CHAPTER 4

CASE MANAGEMENT AND PROGRAMME IMPLEMENTATION

ÁRPÁD BARÁTH

4.0 INTRODUCTION

The aim of this chapter is to provide a selected series of ground principles and practical guidelines for two most complex tasks in helping the survivors of human trafficking: One is called *case management*, and the other is commonly known as *program implementation*. The first term will be used with reference to a specific knowledge base necessary for providing appropriate assistance at different stages and in different settings of client-helper encounters. The second term refers to strategic planning, decision making, and specific interventions throughout the assistance process. (See Glossary).

The chapter has been organised in two teaching/learning modules. Each module introduces a specific thematic "building block" and related practical skills to guide effective and unobtrusive assessment and intervention. The modules are labelled and described in the following order:

Module 4.1. The art of communication with trafficked persons
Module 4.2. Assessment and intervention – strategies and guidelines

Each module consists of two parts: The first parts provide descriptions and brief discussions of selected key concepts, theoretical principles and guidelines (minimum theoretical knowledge base). The second parts consist of a series of model exercises for effective transfer of specific skills to either professional or paraprofessional helpers, who may have non- or limited experience in casework with trafficked persons (minimum for practical knowledge base).

4.1 THE ART OF COMMUNICATION WITH TRAFFICKED PERSONS

4.1.1 Goal

The aim of this module is to review the effective transfer of basic interviewing and communication skills necessary for building trustful relationships and nurturing (therapeutic) alliances with trafficked persons.

4.1.2 Learning objectives

By the end of this chapter readers will be able to:

- describe a series of basic skills and safety standards for interviewing trafficked persons;
- identify the importance of role taking in the case management of trafficked persons;
- demonstrate the effective use of different strategies of communication with trafficked persons, including skills of unobtrusive and helpful communication with minors.

4.1.3 Teaching resources

- Basic text of this and other chapters of this Manual;
- Suggested readings compiled for this particular chapter;
- Suggested teaching-learning exercises listed for effective use in a "workshop" environment;
- Video-presentation of an encounter with a trafficked person (optional).

4.1.4 Specifics of encounters with trafficked persons

One should discern three basic groups of factors that shape the content and process of encounters with trafficked persons.

1. The individual's special background and personal characteristics;
2. Specific role taking that obliges an interviewer/helper in such encounters;
3. Specific contextual factors that determine the goals and dynamics of these encounters at different sites.

4.1.4.1 Special background and personal characteristics of trafficked individuals

The "injuries" of trafficked persons are much like those of victims of extended systematic torture (Conroy, 2000), in that most exhibit a full range of injuries to their physical integrity, mental functioning, and frequently suffer post-traumatic stress disorders (PTSD) (Tudorache, 2004).

Recent statistics gathered on a sample of 1,231 trafficked persons from Moldova (2000-2003) suggest that the majority of persons are young women between 18-24 years (58%) (Gorceag, Gorceag and Hotineau, 2004). Prior to departure, most of them were living with families (72%). Nearly one half of them were trafficked from rural areas (49%), and the rest from urban settings, including the capital.

Approximately one-third of the sample completed only primary school (36%), while a substantial number of persons completed high school or higher education, including university (32%). Well over one-half (58%) lived in "poor" economic conditions, according to local standards, and most of them were trapped into the web of traffickers while looking for work abroad (88%). The main method of recruitment is shown to be fake job promises (65%).

At the time of return, e.g. at the time of admission to a Rehabilitation Centre in the country of origin, an overwhelming majority of trafficked persons (88%) suffered from anxiety disorders, combined with a full range of other mental dysfunctions. A strikingly high proportion (90%) was probably exposed to domestic violence, including physical violence (37%), emotional-moral abuse (36%), sexual violence (16%), economic violence (5%), and the combination of these from early childhood on (Gorceag, 2004).

This brief reminder should serve as a warning that trafficked persons represent not only a "special" population with a past of abuse and torture, but they are vulnerable in any contact with a "stranger", whatever the purpose of the encounter may be. At the same time, many trafficked persons have already learned to deal with strangers by pretending to be "someone else", even to the extent of lying about age and country of birth. This is one of the most substantial markers of the identity crisis they are trapped into.

4.1.4.2 Specific role taking in helping

Interviewing and providing assistance to trafficked persons is one of the psychologically most complex and ethically most sensitive human encounters. It goes far beyond the "usual" encounters of every-day life.

There are at least three specific factors that make these encounters difficult for both the interviewee and the interviewers:

1. As a general rule, trafficked persons are typically "involuntary clients", who would not ask for help as a client of psychotherapy or psychological counselling, because likely they never had the chance to ask anyone for help. (NB Those who "helped" them, in the paradoxical meaning of the term, were their traffickers, employers, or pimps.)

Exercise 4.1-1. here

2. Typically interviewers would not have had a common or similar personal experience with abuse or trafficking, which they could share with their interviewees.

3. The ethical sensitivity and personal responsibility of interviewing trafficked persons is very high. This is why one should be well aware of the ethical codes and safety standards of interviewing trafficked persons, listed in WHO's recommendations (WHO, 2003).

Exercise 4.1-2. here

The role of caseworker assisting trafficked persons is multiple and at times overlapping (Rothman, 1994). A helper who integrates several roles has been recognised in the professional jargon as a case manager. What this term actually covers in the realm of providing assistance to trafficked persons, is six basic interventive roles, in the following order:

1. *Enabler role.* In earlier literature of social work, this role would be described as "supportive". The enabler encourages, motivates, and supports the client to make relevant decisions, and to take action on his/her own. In some situations, of course, typical for the initial phase of the rescue process, the case manager will have to take actions for the trafficked person, but the ideal is to maximise the persons' involvement in the helping process.

2. *Trainer role*. One should expect that after a long time of abuse and deprivation from basic human rights, many trafficked persons will not have the necessary skills to make even the most elementary personal decisions, such as a decision for or against being interviewed. Training programs designed to teach various skills across the life span (e.g. survival skills such as shopping, house cleaning, using public transportation, managing money etc.), should be provided all along the case management and recovery programme not just by a single case manager but by a full team of rescue workers (Curran and Monti, 1982).

3. *Referral role*. The referral role represents one of the most common activities in case management. Knowledge of the formal, informal, and indigenous resources in a community where the case management is taking place is critical to the success of program planning and implementation. However, knowledge alone will not guarantee "success". *Linking* and *community networking* are also essential functions of case management. Both ask for the caregiver's ability to develop contacts and create close working alliances with other case managers, professionals, other potential helpers and the local authorities in the community (in some cases, for instance, a working alliance with religious community leaders may be more promising than working with local policy makers or NGOs).

4. *Mediator role*. The purpose of mediation is not to create new linkages, as in the *referral role*, but to improve the trafficked person's existing connections and relationships in his/her new social environment or community of origin. The ethical issue in mediation is that the case manager must stay "neutral", or at least appear neutral to all involved, because a mediator is not an "advocate", but should take a position between the helped person and her potential resource group.

5. *Resource develope*r. In many cases, the focal problem is the lack of resources for reintegration. Resource development can be conceptualised at two levels: There is the large-scale programme development approach which attempts to create services and resources for a large number of persons with the same experience (e.g. prevention program of re-trafficking). The other, more narrow-scoped level is focused on the development, mobilisation, or reorganisation of close interpersonal resources, such as initiating self-help/mutual aid associations at municipal or national level.

6. *Advocacy role*. By definition, advocacy is a *partisan* role. Unlike in all above listed roles, as an advocate the case manager must take a firm position with (or on behalf of) the trafficked person to address the injustice that has befallen him/her from persons or groups s/he has been (and perhaps still is) attached to. Of the many different forms of advocacy, the crucial role of *case advocacy* should be highlighted. This is a specific kind of reintegration help not only for individual persons, but for whole groups (or classes) of persons with trafficking experience. Case advocacy should be at the level of local communities and "natural" social support systems ("old" or "new" ones), which might otherwise socially exclude trafficked persons.

Exercise 4.1-3. here

4.1.4.3 Context specific features of encounters

As described in earlier chapters, case management from both the individual's and provider's perspective means a stage-wise process that optimally ranges from the detention phase in the country of destination to "home-coming" in the country of origin. One has to be fully aware that from the individual's perspective, the return is most complex, and perhaps psychologically as taxing as the very process of trafficking, if not more. Specifically, during "homecoming", trafficked persons are approached by a countless number of "interviewers", many of whom may have no understanding of "human trafficking", and its lasting impact on the personal and social well-being of the individual (see WHO, 2003.).

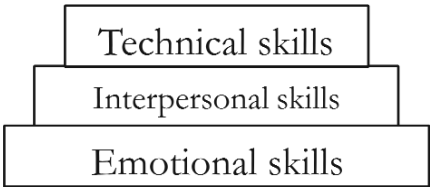
"In response to the global rise in trafficking and growing demands for information on trafficking by policy makers, donors, service providers, and the media, women who have been trafficked are increasingly being interviewed to discuss their experiences. Women are being interviewed both while they are in trafficking situations under the control of traffickers, employers, or pimps, and after they left the trafficking setting, such as while in shelters, under the care of service agencies, or once they have returned home or re-established their lives elsewhere. In any of these situations, interviewing a woman who has been trafficked raises a number of ethical questions and safety concerns for the woman, others close to her, and for the interviewer."

(WHO, 2003. p. 3)

Exercise 4.1-4. here

4.1.5 ELEMENTS OF EFFECTIVE COMMUNICATION

Most experts would underline three basic skills for effective communication, in general (Dick, 1997). These are technical, interpersonal and emotional skills, and they can be hierarchically structured as such:



Emotional skills are thought to be the base of all communication skills. From a management point of view, they simply mean one's ability to make difficult decisions, and to take responsibilities. To put it simply, emotional skills mean courage, with elements of self-management. Without emotional skills the interpersonal skills, such as non-verbal communication skills, would have no basis, and without interpersonal skills the technical skills, such as asking appropriate questions at the right time and in the right manner, would remind of a mechanic examining an engine.

Another way to look at effective communication is to stress three rather specific skills of building a meaningful, non-threatening relationship with the other person, each requiring emotional skills as a base:

- Expressive skills to convey information to others.
- Listening skills to obtain information from others.
- Skills for managing the overall process of communication, that is identifying and selecting the information needed – which one to give or receive?

Factual information is usually conveyed and deduced by words, whereas affective contents and attitudinal information is usually derived from non-verbal expressions. These include the characteristics of the person's speech (e.g. tone of voice, pace, intonation), posture, facial expression, gestures, nearness etc. The following brief quotation should make the general importance of non-verbal expressive skills at the first place in communication with persons in distress.

"We are often unaware of our non-verbal behaviour. We often process other people's non-verbal [messages] without conscious attention (...) In understanding other people's feelings, however, there are some overall patterns which can be used. Large-silhouette postures, advancing gestures, threatening facial expression, loud volume, sustained eye contact together may indicate aggression. Small-silhouette postures, retiring gestures, troubled or masked facial expression, low volume, and avoidance of eye contact together may indicate appeasement or withdrawal." (Dick, 2001:5)

Exercise 4.1-5. here

4.1.6 Interviewing skills

Contemporary textbooks and practical guides for teaching-learning the strategies and skills of effective interviewing and helping, provide catalogues of specific communication skills recommended at different levels and purposes. Some of these skills would be qualified as basic; others are intermediate, while still others as advanced and specialised skills (Trevitchic, 2000). It would go far beyond the scope and purpose of this particular chapter to make a long listing of specific interviewing skills, and to discuss them at any length. Instead, we selected three basic skills that, indeed, represent the backbone of effective interviewing and helping. These are:

- Rapport building and empathetic communication,
- Questioning skills,
- Listening skills and reflecting.

4.1.6.1 Rapport building and empathetic communication

The notion of *rapport* is best captured as a spontaneous interaction between two or more people, based on mutual understanding to accomplish a joint task (working alliance). In simple terms: Rapport in helping relationships is nothing more than *care with caring*.

"Establishing rapport involves creating a climate where the interviewee can begin to gain confidence in our personal and professional integrity. This is important because it creates the favourable conditions necessary for people to be able to discuss and reveal problems or difficulties, successes or failures, and strengths and weaknesses in ways that aid understanding and allow for a realistic plan of action to be created." (Trevitchick, 2000: 76)

In addition, there are the notions of *empathy* and *sympathy*, i.e. two concepts which are usually mixed up in lay understanding. The difference is that whereas *"sympathising"* with someone means being ourselves moved by certain emotions observed in another person's behaviour or verbal statements (e.g. seeing someone crying), *"empathising"* means 'putting ourselves in another person's place' (Egan, 1990).

Empathetic communication involves three specific skills (Kadushin, 1999):

- *reaching for feelings*, that is, 'stepping into another person's shoes' to get as close as humanly possible to his/her very personal experience (inner way of knowing and feeling);
- *displaying understanding of the other person's feelings*, which essentially means indicating through works, gestures, expressions, physical posture, or touch (if appropriate) the interviewer's comprehension of the expressed effect;
- *putting the interviewee's feelings into words*, which is particularly important whenever the person is unable to articulate (label) certain feelings, for whatever reason (e.g. language barriers, feeling inappropriate to verbalise feelings at the given moment, state of mental confusion etc.).

In summary, rapport and emphatic communication, as the two core elements of helping relationships, represent two sides of the same coin, which we call here: the basic humane elements of case management. These elements, of course, have very specific behavioural (manifest) components that should be learned, practised (rehearsed), and checked for quality, in every single encounter with trafficked persons. The table below displays a summary of the behavioural components of rapport building and empathetic communication.

Table 4.1.1. Behavioural components of rapport building and empathetic communication

Communicating willingness to listen:

1. Varied eye contact
2. Relaxed posture
3. Appropriate, comfortable gestures
4. Rotation toward client
5. Leaning toward client
6. Appropriate seating distance

Communicating interest and facilitating the individual's telling of his/her own story:

1. Nodding of head
2. Facial expression of interest
3. Voice tone
4. Avoidance of interruptions
5. Repetition of key words
6. Single questions
7. Open questions
8. Paraphrasing (reflecting emotions and affects)

Communicating respect for individual's worth, integrity, and abilities

1. Use of non-evaluative and non-absolute (non-categorical) language
2. Use of client's name
3. Positive statements about the client
4. Avoidance of stereotyped gestures and responses
5. Leaving option to the client

Source: Authier and Gustafson (1982: 105)

4.1.6.2 Questioning

In the realm of helping relationships, the art of questioning involves four main groups of interviewing skills:

1. open questions
2. closed questions
3. 'what' questions
4. intervening (therapeutic) questions.

Before discussing the four basic questioning skills in detail, let us highlight five forms of unhelpful questioning, which most frequently occur during interviews conducted by largely untrained (lay) interviewers:

1. leading or suggestive forms of questioning
2. too many 'yes'/'no' questions
3. garbled or unclear questions
4. double or multiple questions
5. too many 'why' questions.

1. *Open questions*. Open questions are designed to provide freedom for choice, enabling the interviewees to express their thoughts and feelings in their own words and in their own time; to choose or ignore certain concerns. It is suggested that open-ended questions should form a major part of an initial interview or first encounter. The risk of open-ended questions may be in their ambiguity of 'what is expected', as well in their answering difficulty, as compared to closed question (Baráth, 1976).

