFIC CONDITIONS

USER MANUAL FOR SCHOOL COUNSELLORS



COUNSELLING GUIDELINES FOR SPECIFIC CONDITIONS

USER MANUAL FOR SCHOOL COUNSELLORS

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CHAPTER 1

SUBSTANCE ABUSE

This chapter is intended to provide you with guidelines for working with children who are suspected or are known to be using alcohol or drugs. As a counsellor, you will be dealing with different degrees of substance use varying from experimentation to dependence. In addition, the children that you see will be at different levels in terms of their motivation to change. This chapter will provide you with information about the risk factors for substance use and helps identify children who may be using substances. It includes some practical steps to follow when dealing with children using substances.

Definition of terms

Alcohol – Beverages that contain ethanol. Examples include rum, vodka, whiskey, liquors and beer.

Drugs – Include explicit and prescription substances such as crack cocaine, codeine, marijuana, tobacco, etc.

Triggers – Factors such as thoughts, feelings, events, places, people, circumstances, etc. that initiate the desire to use alcohol or drugs.

Remission – A period during which alcohol or drug use discontinuation is maintained. During a period of remission, a child will not consume alcohol or drugs. They will be able to manage withdrawal symptoms and cravings. They will be able to manage or avoid triggers.

Relapse – The event of consuming alcohol or drugs after a decision to discontinue use and a period of sobriety. Relapses usually occur when an individual is ill-prepared for or unable to deal with a trigger.

Maintaining factors – Enablers are the agents within a child's environment that promote alcohol use by not restricting access or consumption behaviours. Other maintaining factors include stressors and circumstances that make it necessary for the child to consume drugs or alcohol.

Social support – This is the sense that one belongs to a system where you have access to support and assistance. The resources of support can be in the form of information, material support or emotional support during difficult times or when carrying through on difficult decisions such as smoking cessation.

Withdrawal – The experience of a set of symptoms once abruptly discontinuing the use of alcohol or drugs. This is experienced when the individual is dependent on the substance.

Tolerance – Associated with dependence, tolerance means that the individual requires progressively larger amounts of a substance in order to achieve the same physical effects.

Addiction/ Substance Use Disorder – Difficulty with cessation of substance use. Addiction involves increased tolerance, withdrawal symptoms as well as continued use despite negative consequences of the individual and the people around them.

Protective factors – These are the skills, strengths, resources, coping strategies and support that the individual has access to.

Risk factors for substance use

Children use substances for a number of reasons. Listed below, are the most common risk factors that you as a counsellor should be aware of. Knowing these risk factors will help you to identify vulnerable children. They also provide you with information about potential triggers of relapse once the child has decided to discontinue substance use.

× Unstable home environment and family dynamics
× Parents and caregivers who abuse alcohol
× Being a victim of physical, emotional or sexual abuse
× Association with peers who use substances
× Low self-esteem
× Negative attitude towards and challenges in school and with academic activities
× Mental health problems
× Access to substances
× Poverty

Identifying children who use substances

There are a number of signs that help identify children who use substances. Children are unlikely to be forthcoming about their substance use habits. They may deny using drugs or alcohol because they know that it is illegal and that they may get into trouble. If you can identify the below signs in children that you are working with, you can continue further screening after establishing a relationship of trust with the child.

- Changes in peer groups
- Careless grooming
- Decline in academic performance
- Disciplinary problems
- Problems with the law
- Increased aggression
- Withdrawal
- Theft of money and other valuable items
- Inattention and distractibility in class
- Social withdrawal
- Changes in eating and sleeping patterns
- Absenteeism from school

The transtheoretical model/ stages of change

As a counsellor, it is important that you be able to identify the stage of change that the child is in. The stage of change predicts the child's level of motivation to changing his/her behaviour and so determines which strategies you can use to help the child move in a positive direction. It determines the nature of support needed. It also determines the type of information that you should provide the child with.

Pre-contemplation

During the pre-contemplation stage of behaviour change, the child may not be aware of the negative consequences of substance use. The child is likely to underestimate the advantages of changing his/ her behaviour and may focus on all the negatives related to changing behaviour.

During this stage, your role as a counsellor will be to provide the child with as much information as possible about the consequences of substance use. Remember that the information you provide must be age-appropriate. See Appendix 1 for information sheets that you can share with the child. The same appendix also includes activities that you can use to create a better understanding of the child's substance use for themselves.

Contemplation

During this stage, the child begins to become aware that their current behaviour (substance use), might be problematic. The child may develop the intention to change behaviour in the future. During this stage, there is usually still ambivalence toward change.

When a child is in this stage, education will still be important. The child would need information about how support can help them make important changes, e.g. it may be helpful to know that there is medication available to help them with withdrawal.

Preparation

During this stage, the child is ready to make behavioural changes and begins to take small steps toward doing things differently. The child will at this stage also be convinced that making changes will allow them to live a healthier and happier life. When the child is in this stage, you can assist them by discussing the benefits of change as well as possible substitute positive for current negative behaviours. This may reinforce motivation to make changes. See Appendix 1 for possible activities.

Action

This is the stage during which problematic behaviours have recently been changed. New positive substitute behaviours have been implemented and the child intends to move forward with the changes.

During this stage, it is important to build self-esteem by affirming the child for the changes. Reflect on the positive impacts of the changes on the child's life and the lives of those around the child. At this stage is important to find out what challenges the child faces and determine ways of solving problems and coping with stressors. Coping skills, communication skills and the development of healthy hobbies and leisure activities are essential at the stage during which the child may feel good about himself/ herself. The above is essential in preparation for the maintenance stage. See Appendix 1 for possible activities that you can do with the child.

Maintenance

During this stage behavioural change has been sustained for a while and the child will hold intentions to maintain the changes that have been implemented. During this stage, an important goal is to prevent relapse.

For you as a counsellor, it is essential to educate the child on trigger identification and management at this stage. It is also important to warn the child against overconfidence and to teach the child about the potential for relapse. Remember that if a relapse takes place, the child may regress back to earlier stages of change. Ongoing support will be necessary during the maintenance stage.

Although the stages of change are an imperative consideration when working with children who use substances, they do not always flow in a perfect order and do not go unaffected by other factors. In other words, motivation and insight are not the only factors that determine change when it comes to substance use. A child may be highly motivated to change but may lack the discipline or support to actually break bad habits and maintain sobriety. When working with the child, be aware of the necessary referral to professionals such as Doctors, Social Workers, and Psychologists.

Your role as counsellor

Establish a relationship with the child	Greet the child with a warm, caring and friendly attitude. Avoid judgmental comments and labelling vocabulary. Reassure the child that you are here to listen and show genuine interest while the child talks. Remind the child about confidentiality. Find out whether the child knows why they have been referred to you. Try to find out what the child's current situation looks like and whether the child experience any challenges. Once the child is comfortable talking to you, use one of the activities in Appendix 1 to assess substance use.
Create insight	Provide the child with personal feedback about the activities for self-assessment. Provide the child with information specific to the substance that they are involved with. Emphasize the negative consequences of substance use. Let the child do cost analysis in Appendix 1

Help the child make changes	Collaborate with the child to set realistic goals. Explore how the goals can be achieved. Identify the support structures to help them make the necessary changes. Include the substitution of negative behaviour with positive behaviours.
Help the child deal with potential or actual relapse	Arrange regular sessions during which the child can discuss stressors and problems and explore solutions with your assistance. Teach the child about triggers. Collaboratively come up with strategies to manage triggers. Help the child to identify healthy leisure and relaxation activities. Teach the child how to engage in self-care. Help the child to become involved in a network of social support.
Refer the child for further assistance	Refer the child to a social worker if the family circumstances perpetuate the child's substance use. Refer the child to a psychologist if there are serious addiction concerns. Use the regional school counsellor to find out which referral agents are available in your region.

CHAPTER 2

AGGRESSION

This chapter is intended to provide you with the guidelines for working with children who display aggressive behaviours. It covers the key definitions related to aggression, identifies the causes of aggressive behaviour and describes a practical approach that you as the counsellor can follow in order to work with aggressive children. It is important to be able to identify and assist children with problems related to aggression. If left unchanged, these behaviours may become fixed ways of solving problems, resulting in the violation of the rights of as well as infringement on the safety of others.

Definition of terms

Emotions – Feelings that are derived from the perceptions about personal circumstances. Feelings affect how people behave and interact with others in interpersonal relationships.

Anger – A negative emotional state that is usually triggered by provocation, frustration or being hurt. Anger may lead to verbally or physically aggressive behaviour.

Frustration – A negative emotional state that arises when the fulfilment of a personal goal, need, or desire is resisted or denied. The feeling may also arise when dealing with personal inadequacies such as a low skill set to master the demands of a situation and life situations that are out of a person's control.

Conflict – When there is a difference in opinions, beliefs, needs or approach resulting in competition or dispute.

Aggression – Behaviour that is physically, verbally or emotionally hostile or inflicts damage. It is often an expression of frustration, anxiety, fear or vulnerability.

Verbally aggressive behaviour – Acts such as yelling, swearing, cursing, teasing, insulting or threatening.

Physically aggressive behaviour – Acts such as biting, kicking, hitting, beating or fighting.

Self-esteem – Self-confidence and personal judgement of abilities and strengths. Self-esteem determines how good a person feels about themselves.

Triggers – Circumstances that cause specific reactions. Triggers of anger and aggression may include a sense of personal inadequacy, physical provocation, etc.

Social skills – The skills used to effectively and appropriately interact and communicate with others within different interpersonal relationships.

Emotion regulation – The ability to control and tolerate emotions, moods and affect.

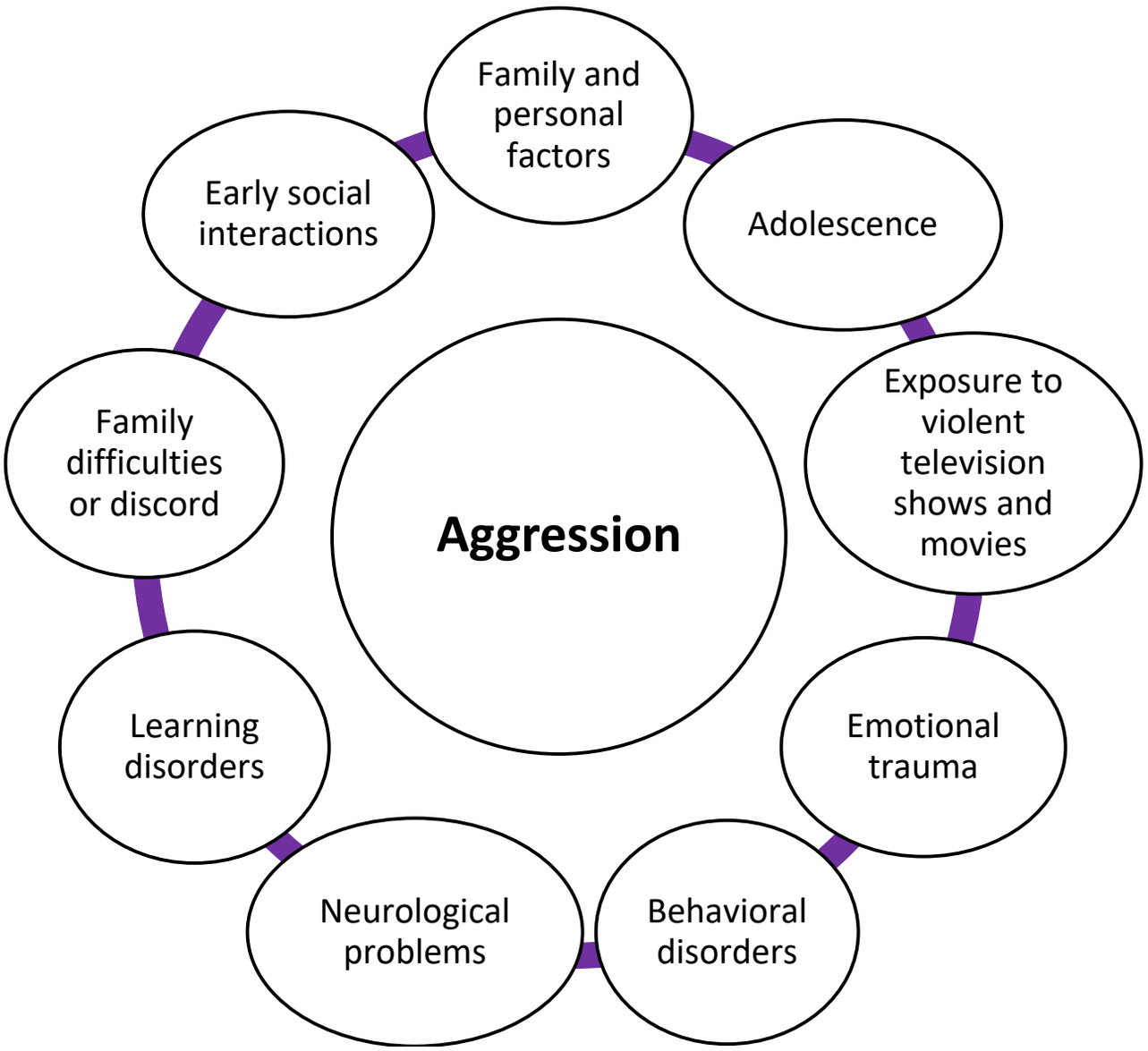
Oppositional Defiant Disorder – A persistent pattern of hostile, negative and defiant behaviour involving short temper, argumentativeness, defying authority and rules, deliberately annoying others, blaming others, being easily annoyed, being resentful and being spiteful.

Conduct Disorder – A persistent pattern of antisocial behaviour, difficulty following rules, lack of empathy toward others and threatening the safety of others.

Intermittent Explosive Disorder – A persistent pattern of difficulty with impulse control and episodes of unwarranted anger and aggressive outbursts.

Risk factors

There are a number of risk factors that may contribute to children acting in aggressive ways. Most of the time, the behaviour results from a combination of factors. As a counsellor, you should try to understand all the risk factors that affect each child specifically.



Characteristics of an aggressive child

Listed below, are some of the indications that you as a counsellor should be on the lookout for. It is important to remember that children usually act aggressively in more than one setting. As a counsellor, you have to gain access to as much information as possible to understand each context of a child's aggressive behaviour.