Example 1: Sample questions that may be asked to assess security

Q: *"Do you have any concerns about carrying out this interview with me?"*
Q: *"Do you think that talking to me could pose any problems for you, for example, with those who trafficked you, your family, friends, or anyone who is assisting you?"*
Q: *"Have you ever spoken with someone [interviewer's profession] before? How was that experience?"*
Q: *"Do you feel this is a good time and place to discuss your experience? If not, is there a better time and place?"*

Example 2. Open question for initial interview or assessment

Interviewer: I've got some information about what happened to you [shows charge sheet] but I would like to ask you to tell me what happened – in your own words.

Example 3. Life-story work (narrative interview)

Interviewer: One way for me to get to know you better, would be perhaps to say a few things about yourself, that you think are important and helpful f or both you and me. How does this sound? [Nod] Where would you like to begin?

2. *Closed questions*. Closed questions could take different forms (e.g. 'yes-no' queries, self-categorisations, Likert-type rating scales). In general, they seem to be 'easy to answer' type of questions, however, they are more difficult for comprehension than open-ended queries. Moreover, closed questions are likely leading (suggestive) questions, and they likely produce a full range of response biases such as 'yea' or 'nay' saying, social desirability towards "expected" answers, and the like. Above all, closed questions tend to create a potential "threat" (and risk) both for the interviewer and the interviewee, because of (a) the choice of words, (b) the intonation, and (c) the timing. In one context, for instance, asking for a person's place of birth might be utmost threatening, while in another context the contrary may be true. Consequently, one of the basic recommendations is to avoid asking too many closed questions in a single series of queries!

Example 1: Gathering basic information

Interviewer: Okay. Can I have your name, date and place of birth, please?

Example 2: Clarifying the reason for the referral to a Transit Centre

Interviewer: I can see from your documents at hand, that you have just 'run away' from a certain place you have been before [destination of 'work'], and someone told you that you should see me, in person, at some point of time. Could you tell me, who was the person suggesting this meeting for you, and what she or he told you about the reason for this referral?

3. *'What' questions*. This form of questioning is particularly popular in certain types of psychological counselling and brief therapy. The question leaves the interviewee free to define for him/herself the issue or concerns that s/he wishes to focus on. 'What' questions are utmost useful in attempting to explore wider issues.

Examples for 'what' questions:

Interviewer: What happened to you, Mary, in the last 12 months – as you see it?

Interviewer: What will happen to you, Mary, in the next 12 months – as far you can see it?

Interviewer: What do you think will happen if you stay where you are now [place]?

4. *Interventive questioning*. Of a rather rich literature on therapeutic questioning, it seems useful to highlight some of the most popular "typologies" of interview questions that are essential for in-depth exploration of an individual's problems and perspectives for change. There are four major groups of questions in the context of psychological counselling and related helping relationships (Tom, 1988).

- *Lineal questions*. By definition, lineal questions are investigative (fact-finding) queries. The basic types of these queries are: "Who did what? Where? When?, and Why? Most interviews begin with at least some lineal questions.

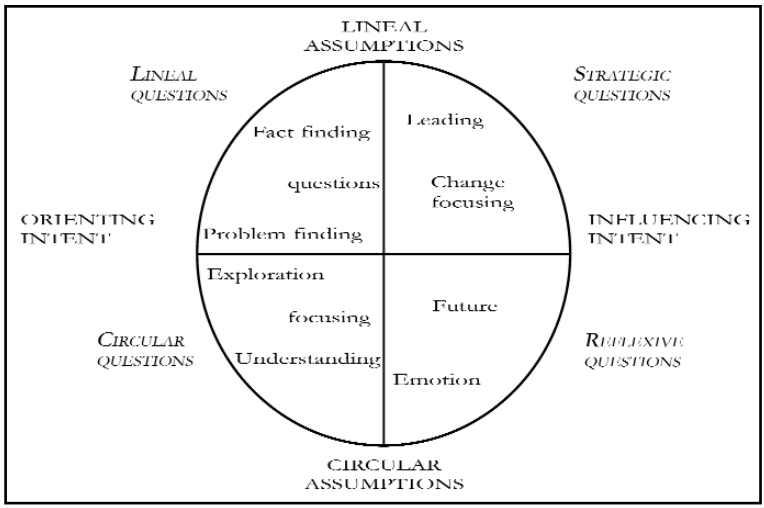
- *Circular questions*. The intent behind these questions is predominantly exploratory of 'patterns that connect' persons, objects, actions, perceptions, ideas, feelings, events etc. in recurrent or cybernetic circuits. The basic types of these queries are typically 'before and after' questions, which focus on changes that have taken place in relation to a particular event (e.g. "What do you think happened, when you left home?"); 'comparison' or 'ranking' questions, which seek to identify different reactions among different participants of a particular event (e.g. "Who was more depressed at that moment – you or your mother?")

- *Strategic questions*. The intent behind these questions is predominantly corrective. By asking such questions, the interviewer takes the role "as if..." s/he were a teacher, instructor, judge or the like. The question operates on the basis of certain assumptions that some answers are more "correct" than others, but s/he intends to guide the interviewee to decide and choose what s/he thinks is more "correct" (true, viable, appropriate) for thinking, feeling and action. Typical types of these questions are the, so called, "challenges for action" (e.g. "Why don't you talk to them about your worries instead of just worrying about them?")

- *Reflexive questions*. The intent behind these questions is facilitative (reinforcement, empowerment). The therapeutic assumption is that the person is an autonomous, self-conscious, self-organising individual, or at least wants to become, and cannot be instructed directly. Thus, the interviewer takes the role of a guide or coach encouraging the person to mobilise his/her own problem-solving resources in the most meaningful and creative way (e.g. "As far as I understand, you want to do that but don't know how to get from here to there...?").

The diagram below summarises the four strategies of interventive interviewing.

Figure 4.1.1 Strategies of interventive interviewing



Source: Adapted from K. Tomm (1988:6)

4.1.6.3 Listening skills and reflecting

Listening skills are usually addressed in the literature as skills for active listening, as an essential part of interviewing competency.

> *"Active listening describes a special and demanding alertness on the part of the listener, where the aim is to listen to the details of what is being conveyed and to ensure that the (person) is aware that this is happening. Credulous listening is about believing what is being communicated." (Feldham and Dryden, 1993: 105)*

One of the best ways to distinguish "good" (helpful) from "bad" (harmful) listeners, is to sort out the basic patterns of behaviour on each side.

Being a "good listener" is more than simply attending and hearing what the other person says. Active listening means encouragement, support and care for the speaker. A *"good listener"*:

- Looks at the speaker for most of the time;
- Encourages the speaker with nods, smiles;
- Makes encouraging, approving vocalisations (uh…hmmm);
- Is sympathetic, patient and accepting;
- Shows interest, listens carefully, takes an appropriate (attending) posture;
- Asks questions to make things clear, asks about details;
- Gives advise that is concrete and specific, if asked for that or thinks needed;
- Does not interrupt;
- Does not judge or criticise;
- Expresses confidentiality.

On the contrary, a *"bad listener"*:

- Hardly looks at the speaker;
- Is not sympathetic;
- Does not listen to what is being said;
- Frequently interrupts the speaker with questions or comments;
- Criticises, makes sarcastic comments or judges the speaker;
- Talks too much instead of listening;
- Argues;
- Does other things while s/he is supposed to be listening (e.g. looks at own nails);
- Laughs at the speaker, does not take him/her seriously.

It was certainly one of the greatest innovations in the theory and practice of humanistic (person-centred) psychology, when Carl R. Rogers and his co-workers introduced the concept and technique of reflecting, as one of the core elements of empathetic understanding and communication. At this point, the best would be to quote C..J. Rogers himself:

The third facilitative aspect of the relationship is emphatic understanding. It means that the therapist senses accurately the feelings and personal meanings that the client is experiencing and communicates this acceptant understanding to the client. When functioning best, the therapist is so much inside the private world of the other that he or she can clarify not only the meanings of which the client is aware but even those just below the level of awareness. Listening, of this special, active kind, is one of the most potent forces for change that I know." (Rogers, 1986: 198)*

*Note: In Rogers' theoretical framework, the first element of therapy is *"genuineness, realness, or congruence"*, and the second attitude of importance is *"acceptance, or caring, or prizing – unconditional positive regard"* – A.B.

In practice, reflecting is a set of special skills (verbal and non-verbal) that a helper employs to "mirror back" to the interviewee her deep-seated feelings, thoughts, intentions, attitudes, non-verbal experiences etc. of which s/he may not be fully aware, or simply cannot formulate in a clear and coherent way because of denial or other defences.

The term "reflective interviewing skills" covers a set of four different techniques. (Brammer, Shostrom and Abrego, 1989.)

1. *Reflection of feelings*. This is an attempt by the counsellor to paraphrase in "fresh" words the essential attitudes (not the verbatim content) expressed by the client.
2. *Reflection of non-verbal experience*. This is when the counsellor attempts to match or "pace" his/her own non-verbal behaviour to a client's non-verbal behaviour (e.g. gestures, posture) in order to facilitate rapport and empathetic relationship.
3. *Sharing of experiences*. This would involve sharing the counsellor's own personal experiences with some aspects of the client's personal experience, if and only if appropriate.
4. *Identifying (labelling) feelings.* In general, this means the sensibility and experience to recognise and express in words the core feeling of the other person that s/he actually experiences ("immersed into") at the given moment. This is to say, that the counsellor is expected to identify and spell out the predominant feeling/state of the person from one of the three broad categories: positive, negative, and ambivalent. "Positive" are the feelings, which are ego-constructive, self-empowering, self-actualising, while negative feelings are generally ego-destroying.

The following table provides some examples of labels that fall into the two main categories of feelings, positive vs. negative.

Table 4.1.2. An example of labels for positive and negative feelings

Positive		Negative	
Happiness	Self-worth	Guilt	Disgust
Security	Love	Resentment	Antagonism
Gratitude	Optimism	Fear	Rebellion
Self-confidence	Contentment	Depression	Rejection
	Warmth		Hostility

Exercise 4.1-6. here

4.1.7 Communication with minors

As stressed in earlier chapters of this Manual, a very high proportion of trafficked persons are minors, both boys and girls. According to recent estimates, some 1.2 million children are trafficked around the world, of which some are victims of forced begging, while still many are trafficked for different sectors of the sex market (UNICEF, 2003).

According to the UNICEF (2003) report, Europe is the biggest market for child trafficking. The children are often brought to the continent to work as domestic or sexual slaves. West Africa and Eastern Europe are the biggest suppliers, although regions in Asia show significant numbers of child trafficking. Southeast Asia, for instance, accounts for one-third of the domestic and international child trafficking.

Source: Lowell, Reuters (2003)

Exercise 4.1-7. here

4.1.7.1 Age-specific patterns of coping with lasting distress

Thus far, we have no reliable research evidence regarding the presumably specific coping strategies of children caught by different webs of human trafficking. Moreover, we have scarce evidence on specific coping mechanisms of the millions of children sexually or otherwise abused by their own relatives or others in their close environment. We only know that that children of different age categories cope differently with traumatic life events. The patterns of these differences are summarized in the next table.

Table 4.1.3. Age-specific patterns of coping of children with distress

Preschoolers	Elementary school-age children	Preadolescents and adolescents
Crying *Thumb sucking* *Loss of bowel/bladder control* *Fear of being left alone* *Fear of strangers* *Irritability* *Confusion* *Clinging* *Immobility*	*Headaches, other physical complaints* *Depression* *Fears from (…)-, about personal, family and communal safety* *Confusion* *Inability to concentrate* *Poor performance at school* *Fighting* *Withdrawal from peers*	*Headaches, other physical complaints* *Depression* *Confusion* *Poor performance at school and/or in other areas of social role taking (e.g. in sports)* *Generalized aggressive, antisocial behaviours and self-defeating tendencies (e.g. alcohol abuse, early drug dependency, delinquency)* *Withdrawal and isolation from family, peers and authorities*

Source: After Lystad, (1985: 65-66)

The table provides an orientation of what "regression" means in coping with stressful life conditions. While by definition, "regression" means lowering one's ego-functioning at time of excessive distress from a higher (more adaptive) to lower (less adaptive) levels of physiological, mental and social functioning, the above table provides some understanding as to why children of older ages tend to behave like "pre-adolescents", and the latter as "preschoolers" in conditions of lasting distress.

4.1.7.2 Specific needs of children in distress

Abused and neglected children likely become noticed, for the first time, in settings for paediatric interviewing. The first and most visible clue for their identification is a high index of suspicion about illness or injuries that may not have occurred "accidentally", according to professional diagnostic criteria (medical or else). Secondly, the child's general appearance often supports the impression of abuse or neglect (uncared physical appearance, below or above normal weight for no obvious reason). Thirdly, abused and/or neglected children are often unusually quiet. Developmental delays, long histories of poor social infarctions, unrealistic expectations from self and others made them "silent observers" of the world around, and non-observers of themselves. Last but not least, abused and/or neglected children typically do not posses basic communication skills, nor verbal or non-verbal modes of interpersonal communication, that fit their chronological age.

"As children grow we expect them to grow in their capacities to communicate, solve problems, take responsibility, do school work, and so on. For children living through wars and disasters, this development is often interrupted; children may even go "backwards" in their achievements. Younger children stop speaking or start stammering, they begin to wet the bed again, they are afraid to be separated from their family. Many older children have locked normal social and learning experiences. They find it difficult to study in school or form friendships, and want to be treated like younger children, for example, an adolescent might have tempers and make demands like a three-years old. We have to adapt our ways of communication with these children, and accept that we may need to treat them as though they were younger." (Richman 1993: pp. 14)

4.1.7.3 Six basic values of communication with children in distress

We come to discover and appreciate the importance and specific values of communication with children in distress. These are:

1. *Moral support*: First and most importantly, abused children need moral support as well as practical help. Those without families are especially in need of an adult to support and advise them, but even those with families may have no one to confide in.
2. *Someone to confide in*: Children living in their biological families, with step- or foster parents, in orphanages or hostels or on the street, can all be in need of someone to help them deal with difficulties. Those suffering from the lasting impact of sexual or physical abuse need to tell someone about this. If there is no one to listen and help, the child remains alone with the distress.

3. *A sense of relief*: Children usually feel relieved when they tell someone about how they feel or can communicate their feelings through drawing or play. The load is lighter now that an adult (or possibly an older child) is sharing their sadness and worries.

4. *Coming to terms with experiences*: The child can begin to:

   - distance or separate him/herself from his/her painful emotions;
   - have a different viewpoint of what has happened to him/her, and see that others have similar problems;
   - try to resolve his/her current problems;
   - gradually start to look towards the future.

5. *Communicating in a group*: The moral support and friendship of a group of children/youth is also essential. This is why it is important to recognise and help children who have no friends, and encourage group discussions and activities.

6. *The importance of different kinds (channels) of communications*: Children have many ways of communicating. They express themselves through their play, drawings, modelling, music and singing, dancing and writing. While talking helps to regain confidence, and work out ways of dealing with difficulties, children also need opportunities to renew normal life, to play, study and work.

4.1.7.4 Most important communication skills for children

1. Tone of voice: Everyone, from his/her earliest childhood, is able to distinguish a harsh from a soft human voice. Children in distress are especially sensitive to human voices. Most of them rely on the pitch, timber (intonation) and rhythm of the speech and are quick to categorise their conversant into a "good" or "bad" character.

2. Facial expression: Similarly, facial expression is another leading clue for children in making a judgement about the mood and character of people – whether they are "good" (helpful) or "bad" (threatening). In talking to children who are in distress one should realise that they keep observing facial expressions and movements (encouraging or discouraging noises, nods, smiles, moves of eyebrows etc.) very carefully, even if one is not aware of it. They do so because they have to make a decision to accept the person in front of them as a friend whom they may trust, or as an enemy.