- Frequently lose their tempers experience intense anger;
- Are generally irritable or impulsive and have trouble staying focused;
- Become easily frustrated;
- Are usually involved in physical attacks and fights with others;
- Are frequently disruptive, argumentative, or sullen;
- Generally performs poorly in school and do not participate in their; classrooms or other organized activities;
- Have experience challenges with social participation and making friends;
- Tend to argue or fight constantly with family members;
- Generally challenge authority and become disobedient;
- Frequently deny responsibility for their own misbehaviour and blame

Your role as counsellor

1. Establish rapport with the child and provide a safe space for the child to calm down	Respond immediately when the child acts out. Remove the child from the context where aggressive behaviour is taking place. Go to a quiet and private place where the child can cool down before you begin speaking with the child. As a counsellor, you should not respond to the child's aggression with aggression. Approach the interaction with the child with a kind, warm and understanding attitude. Let the child know that you can see that they are genuinely upset and encourage them to take a moment to calm down as you are in no hurry to go anywhere. Allow the child to verbally discharge, cry or breathe heavily until they feel calmer.
2. Collaboratively evaluate the child's current behaviour and the context of aggressive behaviour	Ask the child about what had happened to make them act aggressively. Reassure the child that they are safe and show genuine interest while the child is talking about their experience. Ask about other situations that give the child the same feelings that the most recent incident caused in order to help you understand the contexts in which the child behaves aggressively. Talk about how the child feels after acting aggressively. This will inform you whether the child has remorse and whether they understand that their behaviour might be destructive. Offer to teach the child a few skills to help them deal more productively with unpleasant emotional states. Explain that healthier coping skills will help them get into less trouble and may help them deal with their feelings better.
3. Teach the child to recognize feelings	Use activities from Appendix 1
4. Guide the child by teaching appropriate ways of expressing feelings such as anger and frustration	Use activities from Appendix 1

5. Involve parents and teachers where possible	In as much as you teach the child appropriate behavioural expression of emotions, teachers and caregivers must be equipped to reinforce these. One of the responsibilities you have, to inform the relevant people that they should not respond to a child's aggression with aggression of their own. Instead, they should practice consistently fair and corrective discipline and use positive approaches such as praise and rewards to regulate behaviour. Children should be protected from exposure to aggression and violence on social media or television. In addition, parents and teachers should be aware of the behaviours that they are modelling to children and encourage children to talk about their feelings openly by creating healthy relationships with these children.
6. Refer the child for further assistance	Sometime, the child problems related to aggression may be more serious than you are equipped to handle using basic counselling. It may be for example, that a child is from a home where they are being severely abused daily and has now developed conduct disorder. In such cases, you must make the appropriate referrals to a psychologist, doctor, psychiatrist or social worker for further management.

CHAPTER 3

BEREAVEMENT

Death is a normal part of life. The death or a loss of a beloved one can bring about a number of changes as well as physical and emotional reactions in children. This chapter is intended to provide guidelines for working with a child who has been referred to you because of emotional, behavioural or academic difficulties related to bereavement.

Definition of terms

Death – The end of life. It can occur in different ways; suicide, car accident, disease, etc

Loss – Losing or being separated from a significant person, object or anything else of value. Examples of losses include a relationship coming to an end, a loved one passing away, losing a job, etc.

Grief – The thoughts, feelings, and behaviours (responses) that are associated with loss. Grief usually applies in the context of bereavement.

Bereavement – The period during which a loved one is mourned after their death. This period is characterized by different stages and every person goes through a unique, individual process of bereavement.

Mourning – This process involves rituals that help to add structure during the confusing time after losing a loved one. These rituals include; wearing black, attending the funeral, and wakes, and commemorating anniversaries in remembrance of the deceased. These rituals allow for saying farewell and affirming the death usually before the actual grieving process can happen.

Complicated grief – An enduring pattern of thoughts, feelings and behaviours associated with unresolved loss and despair over an extended period of time. Complicated grief may affect physical and mental health in a negative way and may require that a child is referred for more advanced psychological intervention.

Adjustment – The process of noticing the changes in one's reality and learning to live with the new definition of your world.

Coping skills – These are the tools that help to reduce the intensity of negative physical and emotional reactions to life stressors.

Problem-solving skills – Skills that allow effective evaluation of problem situations. These skills further involve the ability to identify measures required to resolve problem situations.

When may bereavement counselling become necessary?

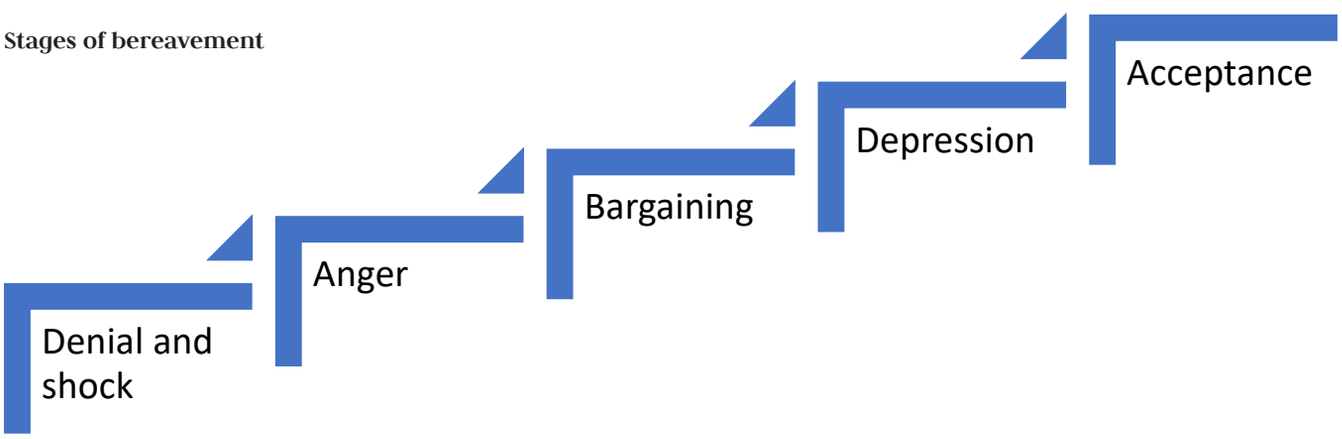
- The death of a family member, friend or other close person in the child's life. The loss may be recent or have taken place a long time ago;
- The death of a pet;
- Separation from a close attachment figure.

Bereavement counselling should not be done in every case where there has been a loss, instead, a counsellor should be aware of referral information about a child's thoughts feelings and behaviours in response to a loss.

Counselling objectives

Identify when a child is dealing with complicated grief and may need further professional assistance. Be aware of the referral channels to follow when a child has complex counselling needs.			To help the child understand the grieving process and eventually accept loss.
To help the child build and maintain healthy self -esteem.	To help the child to identify, express, process and accept feelings. To help the child cope with feelings and to teach others how to support them when going through the different stages of grief.	To help the child navigate the process of adjusting to the loss life without their loved one.	To educate and teach copings skills. To make sure that the child has the correct information to ensure good self-care.

Stages of bereavement



As a counsellor, you will have a very important role to play in helping children to find ways of expressing their grief and to mourn during the bereavement period. Every person goes through the stages of bereavement in a unique way. Children of different ages also experience the bereavement process in a unique way.

For you as the counsellor, it is important to be able to identify the stage that a child is in. This is important because the bereavement period can be a confusing time with overwhelming emotions for the one experiencing it. Being aware of the stage that the child is in will put you as a counsellor in a good position to offer appropriate support and teach problem-solving and coping skills.

A stage is identified by the nature of thoughts and feelings that a child is experiencing, or by the way that they are behaving. Most people go through all the stages when they grieve. However, some become stuck at a specific stage and find it hard to move on. This results in complicated grief. Elisabeth Kübler-Ross proposed the following stages of grief:

Denial

This is usually the first stage and it involves strategies that minimize the pain of the loss. It is not simply pretending that death has not happened. It has to do with the process of absorbing the pain of what has happened. Denial helps to slow down the process of dealing with all the information to do with the loss at once. It is a strategy that helps the bereaved child to survive the emotional pain of dealing with the loss all at once especially since death always comes with a sense of shock.

Denial is usually characterized by numbness and somatic (physical) symptoms. The shock and numbness may come from the process during which the bereaved child tries to make a shift with reality that has changed from being related to a living human being, who now, after the loss is no longer alive.

Anger

Anger is a common emotion that is experienced especially by children after the loss of a loved one. Because there is an overwhelming sense of emotional discomfort after losing a loved one, anger may serve as an emotional outlet. It is a convenient emotional as it does not make one feel as vulnerable as you would if you are feeling sad or scared. Therefore one can express emotional discomfort through anger without fear of judgement or social rejection. Anger does create problems for the bereaved individual, in that it may make the individual seem unapproachable and lead to isolation during times when they are especially in need of support.

Bargaining

When someone loses a loved one, the pain can be so overwhelming that they feel desperate and will resort to almost anything possible in order to reduce the discomfort that they are experiencing. The loss makes the bereaved reflect on the relationship they had with the deceased, the regrets and the personal faults which create guilt.

At this stage, requests are usually directed toward higher power, with requests for other outcomes than death. During this time, individuals become aware that they are human and unable to influence a different outcome. The helplessness during this stage is what drives the bereaved to bargain in order to achieve a sense of perceived control over a situation that feels out of control. Examples of bargains include "I promise to be better if you bring this person back to me.", "God, if you can bring back this person I will turn my life around."

Depression

When during the grief process the bereaved child starts to realize that their loved one is truly gone and will not return, bargaining is no longer an option. At this stage, the true feeling of loss is experienced. The bereaved child is likely to pull more inward, become less sociable and experience growing sadness. This is a natural part of the grieving process but it can create an intense feeling of isolation and deep sadness.

Acceptance

The place of acceptance is not one where the pain of the loss is no longer experienced. There is just no longer any denial of the reality that the person will not come back. Although the sadness and sense of loss continue, the child should at this stage be able to use more adaptive coping skills instead of denial, bargaining and anger to deal with thoughts of the loss.
At this stage, it is noticeable that the bereaved child has started to accept the loss that has happened. They allow themselves to experience the pain of what has happened and try to reorient their lives to surviving without the deceased person. Also, less time is spent grieving and experiencing intense sadness.

Important considerations

- Create a safe and private environment where the counselling session can take place;
- Ensure that you have tissues available in case the child might need these;
- Approach the child in a warm and respectful manner that allows him/her to feel that you are genuinely interested;
- Remember to speak of the deceased in the past tense;
- Obtain an idea about the circumstances of the death and the nature of rituals performed such as a funeral or memorial services;
- Find out how the grieving process started and how the child has been so far;
- Explore the relationship with the deceased;
- Ask questions to obtain information about sleeping habits and appetite, specific challenges, previous loses, coping skills, resources, and self-esteem;
- Provide affirmation, warn against drastic changes, normalize the intensity of the child's emotions, help identify feelings;
- Give the child permission to cry;
- Remind the child to practice good self-care;
- Provide information about the grieving process;
- Encourage realistic expectations;
- Initiate goal setting and return to normal routine after some time;
- Affirm the right to eventually feel joy and hope without guilt.

You may find it challenging to cover all of the above during the first counselling session. However, these are the most important areas to touch on during the counselling sessions in order to ensure that your counselling interaction with the child is effective. Some of the areas such as building coping skills, enhancing self-care, encouraging realistic expectations, returning to normal routine and affirming the right to feel joy, will merely be introduced during this first session and will be handled in more detail during follow up sessions.

The role of the counsellor

Meet and greet
Introduce yourself to the child if you are not familiar with one another. Ask the child to introduce him/herself. Ask about age and grade. Remember to be friendly and show genuine interest. Communicate with the child in age-appropriate language and pay attention to how the child responds.
Death and the beginning of the grieving process
In a conversational style, ask the child whether they are aware of why they are here, speaking to you today. If the child does not know, explain that you were told by the person who referred the child that the child had recently lost someone important to them through death and was ever since, noticed to be isolated and feeling down (seek guidance from the referral reason or what you were told by the referring teacher). If the child says the reason, make sure that you reframe it to mean that they were sent to you to help deal with the loss of a loved one. Next, start asking the child to tell you about death. This may be hard for the child. Remain supportive and present. You can say "can you tell me about the death", "you can go only as far as you feel comfortable", "this seems to be very difficult to talk about... take your time, I'm right here". It is important to probe in order to find out who died, the nature of the death, how recently it happened, how the child learned of the death, and whether the child may have been expecting the death. NB: IDENTIFY IN WHICH STAGE OF GRIEF THE CHILD IS After finding out the details of the death, explore the rituals that took place after death. These may include a funeral or memorial service. As a counsellor, it is your responsibility to find out how involved the child was because it will tell you whether or not the child has started the grieving process. NB: FIND OUT HOW THE CHILD'S LIFE HAS BEEN AFFECTED BY THE DEATH You should also find out from the child how they have been and how their life has been affected after the death of their loved one.
Explore specific difficulties
NB: USE EMPATHY NB: USE REFLECTION TO MAKE SURE YOU UNDERSTAND THE CHILD'S DIFFICULTIES Find out from the child whether there are specific difficulties that they are experiencing. Are there specific issues that the child is thinking about? Does the child experience specific emotional difficulties? Is the child aware of any specific behavioural difficulties or problems? Repeat to the child, what you understand to be the specific difficulties. This will give the child an opportunity to hear their problems and to clarify any misunderstandings.
Explore coping skills

NB: AFFIRM STRENGTHS AND REINFORCE EXISTING COPING SKILLS

Once you have an idea of the specific challenges that the child faces, explore with the child whether they have experienced difficult times and losses in the past. Find out how they have coped with these crisis situations and what resources and skills they are using to cope with the current difficulty. Strengthen these coping strategies.

Tell the child how brave they have been and highlight their positive coping skills and resources. Teach the child new coping skills that can be useful for specific problems that are currently disturbing. Use the strengths of the past and acknowledge the child's accomplishments in order to boost self-esteem.

Explore the relationship with the deceased

Ask the child about the relationship that they had with the deceased. Explore the nature of the relationship and how close the attachment was. Explore what the child appreciated about the relationship with the deceased. Try to find out which special qualities made the deceased important to the child.

This will tell you, the counsellor, what it is that the child will miss most about the deceased. It may further help you identify the needs of the child that were catered for by the deceased. In this way, you can help the child identify healthy ways of still having their needs met.

Explore feelings of loss, provide permission to cry and provide education

Tie in with the relationship that the child had with the deceased. Tell the child that given the relationship with the deceased, it is normal to feel a longing for the deceased, to miss the person that has died and to feel sad because the person is not around anymore. Try to ask questions that explore how the child feels about the loss.