3. Jokes and laughter: Small jokes, humorous comments, smiles and laughs make people relaxed and trust each other. This is also the case with children. However, it may also work conversely! When inappropriate or culturally unacceptable, making jokes and laughing may stigmatise someone as a mean person, both in the eyes of children and adults.

4. Eye contact: Eye contact with children represents perhaps the most important channel of non-verbal communication. Within certain time limits and according to cultural codes, eye contact certainly represents one of the major tools in the creation and maintenance of helping alliance with children in distress.

5. Rapport building (sharing): On the part of the helper, rapport means building ability for closeness, intimacy, mutual trust and sharing. On the part of the child it means resuming the feeling of safety, positive self-image, self-empowerment, and the acceptance of care and guidance offered by an adult helper.

6. Spatial behaviour & seating arrangement: The spatial patterns of seating, walking, resting, holding speech are as important as all other channels of non-verbal communication. In close encounters, such as in play rooms or at creativity workshops, both children and adults find themselves most comfortable in the seating arrangement of a circle or ellipse, and sitting on the floor, if acceptable.

7. Closed questions: Closed questions suggest one-word responses. They sound simple but are often hardest to answer, in particular for children, because such questions either ask for facts or clear-cut judgements. Moreover, they may be threatening if no factual knowledge is available or no clear criteria are given for (qualitative) assessment (e.g. "Are you tired?" "Where do you live?"). Special kinds of closed questions, called leading questions, are especially threatening because they strongly suggest an answer expected by the interrogator (e.g. "Seems you like living here, don't you?"). By this way they tend to force the respondents toward biased reporting.

8. Open-ended questions: Open questions announce a topic of interest (e.g. "What happened to you yesterday?") They do not suggest the content or structure of the answer. Open-ended questions are more than an interviewing technique. They reflect an inquisitive attitude, and if properly phrased, they offer the opportunity for more in-depth communication.

9. Using simple language: One of the largest barriers of communication between adults and children is the use of long or difficult words, complicated sentences or ideas that the child simply does not understand. Children's language is simple, it draws upon everyday experiences and involves short sentences.

10. Giving and receiving feedback: How do you know whether you are being understood? How does your conversant know whether you understand him/her? The way of knowing is called feedback. Feedback includes: eye contact, subtle signs of letting know that you follow what has been said (head nods, smiles, facial expression, short vocalisation "Uh-hmmm", attending posture etc.). In short, feedback is needed to check whether the actual results of your communication are the same as you meant them to be. Children in distress are in special need for feedback simply because they have to find out whom to confide in. Avoid asking a child questions such as "Do you understand what I said?" or "Is that clear?" or the like, as many teachers do so in their day-to-day teaching practice. These questions are leading (see above) and threatening, and children are likely to say "yes" even if they do not understand a single word you are saying.

Exercise 4.1-8. here

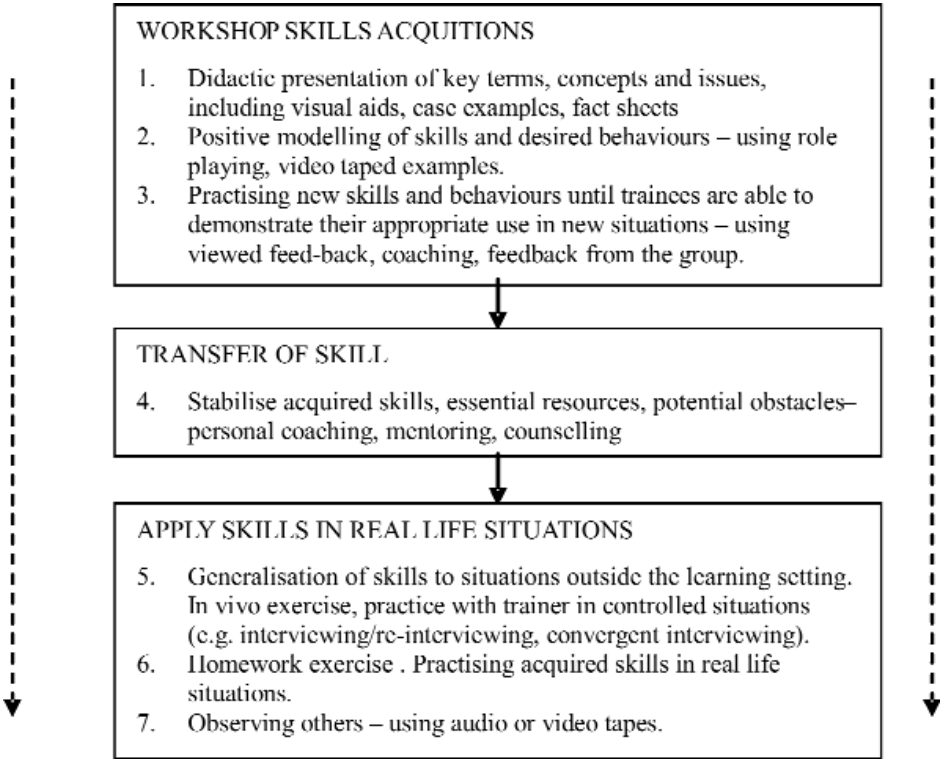
4.1.8 Some suggestions for teaching effective communication and helping

There is an abundance of theoretical literature on effective communication, yet good text-books for effective transfer of specific skills are rare. Those which exist are mostly written for professional helpers; some of them are listed in the reference list (see Marshall and Kurtz, 1982; Eagan 1990; Trevitchic, 2000). On the other hand, many skilled practitioners never went through any formal training in communication, hence, most of the skills are learned through experience, and used intuitively in everyday practice. Many of these day-to-day practices happen unnoticed, unless the person is a professional psychotherapist (or social worker) involved in professional supervision.

4.1.8.1 A general communication skill acquisition paradigm

Learning-teaching communication skills, can be regarded as a process of step-by-step transfer of all "building-block knowledge" that trainers use in virtually all realms of human encounters, including management, human resources development, skills training for social work practice, to name a few. In this respect, the following diagram serves as a (theoretical) guideline for pointing out the specific elements of this step-by-step training process (see Figure 4.1.2).

Figure 4.1.2 Communication skills acquisition paradigm



4.1.8.2 A proposed module for teaching communication skills

The following general thematic module structure seems most appropriate in teaching general and specific communication skills for case workers involved in helping trafficked persons:

- Introduction
- Basic rules of information chain (and exchange)
- General and specific skills of communication
- Non-verbal communication and expression
- Expressive skills
- Listening skills
- Managing the overall process
- Communication with other helpers
- Communication with community resource groups
- Monitoring and mentoring
- Field practice and back-reporting
- Conclusion

This specific communication training program could be accomplished in six days of intensive work, combining theoretical lecturing (morning hours) and workshop exercise sessions

Exercises 4.1-9. here

(afternoon hours).

4.2 ASSESSMENT AND INTERVENTION – STRATEGIES AND RECOMMENDATIONS

4.2.1 Goal

The aim of this module is to understand and learn strategies and guidelines for the effective teaching of a selected number of assessment and intervention skills recommended for general use when working with trafficked persons/groups.

4.2.2 Learning objectives

By the end of this chapter readers will be able to:

- understand the basic rules of effective case management;
- demonstrate an understanding of the codes of conduct in assessment and intervention;
- think critically about the purpose of assessment and intervention in practice;
- demonstrate basic skills for conducting crisis assessment and intervention;
- describe the basic principles and tools of monitoring and evaluating progress;
- construct a teaching-learning module for acute crisis assessment and intervention.

4.2.3 Case management as problem-solving

Theoretically, case management is a step-by-step process of *problem-solving* that flows through a series of counselling sessions, interviews, decisions, interventions and many other processes, shared by helpers, at different stages of personal contact. The main features of the problem-solving approach are well known in the theory and practice of helping professions, including social work (Turner, 1986).

Essentially, the paradigm stems from the realms of psychology, specifically creativity, with its roots in the psychology of creative problem solving (CPS) (Parnes, 1992). It has its "natural" place in the realm of case management of trafficked persons simply because it focuses on change. In its simplest form, the process model dictates five basic steps, in the following order:

Step 1: Establishing the relationship. The main process goal involves establishing and maintaining a supportive, caring "therapeutic alliance" The general goal is to enable clients (in our case, the trafficked individuals) to open up, regain self-esteem and develop trust in self and in others.

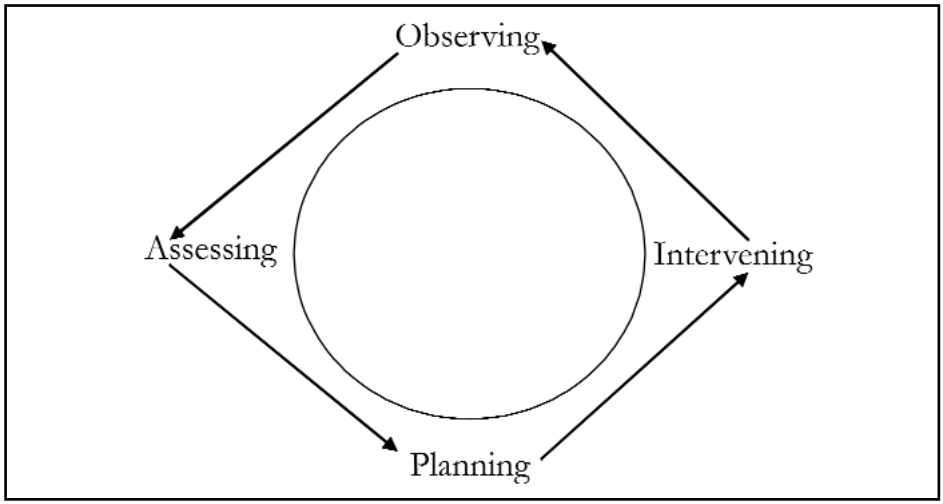
Step 2. Problem identification and assessment. This step is concerned with identifying and assessing the person's problems from different perspectives, i.e. from his/her own perspectives, from the perspective of how significant others see and interpret them, and finally, how an immediate helper (case manager, counsellor) sees and interprets them.

Step 3. Facilitating change. This process goal involves initiating strategies and interventions to facilitate change that is acceptable, appropriate and desirable both from the person's perspectives, and acceptable (constructive) from the perspective of close others, including the helper. During this phase the persons and her/his closest helper (case manager) construct alternative action plans, evaluate the possible consequences of various alternatives, and decide how to proceed at the particular moment.

Step 4. Evaluation and termination. This process goal involves evaluation of the outcomes of action and interventions in comparison with short-term or long-term goals. Significant progress evaluation for the case manager includes: Did this (my) relationship-building help the person, after all? In what respect did it help? If it did not help, why not?

According to this model, case management should be viewed as an open-ended process with four interwoven building blocs, as shown in Figure 4.2.1

Figure 4.2.1 A "circular" feedback model of case management



Exercises 4.2-1. here

4.2.4 Code of conduct in assessment and intervention

As pointed out earlier, assessments and interventions in the context of counter-trafficking and helping trafficked persons probably take place at different sites, in different settings, and are accomplished by different teams of professional and/or paraprofessional helpers. However, regardless of the expected variety of settings and circumstances in which assessments and interventions are conducted, the following ethical standards have to be respected:

1. Informed consent of the person (or her legal representative) has to be unconditionally required and endorsed for any kind of assessment and intervention.
2. Keep the assessment and intervention procedures short, simple, paced, and appropriate to the physical, intellectual and emotional conditions of the person to co-operate in a meaningful and constructive way, unless otherwise recommended (e.g. in case of life-saving, emergency interventions).
3. Strict confidentiality should be ensured regarding archiving and transfer of information and documents from one helping site to another, including referrals to health and social institutions.
4. Avoid any replication of assessment procedures, including re-interviewing or re-examining the person for the same factual data, if otherwise not recommended and professionally justified.
5. The use of psychological tests, standardised diagnostic instruments and/or specific interventions, such as psychological counselling, should be entrusted to professional helpers with adequate (accredited) training, as well as with personal and moral credibility to work with persons and groups impacted by trafficking in humans.

The above listed codes of conduct are only excerpts from the ethical codex of many helping professions, which are basically similar as far as the protection of human rights, and the protection of particular professions is concerned.

Exercises 4.2-2. here

4.2.5 Principles of assessment and intervention

4.2.5.1 Critical thinking

From a professional point of view, the purpose of assessment is to establish what kind, and how much information is required to make a sound *intervention* plan (see Glossary of terms). However, standards for assessment and intervention are often loosely defined, both in the realm of public health and social services. Specifically, many agencies and organisations impose long series of assessment and evaluation procedures on their clients, for what they call a "comprehensive assessment". Such comprehensive data collection would include extended family histories, medical histories, psychological tests, psychiatric evaluations, and many more items. Many of these long and standard assessment protocols are repetitive and often processed by administrators, with little knowledge about the purposes of the tests or for whom data are collected. Such routine assessments may be threatening and stigmatising for the client, and sometimes the client is not properly asked for co-operation, on a fully informed consensual basis.

Experience shows that many of these critical observations equally apply to administration procedures of case work in the realm of counter-trafficking. Specifically, trafficked persons are battered with a large number of psychological tests, which take several hours to complete (such as MMPI), as part of an intake procedure at shelters. Such in-depth clinical testing may neither be necessary nor acceptable, from a professional point of view (see APA Ethical standards, 1994). Also, one should be cautious with the usage of classification schemes for trafficked persons, as diagnostic categories such as "anxiety disorders with or without PTSD", "depression", "personality disorders" and the like, may not necessarily follow the diagnosis of internationally accepted instruments and therefore only the person who assigned the diagnostic categories knows what was meant. In short, utmost care, responsibility and, above all, critical thinking ought to be present as a leading principle whenever assessment and intervention issues are concerned.

"Critical consciousness is an essential tool to help us recognise, understand, and work to change the social forces that shape our societies, ourselves, and the lives of our clients. Without critical consciousness, social workers practice too often do not recognise and build on important differences among people, and it perpetuates or at least does not challenge dynamics which perpetuate social injustice." (Garvin and Seabury, 1997: 46).

The rest of this module will be devoted to a brief overview of three conceptual guidelines for assessment and intervention that seem to be particularly needed in day-to-day practice of helping in the context of counter-trafficking:

1. An ecological approach to assessment and intervention
2. A nursing process approach to assessment and intervention
3. Elements of crisis intervention

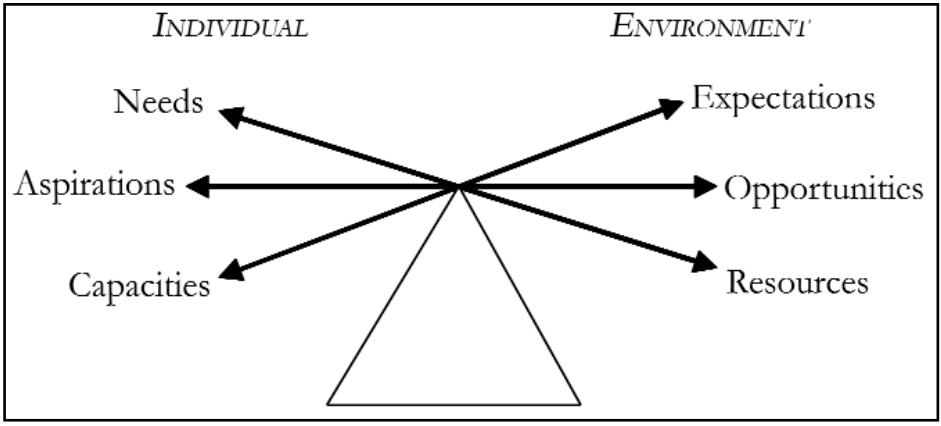
4.2.5.2 An ecological approach

Trafficked persons, much like individuals who experience other dramatic life events, such as war or torture, must handle not only the many mental and moral injuries of the violent acts (i.e. coping with the experience per se), but must also balance a full range of individual factors from their past or present environmental realities. In theory, we can agree that a trafficked person needs at least three critical transactions with his/her environment in order to gain a balanced perspective for a healthy growth (cf. Garvin and Seabury, 1997):

- Individual needs must be balanced by environmental resources,
- Individual desires and aspirations must be balanced by environmental opportunities,
- Individual skills and capacities must be balanced by environmental demands.