Remember to explain that grief is an important part of losing someone to death and that pain and sadness are valid feelings. Tell the child that they are allowed to cry and express their feelings in other healthy ways. Reflect the child that this may be a difficult time and that there may be ups and downs. Tell the child that it is important to be aware of how they are feeling. It is not necessary to keep feelings bottled up. Talking about or expressing feelings often helps a person to feel better.

Teach self-care and boundary setting and encourage patience

Explain to the child that because this is such a stressful time, it is important to take good care of themselves. Encourage the child to eat healthy, get regular rest, drink enough water and do light exercises (going for a walk, skipping rope, going for a jog, playing soccer, etc.). Explain that one often does not feel like talking, prefers to be alone, does not feel like bathing or going to school, but these activities are important to ensure good health. These are also a healthy way of coping with challenging life situations.

Introduce distraction for coping and reorientation

Because grieving is such an exhausting process, encourage the child to take one day at a time. It is important that the child maintains realistic expectations about how soon they will heal and feel better. Remember everyone has a unique process to follow. Introduce the idea that the child should eventually be able to return to engaging in some of the activities that he or she used to be involved with.

Explore with the child what his/her hobbies included before the death of their loved one. Explore the strengths and interests. Explore the life goals of the child. In some cases, these life goals may have included the deceased. It is important to note these down and to help the child identify which life goals can still be achieved, though now not with the deceased but at least in their honour. By setting goals, the child is able to reestablish a little bit of security and a sense of control over their life.

Give permission for the experience of joy, hope and new relationships
Tell the child that there will be moments when they feel that they are happy or experience joy. Explain to the child that when the opportunity or urge to laugh or experience joy arises, they should allow themselves to have these positive experiences. Tell the child that people can be sad about a loved one who passed away while they experience moments of joy and happiness about other events and situations in life at the same time. Help the child to experience joy by exploring the things in life that still makes him or her happy.
Be on the look-out for complicated grief and make the appropriate referrals
Complicated grief is a serious condition that may require professional intervention. As the counsellor, you should ensure that you identify when the child's grief is prolonged, persistent and the severity is to the extent that it interferes with the child's daily functioning.

CHAPTER 4

SEXUAL ABUSE

This chapter is intended to provide you with guidelines for managing children who have been referred to following sexual abuse. It covers the terms that you as the counsellor should be aware of when dealing with children who have been sexually abused. The chapter further describes some of the myths related to child sexual abuse. It covers the most common identifiers of such children and provides a few steps to follow in order to help and support victims of sexual abuse. When dealing with sexually abused children, it is essential that legal considerations and further referrals not be overlooked. An outline of the referral system is provided in this regard.

Definition of terms

Sexual abuse – A form of abuse that involves non-consensual sexual contact. This form of abuse involves coercive sexual involvement where an individual may be forced (against their will) to perform or endure sexual acts that they do not feel comfortable with.

Child sexual abuse – This is a form of sexual abuse involving a child or minor. The child victim is usually in a position of emotional, physical or other power disadvantage. The perpetrator of such abuse is usually older and stronger within the relationship with the child. Sexual abuse can include both physical contact and non-contact.

Sexual trauma – Trauma is an ongoing, distressing emotional response to an event that continues even after the event has ceased. Sexual trauma is the traumatic effect of sexual abuse. Trauma may interfere with a child's ability to progress naturally through the different developmental stages. It may have negative consequences on a child's thoughts, feelings and behaviours which may cause academic and social difficulties. Although not all encounters of sexual abuse are immediately traumatic, they may leave children with false beliefs about themselves which may limit full participation in everyday life. Examples of such beliefs may include "I am not good enough".

Power in the abusive relationship – In abusive situations, the sexual encounter is not mutually undertaken. There is always a party with more control and authority in the relationship, e.g. a father, teacher, etc. The authority figure/ offender usually has more power or influence in terms of age, physical built or knowledge.

Sexual offender – The perpetrator of sexual abuse. In most cases of child sexual abuse, the perpetrator is known to the victim. This is usually a trusted or respected person to the victim.

Statutory rape – Sexual intercourse with a person who is legally defined as under-aged (even with their consent). Children are usually physically and emotionally dependent on adults and so cannot be considered able to give consent. Consent can only be recognized when individuals are equal. Therefore the law must protect more vulnerable members of society, children.

Consent – Agreement to participating in sexual activities that is free from coercion or manipulation.

Grooming – Measures taken to prepare a vulnerable person for sexually abusive encounter. The perpetrator uses different strategies to lure in potential victims. The perpetrator approaches victims in such a manner that once they are sexually abused, they have been aroused to believe that the gratification has been mutual.

Forms of child sexual abuse

As a counsellor, you should listen to the referral information carefully. Both contact and non-contact sexual abuse can be significantly traumatizing for victims thereof. Identify inappropriate sexual situations that children are facing. If unidentified, sexual abuse may continue for years without end.

Non-contact sexual abuse	Contact sexual abuse
• Making sexual comments in front of the child • Making verbal sexual advances at the child • Watching pornographic material in the presence of the child • Inviting a child to watch pornographic material • Coercing a child to make verbal sexual comments toward the perpetrator	• Touching/ fondling a child's genitals, buttocks, breasts or other body parts • Rubbing genitals or other body parts against a child • Inserting finger/ other object into the anus or vagina • Coercing a child to insert their finger or another object into the anus or vagina of the perpetrator • Oral sex – licking/ sucking/ kissing/ biting the breasts or genitals/ inserting tongue into vagina/ anus of child/ coercing child to do the above to the perpetrator • Penetrative anal or vaginal sex with a child

Myths about child sexual abuse

There are a number of misconceptions about child sexual abuse. As a counsellor, it is important to be aware of these myths. The children that you are working with may hold some of these misconceptions that further complicate their ability to move past what has happened to them.

× The abuser is usually a stranger
× Incest is not common among civilized people
× Drug addicts and deviants do it, but never families like ours
× Sexual abuse never happened and the child is making it up
× Men molest children when their wives are not satisfying them sexually
× Children do not report sexual abuse because they are enjoying it
× No damage is done by sexual abuse if the child is not physically harmed
× Some children are seductive and cause adults to be sexually aroused
× My child who was sexually abused seems fine and does not need counselling
× All homosexual men molest and sexually abuse young boys
× The child asked for it
× The abuser was just playing with the child, it was just joking
× The child is exaggerating

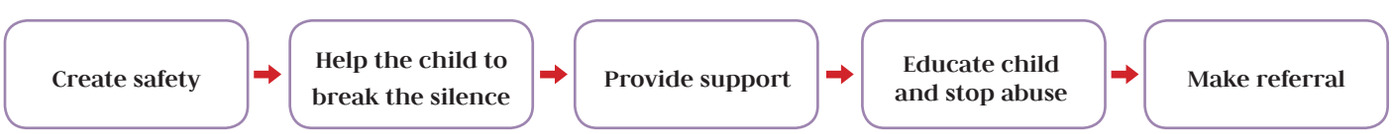
Identifying victims of sexual abuse

Children who have been/ are victims of sexual abuse may show identifiable signs of abuse. As a counsellor, it is essential that you are able to identify emotional and behavioural changes. Children often do not openly speak about their difficult experiences. The indicators below may alert you of the possibility of sexual abuse and may further point you to the areas in which the child experiences difficulty.

Behavioural indicators	Emotional indicators
• Aggressive behaviours • Fighting • Hypersexual behaviour (promiscuity/ sexual play) • Hyperactivity • Withdrawal from usual activities • Not wanting to go home from school/ school activities • Running away from home • Suicide attempts • Bedwetting, pants wetting/ soiling • Engaging in abusive relationships • Sleeping problems • Appetite changes • Temper tantrums and excessive crying	• Anger • Anxiety • Shame • Guilt • Low mood and depression • Fear • Betrayal • Distrust • Helplessness
Cognitive indicators	**Physical Indicators**
• Thoughts that lead to low self-confidence: • I am a bad person, bad things happen to me, it's all my fault, I am damaged, people will treat me badly, I cannot do anything about my situation, no one will believe me, no one can help me • Nightmares and other memories about situations of fear and powerlessness • Inattention • Memory problems	• Unexplained swelling, bleeding, irritation or pain around the mouth, genital or anal area • Sexually transmitted infections (sores, a discharge, frequent itching of the genitals) • Pregnancy • Unexplained walking, sitting or standing difficulties • Increase in physical complains such as headaches or stomach aches

It does not matter how few or many indicators of sexual abuse are present, as a counsellor you should make sure that the possibility of abuse is not overlooked. The situation must be investigated and the child must be referred to all the relevant professionals for examination and treatment. The situation of abuse must further be stopped as quickly as possible to prevent further trauma for the child.

Your role as counsellor



Create safety

Find a quiet and private place where you can speak to the child. Talk to them in a warm, friendly and age-appropriate manner. Be aware that if you are the same gender as the perpetrator, the situation may be more uncomfortable for the child and you must be careful of your non-verbal body language and choice of words.

Introduce yourself to the child and ask the child to introduce themselves to you. Before asking the child or talking to the child about the reason for seeing you, do an age-appropriate safety activity from Appendix 4 with the child.

Break the silence

Ask the child whether they are aware of the reason for being here. Once the child has explained, restate what the child has said. Explain to the child that it may be difficult to talk about sad and painful life events. Talking about our experiences helps. Tell the child that in order for you to help, you will have to share a little bit about what they are going through. Encourage the child by saying that keeping quiet about things may often prevent these things from stopping.

It may make things worse if the child keeps their pain to themselves. Remind the child that they are safe now and that they can trust you to make sure that they remain safe and protected. Tell the child how proud they should be for speaking up. Also, say that you know that it has taken a lot of courage and that this shows just how brave the child is. Refer to the Appendix for activities for identifying and expressing feelings.

Provide support

Show kindness, stay attentive and listen carefully to what the child is telling you. Be present and show the child that you are genuinely interested. Once the child has spoken about what has happened or is ongoing, reflect on the child's feelings and tell the child that the feelings they are experiencing are normal, given the situation that they are in. Allow the child to express feelings such as anger and sadness. Remind the child that you are available and they can come and speak to you whenever they feel that they need a trusted adult to listen to them or to help.

Make the child understand that what has happened is not their fault and they do not have to feel guilty about it. Help the child to identify activities that they can engage in to help them feel better in order to boost self-esteem. Further help the child identify individuals on whom they can rely on social support. Refer to the Appendix for activities to help build self-esteem and find social support.

Educate and stop abuse

Provide the child with age-appropriate sex education. Challenge any myths about sexual abuse that the child may hold as true. Make the child understand that children have adults in their lives to protect them from harm. Remind the child to know that what has happened is not their fault and that children must be protected. As an adult, your role is to do whatever is necessary to ensure that the child is safe. In the beginning, it might be normal for the child to be afraid.

They may feel that they will be in trouble for telling someone about the sexual abuse that they have experienced. Remind the child that they have done the right thing to speak up. Explain to the child that you have to refer them for a medical check-up, to ensure that no permanent damage has been done to their health.

Further inform the child of the involvement of other professionals such as social workers, police officers and psychologists that may follow. Explain to the child that nothing will be done to cause them further harm and that you are going to have to break confidentiality in order to ensure that no further abuse continues. This may mean that a child is to be removed from school, or home until the appropriate action can be taken against the perpetrator of the abuse.

Make referral

Contact the regional school counsellor or other professionals such as nurses at the nearest clinic to find out which referral agents are available in your region. Stay with the child and personally introduce the child to the next person on the referral chain.

CHAPTER 5

MASS HYSTERIA

This chapter provides guidelines for working with children who have been exposed to or involved in mass hysteria at school. It provides basic definitions related to mass hysteria. It further provides information about the causes of the phenomenon as well as steps to follow in order to manage it within the schools. Historically mass hysteria illnesses have been found throughout history. Hippocrates, around 400 BC introduced the term "hysteria" meaning illness caused by a wandering womb. Symptoms included convulsions, twitching, muscle spasms, abdominal cramps nausea, and headaches in unmarried Greek women. Symptoms typically spread quickly to other women in the vicinity of the victim.

Definition of terms

Mass Hysteria - Mass hysteria is defined as the occurrence in a group of people of a constellation of physical symptoms suggesting an organic illness but resulting from psychological cause.

Mass psychogenic illness "Mass psychogenic illness" or "contagious psychogenic illness" is defined as the collective occurrence of a set of physical symptoms and related beliefs among several individuals without an identifiable pathogen (Colligan and Murphy,1982).

Hysterical contagion - Hysterical contagion consists of quick dissemination within a collection of people of a symptom, or a set of symptoms for which no physical explanation can be found.

How to identify mass hysteria

- Mass hysteria typically begins when an individual becomes ill or hysterical during a period of stress. After this initial individual shows symptoms, others begin to manifest similar symptoms.
- Symptoms recorded during outbreaks of mass hysteria include abdominal pains, chest tightness, dizziness, fainting, headaches, hyperventilation, nausea, vomiting, palpitations; anxiety, conversion disorder and screaming.
- Mass hysteria is a social phenomenon often occurring among otherwise healthy people who suddenly believe they have been made ill by some external factor. It spreads by sight and or sound and occurs most often among adolescents or preadolescents.
- In groups of students, its incidence is reportedly higher among girls than boys.
- Symptoms often follow an environmental trigger or illness in an index case and spread rapidly by audio-visual cues, often aggravated by a prominent emergency or media response.
- Symptoms frequently resolve after patients are separated from each other, removed from the environment in which the outbreak began and after being convinced that the illness is over or never existed.
- Literature suggests that mass hysteria episodes have frequently occurred in Africa although there were some outbreaks in the Western world

Diagnostic issues

Given the nature of the term 'mass hysteria', others such as 'mass sociogenic illness', 'mass psychogenic illness', and 'outbreaks of multiple unexplained symptoms' have been offered.

- DSM 5 subsumes this condition under the rubric of 'Somatic symptom and related disorders' and within the subcategory 'Conversion disorder'
- The phenomenon is generally defined as '. . . the rapid spread of illness signs and symptoms affecting members of a cohesive group, whereby physical complaints that are exhibited unconsciously have no corresponding organic aetiology'

- One or more symptoms of altered voluntary motor or sensory function.
- There is no compatibility with symptoms and recognised neurological and medical conditions.
- The symptoms cannot better be explained by another medical condition of mental disorder.
- The symptoms cause significant impairment in social, occupational or any other areas.