The notion of "balancing" in this context could be visualised by the following simple diagram.

Figure 4.2.2 "Balancing" between individual factors and environmental realities



In the literature, the ecological approach is often called "Person-in-Environment Systems Approach", or simply called - "PIE" Model (Karls and Wandrei, 1994). This approach puts a strong emphasis on social functioning rather than on mental malfunctioning, as often defined and classified by traditional psychiatric diagnostic systems such as the American Psychological Association Diagnostic and Statistical Manual of Mental Disorders (APA DSM) (see Kirk, 1992).

In summary, an ecological approach would suggest three basic tasks for assessment and intervention:

1. Needs assessment (both former and present) – in the context of available resources;
2. Assessment of personal aspirations (both former and present) – in the context of available opportunities;
3. Assessment of personal assets (capacities) at the time being – in the context of personal or general (societal) expectations for change.

Exercises 4.2-3. here

4.2.5.3 A nursing process approach

Of all theoretical approaches, the paradigm of nursing process has by far the largest interface with the day-to-day practice of case work in the realm of caring for trafficked persons (see Glossary of terms). There are three fundamental reasons to believe so. First, nursing provides one of the broadest perspectives on caring, including caring for an individual's physical, mental and social well-being. Secondly, as an art and science, contemporary nursing offers specific standards and knowledge for the full process of caring, from the present until the moment of death. Last but not least, a nursing approach can provide us with one of the most comprehensive didactic frameworks in teaching specific skills of helping trafficked persons.

"Unlike the medical model, which focuses on treating the disease, the nursing process is holistic in focus, considering both the problems at hand and the effect of the problems upon how the person functions as a unique human being. Maintaining this holistic focus complements the work of the physician, ensures that the unique needs are met, and assists [the carers] to tailor interventions to the individual (and family), rather then the disease." (Alfaro, 1990: 9)

In essence, the nursing process is a step-by-step guide to caring, and it requires the following tasks to be accomplished:

- *Assessment*: During the assessment phase, one will need to gather and examine information (data) to obtain all the facts necessary to determine the person's health status and describe his/her strengths and problems.
- *Diagnosis*: In possession of the necessary facts, one is ready to analyse the data to identify strengths (which will be reinforced and used in developing the plan of care), as well actual and potential problems (which will become the basis for planning the care). One should decide which problems can be resolved or eased immediately through direct, independent intervention (appropriate to qualification), and which problems will require intervention that must be initiated and/or prescribed by other qualified health- or social care professionals (referral networking).

- *Planning*: Once the strengths and problems are identified, one is ready to work with the "case" (the person or group or family), with the specific task of developing a plan of action that will reduce or eliminate the problems and promote health. Planning includes the following key activities:
  - *Setting priorities*: What problems need immediate attention? What problems must be addressed in the care plan? What problems must be referred? And in what order should tasks be planned?
  - *Establishing goals*: What are the expectations for accomplishment and in what time frame?
  - *Determining interventions*: What actions will help (and what actions may hurt) to achieve the set goals?
  - *Documenting the care plan*: Other helpers need to know the plan of care and the expected goals.
- *Implementation*: Now is the time to put the plan into action, which involves carrying out the following tasks:
  - *Continuing to collect information about the client*: Keep assessing how the client is responding to interventions and identify new problems that may emerge.
  - *Performing interventions and activities* set on the agenda during the planning phase.
  - *Recording (charting) and communicating the client's health status and response to interventions in progress*. Since the caregiver will not be present 24 hours a day, other helpers (team members) need to know how the client in care is doing and how the intervention plan is working.
- *Evaluation*: The caregiver must assess and determine (e.g. on a daily or weekly basis) how well the plan has worked so far, and whether there are any changes in the plan of care. The following key questions should be answered:
  - *How far did you go in achieving the goals in your Plan of Action?* Did you achieve more than you originally hoped for? What made the Plan work? What barriers and gaps have you faced so far? Should you set new goals?
  - *Assess to what extent you achieved "your" goals set in your Plan of Action: Fully – Partially – Not at all?* Examine critically what were the major strengths, and what were the major weaknesses (errors) in your Action Plan? Can you learn (and teach others) from errors made? Were the goals realistic? Are the initial goals still important? Did you have enough time and resources to achieve "your" initial goals? Did you put all efforts and mobilise all available resources to achieve all the goals you and "your" client agreed upon? What changes are you about to initiate in the whole intervention (and referral) plan you created at the very beginning of the whole process?

Summary of steps of the nursing process:

- ***A****ssessment* – Gathering and examining data (fact-finding).
- ***D****iagnosing* – Analysing data to identify strengths and problems (problem-finding).
- ***P****lanning* – Setting goals and developing a plan of action (solution-findings).
- ***I****mplementation* – Putting the plan in action (doing).
- ***E****valuation* – Determining whether the plan has worked, and "what now?" (critical thinking).

To remember the critical steps in the caring process, use the following simple techniques for memorising the first letters of each of the steps – ***ADPIE****.*

Exercises 4.2-4. here

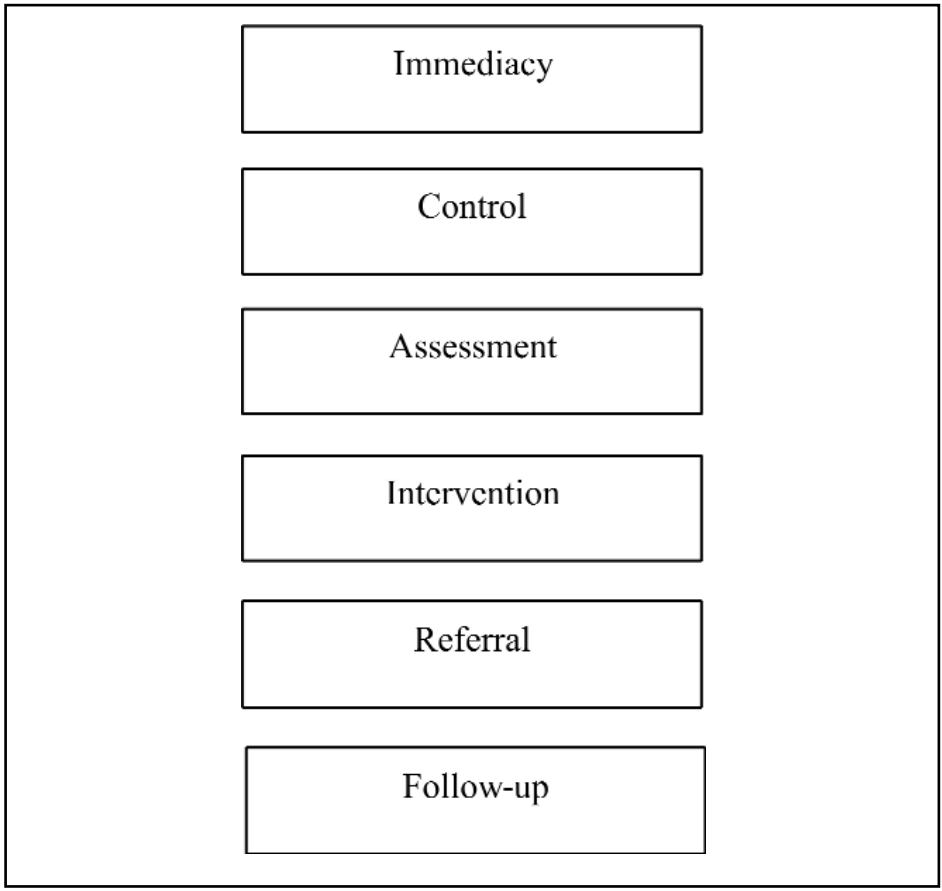
4.2.5.4 Elements of crisis intervention

Basic knowledge and competency of a caseworker in crisis assessment and intervention would represent the third "building-block" of human resources throughout the entire process of helping and caring for trafficked persons. This is because most persons do need psychological first aid at several points of their case management, from detention centres and shelters in countries of destination, all along their way to rehabilitation/reintegration centres in the home country, if any such exists, and beyond.

4.2.5.4.1 Strategy and goal setting

By definition, "crisis intervention" is a paradigm of caring in emergency situations. Given the urgency and limited time frame, assessment and intervention in crisis management are two closely interrelated procedures, and they are only parts of a rather complex process, as shown below (see Figure 4.2.3)

Figure 4.2.3 Steps in crisis intervention procedure



Source: Adapted from Greenston and Leviton (1993: 10)

Most steps involved in crisis management have already been addressed in this chapter. However, some specific rules should be highlighted:

Rule 1: *Immediacy*. You cannot put a person in crisis on the waiting list…! The sooner the intervention comes, the greater the chance for preventing long-term impact of traumatic events from the near past.

Rule 2: *Proximity*. The closer you approach the physical context of traumatic events, the more you can prevent distorted memories and false imagination! This simply means either intervening as close as possible to the original physical allocation of events, or placing the imagery work as close as possible into the physical environment of stressful/traumatic events.

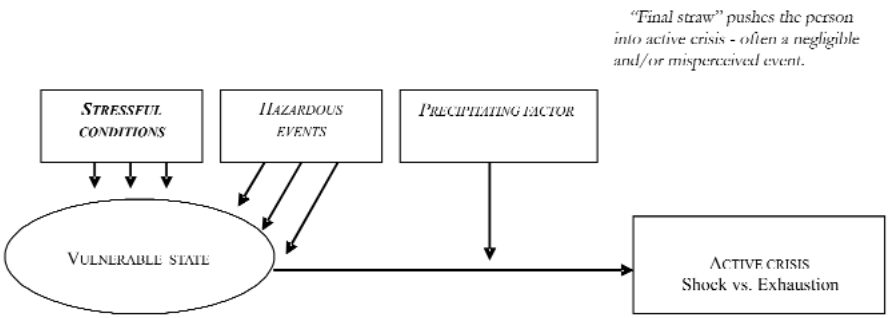
Rule 3: *Personal involvement (client-centring)*. You cannot help a person in a deep personal crisis, unless you are willing to truly understand what they went through. This means personal engagement, including emotional investment, on the grounds of mutual consent between you and the person you attempt to help.

Rule 4: *Action*. The old wisdom of ecological thinking says, "Before we change ourselves (very difficult), let's see what we can change in our environment and in our relationship to it!". This is perhaps the most complex, most difficult rule to follow, given the limited time and space for intervention in the context of crisis intervention. However, since trafficked persons typically experience *identity crises*, the intervener should act in the present physical and social environment. At the same time, caregivers should look ahead at the future of the cared person from different angles than s/he has so far.

4.2.5.4.2 Elements of crisis assessment

The following diagram summarises the key elements of the emergence of a crisis state.

Figure 4.2.4 Elements of assessment and understanding person (or groups) in crisis



Increase in Tension – Attempts to Cope Events experienced as: • Threat (anxiety) • Loss (depression • Challenge (excitement)	Active coping vanishes; emotional and psychological turmoil or collapse; break-down in basic patterns of conduct

Source: Adapted from Garvin and Seabury (1984: 189)

The assessment procedure will reveal :

- *Vulnerable state* (stressful conditions that preceded the acute crisis state, e.g. former family conditions, traumatic events);
- *Hazardous events* and *conditions* that the person was exposed to, and coped with over the last 12 months or so, and probably has to struggle with in the near future (such as impact of physical abuse or psychological torture);
- *Coping strategies* the persons typically/habitually employed when excessively distressed (e.g. crying, excessive withdrawal, excessive abuse of alcohol or drugs, acting out);
- *Precipitating events and/or conditions*, i.e. factors that triggered the acute crisis state with person-specific manifest signs and patterns of abnormal (unusual) behaviour.

4.2.5.4.3 Elements of crisis assessment interview

One of the simplest, least obtrusive, and surely most helpful tools of crisis assessment is an interview. The timing and setting of the crisis interview should be adjusted to the physical and mental conditions of the person. In emergency situation only basic data should be collected, while later on (e.g. 2-3 days after arrival to a transit unit) a more in-depth interview should be arranged. It is highly recommended to use checklists of the most common crisis-related indicators, as reminders for the interviewer. These check-lists, and all other paper-work should ideally be completed after the personal encounter. The following table provides such a symptom's checklist for the assessment of acute crisis states, whereas a more elaborate case-reporting form shall follow later (see section "Recommended Assessment Tools and Techniques").

Table 4.2.1 Symptoms checklist for crisis assessment.

Part A. *INDICATORS THAT CAN CHARACTERISE A CRISIS-PRONE PERSON (VULNERABILITY ASSESSMENT)*:

- Alienation from lasting and meaningful personal relationships
- Inability to use life support system such as family, friends, social groups
- Difficulty in learning from experience; the individual continues to make the same mistakes
- A history of previously experienced crisis that have not been effectively resolved
- A history of mental disorder or sever emotional imbalance
- Feeling of low self-esteem
- A history of provocative, impulsive behaviour resulting from unresolved inner conflict
- A history of poor marital relationship, or partnership
- Excessive use of drugs of any kind, including alcohol abuse, sleeping pills, tranquillisers etc.
- Marginal family or personal income, or no income
- Lack of regular, full-time or part-time job
- Poor academic achievement; skipping school or running away from home
- Unusual or frequent physical injuries
- Frequent changes of residence
- Foreclosure on a mortgage or loan
- Frequent encounters with the law

Part B. *EVENTS THAT CAN PRECIPITATE A CRISIS (PRECIPITATING FACTOR ASSESSMENT):*

- An accident, with or without physical injury (e.g. in the house)
- A traffic accident, with or without injury
- Being arrested; caught by the police; appearing in court
- Change in job situation; major change in living conditions
- Death of significant other
- Divorce or separation
- Physical abuse; emotional or moral abuse (e.g. threat)
- Sexual abuse (e.g. rape)

- Abortion or out-of-wedlock pregnancy
- Physical illness
- Acute episode of mental disorder
- Dealing with a blended family

Part C. *RECOGNISING A PERSON IN ACTIVE CRISIS:*

1. Recognition depends on:
   a) Intervener's awareness of what the victim is communicating verbally and non-verbally
   b) Intervener's sensing capabilities
2. Different people may indicate crisis in different way:
   a) Crying out, exploding, verbalising
   b) Withdrawal, depression, or both
3. If possible, the intervener should obtain information from independent sources about the person's pre-crisis behaviour and note disruptions in previous behaviour, as well as modes of ineffective functioning.
4. "Typical" profile of a persons in active crisis (main markers)
   a) Bewilderment: "I never felt this way before."
   b) Sensing danger: "I am so nervous and scared."
   c) Confusion: "I can't think clearly."
   d) Impasse: „I feel stuck; nothing I do helps."
   e) Desperation: "I've got to do something."
   f) Apathy: "Nothing can help me."
   g) Helplessness: "I can't take care of myself."
   h) Urgency: "I need help now!!!!!!"
   i) Discomfort: "I feel miserable, restless, and unsettled

Part D. *SUMMARY TABLE OF COMMON SIGNS AND SYMPTOMS OF PSYCHOLOGICAL REACTION TO ACTIVE CRISIS*

Emotional	Cognitive	Behavioural
Anger	Confusion	Alcohol or drug abuse
Anticipatory anxiety	Difficulties in decision making	Anger at God
Denial	Flashbacks	Angry outburst
Despair	Loss of trust	Antisocial acts
Fear	Nightmares	Change in activity
Feeling out of control	Poor attention span	Change in appetite
Feeling overwhelmed	Poor concentration	Change in communication
Frustration	Poor language performance	Crying
General irritability		Difficulty functioning
Generalised anxiety		Excessive preoccupation with crisis
Grief		Hate speech
Helplessness		Hysteric reactions

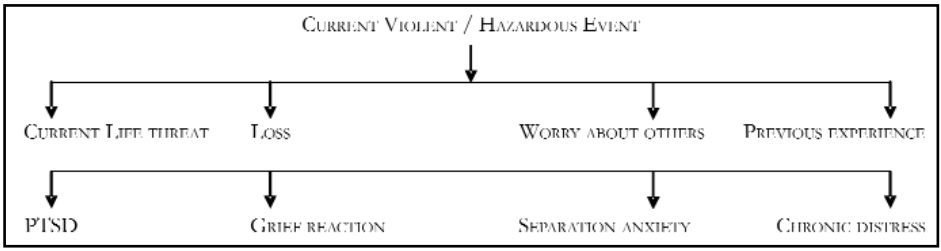
Emotional	Cognitive	Behavioural
Inadequacy		Increased fatigue
Insecurity		Irritability
Numbness		Non-specific complaints
Outrage		Outburst of rage
Panic		Regression
Shock		Sleep disturbances
Survival guilt		Unresponsiveness
Uncertainty		Withdrawal

Source: Greenstone and Leviton, 1993: 4-7.

4.2.5.4.4 Elements of crisis intervention

The main task of a crisis intervener (helper) is to discern "what" are the prime causes, and what are the prime psychological consequences of a recent violent (hazardous) event that triggered the acute crisis in her/his client's mental and social functioning. In this respect, the following chart may help the helper to make a difference between four major patterns of crisis reaction, and their causes.

Figure 4.2.5 Treatment flow chart



Source: Adapted from Pynoos and Nader (1988:463)

The chart is instructive for two things. On one hand, it instructs not to mix up PTSD (Post Traumatic Symptoms Disorders) with Anxiety Disorders, for instance, because the two patterns of crisis reaction are different both in ethnology (causes) and manifestation (effects). On the other hand, the chart is useful for setting priorities for interventions.

Beyond diagnostics, most helpers would ask for the thematic structuring of their crisis interviews. On this matter, however, no prescribed standard exists; only guiding principles are available. One useful structuring principle in the literature is Psychological Debriefing (PD), originally designed by Norwegian teams of psychologists specialised in crisis interventions (Dyregrov, 1989). The elements of a PD are the following:

1. *Rapid outreach*. It is recommended that the PD (psychological first aid) interview session should be held within the first two days following the hazardous event.

2. *Focusing on the present*. The focus of the PD should be on present (most current) events and their consequences.

3. *Mobilisation of resources*. If appropriate and acceptable, a small-group session (group counselling) design seems best for PD, rather than an individual interview, for the purpose of activating peer-support resources. On the other hand, a peer support group's internal resources can be of utmost help for "normalising" stress-related reactions (e.g. panic fear), and making these resources available for further use.

4. *Structure of the PD session*: There is enough room for flexibility, yet the following thematic structuring of the whole session should be respected (see below):

- Introduction:
  - Introduction of the team and participants
  - Rule setting
- Facts
  - What happened?
- Thoughts and sensory impressions
  - First thoughts
  - Decisions
  - Impressions
- Emotional reactions
  - Question about thoughts lead to answers about feelings
  - What was the worst about what happened?
  - Accepting reactions
  - Reaction at the scene, and later
  - Emotional, physical and cognitive reactions
- Normalisation
  - Commenting on reactions
  - Anticipatory guidance
  - Advice on helpful coping
- Future planning and coping
  - Mobilising support (at hand)
  - Mobilising "natural" (former) support network, e.g., family, children, friends (if any)
- Closure (disengagement)
  - Summing-up
  - Follow-up resources.

Certainly, this is not the place to go into an in-depth discussion of the psychological rationale for such thematic structuring of PD sessions. However, certain psychological rules have to be respected:

Rule #1: *Introduction*. The time frame and codes of conduct should be set, including identification of the case worker's role as stake-holder (facilitator) of the whole session, and the purpose of the session. The focus should be on trust-building, and ruling out any suspicions regarding the confidentiality of the information disclosed later on. Participants should not be forced to say anything, other than stating what they experienced, and how they feel now. Note-taking, tape-recording, video-taping, presence of an external observer is NOT recommended!

Rule #2: *Focusing on facts*. The session proceeds with strategic (lineal) questioning to bring forward psychologically important facts (unquestionable personal experience) about recent events, as perceived by the client. In this phase, the interviewer should be fully aware of his/her specific role, that s/he should not give judgmental , but instead take a trustful and appropriate helping role, selected from a range of options that we described and discussed at length in the previous Module (see Module 1: Section "Role taking").

Rule #3: *Focusing on thoughts and rational thinking*. In this phase, the PD session will proceed with questions that prompt rational thinking and reflection (personal cognition, experience, "inner way of knowing") with the main task to express (either in words or non-verbally) the personal reasoning of cause-effect relations of events, or what psychologists would call, getting evidence on subjectively perceived "Locus of Health Control" (internal vs. external), as the base for further steps in case management.

Rule #4: *Focusing on sensory experience (body awareness)*. In approaching the closing part of the PD session, attention should be paid to the person's recent bodily-sensory experiences (no more than one-week span in the past). This is an utmost important part of crisis intervention simply because it helps the person to, for the first time, become aware of the many dysfunctions that have been dismissed (forgotten) until now, due to various personality defences (e.g. repression). On the other hand, this surely helps the helper to learn more about the personality dynamics in coping with bodily functions and dysfunctions, as a baseline knowledge for designing the process of case management, both in terms of medical and mental health interventions.

Rule #5: *Focusing on basic affective (psycho-physiological) states and reactions*. Questions concerning thoughts and impressions, then bodily experiences, often lead to opening-up, in a natural and unobtrusive way. Of the full range of potential emotional reactions, of which some would be hard to express verbally, the following basic affect states should be addressed:

- Fear, horror
- Anger, rage
- Joy, love
- Sadness, grief
- Acceptance, trust
- Disgust, nausea
- Hope, curiosity
- Surprise, expectation
- Boredom, emptiness

Rule #6: *Normalisation.* "Normalisation" in this context means making judgements for otherwise "abnormal" reactions, i.e. stressful, traumatic life events and circumstances. In the normalisation or anticipatory guidance, the debriefing-leader ties together the impressions and affective reactions (cognition and affects) the person talked about. The debriefing leaders may disclose his/her own experiences and knowledge from similar situations, including knowledge from the professional literature. The phase of "normalisation" might be the right place and time to make sure that coping mechanisms are "normal" (e.g. humour).

Rule #7: *Future planning and coping.* When approaching the closure of the session, participants likely become more active, curious and open to questions regarding their outlook to the future ("what now...?"). One of the "Golden Rules" applied should be to say: "Do not promise anything that you cannot accomplish all by yourself!" This is the time to investigate potential social support systems both in the present, and future life of the persons participating in the session, including model role-playing, if appropriate.

Rule #8: *Disengagement (termination).* At the end of the psychological debriefing, any unattended areas are open to be discussed, questions may be raised etc. However, what is special about the termination of a psychological debriefing session (as opposed to the termination of a psychotherapeutic session) is the obligation of the PD session facilitator to tell the participants three basic facts:

- Symptoms of distress do not disappear over night. They will likely remain for some time (approximately 6 months) after the intrusion of the specific violent event that triggered the acute crisis state.
- Symptoms tend to increase over time.
- Some may not be able to function normally (adequately) according to one's own or societal expectations for at least 6 months. This does not necessarily imply an alarming state of mind that requires sick-leave or specialized care. Rather, it requires patience in coping with the aftermath of traumatic life events.
- Some may experience an identity crisis or other feelings of deep distress in the months to come. The facilitator of the debriefing session should inform persons about all available resources for further help (e.g. where to call for help /services, 24 hours a day).

Exercises 4.2-5. here

4.2.5.5 Recommended assessment tools and techniques

Hundreds of "mental health tests" were made available in the past century for professional usage. Simultaneously, another pile of so-called, "self--tests" for the general public is available on news stands throughout the world, including test for "Cognitive IQ, "Emotional IQ", "Social IQ, "Cultural IQ". For many lay readers and users, the "test-market" of mental health assessment tools and techniques seems rather chaotic. For this reason, critical thinking is required when recommending mental health assessment tools for trafficked persons. Making a choice is not as hard as one would think, sine there are only a

few "key" mental health variables that need assessment by means of valid and reliable measuring instruments. These are:

1. A tool for crisis assessment (summary reporting of case workers),
2. A tool for stress assessment (major life changes in the past 12 months),
3. A tool for assessment of impact of traumatic events (PTSD screening),
4. A tool for assessment of family support resources,
5. A tool for screening (eventual) alcohol and/or dug dependency.

The next few pages shall be devoted to present assessment tools for each of these "key" variables, while considering their actual use in practice or for training (optional).

4.2.5.5.1 Crisis Assessment

CRISIS INTERVENER'S SUMMARY REPORT FORM

DATE _____

PERSON'S NAME (OR ID CODE): _____ INTERVIEWERS NAME (OR ID CODE) _____

Instruction (interviewer – intervener)

Circle response in appropriate row and column, and place score from top columns in extreme right column. Sum all scores and match total with criteria.

	0	1	2	3	4	Score
Age	0-8	9-12	13-15	16-18	19+	
Current Marital Status	Married with children	Married without children	Divorced	Widowed	Single	
Physical Appearance Acute Distress	Good Low	Fair	 Medium	Poor	Very poor High	
Emotional Functioning	Stable				Very unstable	
Cognitive Functioning	Coherent				Very confused	
Behavioural Functioning Communication	Appropriate Open	 Sustained		 Difficult	Very unusual Blocked	
Depressed/ Agitated	No				Yes	
Signs of Current/ Former Injuries	None				Many	
Drug Dependency Prior Suicidal Behaviour	Absent No		Suspected Suspected		Present Yes	
Suicidal Plan	None		Suspected (imagery)		Highly specific plan	
Prior Relationship with Significant Others	Helpful/ supportive				Harmful/ abusive	
Current Relationship with Significant Others	Helpful/ supportive				Harmful/ abusive	
Pre Departure Residence	Rural	Small town	Suburban	Urban	Homeless	
Pre-Departure Job	Employed full time	Employed part time		Unemployed less then one year	Unemployed more then one year	
Pre-Departure Loss of Significant Other	No				Yes	
Pre departure Divorce or Separation	No				Yes	
Pre-Departure Detention in Jail or other Institution	No				Yes	

Source: After Greenstone and Leviton (1993: 20).

Scoring criteria:		
	Minimal risk	(0-20) _____
	Low risk	(21-35) _____
	Medium risk	(36-50) _____
	High risk	(50+) _____

4.2.5.5.2 Stress Assessment

LIFE CHANGE INDEX SCALE (Holmes and Rahe, 1967)*

Instruction: (for self-assessment)

Look over the "Events" listed below, in the left column of the table. Check (x) a given event if it has happened to you within the last twelve months, i.e., second column in the table. Leave the third column unmarked, for scoring your original answers later.

Event		Check (x) if happened	*Points*
1)	Death of spouse	1.	*100*
2)	Divorce	2.	*73*
3)	Separation from spouse or partner	3.	*65*
4)	Detention in jail or other institution	4.	*63*
5)	Death of a close family member	5.	*63*
6)	Major personal injury or illness	6.	*53*
7)	Marriage	7.	*50*
8)	Being fired at work	8.	*47*
9)	Marital (or partnership) reconciliation	9.	*45*
10)	Retirement from work	10.	*45*
11)	Major change in the health or behaviour of a family members	11.	*44*
12)	Pregnancy	12.	*40*
13)	Sexual difficulties	13.	*39*
14)	Gaining a new family members (e.g., through birth, adoption, oldster moving in, etc.)	14.	*39*
15)	Major business readjustment (e.g., merger, reorganisation, bankruptcy, etc.)	15.	*38*
16)	Major change in financial state (e.g., either a lot worse off or better off then usual)	16.	*37*
17)	Death of a close friend	17.	*36*
18)	Changing to a different line of work	18.	*36*
19)	Major change in number of arguments with spouse or partner (e.g., either more or less then usual)	19.	*35*
20)	Taking on a mortgage greater then $10.000 (e.g., purchasing a house, business, etc.)	20.	*31*
21)	Foreclosure on a mortgage or loan	21.	*30*
22)	Major change in responsibilities at work (e.g., promotion, demotion, lateral transfer)	22.	*29*
23)	Son or daughter leaving home (e.g., marriage, attending college, etc.)	23.	*29*
24)	In-law troubles	24.	*29*
25)	Outstanding personal achievement	25.	*28*
26)	Spouse or partner beginning or ceasing work outside the home	26.	*26*
27)	Beginning or ceasing formal schooling	27.	*26*
28)	Major change in living conditions (e.g., building a new home, remodelling, leaving home)	28.	*25*
29)	Revision of personal habits (dress, manners, personal relationships, etc.)	29.	*24*
30)	Troubles with the boss or peers at work	30.	*23*
31)	Major change in working hours or conditions	31.	*20*
32)	Changing residence	32.	*20*
33)	Change to a new school	33.	*20*
34)	Major change in usual type and/or amount of recreation	34.	*19*
35)	Major change in religious activities (e.g., a more or a lot less than usual)	35.	*19*
36)	Major change in social activities (e.g., clubs, dancing, movies, visiting, etc.)	36.	*18*
37)	Taking on a mortgage or loan less than $10.000 (e.g., purchasing a car, etc.)	37.	*17*
38)	Major change in sleeping habits (a lot more or a lot less than usual)	38.	*16*
39)	Major change in number of family get togethers (e.g., a lot more or a lot less then usual)	39.	*15*
40)	Major change in eating habits (a lot more or a lot less food intake than usual, or very different meal time)	40.	*15*
41)	Vacation	41.	*13*
42)	Christmas (or other major national/religious/family events)	42.	*12*
43)	Major violation of the law (e.g., traffic tickets, disturbing the peace)	43.	*11*
44)	OTHER (describe)		

Source: Holmes and Rahe (1967: 213-218).

*Note: The Scale is not adjusted to any specific target group. (I assume it is not for 'public use' (like a 'news stand test') but in a therapeutic context)

SCORING SCALE

Add the number of points next to each of your check marks (x). Place the total in the box.

Total Life Change Units (LCU): ☐

INTERPRETING YOUR SCORE:

0 – 150	No significant problems
150 – 199	Mild Life Crisis Level (with 35 percent chance of illness)
200 – 299	Moderate Life Crisis Level (with 50 percent chance of illness)
300 or over	Major Life Crisis Level (with an 80 percent chance of illness)

4.2.5.5.3 PTSD Symptoms Assessment

PTSD-12 SELF-ASSESSMENT SCALES (Baráth, 1992)*

Part 1.

Instruction (for self-assessment)

Of all the events that have happened to you during the last twelve months, or that are happening to you right now, select and describe the most frightening event in one sentence. Alternatively, you can make a drawing of the event, and give it a short title.