Some causes of mass hysteria

- Most epidemics of mass hysteria are initiated by an actual event, but some can originate from mere rumours of a catastrophic situation.
- In cases associated with water contamination, smog, nuclear accidents, or chemical exposure, a common trigger is an odour or perception of an odour.
- The outbreak may then be perpetuated by a variety of factors such as physical or visual proximity to casualties, general excitement of the event, presence of media at the event, litigation and/or compensation cases,
- Epidemics of hysteria rely on the power of suggestion, but they are nourished by fear, sadness and anxiety.
- Victims tend to be subjected to severe psychological strain over the preceding weeks or months.
- One or more then develop a psychosomatic symptom, and those made suggestible by pent-up anxiety quickly follow suit.
- Before long, dozens are stricken in a variety of ways such as vomiting, fainting and screaming.
- The strain of exams is a common trigger.
- Reports suggest that in many African schools pupils are placed under such extreme pressure that mass hysteria has become virtually endemic.
- Research has also shown that certain personality types are prone to develop hysteria.
- The personalities are described as being more extroverted, more paranoid and hysterical, of lower IQ, being more likely to be female or having experienced the death of a significant other in early childhood.

Symptoms and characteristics of mass hysteria

⇨ **Sudden onset with dramatic symptoms, rapid spread and rapid recovery.**

- All studies reporting psychogenic illness discuss the rapidity of the onset of the illness. Most of these epidemics disappear in a matter of few hours or days.
- The most effective way to curb the spread of the symptoms is to separate the victim(s) from the group.
- The attack rate is generally about "8 to 10% in large groups and from 30 to 50% in small groups".

⇨ **Predominantly young female populations.**

- From 60 to 90% of victims of psychogenic illnesses have "historically been young females".
- Groups of females working, living or eating together are most at risk for this behaviour.
- Even if males are present females comprise most of the victims as is illustrated in some of the most recent examples from the literature.

⇨ **Victims often know each other or are in the same friendship circles.**

- Observing a friend become sick is the best predictor of the development of symptoms.

⇨ **A triggering stimulant.**

- An auditory or visual triggering stimulus is generally found. Victims interpret this stimulus as a toxic fume or gas, tainted food, bug bites or toxic pollutant.
- Upon investigation, an odour can even be detected, cleaning solvent, painting, machinery or repair liquids, unfamiliar construction or fumigation odours have sometimes been found.

⇨ **Apparent transmission by sight, sound or both.**

- Seeing a victim collapse is a predictor of others getting the symptoms.

⇨ **Negative laboratory or physical findings confirming a specific organic cause or pathogen.**

- The illnesses are "real," however, there is an absence of any chemical toxin or biological pathogen. The diagnosis of psychogenic illness is generally made after all possible factors have been ruled out.

- Victims are often reluctant to accept a diagnosis of mass hysteria and sometimes accuse the institution of a "coverup."
- In some cases, there may be unexpected laboratory results which cause confusion and promote controversy about suspected aetiologies.

Underlying psychological or physical stress.

- Individual stress from an unfamiliar environment or performance anxiety; social stress including war, rapid technological change, or epidemic diseases; and school and work-related stress including the beginning of the school year are common.

Boredom, or perceived boredom.

- Worker boredom with routine tasks has been found in many cases of illness.
- A felt lack of emotional or social support.
- This is more likely to occur among new members in a collection of people.

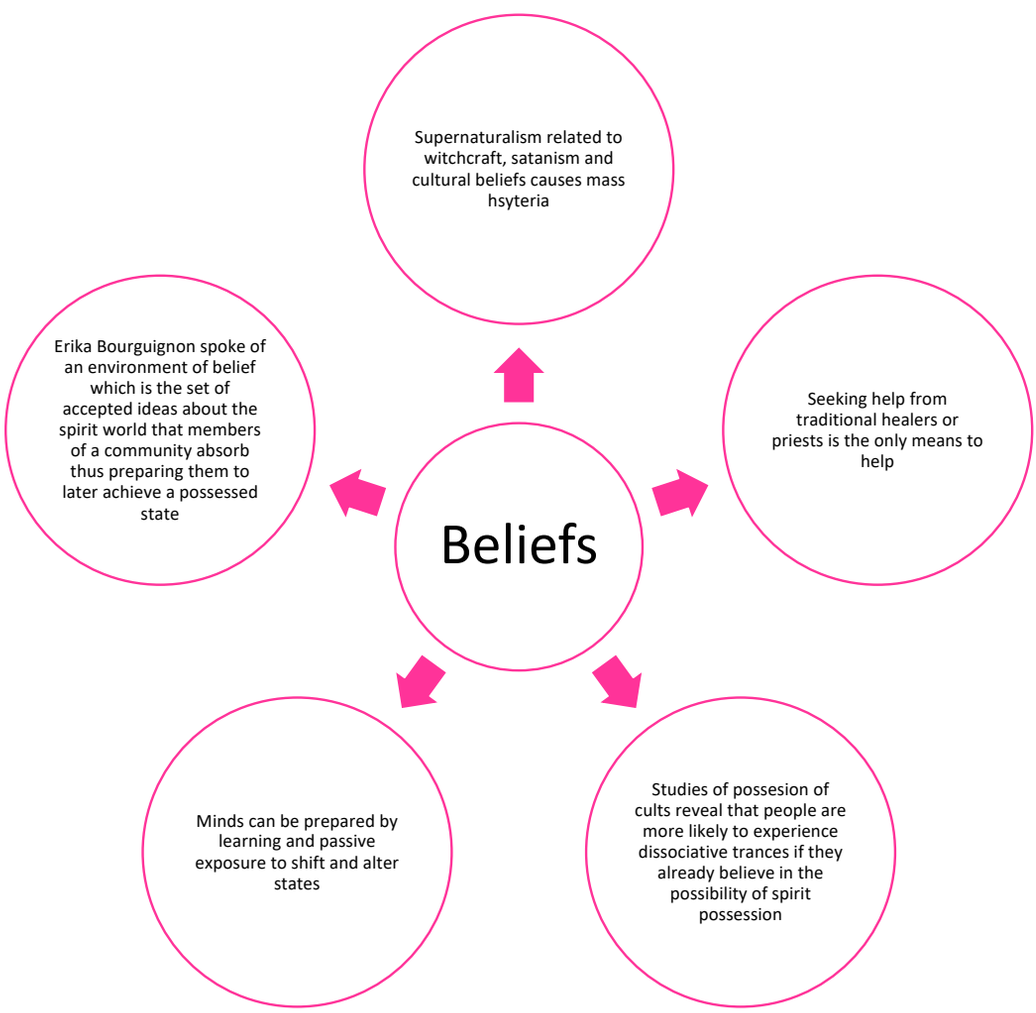
Unrelated symptoms among a group of individuals affected.

- Hyperventilation or fainting is the most common. Other symptoms discussed in literature include dizziness, nausea and vomiting, headaches, chest pains, chills, eye or mouth stinging, flushing, hives, convulsions, stinging or paralysis in extremities, swollen and bloody lips, skin disorders, asthma attacks, and disorientation in time/space.

Relapse of illness.

- Relapse of the illnesses among victims in the same setting have sometimes been found to occur.

Mass hysteria beliefs



Your role in the management of mass hysteria

Calm the situation	Bring in, medical experts and other emergency workers. Take affected children to a safe and private place such as the principal's office. Transport learners to the nearest healthcare facility
Prevent suggestibility	Prevent the gathering of informal groups that discuss what has happened. The principal should address the learners with the correct information about what is happening and must give assurance that the situation is under control.
Ensure safety	Environmental and risk management experts are to visit the school premises and rule out probable triggers such as toxic gases. Affected learners are to be sent home and only return once they are stable. These learners may be referred for mental health interventions involving psychologists, social workers, medical doctors and/or psychiatrists.
Investigate	You must uncover the beliefs that may be propagating the hysteria such as witchcraft, etc. The above will help you to deal with the problem within the cultural/ spiritual context
Involve the community and relevant authorities	They may help with coordination. Information dissemination of consistent and accurate information should take place.

MASS HYSTERIA CASE STUDY: SOUTH AFRICA

A few days before the outbreak of the epidemic it was noted that during the morning prayers a few female students had fallen down 'unconscious'. They were taken to the staff room and a few minutes later regained consciousness. The pupils went on to attend classes as usual. On the morning of 21 May 1999 during the morning prayers, female students started screaming and falling in rapid succession.

A total of 50 students out of a population of 765 were involved, and they were ferried to the local hospital and clinics. The school principal was interviewed and the school inspected looking for any possible trigger factors. A questionnaire was given to the 21 teachers present during the outbreak. The following trigger mechanisms were identified:

(i) the index case was found to be a young student with problematic family relations; (ii) the June examinations were approaching; (iii) there was a church nearby the school where the students and members of the community believed that Satanism was being practiced; (iv) the students were living under stressful conditions at the hostel.

On the return of the students the principal stressed that: (i) there were no evil spirits or demons at the school;
(ii) while the outbreak was a result of anxiety at the approaching June examination, the latter would not be postponed; (iii) stressful living conditions at the hostel would be investigated and rectified; and (iv) at the slightest indication of a relapse, the index student would be sent home for the rest of the year. There were no further outbreaks after this announcement.

In February 2000, about 1430 learners, particularly girls, at schools in Mangaung and Heidedal, in the Free State Province of South Africa presented with mass itching of unknown origin. The affected learners were taken to the principal's office and those who came to observe what was happening, experienced an onset of itching. No organic cause was found for the itching and finally, a diagnosis of anxiety mass hysteria was given for this outbreak. The schools were closed and fumigated, when the learners went back, the headmasters set limits and the itching stopped.

Another episode was reported in 2002, at a primary school in Kwa-Dukuza, KwaZulu-Natal, South Africa, 27 children who had been well when they left their homes collapsed at school, displaying tremors and shivers throughout their bodies. Many of the children also presented with abdominal cramps and nausea. Almost all the children experienced a feeling of tightness in their chests as well as hyperventilation, which was then followed by fainting. This hysteria spread by line of sight.

In 2009, a wave of mass hysteria overcame a Pretoria high school in South Africa as dozens of children collapsed, screaming in unexplained convulsions and fits. The hysteria started when a Grade 9 girl collapsed at her desk at Daspoort Secondary School in Claremont. Within moments of the unexplained attack about 25 pupils in various classes and grades were affected .The attacks came two weeks after a pupil at the school committed suicide.

CHAPTER 6

SUICIDE

This chapter is intended to provide a guideline to you when working with children who are suicidal in terms of their intention to commit suicide or past attempt at ending their own life. The chapter hence focusses on providing counselling for survivors of suicide attempt(s). The chapter begins by defining some of the key concepts related to counselling suicidal children and continues to list the risk factors as well as the identifiers of children who are at risk of suicidal behaviours. There is also a brief mention of the myths that may cloud the appropriate identification of suicidal children as well as the guidelines for handling these cases by strengthening child's inner resources.

Definition of terms

Suicide – These are acts of self-harm that are intended to result in the ending of a person's own life.

Suicidal attempt – When a person tries to end his/her own life but fails.

Suicidal behaviours – Include suicide, attempted suicide and suicidal ideation or thoughts.

Suicidal ideation - Involves thinking about engaging in suicidal behaviour, with or without a specific suicide plan to end one's own life.

Suicide plan – The intention, accompanied by a thought-through idea about the method, time and place where suicide will be committed.

Suicide contract – A contract constructed by the counsellor and child that stipulates the steps to be followed in order to prevent the actual act of suicide happening. It facilitates that the child takes responsibility for their wellbeing and honours the agreement between themselves and the counsellor to try and address some of the problems that are causing suicidal ideation.

Self-harming – The the direct and deliberate act of harming one's own body without the conscious intention to end life.

Risk factors – The different factors that increase the likelihood of an adverse event or outcome. These include the particular features of illness, behaviour or circumstances that increase risk.

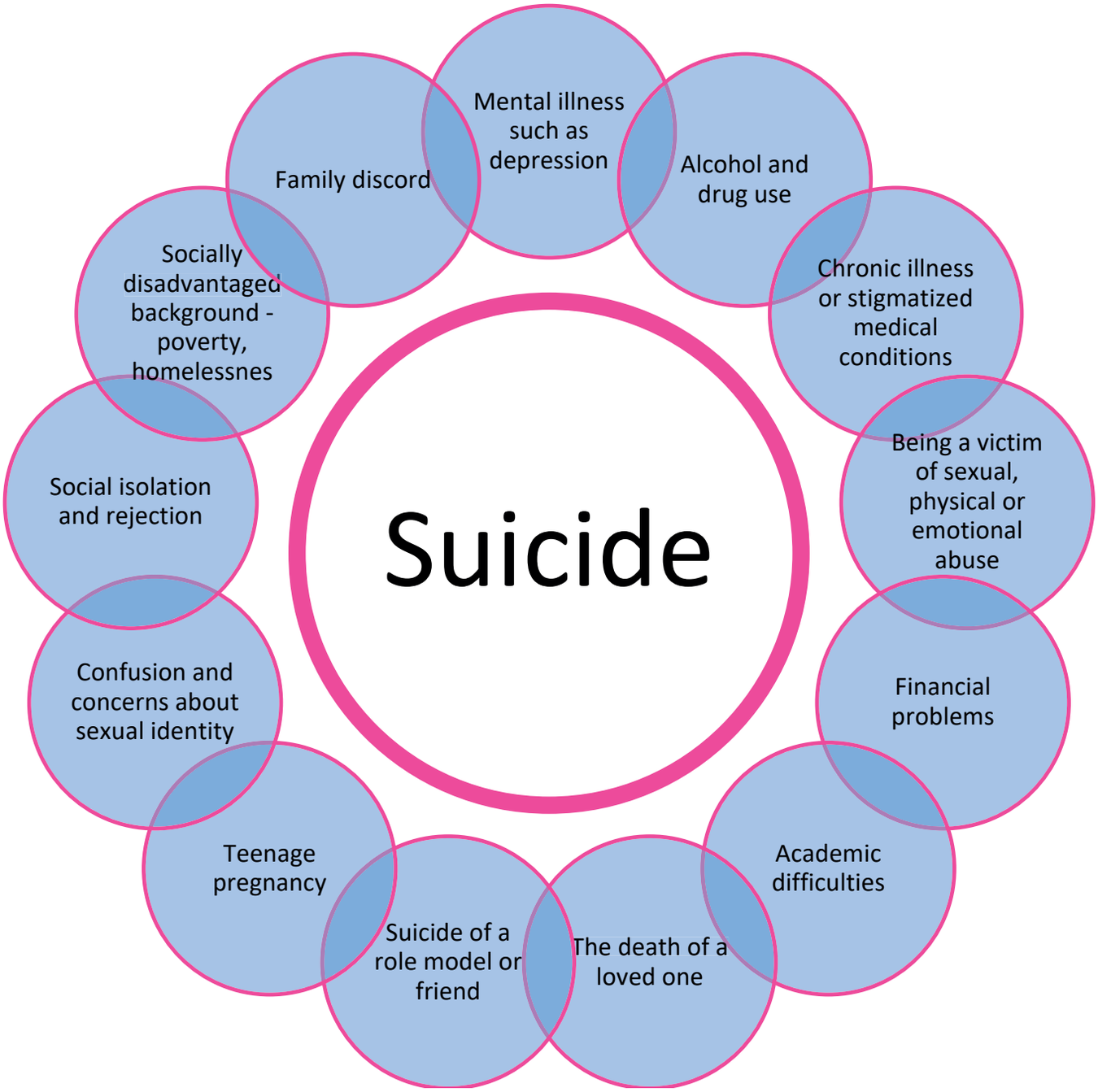
Risk assessment – The estimation of the probability that particular events, circumstances or outcomes will result.