Text (ar drawing with a title)

Part 2.

Instruction

Below, you find a series of 24 statements, which describe how children usually feel after they experienced some fearful (dramatic, traumatic) event. Think about the event that you just described above (in text box, Part 1.). Your task is to assess how often you thought about that particular event in the last two weeks, and what you felt while remembering it. For each statement, circle one of the following scores that best describes how often the feelings implied in the specific statement come to your mind:

0 = Never; 1 = Rarely; 2 = From time to time; 3 = Often; 4 = Always:

DURING THE LAST TWO WEEKS...?	FREQUENCY ASSESSMENT SCORES				
1. I had bad images that kept coming back to my "eyes" even if I didn't want to remember.	0	1	2	3	4
2. I wondered: "Why did this happen to me?"	0	1	2	3	4
3. I felt ashamed and bad about myself.	0	1	2	3	4
4. My memories were vague and I did things without knowing why.	0	1	2	3	4
5. I only felt anger whenever I thought about what has happened.	0	1	2	3	4
6. I had a rapid heartbeat, shortness of breath, stomach aches, and other signs of general tension and weakness.	0	1	2	3	4
7. I felt guilty for what I did or didn't accomplish.	0	1	2	3	4
8. I avoided people because I didn't want to cry or show how I feel.	0	1	2	3	4
9. I had an urge to hurt myself or cause some accident.	0	1	2	3	4
10. I thought of punishing whoever was responsible for what happened.	0	1	2	3	4
11. All what happened to me seems meaningless, and wonder what will become of me.	0	1	2	3	4
12. I thought that someone wanted this to happen to me.	0	1	2	3	4
13. I felt like a victim and afraid that it's going to happen to me again and again.	0	1	2	3	4
14. I felt confused in my head, and had difficulty concentrating on anything .	0	1	2	3	4
15. I tried to trust in persons, who otherwise betrayed me.	0	1	2	3	4
16. It seemed to me that these events never happened.	0	1	2	3	4
17. I felt nervous and got into arguments easily.	0	1	2	3	4
18. Any sudden noise or loud speech startled me.	0	1	2	3	4
19. I felt guilty that I have survived, after all.	0	1	2	3	4
20. I felt numb, and couldn't keep from crying.	0	1	2	3	4
21. I felt sad, fatigued, listless, depressed, and I had thoughts that I'd rather be dead.	0	1	2	3	4
22. I felt bitter, and felt like hurting or killing those who were responsible for all of this.	0	1	2	3	4
23. I felt far away from God, and detached from praying.	0	1	2	3	4
24. I felt distant from other people, and didn't want to get close to anyone.	0	1	2	3	4

Source: Baráth, Matul and Sabljak (1996: 355-357)

* Note: The Scale is not adjusted to any specific target group (see comment above)

Part 3.

SCORING SCALE

Add the scores you circled, and enter t the result here:

Total score (PTSD): ☐

INTERPRETING YOUR SCORE:

0 – 19	No symptoms or minimal (no treatment necessary)
20 – 39	Mild symptoms (psychological counselling recommended)
40 – 69	Fairly serious symptoms (clinical diagnostic interview recommended)
70 or over	Very serious symptoms (clinical diagnostic interview and intervention recommended

4.2.5.5.4 Family Support vs. Family Conflict Assessment

INDEX OF FAMILY RELATIONS (Hudson, 1977)

Instruction (for self-assessment)

This questionnaire is designed to measure the way you feel about your family as a whole (including parents, relatives, your children, if any). There are no right or wrong answers. Answer each item as carefully and accurately as you can by placing a number besides each one as follows:

1 = Rarely or never; 2 = A little ; 3 = Some of the time; 4 = A good part of the time; 5 = Most of or all the time:

Items		*Ratings*
1)	The members of my family rarely care about each other.	1.
2)	I think my family is terrific.	2.
3)	My family gets on my nerves.	3.
4)	I really enjoy my family.	4.
5)	I can really depend on my family.	5.
6)	I really do not care to be around my family.	6.
7)	I wish I were not part of this family.	7.
8)	I get along well with my family.	8.
9)	Members of my family argue too much.	9.
10)	There is no sense of closeness in my family.	10.
11)	I feel like a stranger in my family.	11.
12)	My family does not understand me.	12.
13)	There is too much hatred in my family.	13.
14)	Members of my family are really good to one another.	14.
15)	My family is well respected by those who know us.	15.
16)	There seems to be a lot of friction in my family.	16.
17)	There is a lot of love in my family.	17.
18)	Members of my family get along well together.	18.
19)	Life in my family is generally unpleasant.	19.
20)	My family is a great joy for me.	20.
21)	I feel proud of my family.	21.
22)	Other families seem to get along better than ours.	22.
23)	My family is a real source of comfort to me.	23.
24)	I feel left out of my family.	24.
25)	My family is an unhappy one.	25.

Source: Aero and Weiner (1981: 103-105)

* Note: The Scale is not adjusted to any specific target group.

SCORING KEY

	A	B
1.	Reverse:	
2.	Reverse	
3.		
4.	Reverse	
5.	Reverse:	
6.		
7.		
8.	Reverse	
9.		
10.		
11.		
12.		
13.		
14.	Reverse	
15.	Reverse	
16.		
17.		
18.		
19.		
20.	Reverse	
21.	Reverse	
22.		
23.	Reverse	
24.		
25.		

(A+B) – TOTAL SCORE: ☐

SCORING INSTRUCTIONS:

- ✓ *First, transfer your answers into the spaces in Column A for items 3, 6, 7, 9, etc., that is in all blank cells.*
- ✓ *Next, in Column B, reverse the numerical values of your answers for items 1, 2, 4, 5, etc., according to the following scheme:*
  - *Original score 1 – 5*
  - *Original score 2 = 4*
  - *Original score 3 – 3*
  - *Original score 4 2*
  - *Original score 5 – 1*
- ✓ *To find your total score add together the total points in Column A and the total points in Column B. From this sum subtract 25 points. The result is your final score*

INTERPRETING YOUR SCORE:

Low Scorers (0-29): Low scorers are reporting a high level of family satisfaction.

High Scorers (30 -100). The higher your score in this index, the more dissatisfaction with your family you are reporting.

4.2.5.5.5 Screening for Alcohol and Drug Abuse

SAMPLE QUESTIONS FROM ADOLESCENT DIAGNOSTIC INTERVIEW – AID (Winter and Henly, 1993)

Section C: Substance Use/Consumption History

Alcohol

1) Have you ever drunk alcohol?
☐ Yes
☐ No

[Instruction to interviewer: Check "No" if the client's only experience with alcohol has been only a small sip given by another person – such as what might occur during a family function (e.g., a wedding or holiday). Answer "Yes", however, if the sanctioned sip progressed to the point of intoxication, and there were negative consequences (e.g., nausea, headaches). If your answer is "No", proceed directly to item 10.]

2) Have you had alcohol five or more times in your life?
☐ Yes
☐ No

Cannabis

10) Have you ever used cannabis, whether in the form of marijuana, hashish, or other?
☐ Yes
☐ No

11) Have you used any form of cannabis five or more times in your life?
☐ Yes
☐ No

Additional Susbstances

[Instruction to interviewer: Mark below each type of drug that the client has used, as indicated. Record the use of combination of drugs in the column labelled "Unspecified". If the client has not used any substances other than alcohol and/or marijuana, proceed directly to Section D (Alcohol Use Symptoms).]

Amphetamines	Barbiturates	Cocaine	Opioids	Hallucinogens	Person Created	Inhalants	Unspecified
A	B	C	O	H	P	I	H

19) Which drugs have you used five or more times in your life? (Circle as many as apply).

A	B	C	O	H	P	I	H

20) Did a doctor prescribe any of these drugs for you?

A	B	C	O	H	P	I	H

Section D: Alcohol Use Symptoms

[Instruction to interviewer. If the clients answered "No" to Item 1 or Item 2, in Section C, skip this section and proceed directly to Section E (Cannabis Use Symptoms).]

I'm going to ask you some questions about your use of alcohol. [Unless otherwise indicated, the criterion is met if the client's response is "Yes " (drinking habit present), and s/he has been intoxicated by alcohol five or more times.]

2) Have you ever tried to reduce your alcohol use by "switching" (between being completely sober vs. tipsy)?
☐ Yes
☐ No

3) Do you often wish that you could control your alcohol use?
☐ Yes
☐ No

Note: The interview would continue focusing on all specific drugs, indicated as being used/abused above the limits of consensually set criteria – five or more times in one's life-time.

(…)

Source: Allen and Columbus (1995: 182-185)

4.2.5.6 Monitoring and evaluation of change

Monitoring and evaluation are often the "two forgotten children" of case work. This is mainly because fear from learning from errors is a factor that prevents most of us from critical thinking.

Many practitioners mix "supervision" with "monitoring" and "evaluation." To make a distinction, "supervision" belongs to the realm of psychotherapy, for instance when a student of this particular discipline is obliged to attend specific sessions with his/her mentor (teacher) in order to clear-up personal problems encountered in the course of therapeutic work. (NB. On this matter, see more in the next chapter, Chapter 5).

"Monitoring" is the recording of actions and important events that occur in the flow of case management. The recording may take different forms and techniques, ranging from hand-written notes to electronic recording. Monitoring and evaluation should be part of the entire case management process and program implementation, for two basic reasons. First, the person whom you attempt to help (client) has the right to know about his/her own progress (or regress) in the course of your intervention plan. Secondly, your colleagues at different sites of referral, including international networks, have the right to know about changes in the well-being of your clients, for better or worse, in the course of your intervention and treatment procedures.

There are a great variety of monitoring systems, usually called Process Recording Systems. The most commonly used systems are:

1 *Process records*. These are traditional ways to trace what a case worker has done in the casework s/he was assigned to, and what were the immediate effects of his/her intervention. This is what one would call "case reports" (or diary reports) in day-to-day practice.

2. *Critical incident recording*. The critical incident records are a modified form of process recording with the difference that they make a strict selection for "typical" cases that highlight the major issues (e.g. dilemmas) in the day-to-day practice.

3. *Coded recording forms*. More recently, social services related agencies introduced problem-oriented record keeping systems, that made clients' subjective data approachable, including self-assessment records.

On other hand, "evaluation" means "judgement" as to whether, and to what extent, changes have taken place in the client's personal life and well-being. Traditionally, such measures were left with the case worker's process records, and often left unchecked against any external criteria. As of today, many rather strict evaluation criteria are asked to be implemented, and reported. The most frequently used evaluation criteria are the following:

1. *Behavioural counts*. These consist of counting the number of times a client acts in a specific way (e.g. counting the number of "sleepless nights" per week).

2. *Goal attainment scaling*. This is a way of approaching to what extent the person feels closer (or further) from personal goals s/he set at very beginning of the entire process of casework.

3. *Client's self-ratings on emotional states*. From a psychological perspective, this is perhaps the most important of all evaluation criteria. The gathering of data on client's (verbal or non-verbal) expressions, such as sadness, anxiety, lack of pleasure or joy, should represent the ultimate criteria for judging the value of care.

4. *Caseworker's self-ratings*. On other side of the same "coin", caseworkers' self-assessment should proceed parallel with the client's self-assessment.

5. Peer-debriefings. There are many alternative forms of organising and mobilising peer-support with the major goal to help-the-helpers (see Chapter 5). One of the simplest and most unobtrusive ways to do that is to organise regular peer-briefings in a similar way, as we described earlier (see "Psychological Debriefing"). The methods and techniques of organising such support groups are well-known in the literature by the name of "Bálint-groups" (Bálint, 1957).

Exercise 4.2-6. here

4.3 RECOMMENDED READINGS FOR THIS CHAPTER

- Alfaro, R., Applying nursing diagnosis and nursing process: A step-by-step guide. 2nd ed. Philadelphia: J.P. Lippincott Company; 1990.

- American Psychological Association (APA), New APA "Ethical Principles of Psychologists and Code of Conduct," adopted by the Council of Representatives. The Codes taken effect on December 1, 1992. American Psychologist, December 1992.

- Baráth, Á., Comprehensibility, answering difficulty, and affective loading of survey questions. Doctoral dissertation. Ann Arbor (MI): University of Michigan, Institute for Social Research, Survey Research Center, 1977.

- Borkman, J.B., Experiential, professional, and lay frames of reference. In T.J. Powell (ed). *Working with Self-help*. Silver Spring, Maryland: NASW Press. (pp. 3-30); 1990.

- Brammer, L.M., Shostrom, E.L. and Abrego, Therapeutic psychology: Fundamentals of counselling and psychotherapy. Fifth edition. Englewood Cliffs (NJ): Prentice Hall; 1989.

- Carpentino, L.J., Handbook of nursing diagnosis 1989-90. Cambridge: J.B. Lippincott Company, Philadelphia; 1989.

- Conroy, B., *Unspeakable acts, ordinary people: The dynamics of torture*. New York: Knopf; 2000.

- Gorceag, V., Gorceag, L., Hotineau, M., Statistics from IOM Rehabilitation Centre in Chisinau. Conference Reporting at IOM Expert Meeting *"Mental Health and Trafficking."* Kiev, March 29, 2004.

- Lystad, M. (ed), Innovations in mental health services to disaster victims. Rockville (Maryland): Center for Mental Health Studies of Emergencies – National Institute of Mental Health; 1985.

- *Norway's Plan of Action for Combating Trafficking in Women and Children* 2003-2005. Oslo: Norwegian Ministry of Justice and the Police.

- Rothman, J., *Practice with highly vulnerable clients: Case management and community based services.* Englewood Cliffs, N.J. Prentice-Hall; 1994.

REFERENCES

Alfaro, R., Applying nursing diagnosis and nursing process: A step-by-step guide. 2nd ed. Philadelphia: J.P. Lippincott Company; 1990.

American Psychological Association (APA), New APA "Ethical Principles of Psychologists and Code of Conduct," adopted by the Council of Representatives. The Codes taken effect on December 1, 1992. American Psychologist, December 1992.

Authir, J. And Gustafson, K., Microtraining: Focusing on specific skills. In E. K. Marshall, P.D. Kurtz and Associates (eds.). Interpersonal helping skills. Chapter 4. San Francisco (CA): Jossey-Bass Publishers; 1982.

Bálint, M., The doctor, his patient and the illness. London: Pitman; 1957.

Baráth, Á., Comprehensibility, answering difficulty, and affective loading of survey questions. Doctoral dissertation. Ann Arbor (MI): University of Michigan, Institute for Social Research, Survey Research Center; 1977.

Borkman, J.B., Experiential, professional, and lay frames of reference. In T.J. Powell (ed). *Working with Self-help*. Silver Spring, Maryland: NASW Press. (pp. 3-30); 1990.

Brammer, L.M., Shostrom, E.L. and Abrego, Therapeutic psychology: Fundamentals of counselling and psychotherapy. Fifth edition. Englewood Cliffs (NJ): Prentice Hall.; 1989.

Carpentino, L.J., Handbook of nursing diagnosis 1989-90. Cambridge: J.B. Lippincott Company, Philadelphia; 1989.

Conroy, B., *Unspeakable acts, ordinary people: The dynamics of torture*. New York: Knopf; 2000.

Curran, J.P. and Monti, P.M., (eds). *Social skills training: A practical handbook for assessment and treatment*. Washington Square (NY): The New York University Press; 1982.

Diagnostic and Statistical Manual – IV (DSM IV), Washington D.C. American Psychiatric Association; 1994.

Dick, B., Resource papaers in action research: Communication; 2000. [Available online]. http://www.scu.edu.au/schools/gcm/ar/arp/communicn.html

Eagan, G., The skilled helper: A systematic approach to effective helping. Pracific Grove (CA): Brooks/Cole; 1990.