Major Depressive Disorder – This is a psychological disorder that is characterized by low mood, loss of interest in pleasurable activities, changes in appetite and sleeping patterns, a sense of hopelessness and guilt, constant fatigue and low energy, poor attention and indecisiveness and suicide ideation.

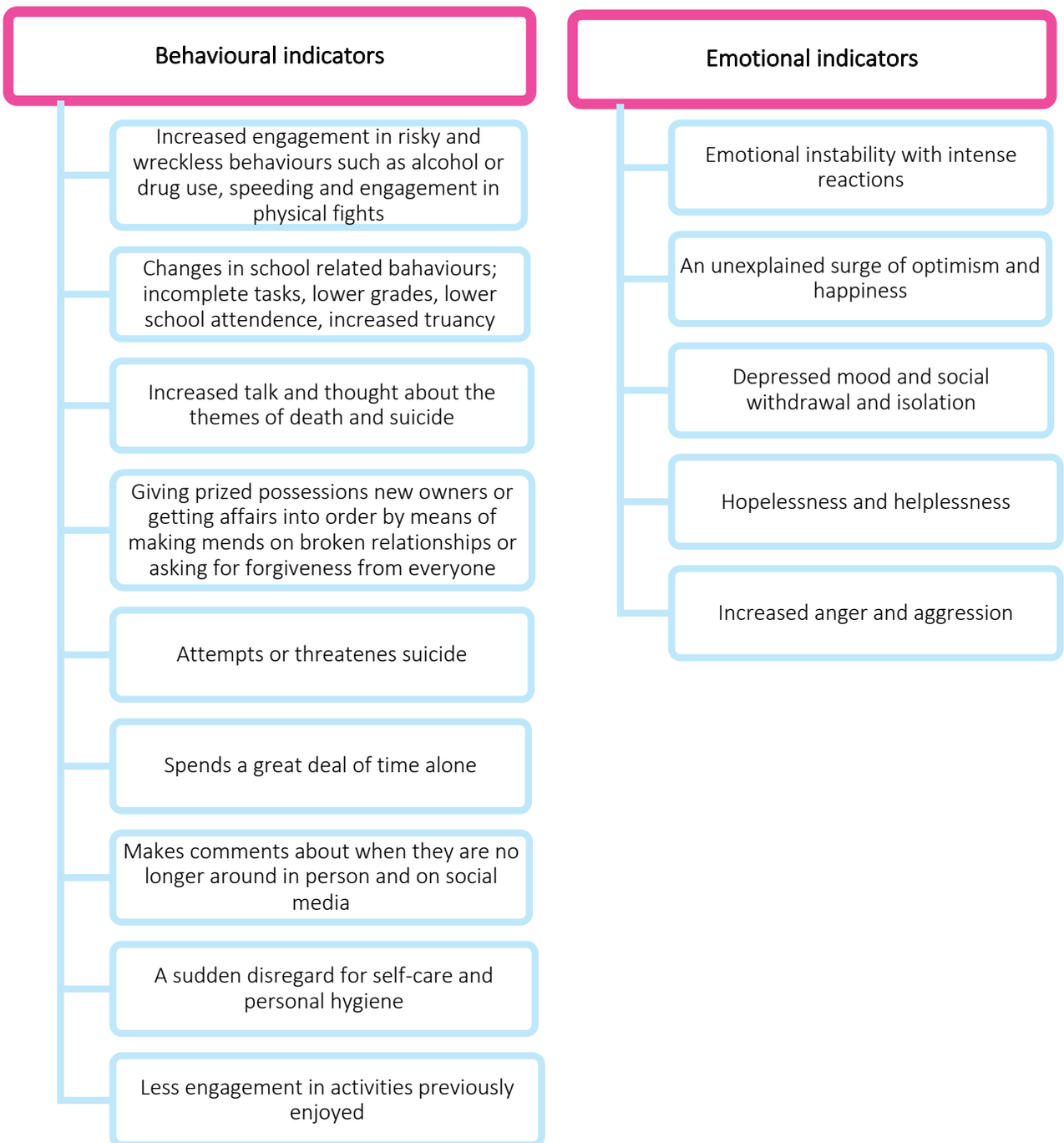
Protective Factors – These are the skills and strengths (resources) that promote resilience during everyday life and to deal with traumatic life events.

Commonly recognized risk factors for suicide

In cases related to suicide, there may be a number of factors that contribute to the actual act of suicide. The presence of any or a combination of the following factors may identify children who are at greater risk of suicide. It should be noted that the presence of these factors does not necessarily always result in self-harm or suicide. As a counsellor, you should be aware of the risk factors that are relevant to the specific child you are dealing with. This awareness will help you to identify how to support the child and which areas must be addressed in order to reduce the risk. From the list below, you may realise that most of the risk factors are not within the control of the child experiencing them. This often leads to a sense of helplessness which results in hopelessness if no intervention is available. The hopelessness of reality is what results in children believing that the only way to improve their circumstances is by leaving – death.


Suicide
Mental illness such as depression
Alcohol and drug use
Chronic illness or stigmatized medical conditions
Being a victim of sexual, physical or emotional abuse
Financial problems
Academic difficulties
The death of a loved one
Suicide of a role model or friend
Teenage pregnancy
Confusion and concerns about sexual identity
Social isolation and rejection
Socially disadvantaged background - poverty, homelessnes
Family discord

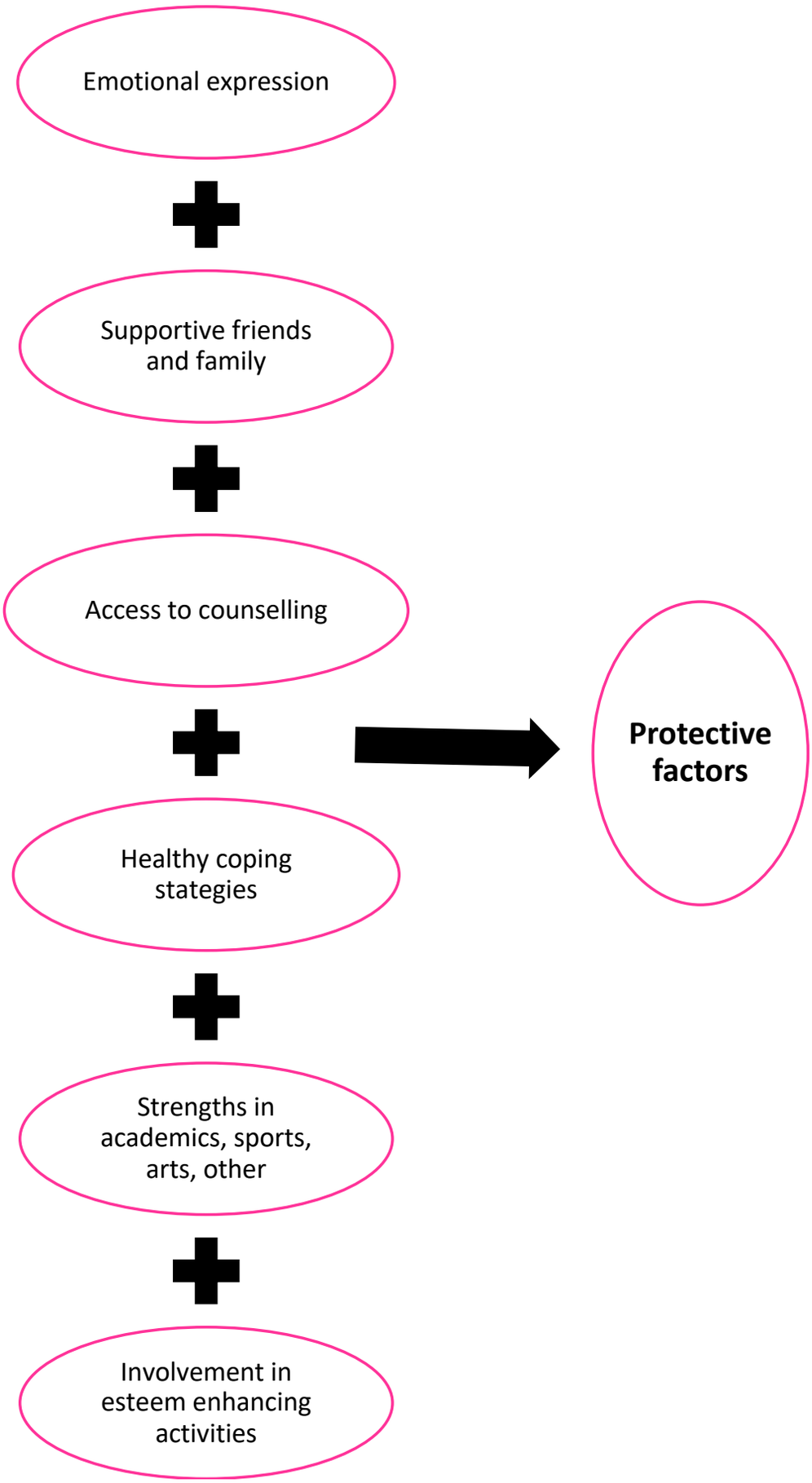
Signs of distress and suicidal ideation



Myths that limit help and cloud the early identification of children who are at risk

Myth 1: At-risk children do not show signs
Myth 2: Suicide mostly occurs over holidays
Myth 3: Someone who threatens suicide is unlikely to actually go through with it
Myth 4: Only people that are severely depressed and always look unhappy can commit suicide
Myth 5: When someone is under the influence of alcohol or another substance, their suicidal threats should not be taken seriously
Myth 6: Suicide is mostly committed by adults
Myth 7: Suicidal people want to die
Myth 8: Talking to someone about suicide encourages them to commit the act
Myth 9: Suicide attempts are acts of seeking attention
Myth 10: I may not tell anyone that a child is suicidal because that would break confidentiality

Protective factors



The role of counselling after a suicide attempt or suicide

As a counsellor, your role is firstly to ensure that the child is out of harms way. Once this is achieved, you must provide a safe and supportive environment in which the child can achieve a better understanding of what is going on in their life, recognise that their experiences and feelings are normal (responses to daily life and challenging circumstance), identify strengths and skills, strengthen these resources and find positive pathways for future health and wellbeing by developing independent problem-solving skills.

With your assistance children who might otherwise continue to feel overwhelmed by their life experiences may feel safe and supportive, giving them a better sense of control over and hope for their lives.

Step 1: Create safety	Talk to the child about the counselling process. Explain that it may help relieve some of the difficult experiences that they are currently facing. Tell the child that it is your responsibility to make sure that nothing happens to them. Explain the suicide contract and that you may have to tell a support person to keep an eye over them. Leave this discussion and return to it at the end of every session. See Appendix for tools
Step 2: Provide an environment for storytelling Listen for problems and hear feelings	Show genuine interest and listen to the challenges that the child is experiencing. Reflect on the child's feelings and let them know that these are normal reactions to the stressful situations that they are facing. Make sure to identify all the risk factors that must be addressed. Some risk factors will require that you as a counsellor make further referrals
Step 3: Support	Reassure the child that they are not on their own. Let them know that you will work with them to identify areas in which they need assistance as children often need to be able to rely on adults. Tell the child that you may have to refer them for assistance in the cases of certain risk factors such as domestic abuse, etc.
Step 4: Explore coping skills and strengthen resources	Ask the child about how they have been coping with the problems that they had encountered in life thus far. Help the child to identify their strengths, coping skills and support resources that they have relied on thus far. Use affirmation and highlight how powerful these resources are. Encourage the child to revert back to these ways of coping. Teach additional practical coping skills and encourage the child to identify and reach out to people who can render them support.
Step 5: Discuss problem-solving skills and explore solutions	Teach the child practical problem-solving skills and help them to match the different skills with the problems that have been reported. Help children recognize the circumstances that are beyond their control and ensure that they identify the appropriate sources of help.
Step 6: Make plans for the future	As a means to instil hope, explore with the child whether there may be things that they can look forward to in the future. With this future orientation, help the child to identify opportunities for happiness, better wellbeing and improved circumstances in the future. By focusing on the future, the child may be distracted from unpleasant and overwhelming emotional experiences. The child may further have reason to endure current problems and feel motivated to solve current difficulties.
Step 7: Secure safety	Revisit the suicide contract and together with the child, sign it. Collaborate to create a safety plan that the child must adhere to. If at the end of the session you and uncomfortable with the level of risk still present, you must inform someone who will agree to remain with the child and ensure safety. The alternative is that you refer the child for hospital admission or some other form of suicide watch.

CHAPTER 7

CYBERBULLYING

Information communication technology (ICT) has opened new and amazing vistas in the way that learning and teaching take place. It allows the dissemination and access of infinite amounts of information on the click of the button. People are able to share virtually everything instantaneously. However, the great gains from ICT have a dark side to them because it comes along with a massive potential for abuse. One such price that stands out from the widespread use of ICT in this digital world is the phenomenon of cyberbullying. In this chapter, the spotlight is on the psychological, emotional, and social effects of cyberbullying as well as the role that the school counselor can play in mitigating this vice. As an educationist who is specifically tasked with the responsibility of promoting and safeguarding the mental health of learners, the counsellor should spearhead the process of designing and implementing educative, preventive and intervention strategies to curb the spread of this epidemic.

School counsellors and other school personnel's lack of familiarity with many forms and capabilities of electronic communication tools could hamper their efforts to assist students experiencing cyberbullying. Gaining relevant knowledge about cyberbullying and its modalities, and being viewed as a knowledgeable resource person is thus an important first step for school counsellors to take. The counsellor must acquire relevant knowledge about cyberbullying and its various modalities so he/she can be viewed by learners, other teachers and family members of victims and perpetrators as a credible resource person.

Definition of terms

Bullying – Deliberate, repeated and hostile actions by an individual or group that is intended to embarrass, shame, hurt or exclude the victim.

Direct bullying – Involves the application of physical aggression

Indirect bullying – Involves forcing the victim into submission by socially isolating him/her. It is also known as social aggression.

Table 7.1. Below depicts examples of tactics that used in these two forms of bullying.

Table 7.1: Tactics used in Direct and Indirect Forms of Bullying

Direct Bullying	Indirect Bullying
• Shoving and pushing • Pinching, • Verbal threats • Spitting at the victim • Demanding money, property, or service • Stabbing • Choking/strangling • Burning • Shooting • Hitting/punching • Kicking • Biting • Throwing objects at the victim	• Name-calling • Spreading rumours or untruths • Refusing to socialize with the victim • Put pressure on others not to socialize with the victim • Viciously criticizing the victim's appearance, dress code, race, e.tc. • Silent treatment • Arguing • Manipulating • Laughing or joking at the expense of the victim

As can be deduced from Table 7.1 above, cyberbullying largely falls in the ambit of indirect forms of bullying.

Cyberbullying actions

Cyberbullies use information communication technologies to harass and threatening their victims through a variety of actions including:

- Posting embarrassing information about the victim, his/her family and/or friends. This information can be true or fabricated
- Posting confidential information that was intended for the sender only
- Posting without permission photographs taken with or without the consent of the victim
- Posting without permission video clips taken with or without the consent of the victim
- Causing a victim to be excluded socially by 'blocking' him or her from the list of friends or other contacts.

Forms of cyberbullying

It is important that counsellors familiarize themselves with the forms of cyberbullying that are frequently used. If the counsellor lacks such knowledge, she/he runs the risk of losing credibility in the eyes of the children that she/he will be trying to assist. Below, some examples of forms of cyberbullying are described.

- **Flaming** – it involves the perpetrator inciting or causing a brief, heated exchange with the target victim through communication technology in chat rooms or discussion groups.

- **Cyber**- harassment – the perpetrator repeatedly send offensive messages to a target victim via e-mail or text messages.

- **Denigration** – it involves the perpetrator disseminating, via web

- page, e-mail, or instant messaging, false and derogatory information or pictures about the target victim with the aim of damaging the reputation of the victim.

- **Impersonation** – is a form of identity theft in which the perpetrator poses as the victim, and then communicates harmful, malicious, harsh information with others. This is done with the intent to hoodwink the others to believe that it is the victim that has communicated such offensive messages.

- **Outing** – this happens when the perpetrator shares personal information about the victim, the personal information which the victim would have preferred to be kept private such as his/her sexual orientation.

- **Trickery** – this occurs when the perpetrator uses deception to make the victim reveal personal information and then shares that information with other people without the consent or knowledge of the victim.

- **Exclusion/ostracism** – this involves the perpetrator taking measure to exclude the victim from taking part or joining certain social forums through the use of passwords to deny entry, deleting the victim from buddy lists, or denying the victim's friend requests

- **Cyberstalking** – is when the perpetrator uses information communication technologies to repeatedly track the victim.

The aims of cyberbullying and conventional bullying are the same, i.e. to embarrass, threaten, shame, hurt or exclude. Cyberbullying is when a victim is harassed through online accounts or social media. Cyberbullying has amplified the scale and scope of the existing problem because it has additional elements, thus making it imperative for the school system to rethink and retool strategies to combat this problem.

Why cyberbullying is fast-growing and particularly harmful

Signs of cyberbullying

- Because victims are young impressionable and vulnerable the effects of cyberbullying are generally dire on the physical, mental and social health of the victims.
- Stress and anxiety-related disorders are a regular fixture because unlike traditional forms of bullying whereby the victim can take "time-out" at the end of each school day when he/she returns home, cyberbullying is typically unrelenting and the victim may feel that he/she no longer have a safe haven to turn for relief.
- Struggling with substance abuse issues is a common sign of cyberbullying, as victims may resort to substances as a way of coping with and numbing themselves of the emotional pain.
- Some victims of cyberbullying are known to gravitate towards violence and aggression in their quest for revenge or to release pent-up energy. So cases of school violence, suicides and homicides can be seen as possible signs cyberbullying.
- Other signs of cyberbullying are more subtle and include, sadness, embarrassment, isolation, poor academic performance, low sense of self-esteem and self-worth, family problems and delinquent behaviour, shame, excessive absenteeism impacting academic performance, truancy, loss of appetite, weight loss or gain, paranoia, sleeping problems, stomach problems and not feeling safe.

The role of the counsellor in mitigating cyberbullying

The counsellors should leverage on their visibility, approachability, ability to relate, and connection with students, to spearhead the fight on cyberbullying at school and in the community. For purposes of brevity and structure, the role of the counsellor in combating cyberbullying is described under the cluster of educational, prevention and intervention strategies.

Educational strategies

The counsellor must make the issues of cyber safety and cyber-bullying more visible in the school system by integrating them into training and professional development programmes for the school. The counsellor must also educate other teachers on the best practices for mitigating cyberbullies. For example, some teachers may advocate for not responding to complaints about cyberbullying on the grounds that it did not occur on the school grounds. Such arguments may be countered by pointing out that the effects of cyberbullying impact the school system because the boundaries between the school, home and community have been increasingly eroded or blurred as the result of the widespread use of ICT.

It is also the role of the counsellor to educate school authorities on the dangers of introducing piece-meal measures to combat cyber-bullying. For example in some schools anti-bullying measures only go as far as just deciding which screening programmes to install in the computers.

Parents should be encouraged to take an interest in and monitor the usage of ICT by their children. The counsellor can educate them on the two key methods of resolving bullying - the human/relational and the technological perspective. In the human/relational problem-solving perspective, the counsellor encourages the parents to develop trusting relationships and open communication with their children. This is particularly important in the light of research findings indicating that only about 10% of children turn to their parents for help when in trouble.

In the technological perspective, parents are encouraged to use technological solutions such as parental settings, filtering or tracking, installing internet safety software, monitoring services, password protection, and greater control and monitoring of cellphone usage by their children.

The parents can also be educated on the behaviours that are unhelpful. Parental overreaction such as banning children from using phones, internet or other forms of ICT has been shown to serve as barriers to reporting cyberbullying by victims. Similarly, concerns over the overreaction of parents may discourage bullies from owning up to their actions.

Another strategy available to the counsellors is to provide classroom instruction to learners regarding the signs, dangers, and consequences of cyberbullying. Such contact creates rapport between the learner and the counsellor thus creating a conducive atmosphere for learners to self-disclose and share their experiences.

The counsellor should also take education to the broader community because children are part of the larger community and have access to technology outside the school environment. The counsellor can, therefore, partner with agencies in the community to disseminate information about cyberbullying.

Prevention strategies

Prevention goes hand in hand with education. It involves adopting a proactive approach instead of a reactive one. The counsellor should cooperate with all members of the school to cultivate and foster a culture of ethical use of the cyberspace. The culture should be supported by clearly laid rules and policies on how they will be enforced in the school.

The counsellor can also help to put in place structures in the school such as a team of school personnel that meets regularly to discuss, survey and document cyberbullying incidents at school as well as organizing educational workshops for teachers, learners and parents.

Prevention strategies for parents include educating them about the necessity of discussing ICT safety and etiquette with their children as well as encouraging them to report cyberbullying. The counsellor can also impress upon the parents to drill into the minds of their children the importance of resisting the temptation to take retaliatory action when they encounter bullying on the cyberspace. Another helpful preventive strategy is to encourage parents to check in with their children regularly and in an approachable way to see if their internet, text, or social media usage has been negatively impacting them in any way. Further, the counsellor may request parents to keep computers in a public area, and taking children's phones away at night so that they can take a break from their online activities.

The classroom or group instructions can also be used to impart learners with skills for healthy conflict resolution, problem-solving, empathic understanding, appropriate behaviours, emotion regulation, anger management, coping, and self-control. The use of peer leaders in which counsellors arrange for learner leaders to speak to other learners about their experiences and the dangers of cyberbullying is a powerful method as peers tend to carry greater credibility with other children.

Intervention strategies

Intervention strategies refer to actions that are taken in the aftermaths of cyberbullying. As a general principle and for optimal results, intervention methods should be implemented within a reasonable amount of time after the occurrence of the incident.

As a counsellor you must be cognisant of the fact that one of the main challenges that you will face is that victims are often reluctant to speak out or seek help due to fear of reprisal, embarrassment, the assumption that adults will not act and the view of bullying as a 'normal rite of passage'. You should work hard to counter these false beliefs or attitudes so as to improve the learners' willingness to open up to you or their parents.

Below is a list of some of the recommended intervention strategies:

- To immediately respond when cyberbullying takes place
- To carefully save and store the evidence
- To match the response to the severity of the cyberbullying. Less serious forms of cyberbullying should be addressed with more moderate or mild forms of sanctions, while more serious forms of bullying should attract more severe forms of response such as reporting to the authorities.
- To inform the perpetrators' family so as to establish consistency and alignment in home and school expectations
- Where appropriate, the counsellor should refer the victims and/or perpetrator to mental health professionals.

The provision of counselling services to the victim and the perpetrators constitute a central cog in the intervention strategies. In the case of the victim, the aim of counselling is to help the victim cope with the trauma of cyberbullying, while in the case of the perpetrator the aim is to rehabilitate.

Because of the disagreeable nature of bullying behaviour, counsellors often neglect their responsibility to facilitate the rehabilitation of the perpetrator. It should not be forgotten that there are often complex underlying reasons for engaging in bullying behaviour, such as frustration, lack of role models, desire to fit in, abuse or neglect in the home or conduct disorder. To gain a balanced understanding of a bully and to enable the counsellor to be non-judgmental and empathic, the counsellor must ask himself a range of questions including:

- "Why does this perpetrator have a lot of internal aggression?"
- "Why does this perpetrator have a need to displace their internal aggression onto others?"
- "Why has this perpetrator not learned how to interact with others in a non-violent manner?"

Depending on the results of the assessment, counselling may focus on teaching the perpetrator impulse control skills, anger management skills, and ways to appropriately express feelings and increasing self-esteem and social skills.

Similarly, victims may be targeted on account of having certain characteristics and thus it may be necessary to counsel them on assertiveness skills, socialization skills, and improving self-concept.

ICT is here to stay. As ICT continues to be embraced by more and younger users the problem of cyberbullying is expected to worsen unless drastic measures are taken to address it. The counsellor is uniquely placed to lead this charge if they continue to remind themselves that they have a legal and ethical responsibility to address this vice. Because cyberbullying is different than conventional forms of bullying it is imperative to rethink the manner in which school management, teachers, learners and parents, approach the problem of cyberbullying.

CHAPTER 8

TEENAGE PREGNANCY/PARENTING

Despite the increased efforts to prevent teenage pregnancy through sex education and awareness-raising, the incidence of teenage pregnancy is still widespread. This chapter provides guidelines for working with children who are affected by the occurrence of teenage pregnancy. It is important that this group of children receive adequate support from the beginning of the pregnancy and that counselling and support continue even after they have given birth and must be reintegrated into the school framework (if there are periods of non-attendance). Teenage parents experience a similar challenge to older parents. However, parenting as a teenager involves special challenges, such as handling judgmental attitudes while trying to finish off school. Support and planning may help a child to overcome some of these challenges. The chapter may help reduce the negative consequences of early childbearing and it looks at some relevant definitions, describes important considerations for you as a counsellor and provides guidelines to follow when dealing with teenage parents.

Definition of terms

Teenage pregnancy – Pregnancy in a female between the ages of 13 and 19. Children of this age are usually still immature and dependent on adults for the fulfilment of basic needs. At this stage, they usually have not yet completed secondary school and have very few, if any skills to become gainfully employed

School dropout – The decision whether voluntarily or because of coercion to discontinue school attendance and participation in academic activities.

Reintegration – The period after the teenage girl has given birth and when she starts attending school again. This is a period characterized by adjustment in that she must be both a learner and a mother at the same time.

Parenting options – The different options for the pregnant mother in terms of what happens next as well as to the baby after delivery.

Abortion – The decision and acts that terminate a pregnancy. Abortion is illegal in Namibia and therefore would not be an option to explore with the child. However, it is a very important topic for which the child should have information regarding the risks and dangers of illegal abortions.

Adoption – The decision to give up a baby to be taken into the legal care of fit parents. This process usually involves legal steps and a screening of the potential adoptive parents to ensure that they are suited to take care of the child. The biological parents forfeit decision making power over their children once they have given them up for adoption.

Social support – The individuals and structures that are available to support and guide the child during difficult times. Support can be in the form of advice, resources and simple presence.

Parenting – The duties associated with being responsible for a child.

Miscarriage – The premature involuntary termination of a pregnancy. There are a number of risk factors for a miscarriage. The experience is often traumatizing for the mother (and father).

Prenatal care – This is a programme offered by the Ministry of Health and Social Services (and other health care providers) to assist pregnant mothers in caring for themselves and their unborn babies. It includes information sessions and regular medical check-ups to monitor the health of both mother and baby.

Birth control – Methods such as taking oral contraceptives or using condoms during sexual intercourse in order to prevent pregnancy.

Risk factors for teenage pregnancy

Most common problems experienced by teenage parents

For you as the counsellor, it is important to be aware of the challenges faced by teens who are expecting to be parents soon. Despite the preventative efforts that you have made, there may still be teens who end up in your office that have fallen pregnant. In order for you to respond appropriately to the needs of a child, you will have to be able to identify the unique challenges of the specific child.

Lack of information

This is both a risk factor for falling pregnant and a challenge experienced by expectant teenager-parents. A lack of accurate information about age-appropriate and safe sexual behaviour is often the cause of unplanned pregnancy. To make matters worse, once a baby is on the way, it can be devastating to not have the correct information to guide self-care, parenting and preventing a recurring pregnancy shortly after.