Feldham, C. And Dryden, W., Dictionary of counselling. London: Whurr; 1993.

Gardner, H., Frames of mind: The theory of multiple intelligence. New Yor. Basic Books, Inc; 1983.

Gorceag, L., Domestic violence and victims of trafficking. IOM Rehabilitation Centre in Chisinau, Moldova . Memo; 2004.

Gorceag, V., Gorceag, L., Hotineau, M., Statistics from IOM Rehabilitation Centre in Chisinau. Conference Reporting at IOM Expert Meeting *"Mental Health and Trafficking."* Kiev, March 29, 2004.

Greenstone, J.L. and Leviton, S.C., Elements of crisis intervention: Crises and how to respond to them. Pacific Grove (CA): Brooks/Cole Publishing Co; 1993.

Holmstrom, L. And Burgess, A.W., Development of diagnostic categories. Am J Nurs 75:1288-1291; 1975.

IOM International Organisation of Migration, *Combating Trafficking in Human Beings in Ukraine. Statistics last updated on 29 February, 2004*. Kiev: Mission Ukraine; 2004a. (Unpublished document)

IOM International Organisation of Migration, *Combating Trafficking in Minors in Ukraine: Protection and Reintegration. Statistics last updated on 29 February, 2004*. Kiev: Mission Ukraine; 2004b. (Unpublished document)

Kadushin, A., The social work interview. New York (NY) Columbia University Press; 1990.

Karls, J.M. and Wandrei, K.E., The PIE classification system for social functioning problems. Washington, D.C.: NASW Press; 1994.

Kirk, S., The selling of DSM: The rhetoric of science in psychiatry. New York: Alice de Gruyter; 1992.

Levinson, D., *A guide to the clinical interview*. Philadelphia: W.B. Saunders Comp; 1987.

Lowell, J., Reuters July 30, 2004, Reuters.
http://www.reuters.co.uk/newsPackageArticle.jhtml?type=topNews

Lystad, M. (ed), Innovations in mental health services to disaster victims. Rockville (Maryland): Center for Mental Health Studies of Emergencies – National Institute of Mental Health; 1985.

Marshall, E.K., Kurtz, P.D. and Associates (eds.), Interpersonal helping skills. San Francisco (SA): Jossey-Bass Publishers; 1982.

Norway's Plan of Action for Combating Trafficking in Women and Children 2003-2005. Oslo: Norwegian Ministry of Justice and the Police.

Parnes, S.J., Visionizing: State-of-the-art processes for encouraging innovative excellent. Buffalo, NY: Creative Education Foundation Press; 1992.

Richman, N., Communicating with children: Helping children in distress. London: Save the Children; 1993.

Rogers, C.J., Client-centered therapy. In I.L.Kutash and A. Wolf (eds.). Psychotherapist's casebook: Theory and technique in the practice of modern therapies. San Francisco (CA): Jossey-Bass Publishers; 1986. (pp. 197-208).

Rothman, J., *Practice with highly vulnerable clients: Case management and community based services*. Englewood Cliffs, N.J. Prentice-Hall; 1994.

Tomm, K., Interventive interviewing: Part III. Intending to ask lineal, circular, strategic, or reflexive questions? Family Process, March 1982, Vol 25 (1): 1-14.; 1988.

Trevitchic, P., Social work skills: a practical handbook. Buckingham (Philadelphia): Open University Press; 2000.

Tudorache, D., General considerations on the psychological aspects of the trafficking phenomenon. In G. Shinina (ed). *Psychological Support to Groups of Victims of Human Trafficking in Transit Situations*. Psychological Notebook. Vol. 4, February 2004. Geneva: IOM International Organisation for Migration, 2004.

Turner, J.J.(ed)., Social work treatment: Interlocking theoretical approaches. New York, NY: The Free Press; 1986.

UNICEF, 2003.
http://www.endchildexploitation.org.uk/pdf/ct/Uktraffickingreportfinal.pdf

World Health Organisation, *WHO Ethnical and Safety Recommendations for interviewing trafficked Women*. Geneva: WHO Publications; 2003.

APPENDIX I

SMALL GROUP EXERCISES - THE ART OF COMMUNICATION WITH VICTIMS OF HUMAN TRAFFICKING

Exercise 4.1-1. Empathizing with involuntary clients

Goal: To help the reader empathise with the feelings of involuntary participants, in general.
Method: Individual exercise and sharing
Material: None
Time: 10 min.
Procedure: Answer the questions listed below on your own, then share your answers and reflections with another member of your training group. Your partner will be your Interviewer in the first round. Shift roles for round 2.

1. Think of a time you were forced by someone (such as a parent or friend) to talk to another person when you did not want to do so. How did you feel about the pressure? How did you feel about the person bringing the pressure?
2. Did you bend to the pressure and see that person? If so, why? If not, why not?
3. How did you deal with the session with the person you were pressured to see? Were you open about your feelings? How much did you talk in that situation? What did you tell? Have you seen that person again?

Exercise 4.1-2. Respecting vs. violating safety standards

Goal: To promote understanding of safety standards recommended for interviewing a trafficked person.
Method: Role-playing
Material: Video camera for play-back analysis of role-play (optional)
Time: 45 min.
Procedure:

Step 1. Read over the "Sample Case" of a trafficked woman described below.

Step 2. Select 3 members of the training group for role-play, on a voluntary basis. Person (A) will play the protagonist from the Sample Case. Person (B), an aggressive journalist, wants to draft a sensational story about women's trafficking in his country, as a headline in one of the leading daily newspapers. Person (C), a trained caseworker at a Transit Centre (shelter), is prepared to conduct his/her first interview with the protagonist after a thorough personal and professional preparation for the encounter.

Step 3: Two role-played interviews take place, separate from each other, with the same protagonist, and in front of the same audience (rest of participants): one with the "journalist", and the other conducted by the "caseworker". Each interview takes 15 minutes (maximum).

Step 4: Group discussion and sharing experience from the two role-plays (forum, 60 min.).

Sample Case (optional): *A fifteen-year-old Romanian girl was trafficked to London from an Albanian prison where she was held for possessing false Italian documents. After a period of time working for her pimp-boyfriend, she ran away and began working in a sauna in another part of London. A "price was put on her head". To win points with her Albanian boyfriend, a female co-worker in the new venue revealed her whereabouts. The Romanian girl was subsequently kidnapped in broad daylight in front of her co-workers. Two years later (now), she is in custody of a shelter, in a Balkan city X, where she was reached for this interview.*

EXERCISE 4.1-3. 'WHO'S WHO' IN A CASE CONFERENCING

Goal: To understanding "role taking" and "role conflict" in case management
Method: Dramatisation, role assessment
Material: Show card: Role Matrix (1 copy/participant).
Time: 5 min.
Procedure:

Step 1. Carefully read the "Sample Case" of a trafficked woman described below (excerpt from an assessment interview), or select a "live" Case Example brought up (suggested) by seminar participants.

Step 2. Select seven members of the training group (6 + 1), on a voluntary basis. The group will improvise a *case management conference* in using the "Sample Case" as a reference document. One person (X) from the team will chair the case conference, and the six others (A-F) will play the chosen roles of interveners (case managers).

Step 3: The six interveners will leave the group, and make a scenario for a brief case conference (max 20 min). The task of players is to dramatise the chosen "intervener roles" in a way as if each of them would have a full "action plan" for what should be done, and what not in helping the Case. The role-playing should be dramatised such that the situation leads to a series of interpersonal conflicts between "interveners" due to the fact that each intervener wants to take more then one role (role confusion).

Step 4: The team of caseworkers ("interveners") returns to the large group, and the case conference begins. The role identity of the players should be kept anonymous from the audience, because by the end they should guess "Who's Who" in the game, i.e. to match the assumed identity of each player (A-F) with one of the listed "intervener roles (#1-6). The audience should record their predictions by marking the selected cells in the Role Matrix (response sheets) distributed beforehand.

Step 4: Collect all individual response sheets, and summarise the results in a large cross tabulation, i.e. a large frequency table on a flip chart, and discuss the results in the large group.

Sample Case (optional):"*For a long time I was looking for a job, but I couldn't find anything. Once in a bar my friend told me that a lot of our citizens go abroad, settle there very well and work there. Sometimes girls marry foreigners and then a fairly tale life comes true. She said she could acquaint me with a man who could help me to depart. When I met Mr. P he told me that I could go to Italy and work there as a waiter in the restaurant with the payment US $2000 per month. His speech was so considerate and nice. When I said I had no money for documents or travel, he said not to worry, he would arrange everything."*

Olena,
Ukraine to Yugoslavia and Kosovo

SHOW CARD
Role Matrix (answer sheet)

Intervener Roles	Players					
	A	B	C	D	E	F
1. "Enabler"						
2. "Trainer"						
3. "Referral"						
4. "Mediator"						
5. "Recourse developer						
6. "Advocate"						

EXERCISE 4.1-4. UNDERSTANDING THE PROCESS STAGES OF HUMAN TRAFFICKING

Goal: To facilitate empathetic understanding of the trafficking process through imagery.
Method: Storytelling, story writing
Material: None
Time: 60 min.
Procedure:

Step 1: The training group splits into 5 subgroups (A-E). The size of each subgroup should not exceed 5-6 members. The task of each subgroup will be to construct an imaginary story of a person, who has been "caught" for an imaginary "interview" by a thoughtful journalist or caseworker, at one of the following stages of the trafficking process: Group A: Write story #1. Pre-departure stage;

Group B: Write story #2. Travel and transit stage;

Group C: Write story #3. Destination stage;

Group D: Write story # 4. Detention stage (criminal evidencing and sheltering)

Group E: Write story #5. "Homecoming" (integration and re-integration)

The brief case summaries displayed below may help the groups to make up their "own" case stories. The time allowed for accomplishing this task is 60 min.

Step 2: Each group will "act out" the story to the audience through an improvised dramatisation (preferred).

Step 3: Plenary discussion

Sample cases (optional):

Pre-departure stage: *"I had to leave my home in Kosovo together with my family in 1998. In the refugee camp I fell in love with a man who, after two weeks, promised to marry me. I ran away with him to Italy without telling anyone."* (Alma, Kosovo to Italy)

Travel and transit stager: *"I was sold from Serbia to Albania, from Albania to Macedonia, from Macedonia to Kosovo. Every time* while *crossing the border I was under the guard of a man with gun. I should be silent and not ask for help at the border."* (Marina, Ukraine to Yugoslavia and Kosovo)

Destination stage*: "They beat me and kicked me. They told me, 'Don't scream or we kill you.' I kept quiet. I was a virgin before they raped me."* (Ellen, Albania to UK)

Detention stage: *"Still now I always feel I am stressed, but it is different. Now I think that little by little, the situation will change.* (Keti, Abania to Italy)

"Homecoming": *"When I returned, I went immediately to the clinic to get treated for diseases so I would not infect my husband. I can' tell him what happened to me. He wouldn't' accept me after this."*(Oksana, Ukraine to Italy)

EXERCISE 4.1-5. "SHOW ME" PANTOMIME EXERCISE

Goal: To provide opportunity for self-expression and feeling safe in a group.
Method: Small-group exercise.
Materials: None.
Time: 30 minutes.
Procedure:
The group makes a circle in sitting position (on chairs or on the floor), and participants come in the centre, one-by-one. The task is to describe through body language (pantomime) either a concrete or abstract concept or natural event. The intention of the players might be very different, such as "I am a shoe..."; "I am a musical instrument..."; "I am a small hungry child..."; "I am a strong wind in the mountains..."; or the like. The audience should continue guessing what the player is attempting to pantomime. The improvisation goes on until the audience comes up with the „right guess". At this point, another actor steps on the stage. *Contraindication*: Do not play the game with groups whose members do not feel comfortable „acting on the scene"!

Discussion after:
- What was easy and what appeared „hard" for you in this exercise?
- What feelings and thoughts crossed your mind while acting out the concept you selected for sharing with the audience?
- What was for you personally, as an observer, the most interesting, exiting and useful learning experience from the series of drama improvisations?

EXERCISE 4.1-6. PAYING ATTENTION TO THE OTHER PERSON

Goal: To learn rapport building (close & trustful personal contact)
Method: Two-person (face-to-face) communication exercise.
Materials: None
Time: Unlimited
Procedure:
The importance of this exercise is to learn to differentiate what we *see*, what *we presume* and what we *value and interpret* (judge) of another person when we come into face-to-face contact. The exercise should be arranged in three parts.

- In the *first* part (two-person exercise), Person A & Person B meet each other face-to-face, in relative social isolation (e.g. on the street). They know each other from before. They shake hands (if appropriate), exchange smiles and other signs of friendly encounter. Person A starts telling what s/he sees on Person B (e.g. a ring or earring, a necklace, a watch, the clothing, the shoes). S/he names each item s/he observes (the more the better!), without adding a value or interpretation. Then they change roles.
- In the *second part* (two-person exercise), Person A makes an effort to value and interpret personal belongings either in a positive or negative way (e.g. "I really like your wrest watch, it must be an expensive one…"). Person B would respond either in an affirmative or negating way (e.g. "Come on, this watch is just a common, inexpensive watch…").
- In the *third par*t (group exercise) – all participants find themselves at an imagined cocktail party where they are supposed to greet, introduce themselves and engage in a series of short but friendly conversations with people they have never met before ("strangers").

Discussion after: Optional

EXERCISE 4.1-7. GROUP INTERVIEW

Goal: To learn skills in questioning
Method: Small-group exercise
Materials: None
Time: 10-15 minutes
Procedure

The group makes a circle. One participant (volunteer) takes a seat in the middle of the circle – on a rotating chair, if available. S/he is the *respondent*. The facilitator points out that the purpose of the interview is to get to know the person being interrogated. Any attack on his personality or judgements should be avoided. The facilitator should also review the basic rules of "good interviewing". The thematic framework of this exercise should be carefully planned and specified by the facilitator, according to the common interest and needs of the participants (e.g. school, family). The facilitator should clarify what questions should *not* be asked during the interview so as to avoid insulting anyone in the group.

Discussion after: Optional

EXERCISE 4.1-8. "ME AND YOU" (EGO-ALTER EGO) GAME

Goal: To promote practical skills in constructing teaching-learning modules
Method: Small group exercise (brainstorming)
Time: Unlimited
Materials: None
Procedure:

Step 1: Specify a target group of trainees (potential or selected case workers) for whom a specific communication training program seems needed in their work with trafficked persons.

Step 2: Specify a limited range of theoretical issues the trainees are supposed to learn (or refresh) from previous personal or professional knowledge of effective communication.

Step3: Specify in detail, what communication skills you want to transfer to your trainees (e.g. "How to establish rapport?", "How to observe?" or "How to ask questions?)

Step 4: Specify the learning goals in detail ("What trainees should know by the end of training?)

Step 5: Define the didactic tools, settings, and concrete teaching-learning activities for the workshop (classroom), including specification of teaching staff (e.g. group facilitators, video materials, workbooks)

Step 6: Plan and organise an independent small group exercise in communication with persons and/or target groups of trafficked persons in different (virtual) settings.

Step 7: Role play of selected small group exercises in interviewing (in front of audience and expert observers/mentors).

Discussion: Plenary session

EXERCISE 4.1-9. PLANNING OF A TRAINING MODULE FOR EFFECTIVE COMMUNICATION

Goal: To promote practical skills in constructing teaching-learning modules
Method: Small group exercise (brainstorming)
Time: Unlimited
Materials: None
Procedure:

Step 1: Specify a target group of trainees (potential or selected case workers) for whom a specific communication training program seems needed in their work with trafficked persons.