Social stigmatization

Our society casts shame and judgement onto teens who fall pregnant while attending school. This can have negative emotional consequences for the affected child. It may further postpone the disclosure of pregnancy until it is in an advanced stage during which it may be too late to access prenatal care. This restricts optimal health practices during pregnancy. The stigma against this phenomenon is often the cause of fear, illegal abortion, low self-esteem and even suicide.

Lack of financial support

For the obvious reason that the parent to be is still attending school and because of reluctance to disclose the pregnancy, it may be difficult to obtain access to the finances needed in order to have a healthy pregnancy. Rejection by the teen's own parent may also cut off financial support and interfere with even basic needs satisfaction.

Lack of moral support

Along with social stigma comes rejection and withdrawal which reduces access to moral support. This can have negative mental health consequences for the teenager.

Discontinuation of education

Teens often end up leaving school because they find it difficult to keep up with the academic demands paired with the pregnancy. Another cause of leaving school is seeking employment to care for their unborn babies. In addition, some find it difficult to cope with the social judgement and rejection at school. Unfortunately, this makes the low socio-economic status even worse. Children who leave school prematurely have lower chances of finding decent employment and becoming financially independent individuals that can provide a conducive environment in which to raise their children.

Dysfunctional families

Teens who fall pregnant are often discharged from their families of origin. Also, relationships from which teenage pregnancy result hardly last and so single mothers or children growing up with grandparents is often the consequence.

Low self-esteem

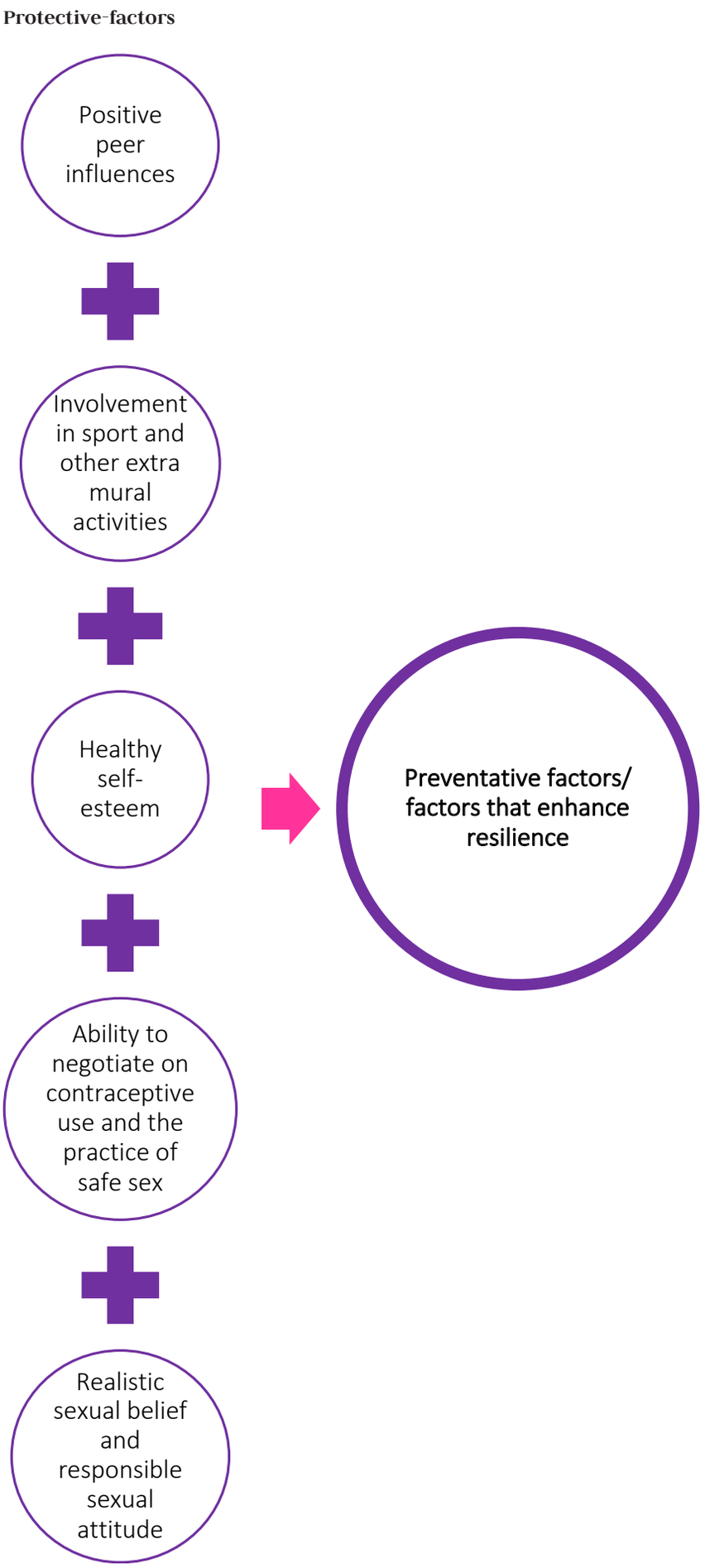
Factors such as being avoided by peers, a lack of moral support, being stigmatized against and discontinuing education may create a sense of inferiority and worthlessness. The resulting consequences on self-esteem are devastating.

Lack of focus

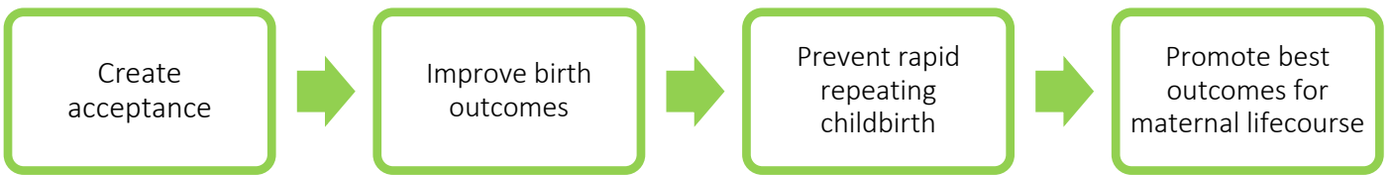
Dealing with the news of being pregnant, a partners response to the pregnancy, the teenager's own parents' response to the news as well as all the rapid changes associated with pregnancy all at once can be overwhelming. All these factors may preoccupy the child and cause distraction resulting in the inability to focus on important life goals such as education.

Avoided by peers

Children are likely to withdraw from their friends who have become pregnant at school. Often this is due to parental influence that fears negative lifestyle influence, judgement or simply the fact that priorities are no longer the same. This may also result from the discomfort the peers have in terms of what to say and how to act around them. This results in loneliness and a lack of peer support.


Protective-factors
Positive peer influences
Involvement in sport and other extra mural activities
Healthy self-esteem
Ability to negotiate on contraceptive use and the practice of safe sex
Realistic sexual belief and responsible sexual attitude
Preventative factors/ factors that enhance resilience

Your role as the counsellor



Creating acceptance:
-Be mindful of your own attitudes about teenage pregnancy.
-Ensure that your approach toward the child is warm and understanding instead of judgemental and cold.
-Create a safe and private place where you can interact with the child.

Improve birth outcomes:
-Discuss the the different options such as adoption and raising the baby with the teenager.
-Warn the child agianst the potential consequences of illegal abortion.
-Involve social services where necesary.
-Refer the teenager to access health services and prenatal acre as soon as possible.
-Involve the family of the child and guide them to provide support instead of rejection and criticism.

Prevent rapid repeating childbirth:
-Provide the child with acces to appropriate sex education and birth control options.
-Evaluate the risk factors for recurring pregnancy and address possible countermeasures with the child. For example, if the child is in an exploitative relationship with an abusive partner, empower them with the appropriate strategies to overcome such challenge.
-Evaluate attitudes toward pregnancy and sexual behaviour in order to influence greater insight and more responsible self management.

Promote best outcomes for maternal life course:
-Provide continued support and strengthen protective factors u.
-Help the teen to identify and access social support.
- Make referrals for further mental health interventions to prevent psot partum depression.
-Encourage the child to engage in good self-care byteaching practical skills in this regard.
- Teach the child coping skills and problem solving skills.
-Encourage the child to continue education and arrange for academic support where necesary.
-Involve the marents of both teen parents in order to identify ways of overcoming financial challenges.

Reintegration

The teenage mother who decides to come back to school after delivery may go through some adjustment challenges.

- She may have lost an academic year due to the pregnancy and delivery and that can be stressful.
- Her former classmates will be in a higher grade and she will join “younger” learners and that can be embarrassing.
- The teenage mother has to deal with the dual roles of being a mother and a learner and such roles may contradict in terms of expectations.
- She may have put on weight and may cause her to feel much older and less attractive.
- Her peers may avoid socializing with her due to the fact that she is now a mother.
- Teachers may treat her differently creating further discomfort.
- The pressure of attending to the child at home and meeting the demands of school such as homework may make the teenage mother exhausted at school and negatively affect her scholastic performance.
- The above issues may cause adjustment problems or disorders.

Your role as a counsellor.

- Engage the teenage mother where possible the first day she comes back to school after delivery.
- Talk to her about the hurdles she may meet as she reintegrates in school as mentioned in the preceeding section.
- Inform her that the decision to come back to school is the beginning of her courage to confront whatever she may need to confront at school.
- Allow her to express her worries and concerns and deal with the presenting issues.
- If the issues e.g. adjustment problems will require the attention of a professional, refer the teenage for such help.

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Appendix:

ACTIVITIES FOR COUNSELLING SESSIONS

Activity 1: Understanding why you use substances and the reasons why you want to stop

Tick the following reasons for substance use that apply to you;

- It makes me feel good quickly
- I sleep better when I have used it
- It makes the pain better
- It helps me feel less stressed
- It helps me avoid things that I don't want to think about
- It takes away and numbs bad feelings
- It takes away my loneliness and gives me something to do
- It makes it easier for me to communicate in social settings
- It makes me feel relaxed
- It makes me feel brave and less shy
- It makes me experience more fun
- It helps me fit in
- It uplifts my spirit and mood when I am down

Other benefits: _____

Now you will notice, these benefits usually only last for a short period of time. They are followed by some effects that are long-lasting and usually less pleasant. Tick the boxes below that you have experienced after making use of a substance;

- I forget what happened
- Had an accident or was involved in something that is unsafe or illegal
- I wasted or lost money or other valuables
- Got into an argument with a family member or friend
- Humiliated myself/ ruined my reputation
- Felt shame and guilt (damaged my self-esteem)
- Experienced negative health consequences
- Hurt or wronged someone that I care about
- Did something that is against my beliefs, morals and values
- Had a temper outburst
- My problems were still there when I sobered up

Other long-term effects:_____

Counsellor notes for Activity 1

You can use this activity by giving it to the child to complete on his/her own or you can do the activity with the child. When discussing this with the child during feedback, you can further use it to explore the child's feelings and to help you understand the challenges that the child is facing. When talking about the short term benefits, you will get a clearer idea of what challenges the child faces. When discussing the long term effects, you may identify reasons why the child wants to stop. If you focus on these, you may be able to help the child to increase motivation to change behaviour and avoid substance use.

Activity 2: Identifying triggers and the skills to respond to triggers

Below is a list of the most common triggers that substance users have in common. Triggers are the events, situations and circumstances that create urges and lead to substance use. Being exposed to triggers makes it difficult not to use substances. Go through the list below and tick the triggers that you have experienced;

When I feel uncomfortable:

- Sadness
- Pain
- Anger
- Symptoms of withdrawal when I have not used the substance in a while
- Loneliness
- Fatigue
- Frustration
- Illness/nausea
- Anxiety
- Boredom

When I have an urge or a craving

- Thoughts about alcohol or drugs
- When I see, smell or hear about the substance
- When I am around peers who are using the substance
- When others encourage or pressurize me to use the substance
- When I want to test my ability to control my use (I think I know when to stop)

To have more fun or make me feel better when I have relationship problems

- To enjoy special events
- To enjoy relaxing activities
- To have fun with my friends
- To reward myself after doing good or working hard

Situations in which you are more likely to use drugs or alcohol

- When I have money
- When I am with certain friends
- After a big test or examination
- After school
- Over weekends
- Seeing friends who use
- On special occasions
- When there is a special event or free day at school

Counsellor notes for Activity 2

Now that you have helped the child to identify his/ her triggers, discuss the list of coping skills that is below with the child. Explore which of the following the child is doing already and try to identify some new skills that the child can adapt:

Learn ways to handle anger
Develop routines that help get things done
Learn ways to handle stress
Learn how to think through problems
Learn ways to handle anxiety
Learn how to be less impulsive
Get more exercise
Learn ways to get support from others
Eat better
Get help managing money
Develop better sleep routines
Find a sponsor/mentor
Have more meaningful/fun ways to spend time

Other ideas: _____

Once you have discussed the list with the child, help the child to set goals and to start practising some of the skills. You can ask them whether they have practised these skills and find out which have worked and which did not work.

Activity 3: Learning the skills to say no to substance use

This activity will help you to handle situations in which you have the opportunity to use of a substance. Take a few minutes to answer the following questions. Practice responses with your counsellor to make sure that you know what to do when such a situation arises.

1. Who is likely to invite you to use the substance?

_____

_____

_

2. When and where will this happen?

_____

_____

3. How will this make you feel?

_____

_____

4. What will the person say?

_____

_____

5. How can you respond (what can you say or do)?

_____

_____

6. Who can help or support you?

_____

_____

Practice this exercise with your counsellor and imagine different situations that you might find yourself in. Try to think of as many possible situations as possible to make sure that you are well prepared.

Counsellor notes for Activity 3

Once the child has identified potential situations in which he/she will be triggered or invited to make use of the substance, it is also important to teach the child how to control impulses and the urge to give in to the moment.

Below, is a list of thing that the child can do when there is a situation in which he/she must try to resist substance use:

- Imagine a big stop sign in front of you. When you see it, be reminded that you must stop and think about the long term effects of your decision to use substances
- Wear a rubber band around my wrist and snap it to stop the thoughts and to avoid the urge of using the substance
- Remind yourself why you do not want to use the substance
- Try to take deep breaths and relax
- Do something interesting or fun to distract yourself
- Have a healthy snack or meal
- Write in your journal
- Remove yourself from the situation
- Do some exercise or take a bath
- Listen to music
- Talk to someone that you can trust
- Write down all the good things that you have achieved in your life

Activity 4: Sentence completion to identify feelings

Below, is a box with a list of feelings open, understanding, confident, free, satisfied, joyous, lucky, delighted, thankful, cheerful, energetic, optimistic, relieved, happy, relaxed, peaceful, blessed, reassured, comfortable, at ease, calm, warm, sympathetic, close, loved, touched, worried, curious, eager, anxious, excited, determined, brave, certain, secure, irritated, angry, unpleasant, resentful, cross, disappointed, ashamed, sad, powerless, guilty, unsure, hesitant, shy, distrustful, tense, alone, incapable, humiliated, ashamed, upset, frustrated, fatigued, useless, insulted, worked up, boiling, bored, disinterested, fearful, terrified, panic, restless, rejected, grief, lonely, heartbroken

Choose words from the above table and complete the sentences below. You can add words that are not found in the list.

- When a person is sworn at they feel.....
- When a child receives good news, she/he feels.....
- When a child is late for school, he/she feels.....
- When a child is in trouble for lying her teacher, she/he feels.....
- When a child is beaten, she/he feels.....
- When a teacher explains to a child why his/her behaviour is not good, the child feels.....
- When a child is in a dangerous situation, he/she feels.....
- When a parent mistreats a child, the child feels....
- When a child's friends do things without him/her, she/he feels.....

Now complete the following sentences;

- I feel sad when.....
- I feel happy when....
- I feel angry when....
- I feel disappointed when....
- I feel afraid when....
- I feel lonely when.....
- I feel frustrated when.....
- I feel bored when.....
- I feel excited when....
- I feel worried when.....
- I feel rejected when.....

Counsellor notes for Activity 4

The aim of this activity is to ensure that children have the correct words to label their feelings. As a counsellor, you may have to teach the child what the different feelings are. You may also have to guide the child to ensure that their labelling of feelings, is appropriate for the situations that cause these feelings. Below, is a list of things that you can coach children to do when they experience unpleasant feelings, such as anger, sadness, disappointment or loneliness;

- Draw or do art
- Take a warm bath
- Wash your face with cold water
- Talk to someone that you trust about how you feel
- Speak to an adult if you have a problem that must be solved
- Do some exercise
- Spend some time with someone that you love
- Look at pictures and think of happy memories
- Breath in deeply and out slowly ten times

Activity 5: How has my behaviour, feelings and thoughts changed.

Think about your life over the past few months or past few years. Has anything changed about you and how you experience life?

Who I used to be	**Who I am now**
Your body	
_____	_____
_____	_____
Your thinking, concentration and memory	
_____	_____
_____	_____
Your health, sleeping, eating and energy levels	
_____	_____
_____	_____
Your feelings and mood	
_____	_____
_____	_____
Other areas of your life	
_____	_____
_____	_____

When did you start noticing these changes? _____

How do you feel about these changes? _____

Counsellor notes for Activity 5

The aim of this activity is to find out if the child is aware that his/ her behaviour, feelings and thoughts have changed. It is also important for the counsellor to find out whether the child experiences these changes as good or bad, comfortable or uncomfortable and whether or not these changes interfere with the child's ability to function and cope with everyday life. This will help the counsellor to guide the child to specific coping skills for specific changes. It will further help the counsellor to identify the extent to which the child may be affected by his/ her problems. Depending on how seriously the child is affected, the counsellor must make a referral to a professional with specialized skills when necessary.

Activity 6: My strengths and challenges

Below is a blank space. In that space, draw the best picture of yourself that you can. Remember, everyone can draw in their own way, so try your best.

Now think of the person that you have drawn above. What are the strengths and challenges of _____ (write down your name)? Strengths are your good qualities and the things that you do with ease or that you have achieved. Challenges are the areas where you experience challenges and face difficulty. Everyone has both strengths and challenges. Use the space below to jot down some ideas that you can discuss with the counsellor;

MY STRENGTHS	MY CHALLENGES

Counsellor notes for Activity 5

The aim of this activity is to find out if the child is aware that his/ her behaviour, feelings and thoughts have changed. It is also important for the counsellor to find out whether the child experiences these changes as good or bad, comfortable or uncomfortable and whether or not these changes interfere with the child's ability to function and cope with everyday life. This will help the counsellor to guide the child to specific coping skills for specific changes. It will further help the counsellor to identify the extent to which the child may be affected by his/ her problems. Depending on how seriously the child is affected, the counsellor must make a referral to a professional with specialized skills when necessary

Activity 6: I can breathe to calm myself down

Sometimes, different situations in life can make you feel very emotional. For example, you may feel extremely angry or outraged from time to time. When you are extremely upset, it can be helpful to breathe slowly and in and out deeply. This helps your body to adjust and regulate your heartbeat. When your heartbeat becomes normal, it helps you to calm down and feel less overwhelmed.

To help you handle difficult situations, try the following;

1. Find a clock and follow the rhythm of counting 3 seconds and then 5 seconds, followed by 3 seconds and then 5 seconds and continue like this
2. For older children, 4 seconds and 7 seconds can be used instead of 3 and 5 seconds
3. Switch from counting out loud to counting in your head
4. Now, as you count, breath in for 3 seconds and breath out for 5 seconds, breath in for 3 seconds and breath out for 5 seconds
5. To make it even more relaxing, you can close your eyes after the first round
6. When you are breathing out, pretend that you re pushing the air gently through a straw
7. Repeat until you feel calm

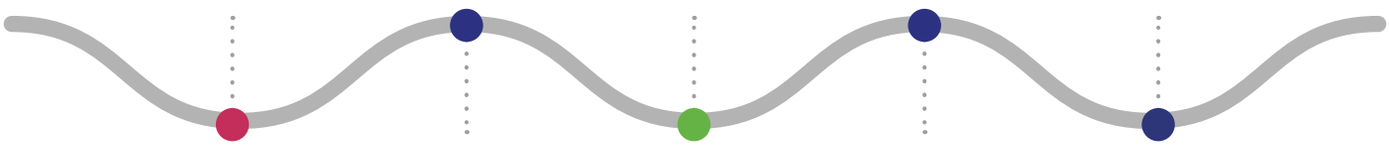
Now, remember, you will not get it right from the start. Children who get very angry and experience other intense emotions, often have difficulties with breathing. You will have to practice it daily, even when you are not feeling upset.

Counsellor notes for Activity 5

The aim of this activity is to teach the child important skills that can be used in situations where the child feels that he/she cannot control emotions such as anger. You must practice it with the child and teach the child that this way of keeping calm is a better alternative to using violence which can create negative consequences. This exercise is practical to use especially with children who present with aggression, excessive nervousness and anxiety.

Activity 6: A timeline of my life (significant life events)

Below is a scribbled line. Number it with dates since you were born and write down next to each date (it can be a year, month, event such as birthday, first day of school, etc) a memory that you have. Try to think of all the important things that have happened in your life. These can be both good and bad things. You can make space for more events on the timeline if you need to.



Counsellor notes for Activity 6

The aim of this activity is to help the child tell his/her story and to provide you with the necessary background information to understand what is going on in the child's life. Sit with the child as she/he completes this activity. After the child is done, ask questions and start discussions about the different good and bad things that the child has experienced. Try to explore the feelings that the child had in each situation. Remember that the child trusts you and you must treat the information that the child gives your compassionately to ensure that you validate the child's emotional experiences.

This activity may also help a child to organize their world and life experiences in a more systematic and ordered fashion. Ordering life experiences creates a sense of stability and reduces chaos for children.

You can encourage the child to draw a line of his/ her own and to make use of different colour or even picture if that is what the child prefers. In some cases, you can give this activity to the child to do as homework and then book out time to discuss it the next day.

Activity 7: My future hopes and dreams (part 1)

Materials required for this activity:

Sciccors
Newspapers/ magazines
Glue
Colouring pencils
Paper

1. Take a blank piece of paper
2. Consider what you hope for and dream of for yourself in the future
3. Use pictures, materials from your environment and the colours and pens to create a collage which tells a story about your future.
4. Try to creative.
5. You can dream and hope for anything.

Counsellor notes for Activity 7

The aim of this activity is to instil hope in a child. This activity will also tell you about the child's imaginative ability. It may be necessary to brainstorm with the child about how to create a collage and what to add to it. Once the child is done with the collage, you must do part two with him/ her. Part two is discussing the steps that the child must follow in order to reach his/ her aspirations. This will involve a discussion with the child. It will also involve rectifying behaviours that set limitations to the mentioned dreams.

Activity 8: Practical steps for handling situations of danger (bullying, physical abuse, sexual abuse)

Below are some steps that you can follow to help yourself in situations of danger. Even though you did not know what to do in these situations in the past, you can learn these steps off by heart so that you know what to do in the future.

- Listen to your body and the feeling that it gives you. Is it good or is it bad?
- Listen to your feelings, are they good or are they bad?
- When you sense danger, leave immediately
- If you cannot leave, use loud and strong words to tell the person who is creating danger to stop immediately
- Try to look for someone around that can help and support you in this situation
- If you know that someone has hurt you in the past, try to avoid that person or stay away from them
- Do not keep quiet about the situation. Tell an adult that you can trust
- If someone bothers me in the classroom, I ask the teacher to have my seat
- If I have to be around a bully, I ignore him/her. I do not look at him/her. I stay out of his/her way.

Counsellor notes for Activity 8

The aim of this activity is to teach the child practical steps to avoid dangerous situations in the future. Together with the list, help the child identify other practical solutions to situations of danger.

Activity 9: My life is not the same since..... left

When someone who is important to use passes away or is no longer a part of our life, many things may change. These changes may make us feel emotional and may make it difficult to go on with life. Below are a few incomplete sentences about change in life. Complete them with your own words.

My life changed since ..... is no longer a part of it

The biggest things that have changed are .....

.....

The most difficult part for me is .....

When I think about this, I feel .....

What I liked most about ..... was .....

What I miss the most about .....

My favourite memory about .....

When I feel ..... I can ..... To feel better .....

I can talk to .....

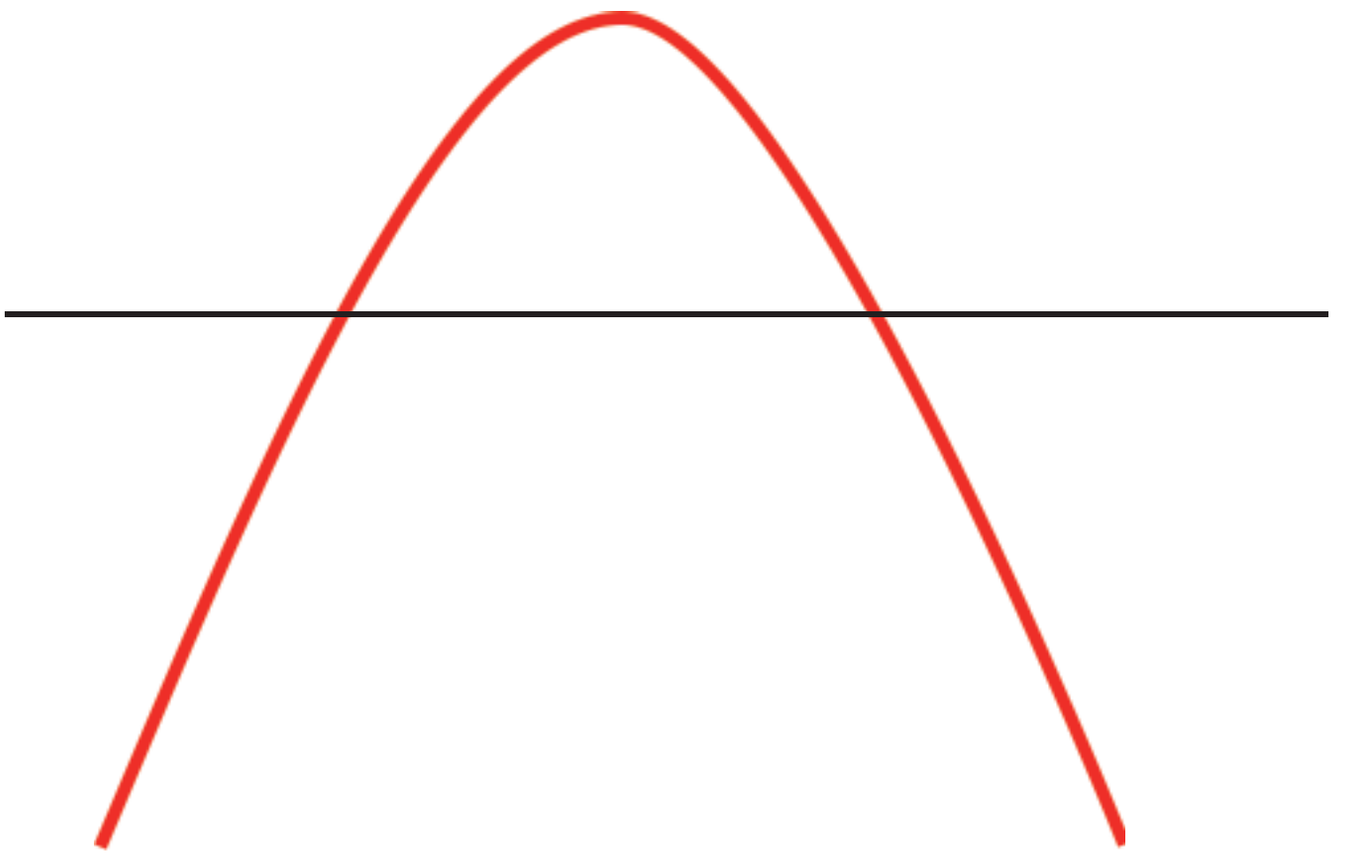
Counsellor notes for Activity 9

The aim of this activity is to help the child through the adjustment after losing someone important in his/ her life. The child may have more than one response for completing each sentence. It is important to explore whether the child has more to say or mention.

Activity 10: My anger is deep

Everyone gets really angry from time to time. Sometimes people get so angry that they end up fighting, hurting other people, saying mean things to others and destroying or breaking things. After getting so angry and doing the above, you may feel embarrassed about your behaviour. You may also get into trouble. Often, we get very angry in one situation because there are other things that have happened that we are still angry about. Think of the last time when you were very angry. Write what happened on the top part of the diagram below. Then think about all the other things that have made you angry in the past, that you still think about sometimes.

What made me angry in that moment



Other things that made me angry in the past that I still hold on to:

_____

_____

_____

Counsellor notes for Activity 10

The aim of this activity is to teach the child that anger can be deep-rooted and that there are a number of things that can contribute to our feeling angry at any given moment. Now that you have identified with the child, what it is that makes him/her upset, consider solutions to the problems that the child is confronted by. You will notice, anger is usually experienced in situations when children feel helpless.

NOTES

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