Step 2: Specify a limited range of theoretical issues the trainees are supposed to learn (or refresh) from previous personal or professional knowledge of effective communication.

Step3: Specify in detail, what communication skills you want to transfer to your trainees (e.g. "How to establish rapport?", "How to observe?" or "How to ask questions?)

Step 4: Specify the learning goals in detail ("What trainees should know by the end of training?)

Step 5: Define the didactic tools, settings, and concrete teaching-learning activities for the workshop (classroom), including specification of teaching staff (e.g. group facilitators, video materials, workbooks)

Step 6: Plan and organise an independent small group exercise in communication with persons and/or target groups of trafficked persons in different (virtual) settings.

Step 7: Role play of selected small group exercises in interviewing (in front of audience and expert observers/mentors).

Discussion: Plenary session

APPENDIX II

SMALL GROUP EXERCISES - ASSESSMENT AND INTERVENTION

EXERCISE 4.2-1 A MODEL EXERCISE IN PROBLEM-SOLVING

Goal:	To learn strategies of creative problem-solving (CPS)
Method:	Exercise in pairs (interviewing)
Materials needed:	Show cards (one/participant)
Time:	90 min.
Procedure:	

Step 1: Start with a warm up exercise in pairs. Self-selected (or matched) pairs of participants should share their thoughts on a wishful statement (displayed on a large transparent): *"A place I would like to reach or go back to..."* The pairs must make an effort to open-up to each other as if they were "twins", i.e. taking the role of "Ego – Alter Ego".

Step 2: The large group comes together, and they disclose the "imaginary journey" such that each member tells the other person's comments (his/her "twin" brother or sister).

Step 3: The facilitator reads the following episode from the life story of a trafficked woman (optional):

"I was delivered to one of the houses near the forest. The employer told me that here I will have to sell my body. I was very scared and I started crying. They confined me in a room for one week. Every day they beat me and forced me to accept the job. The second week I could not bear the pain any more and I agreed to accept the client. Anyway, after eight days of torture, I thought I will accept the job to save my life. I hoped that I might be able to seek help from the client. But every time when I told my story and asked for help the clients told the employer and I was beaten harder and harder. So I accepted my fate. (Ani, Laos to Thailand)

Step 4: Problem statement displayed on a large transparent:

"If you were Ani or one of her first interviewers (at a Transit Centre), how would you manage your first interview?

Step 5: The pairs continue working on the following task (30 min). One member plays the role of *Ani*, and the other member plays the role of her "first interviewer". Each of them gets one of the following cards with the message (random assignment).

ANI

You suspect that your traffickers are after you right now, and this "interviewer" is one of them making an attempt for your re-trafficking. How will you take this interview?

INTERVIWER

You got the task to build trust and confidence with Ani, and gather some information regarding her plans and perspectives for further life. How will you take this interview?

Step 6: The two main groups of participants, i.e. "the Ani's" as one group, and "the Interviewers" as the other, get together and share their experiences from the interviewing role-play.

Discussion after: Optional

EXERCISE 4.2-2 "WHO" IS RESPONSIBLE FOR PSYCHOLOGICAL TESTING – AND "HOW"?

Goal: To learn and critically discuss ethical standards in assessment and intervention
Method: Small group discussion
Materials needed: Show card (see below)
Time: 45 min.
Procedure:

The facilitator displays a list of a selected APA Ethical Standards for Evaluation, Assessment, and Intervention for Psychologists (see Show Card). S/he divides the large group into four groups (mixed professional and national backgrounds), and asks each group to critically discuss (reflect upon) the principles listed, and how they are implemented in their own practice (in countries and institutions), if at all. After 30 min., a forum is held and each group reports their major conclusions and experiences gained regarding the information exchange.

SHOW CARD: APA's Ethnical Code for Evaluation, Assessment, and Intervention for Psychologists (1992). Section 2. Standards 2.1 – 2.10. (Excerpt)

1. *Evaluation, diagnosis, and intervention in professional context. Psychologists perform evaluation, diagnostic services, or interventions only within the context of a defined professional relationship.*
2. *Competence and appropriate use of assessments and intervention. Psychologists who develop, administer, score, interpret, or use psychological assessment techniques, interviews, tests, or instruments do so in a manner and for a purpose that are appropriate in light of the research on or evidence of the usefulness and proper application of the techniques.*
3. *Test construction. Psychologists who develop and conduct research (assessment) with tests and other assessment techniques use scientific procedures and current professional knowledge for test design, standardisation, validation, reduction or elimination of bias, and recommendation for use.*
4. *Use of assessment in general and with special populations. (a) Psychologists who perform interventions or administer, score, interpret, or use assessment techniques are familiar with the reliability, validation, and related standards or outcome studies of, and proper applications and use of, the techniques they use. (…) Psychologists attempt to identify situations in which particular interventions or assessment techniques or norms may not be applicable or may require adjustment in administration or interpretation because of factors such as individuals' gender, age, race, ethnicity, national origin, religion, sexual orientation, disability, language or socio-economic status.*
5. *Interpreting assessment results. When interpreting assessment results, including automated interpretations, psychologists take into account the various test factors and characteristics of the person being assessed that might affect psychologists' judgements or reduce accuracy of their interpretation. They indicate any significant reservation they have about the accuracy or limitations of their interpretation.*
6. *Unqualified persons. Psychologists do not promote the use of psychological assessment techniques by unqualified persons.*
7. *Obsolete tests and outdated test results. Psychologists do not base their assessment or intervention decision or recommendations on data or tests results that are outdated for the current purpose.*
8. *Test scoring and interpretation services. Psychologists who offer assessment or scoring procedures to other professionals accurately describe the purpose, the norms, validity, reliability, and applications of the procedure and any qualifications applicable to their use.*
9. *Explaining assessment results. Unless the nature of the relationship is clearly explained to the person being assessed in advance and precludes provision of an explanation of the results (…), psychologists ensure that an explanation of the results is provided using language that is reasonably understandable to the person assessed or to another legally authorised person on the behalf of the client. Regardless of whether scoring and interpretation are done by the psychologist, or by automated or other outer services, psychologists take reasonable steps to ensure that appropriate explanations of results are given.*
10. *Maintaining security. Psychologists make reasonable efforts to maintain the integrity and security of tests and other assessment techniques consistent with law, contractual obligations, and in a manner that permits compliance with the requirements of this Ethics Code.*

Source: New APA "Ethical Principles of Psychologists and Code of Conduct," adopted by the Council of Representatives. The Code went into effect on December 1, 1992. American Psychologist, December 1992.

EXERCISE 4.2-3 BRAINSTORMING ON "BALANCING" BETWEEN YOURSELF AND YOUR ENVIRONMENT

Goal:	To learn and critically discuss some ethical standards in assessment and intervention
Method:	Small-group "brainstorming" session (5 persons per group)
Materials needed:	None (except for paper and pencil for note-taking by one member of the group)
Time:	30 min.

Procedure:

The facilitator introduces this exercise as a simple, straightforward brainstorming session on the value of "balancing" between personal needs, aspiration and (felt) capacities, on the one hand, and one's environmental factors regarding expectations (of others), opportunities and available resources, on the other. The group has the task of producing as many "ideas" regarding personal needs and listing as many environmental factors in their day-to-day lives as they can, in the time frame of 15 min. The only lead provided for the session is the visual presentation of "balancing" from the main body text of the Module (see Figure 4-2-2). The facilitator explains the following general rules for brainstorming sessions, which have to be respected:

1) *The quantity of ideas produced is what is important, and not the quality of ideas or rhetoric ("wild" ideas are welcome).*
2) *Speak about yourself rather than "others" (whoever they may be).*
3) *Long speeches, rhetoric and lengthy elaboration should be discouraged.*
4) *All and any evaluation has to be ruled out (criticism of self and/ others has no place).*
5) *"Hitch-hiking" on others' ideas and stream of thoughts and feelings should be encouraged (principle of 'group-think').*
6) *There should be no interruption of other participants in self-disclosure (within reasonable time; 1-2 mins per disclosure),*
7) *Let others have an equal opportunity for self-expression ("don't be selfish in holding a speech"),*
8) *One person has to take notes of what has been said (note-taker),*
9) *Report back to the large group (after 15 min of brainstorming).*

EXERCISE 4.2-4 EXERCISE IN CREATING NURSING DIAGNOSIS

Goal:	To learn and critically discuss assessment tasks involved in nursing diagnosis
Method:	Small-group "brainstorming" session (5 persons per group)
Materials needed:	Fact sheet with a selected nursing diagnosis (Didactic Supplement).
Time:	120 min.

Procedure:

Step 1: The group splits into small groups of 5-7 persons (preferably the same from Exercise 4 – 2.3).

Step 2: The facilitator explains the major constituent elements of nursing diagnosis, by using the didactic example (Fact Sheet).

Step 3: Each group selects one of the following major Nursing Diagnostic Categories (NANDA Approved, 1988), and works on a specific problem selected optionally:

Pattern 1: Exchanging *(including, altered nutrition, constipation, diarrhoea, stress incontinence, ineffective breathing pattern, etc.),*

Pattern 2: Communication *(impaired verbal and/or non-verbal communication),*

Pattern 3: Relating *(including impaired social interaction, social isolation, sexual dysfunction, altered family processes, etc.),*

Pattern 4: Valuing *(including spiritual distress, identity crisis, distrust in others, value confusion such as anomie, etc.)*

Pattern 5: Choosing and decision-making *(including ineffective individual coping, defensive coping, denial, ineffective family coping etc.),*

Pattern 6: Moving *(including impaired physical mobility, activity intolerance, fatigue, sleep pattern disturbance, etc.),*

Pattern 7: Perceiving *(including body image disturbance, self-esteem disturbance, chronic low self-esteem, hopelessness, etc.)*

Pattern 8: Knowing *(including knowledge deficit, disorientation in time-and-space, altered thought processes, etc.),*

Pattern 9: Feeling *(including pain, dysfunctional grieving, potential for violence, suicidal plans, post-trauma response, anxiety, fear etc.)*

Step 4: The groups are given 60 minutes to work on a single selected nursing diagnosis, preferably a mental health problem "typical" for trafficked persons (either adults or minors). In this process the use of a Handbook of Nursing Diagnosis or pre-prepared case-reports is not permitted. The exercise should follow the standards and rules of a brainstorming exercise (see Exercise 4- 4.3, above) rather than following the standards and atmosphere of an "academic" testing.

Step 5: The facilitator arranges a Forum Discussion (60 min) that should focus on evaluation of group achievements (checked on the basis of available Manuals).

FACT SHEET (DIDACTIC SUPPLEMENT)

Nursing Diagnosis
Post-trauma Response
Rape Trauma Syndrome
Definition: *Post-trauma Response:* The state in which an individual experiences a sustained painful response to (an) overwhelming traumatic event(s) that has (have) not been assimilated.

Defining Characteristics

Major (Must Be Present)
- Re-experience of the traumatic event, which may be identified in cognitive, affective, and/or sensory-motor activities such as:
  - — Flashbacks, intrusive thoughts
  - — Repetitive dreams/nightmares
  - — Excessive verbalisation of traumatic events
  - — Survival guilt or guilt about behaviour required for survival
  - — Painful emotion, self-blame, shame, or sadness
  - — Vulnerability or helplessness, anxiety, or panic
  - — Fear of
    - Repetition
    - Death
    - Loss of bodily control
  - — Anger outburst/rage, startle reaction
  - — Hyperalertness or hypervigilance

Minor (May Be Present)
- Psychic/emotional numbness:
  - — Impaired interpretation of reality, impaired memory
  - — Confusion, dissociation, or amnesia
  - — Vagueness about traumatic event
  - — Narrowed attention, or inattention/daze
  - — Feeling of numbness, constricted affect
  - — Feeling detached/alienated
  - — Reduced interest in significant activities
  - — Rigid role-adherence or stereotyped behaviour
- Altered life-style
  - — Submissiveness, passiveness, or dependency
  - — Self-destructiveness (alcohol/drug abuse, suicide attempts, reckless driving, illegal activities, etc.)
  - — Difficulty with interpersonal relationships
  - — Developing of phobia regarding trauma
  - — Avoidance of situations or activities that arouse recollection of the trauma
  - — Social isolation/withdrawal, negative self-concept
  - — Sleep disturbances/emotional disturbances
  - — Irritability, poor impulse control, or explosiveness
  - — Loss of faith in people or the world/feeling of meaninglessness in life
  - — Chronic anxiety or/and chronic depression
  - — Somatic preoccupation/multiple physiological symptoms

Etiological, Contributing, Risk Factors
- Situational (Personal, Environmental)
  - — Traumatic events of natural origin (including floods, earthquakes, storms, avalanches etc.)
  - — Traumatic events of human origin (including wars, airplane crashes, serious car accidents, torture, etc.).

Source: Carpentino (1989:116-118).

EXERCISE 4.2-5 AN EXERCISE IN CONVERGENT INTERVIEWING IN ACUTE CRISIS SITUATIONS

Goal:	To learn from others how they felt, what they thought and did in an acute crisis.
Method:	Convergent interviewing. A technique for qualitative data collection
Materials needed:	Memo (A reminder for back-reporting)
Time:	60 min.
Procedure:	

Step 1: The facilitator explains the basic rationale for convergent interviewing (encounter of interviewee and two interviewers) that combines some of the features of structured and unstructured interviews, and uses a systematic process to refine the information collected. The presence of two interviewers (one Interviewer and one Observer) makes the technique utmost useful for collecting data in emergency situations, both for safety issues and many other reasons.

Step 2: The group splits in small groups of three. Upon consent, the interviewing process takes three rounds. In each of the rounds one person takes the role of a "person in crisis", and the other two, the interviewer + observer role. The crisis situations selected are left optional (personal crisis, family crisis, accident etc.).

Step 3: Stage-setting. The protagonist (person in crisis) must enact a behaviour pattern characteristic to him/herself when in acute distress. The interviewers (emergence case workers) arrive to the scene and first try to put the person at ease. When contact/co-operation has been established (with element of rapport), the interviewer asks a simple, broad question. The ground principle is to keep the informant talking as long as possible, by using a full range of interventive questions. The interrogation should, however, end the very moment, that the informant signals "Enough! I would like you to stop questioning me at this very moment."

Step 4: The exercise continues with shifting the roles. Each member of the group should take different roles in the exercise (10 min each), which amounts to 30 min of time spent for role playing.

Step 5: Back-reporting to the forum (see Memo, below). Each team has to report back at least one "case" of the crisis interview (optional selection) as the "best" illustration of how a crisis interview/intervention worked out for them. The following elements should be included in reporting:

MEMO FOR CASE REPORTING:

1) *Description of the situation.*
2) *Description of observed (manifest) signs and symptoms of the person "in crisis"*
3) *Assessment of major factors and events conducive to the acute crisis situation, and "cry for help".*
4) *Major intervention strategies and techniques actually implemented (used) in the given situation.*
5) *Specific safety protection and/or health promotion activities undertaken.*
6) *Early (medical or nursing) diagnosis set, and prompt intervention undertaken (psychological debriefing, referral or else).*

EXERCISE 4.2-6 CRITICAL EVALUATION OF TOOLS AND TECHNIQUES YOU USE IN PRACTICE

Goal:	To facilitate sharing of professional experiences
Method:	Home work
Materials needed:	None
Time:	60 min.
Procedure:	
Participants are requested to prepare a report on most commonly used assessment tools, techniques and monitoring (evaluation) procedures used in their professional practice.	
Discussion:	Forum (or small group discussion)